UPDATE!

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Message From The Chair: My Final Message

Alden Roberts, MD, MMM, FACS

As my second year-long term as WMC chair draws to a close, this will be my final Message from the Chair. Regulatory work is different from clinical work in one major way; clinical work seeks to provide the best care possible for each patient, while regulatory work tries to define what constitutes minimally acceptable care for any patient.

Clinical Care vs Regulatory Management

Optimal clinical care is both protocol-driven and patient specific. A clinician's obligation is generally accepted to be first to the patient and their family, second to their organization (including a solo practice organization), third to the payers and finally to society at large. I would argue, based on disaster management lessons, that a clinician's first obligation should be to themselves and those who provide care, because without us there is no one to provide care. Regulatory management is driven by the legal process under which it was created. We are accountable to the governor and the legislature, to the public at large, and to the physicians and PAs that we regulate.

The Dilemma

Things happen. Patients, or the families of patients, have been hurt or perceive that they have been hurt. They want something done. The public hears simplified stories of highly complex situations. About 75% of the US population view medical practitioners favorably, but it isn't clear that it is humanly possible to meet their expectations. At the heart of medical care are those to whom licensure and regulation apply. They are the highly educated, well trained, caring, ethical, and very smart human beings called Physicians and Physician Assistants. On the one hand, no matter how well trained, caring or educated we may be, we are still just human beings. We have good days. We have bad days. We will make mistakes. We will not meet expectations. A member of the public, a legislator, a governor, an attorney, and even some of our peers demand regulation to fix these problems, but no matter how rigid our rules, we cannot regulate or legislate away bad days or

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Promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rulemaking, and education.

mistakes. You cannot improve my memory by legislating that I not forget.

Trying to do so produces a number of undesirable results. First, mistakes get hidden, and therefore are likely to be repeated both by the individual who made the mistake and by clinicians at large.

Second, no amount of punishment meted out by a regulatory agency can approach the agony that a highly ethical group of people generally inflict upon themselves when someone they have cared for is harmed at their hands. The addition of a disciplinary act runs the risk of advancing physician burn-out and could act as a catalyst for action in someone who is suicidal. A disciplinary act often has unintended consequences, including loss of board certification, loss of job, decreased mobility, rejection from insurance panels, and more. These unintended consequences serve the public poorly and undermine the WMC mission of promoting patient safety and the integrity of the profession.

A disciplinary act often has unintended consequences, including loss of board certification, loss of job, decreased mobility, rejection from insurance panels, and more.

On the other hand, no matter how well trained or educated we may be, we are still just human beings. We hide mistakes from patients for fear of litigation, we do things for which we aren't trained well enough or aren't technically skilled enough, or simply don't do them often enough, to be good enough to do. We rationalize mistakes as being the inevitable risk of medical care, we don't pay attention to what we are doing because we do it every day and we forget that we are dealing with people's lives, we are defensive and refuse to take accountability for outcomes for which we are responsible. We don't participate in patient safety initiatives as simple as washing our hands, we get into habits that put patients at risk. We disrupt teams, we behave in ways that put patients and staff at risk, or drive other professionals away. We have egos that interfere with care, we are hard headed, we think we can't be wrong. We treat people differently from how we would want to be treated. We fall to the foibles of power and compensation without assuming the responsibility of compassion and service. We don't keep up. The public expects a regulatory agency to fix these problems, and these are, in fact, areas in which regulation may be effective to some degree.

Third, no matter how well trained or educated we may be, we are still just human beings. In providing medical care, we are put into a highly complex system that is constantly changing. Medical care is based on innumerable systems and organizational processes run by the actions and interactions of a host of people, all of whom have different training, education, and responsibilities. These systems, because of their complexity, have traps which sooner or later will produce patient harm. The system is designed, albeit unintentionally, in such a way that harm is inevitable. If the steps in the system are not evaluated and changed, that harm will occur again. "Every system is designed to produce exactly the results that it achieves" (Paul Batalden, IHI). Regulation has a limited role here. The clinician is technically responsible for the outcome, the outcome was technically avoidable, but it was going to happen sooner or later. That doesn't mean we can turn our back on what happened, nor that we can assume total responsibility because it was me that made the mistake - instead of you. It means we need to find the time, somehow, to work with others to fix the problem. The public would expect us to help fix the problem, if they are willing to look at why this happened instead of who did it. If you look at yourself as a future patient, YOU would want the system fixed before you need to use it. Where does regulation work here? I believe we have a requirement to assure that the clinician helps, or attempts to help, to fix these sorts of problems.

Finally, no matter how well trained or educated we may be, we are still just human beings. Some of us will commit criminal, ethical or moral offenses. A regulatory agency must step in to stop such conduct. Some of us will develop substance use disorder (SUD). This need not be managed by the regulatory agency if a practitioner health program (PHP) exists that will certify when a practitioner is safe to practice; but the regulatory agency must step in when the PHP is unable to certify that a practitioner is safe to practice. SUD is managed this way in our state.

What's next?

As the outgoing chair, where do I think that the WMC should be headed? How should we address what we ought to manage, and avoid those things which we ought not manage? As in clinical medicine, this is an ongoing process. It is a learning process. The WMC, as it exists now, is a multidisciplinary peer review group that includes public members and has access to specialists in all medical specialties. Our actions are both sanctioned and limited by WA state law. In the six years that I have

Message From the Chair

been on the commission and for the two years that I have been chair, I have seen a significant movement towards adherence to both patient safety and just culture theory. We are attempting to develop processes using highly reliable organization theory, and the staff are using Lean methodology to direct process improvement. We have expressed opinions and concerns regarding potential legislative actions and done our best to develop reasonable rules. We need to continue process improvement in these areas. But change in a regulatory agency, as in clinical medicine, isn't instant. We may need buy-in from across multiple regulatory agencies for consistency in medical care. We must adhere to the legal system, and we may need statutory changes to achieve a desired result. As in clinical medicine, ideas need to be tested and accepted or rejected, and we need data that we don't currently have to evaluate outcomes. To assess our performance and to generate improvements in how we function, we need input from our constituents. We need to develop closer working relationships with professional organizations. We are looking for better ways to communicate with physicians and PAs in everything we do, beginning with who we are, what we do, and the management of an investigation through the development of regulatory requirements in response to legislative mandates. We are working on a process to significantly improve respondent communication when we receive a complaint. We need a better way to work with public organizations and patient safety groups, the legislature, the governor, and other regulatory agencies in medical care. All are lofty goals without clear answers, and we are open to suggestion. What the WMC hopes for from our medical constituents is the development of, and engagement in, patient safety improvements at their clinics and institutions, the improvement of local peer review processes, and involvement in quality improvement projects. All things that require time that physicians and PAs don't have, but are the best routes currently available with which to improve patient care. Take a moment to look into Communication and Resolution Program (CRP) of the Foundation for Health Care Quality and Washington State Safety Coalition to see if this can be brought to your institution.

In contemplating what WMC should do next, I should explain who we are. The WMC staff with whom I work are all highly skilled, caring people who manage a constantly changing group of commissioners and set of legal requirements in a never-ending effort to advance the WMC mission. They don't just attend national licensure and regulatory conferences, they lead them. I have been to Federation of State Medical Boards (FSMB) and Council on Licensure, Enforcement and Regulation (CLEAR) and I am proud of the reputation of the WMC as being a national leader in licensing and regulation. The Commissioners with whom I have worked are intelligent, caring, and relentlessly working to improve both their own performance and the performance of the WMC. They essentially donate their time in an effort to improve medical care for the state of Washington. I have learned more about medical care from them than by any other mechanism since my residency.

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Being chair of the WMC has been an incredibly rewarding and humbling experience. I am grateful to the Commissioners for having elected me to this position twice. I'd like to thank all the amazing WMC staff with whom I have worked closely these last two years. I'd also like specifically to thank Dr. Bundy and the staff at WPHP, whose work is the by far the most successful mechanism to safely return impaired physicians and PAs to practice and to safely keep them in practice. This provides a huge benefit the public, to the individual physician or PA, and to the physician/PA community at large. Mostly, I'd like to thank you, the physicians and PAs across the state of Washington, for the care and excellence that you provide on a daily basis, and have continued to provide during the chaos of this pandemic. Our state is indeed fortunate to have you as a resource providing as good or better medical care as is provided anywhere in the United States.

Thank you.

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News and Announcements

Rules and Regulations In Progress

Frequently Asked Questions (FAQ)

Contact Us

Racism in All Its Forms is a Public Health Issue

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The leadership of the WA State Medical Commission (WMC) joins other medical organizations in condemning acts of racism, such as the death of George Floyd. There is no shortage of examples of cultural systems and structures that act to suppress our citizens who are Black, Indigenous, and People of Color. We recognize and deplore this fact. As we know, racism is not limited to interactions with police, it also causes bias in hiring practices, educational opportunities, employment, housing opportunities and, closest to home for us, in interactions and experiences with the medical community.

The problem is systemic; it is not limited to "a few bad apples". Racism is without question an issue of public health and patient safety. The current, constitutionally protected, protests are manifestations of long-term prioritization of white lives over black lives. We can never fully understand the pain, frustration and anger of the Black community, but we support the protest principles. We must, as a society, recognize, understand and work zealously to eliminate systemic racism in our culture and in medical care specifically. As the ultimate arbiter of medical practice in Washington state, the WMC must go beyond mere lip service or token actions in confronting racism.

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Studies show disparate representation in the health profession and disparate health outcomes for Black, Indigenous, and People of Color. While 4.15% of our state's population and 7.3% of medical graduates are Black, only 2.2% of our MD licensees and 2.0% PA licensees are Black. We are short at least 730 Black MDs and PAs if we are to mirror the demographics of the Washington state. It is incumbent upon the WMC to understand and correct this inequity.

While it is understandable to focus on racially directed police brutality, we must apply that same passion for change to many health care issues, like maternal mortality rates. African American women are four times more likely to suffer from maternal mortality than Caucasian women. Similar statistics exist for breast cancer, heart disease, practitioner assessment of pain perception in black patients, and other disease processes.

The causes of these inequities need to be identified and remedied.

Shameful past public health events such as the Tuskegee experiments, the experimentation done by James Marion Sims on slave women prior to providing his "cure" to white women, or the dubious consent history of Henrietta Lacks has historically undermined trust in the health care system for the Black, Indigenous, and People of Color communities. If we are to have a health system that is equitable, with meaningful outcomes for all, we must collectively act to restore this trust.

Within the WMC, we have taken steps to minimize implicit bias when evaluating applicants for licensure and we are taking steps to minimize the effect of implicit bias in disciplinary actions. We recognize that this is not enough. We recognize that we do not possess sufficient knowledge to know the best way forward. We commit to educating ourselves, and to listening with humility, to those affected by the inequalities of our systems and practices. We commit to continue making changes to achieve equality.

As media coverage of these protests subside, we must not lose sight of the principles we have seen expressed in the protests. We can start with the following key steps:

1. Accept that there is a problem.
2. Acknowledge our role in continuing the systems that produce these outcomes.
3. Use our position and privilege to change the systems to serve all people.
4. As with medical error, we should recognize and apologize when our efforts to effect positive change do not have the desired impacts.

As those entrusted to operate and govern our statutorily authorized medical regulatory system, we can and must do more to achieve human equality in all its facets. We will provide regular updates in this newsletter detailing our plans and actions taken to achieve this goal, the first of which will be in the next edition.

For the partner organizations who quickly and publicly voiced their support, we ask that you turn those words into action, help us change the house of medicine as a whole, and to help us see our blind spots. Perhaps most importantly, to our citizens and licensees of color, we want to hear from you (Medical.Commission@WMC.wa.gov) and we commit to listening to your voice and feedback as we move to create a better future.

Signed,
WMC Executive Committee

Alden Roberts, MD, WMC Chair / John Maldon, 1st Vice Chair / Claire Trescott 2nd Vice Chair / Karen Domino, MD
Warren Howe, MD / Melanie de Leon, JD / Micah Matthews / Heather Carter, JD

Executive Director Report: Licensing Process Update

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Melanie de Leon, JD, MPA

Executive Director

In the winter edition of *Update!* I highlighted some goals we were working on to streamline the licensing process for both renewal and initial applications and we have accomplished many of those goals! While we are still working to update our technology ("the system") we have been able to streamline the process for both renewal and initial license applicants.

The renewal application **-** We removed personal data questions from the renewal application and applications can now be processed and approved in 24 hours.

Initial license application – The Commission approved updating the initial application in the following ways:

- Added a "X" gender option.
- Removed the requirement for actual transcripts and will rely on the information provided by the American Medical Association (AMA) and Federation of State Medical Boards (FSMB) regarding education.
- Reduced the work history documentation requirement to 7 years, with a need to explain gaps of 90 days versus 30 days of employment.
- Removed the requirement to provide information on other state licenses or hospital privileges. Again we will rely on the information from the FSMB, National Practitioner Data Bank (NPDB) and AMA.
- Removed the AIDS education and training attestation.
- Removed the requirement to submit a photograph.

While we are working remotely our ability to implement changes to the initial application may take some time, but we hope the revised version will go live by mid-summer.

All licenses due to expire between April and September 2020 have been automatically renewed in response to the COVID – 19 pandemic and renewal fees are not due until 1 October 2020 for those renewals.

We are continuing to work on streamlining our internal review process to reduce timelines even more and to be able to provide you with real-time status updates or some self-service capabilities.

2020 WMC Conference Update

Due to the ongoing COVID-19 pandemic and uncertainty for the future, we have made the difficult decision to cancel this year's conference. In order to still provide you with educational opportunities, the WMC is launching a webinar series with a variety of subject matter experts, topics and continuing education.

Potential topics include:

- Forging a path toward healthcare equity
- COVID-19 Lessons Learned and Updates
- Telemedicine Implementation
- Opioids in Washington
- The Data Driven Physician
- Legislative Updates
- Urban Homeless Health Needs
- LGBTQ+ healthcare report and recommendations

We are looking for your feedback on topics and times that would fit within your interest and schedule. Please take five minutes to complete this survey on your time preference and desired topics.

PA News: COVID Effect

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Theresa Schimmels, PA-C
Physician Assistant Member

I'm sure you've read the headlines recently about Physician Assistants and other medical professionals being furloughed, laid off or just plain let go. For those of us (most of us!) that keep up with the news they were hard to miss.

"Thousands of physician assistants furloughed during coronavirus outbreak"

"Vital' American Academy of Physician Assistants survey outlines coronavirus struggles: A lack of PPE, furloughs and burnout"

"During a Pandemic, an Unanticipated Problem: Out-of-Work Health Workers"

"UW Medicine furloughs 1,500 staffers, with more on the table"

The so called "COVID Effect" on medicine has been astounding. We have had to save the limited supply of PPE for the folks that needed it the most; those caring for the sickest in COVID wards, ER's, and ICU's. The closure of our economy and pandemic isolation has caused a halt of elective procedures in all medical specialties and general medicine. Less procedures = less revenue = less need for workers. People just plain ol' stayed away from hospitals and clinics to avoid contamination.

And we wanted to stay away, too. Medical provider mortality and illness rates from COVID are in tragically high numbers. Due to lack of PPE and initially not understanding what this particular coronavirus does to the human body, possibly even underestimating its effect. First it's ARDS, then it's autoimmune, then it's vascular, and finding out it's, possibly, all of the above made healthcare environments more dangerous than most of us had ever experienced. Moving to telemedicine/video visits/telephone visits has taken off in the way it probably should have years ago, especially with the rural populations of America and in our lovely state of Washington. Yet, many of us remain unemployed or with hours cut. In surge areas, providers are working their tails off to keep up with the needs of their communities, exhausted beyond imagination. I think we all know a few of those folks.

About a month ago, the Society of Dermatology Physician Assistants put together a panel of dermatology PAs to discuss moving out of our specialty and into COVID response. I was honored to be with three other PAs that have moved laterally into general or acute care medicine as surge response to the pandemic. Two of the panelists were currently furloughed or laid off from their dermatology positions and contracted to provide hospital care in the hard hit areas of New York and New Jersey. The third moved into a busier role within a local hospital organization outside of her regular clinic. I volunteered to join the employee health department at my institution helping with COVID-19 screening and, to a lesser degree, tracking.

The closure of our economy and pandemic isolation has caused a halt of elective procedures in all medical specialties and general medicine.

Here's the thing, physician assistants, and physicians as well, are generalists. We may specialize but we still are required to have overall knowledge of all areas of medicine when we start out.

For the younger, newer colleagues, jumping back into primary care is like being in class or preceptorships again. For those of us that have practiced for many years, it's a little more difficult. Yet we have shown the ability to dust off textbooks and acquaint ourselves with websites, pandemic or critical care CME, and engage colleagues who are willing to fill a vacant position, to fill a need.

I know many of you, both physicians and physician assistants, are struggling. We, medical providers, are a hearty breed, resilient in the face of tragedy, disaster, and now pandemic. Find your safe place. Breath. Visit with social distancing or via the multiple video chat apps. Walk, exercise, rest. Eat good food and don't forget a treat once in a while. Retrain and/or relearn. Continue to learn! Support each other. Support your family, and I don't mean financially. Support your community, both civic and medical. And don't forget to wear your mask and wash your hands. In this uncertain time, take care!

For on articles for job and self-care support during this time go to:

AAPA COVID-19 resource center

COVID-19: Where Doctors Can Get Help for Emotional Distress

Proclamation by the Governor: Healthcare Worker Licensing

Is Tramadol an Opioid or a Nonopioid Analgesic? Yes!

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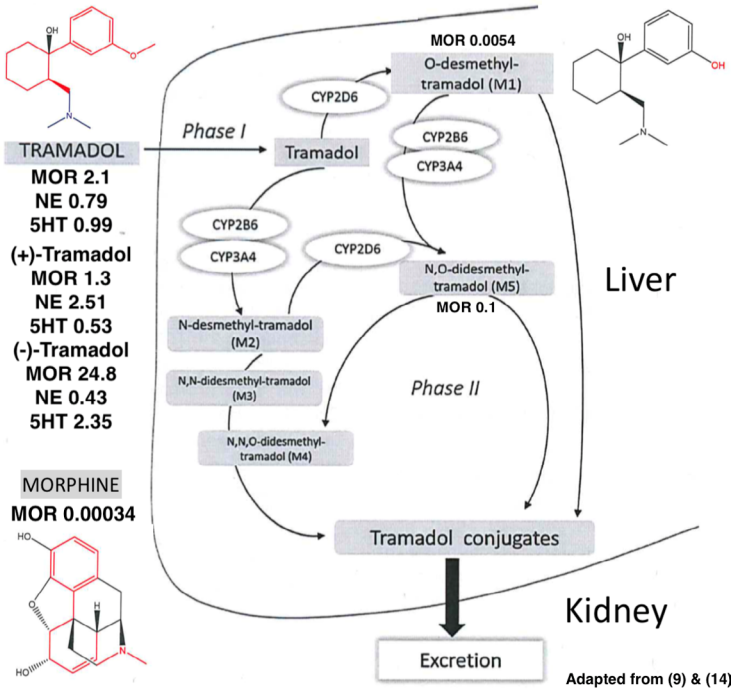
Gregory Terman, MD
Pro Tem Member

I was sitting in a national conference a few years ago when a prominent pharmacist stood up to speak and talked about the ravages of prescription opioids in the United States. He stated that if anyone in his family ever needed pain medications he would never allow them to have opioids. "They would get Tylenol, Toradol and Tramadol". I was shocked that this respected clinical pharmacologist thought that tramadol was not an opioid. He is not alone. When discussing the dangers of opioids, the tramadol "nonopioid" alternative comes up again and again with students, colleagues and even authors in highly respected medical journals [1, 2, 3]. Tramadol is now available in more than 100 countries and is the most commonly prescribed opioid worldwide [4]. In the US, tramadol prescriptions more than doubled between 2007 and 2015, becoming the second most prescribed opioid. Is it possible that the primary care, and particularly nonphysician, prescribers [5] responsible for the increase in tramadol prescribing in the midst of the "opioid epidemic" are prescribing more tramadol because they don't think tramadol is an opioid? If so, it is important to note that data on opioid use after surgery [6] shows that tramadol is at least as likely as other opioids to be continued long-term; a surrogate measure [7] for abuse and overdose. Indeed, according to the Drug Abuse Warning Network, there was a 250% increase in emergency department visits involving misuse or abuse of tramadol between 2005 and 2011 [8]. In this article I will look at the pharmacology of tramadol with an emphasis on distinguishing its opioid and nonopioid properties.

Regulatory Confusion

Grunenthal first synthesized 2-[(dimethyl amino)-methyl]-1-(3-methoxyphenyl)-cyclo-hexanol in Germany in 1962 and marketed the drug there as tramadol in 1977. It was not until 1995 that the US FDA approved tramadol as a "prescription only" non-controlled substance. Both an immediate release and extended release oral formulation are available in the US. In 2014, the drug was reclassified as Schedule IV; a nod to its abuse potential although still not in the Schedule II category occupied by most opioid analgesics. As a result, tramadol is included today in all state prescription drug monitoring programs (PDMPs) nationwide.

Figure 1 - Schematic of tramadol metabolism pathway. Numbers are Ki affinity constants in micromoles for mu opioid receptor (MOR) binding (morphine shown for comparison) or norepinephrine (NE) or serotonin (5HT) reuptake inhibition.



Pro-drug Pharmacology

Tramadol differs from most other opioids in that it is a prodrug, meaning that the drug itself has very limited affinity at the mu opioid receptor (MOR)[9] (Figure 1). Tramadol is marketed as a racemic mixture of (+) and (-) enantiomers. The (+) configuration has 20 times more MOR affinity than the (-) configuration, though still several thousand times less than morphine. On the other hand, the M1 tramadol metabolite (O-desmethyltramadol) has a MOR affinity only 10 times less than morphine [9] and is probably the mechanism by which tramadol has most of its opioid effect. Thus, it is not tramadol, but it's metabolite, that is most responsible for the drug's opioid analgesic effect. Still, no one would argue that codeine, another pro-drug (metabolized to morphine), is not an opioid. Indeed, like codeine, the opioid effects of tramadol are greatly affected by the pharmacogenetics of the cytochrome P-450 enzyme 2D6 (CYP2D6) which selectively metabolizes tramadol to M1. People with genetic polymorphisms reducing the activity of CYP2D6 ("poor metabolizers"), including 20% of African Americans, 10% of Caucasians and 2% of Asians, will lack significant opioid effect from tramadol [10, 11].

Nonopioid Analgesic Mechanisms

Tramadol's monoaminergic reuptake blocking activity, causing increases in synaptic norepinephrine (NE) and serotonin (5HT) both *in vitro* and *in vivo* [9], has been highly publicized. Interestingly, tramadol's isomeric differences in MOR affinity

are also seen in its monoaminergic reuptake blocking effects. With the (+) enantiomer (the superior opioid agonist configuration) blocking 5HT uptake more effectively. While the (-) enantiomer blocks NE reuptake more effectively (Figure 1). Increases in NE are well known to mediate endogenous pain inhibitory systems and are responsible for the analgesic effects of SNRI and TCA antidepressants [12] whereas analgesic effects of increases in CNS 5HT are more controversial [12]. Some of tramadol's analgesic effects therefore are due to its increasing synaptic NE where it acts on alpha2 adrenergic receptors [9] completely independent from MOR [13]. Tapentadol, a second dual action (opioid/NE) analgesic (with reduced 5HT reuptake inhibition and no opioid pro-drug activity), was approved by the FDA in 2008 [14].

Side Effect Profile

Tramadol's multi-modal analgesic effects would be expected to reduce opioid needs and thus opioid side effects compared to other opioids. For example, early reports suggested that tramadol, produced less drug reinforcement and respiratory depression in primates [9]. However, like tramadol's opioid analgesic effects, its opioid side effects are also determined by CYP2D6 pharmacogenetics. People with CYP2D6 polymorphisms potentiating metabolism of tramadol to M1 ("Ultra-metabolizers"), up to 20% of Iran, Saudi Arabia, Egypt and Northeast African regions [10], will experience increased opioid effects from tramadol including dangerous opioid side effects [11, 15]. Thus, tramadol, like any other opioid, can cause opioid use disorder and respiratory depression, the latter, particularly when taken with other sedatives [16]. Further, tramadol produces many of the more common opioid-like side effects including constipation (46%), sedation (25%), and pruritus (<11%) although probably less commonly than other opioids [17]. In contrast, tramadol-induced nausea is actually more frequent (40%) than with other opioids. Tolerance and withdrawal were originally thought to be less common with tramadol than with other opioids [9] although analgesic tolerance is not uncommon today [15]. Moreover, withdrawal from both tramadol's opioid effects (Table 1) and SSRI-like effects (e.g., like those with venlafaxine) (Table 1) have been described [15].

Table 1: Common Opioid and Selective Serotonergic Reuptake Inhibitor (SSRI) Like Withdrawal Symptoms Associated with Abrupt Tramadol Discontinuation[15]

Opioid Withdrawal Symptoms		SSRI-Like Withdrawal Symptoms
Abdominal Cramping	Lacrimation	Confusion
Agitation	Myoclonus	Delusions
Anxiety	Nausea	Hallucinations
Depression	Paresthesia	Panic Attacks
Gooseflesh	Rhinorrhea	Paranoia
Hyperkinesia	Sweating	Restless Leg Syndrome
Insomnia	Tremors	Unusual Sensory Phenomena

Other side effects, not normally associated with opioids, occur with tramadol, including headache (32%), dizziness (28%), dyspepsia (13%) and flushing (<15%), perhaps from increases in central NE and 5HT [17]. However, it is the more dangerous nonopioid side effects of seizures and 5HT syndrome that deserve special consideration from the prescriber as the causes of these effects may be unclear. For example, tramadol-induced seizures are more common in patients who already have a history of seizures or are already taking other drugs which lower seizure thresholds, particularly drugs that increase 5HT such as 5HT reuptake inhibitors and serotonergic psychotropics [18]. These drug interactions point to increased 5HT as responsible for the seizures and may explain why the incidence of tapentadol seizures appears to be less than that of tramadol [14]. On the other hand the increase in tramadol seizure risk with CYP2D6 inhibitors [18] suggests that the seizures are due to tramadol itself (or its nonopioid metabolites) and also explains the increased risk of tramadol seizures in patients with renal failure given tramadol's >90% renal excretion [18]. Finally, naloxone, has been reported to increase tramadol seizures [19] suggesting that tramadol's opioid actually raises seizure thresholds.

As in the epileptogenic effects of tramadol, increased 5HT levels are responsible for its most dangerous nonopioid side effect – 5HT syndrome. 5HT syndrome is a clinical diagnosis lacking any definitive diagnostic tests. It can present with the classic symptom cluster of neuromuscular hyperactivity, autonomic hyperactivity and altered mental status (Table 2) but frequently involves more mild nonspecific symptoms such as sweating, tremors and hyperreflexia (Table 2). Nonetheless, a high index of suspicion must be maintained as severe cases of 5HT syndrome (Table 2) can cause dangerous complications including rhabdomyolysis, renal failure, disseminated intravascular coagulation and acute respiratory distress syndrome and even death [18]. This syndrome must be treated as an emergency, with oxygen, cooling blankets, intravenous fluids, cardiac monitoring and the 5HT antagonist cyproheptadine [18].

Table 2 - Severity and Signs and Symptoms of Serotonin (5HT) Syndrome [18].

Severity	Signs and Symptoms
Mild	Diaphoresis, Tremor, Diarrhea, Irritability, Sleep Disturbances, Tachycardia and Hyperreflexia
Moderate	Agitation, Hypervigilance, Hyperthermia (<41 degrees C), Tachycardia, Hypertension and Myoclonus (Inducible Clonus and Occular Clonus)
Severe	Delirium, Hyperthermia (>41 degrees C), Severe hypertension, Severe Tachycardia, Peripheral Hypertonicity, Trismus, Truncal rigidity and Spontaneous clonus

High dose (2-3 times the recommended maximum dose of 400 mg/day tramadol alone) is occasionally responsible for 5HT syndrome but, as with seizures, tramadol more commonly combines with other drugs which increase 5HT to produce the syndrome [15]. Antidepressants, antiemetics, and headache therapy have all been reported to elicit 5HT syndrome when paired with even normal tramadol doses [18] (Table 3). These are important interactions to keep in mind given the common co-prescribing of antidepressants for pain and the common nausea and headache side effects of tramadol [cf., 20].

Table 3 – Drugs Known to Produce Serotonin (5HT) Syndrome in Patients Also Taking Tramadol [18]

Antirrhythmic agents	Quinidine
Antibiotics	Linezolid
Antiemetics (controversial)	Setrons (e.g., ondansetron), metoclopramide
Antimigraine Agents	Ergot alkaloids, Triptans (e.g., sumatriptan – also are controversial)
Antiretrovirals	Ritonavir
Appetite Suppressants	Sibutramine
Cold and Allergy Agents	Dextromethorphan and chlorpheniramine
Herbal Supplements	St. John's wort (*Hypericum perforatum*), yohimbe, ginseng, L-tryptophan
Illicit Drugs	Ecstacy (MDMA), amphetamines and cocaine
Opioid Analgesics	Fentanyl and methadone (morphine and oxycodone are controversial)
Psychotropics	MAO inhibitors, Tricyclic Antidepressants, SSRIs, SNRIs, nefazodone, maprotiline, amphetamines, second-generation antipsychotics, buproprion, divalproex, and carbamazepine

Patients at risk for noncompliance - including histories of drug abuse and drug overdoses - have been found to have an increased risk of tramadol seizures [18]. Similarly, the most frequent abusers of tramadol are those with a history of prior substance abuse, in addition to a history of chronic pain and those with easy access to the drug including health professionals [15]. In 2004, a review of physician health programs reported that tramadol was the third most frequently reported drug of abuse (outpacing fentanyl and oxycodone)[21].

Sounds Like Toradol – But Isn't

Thus, I am frequently surprised when I see patients with a long history of alcohol or drug abuse coming to surgery on tramadol for their chronic pain. Of course, I do not really think that this is because tramadol (approved in 1995) is being confused with the NSAID Toradol (ketorolac - approved in 1989). Tramadol, unlike Toradol, is an opioid analgesic with a complex pharmacokinetic and pharmacodynamic profile which can produce dangerous and diagnostically challenging opioid and nonopioid side effects. Further, although approved by the FDA for moderate to severe pain like other opioids, tramadol's analgesic efficacy is controversial [e.g., 22] and the WHO recommends tramadol on step 2 of its 3 step analgesic ladder [23,24], below most other opioids. Indeed, in a network meta-analysis of trials evaluating the morphine-sparing effects of a variety of "nonopioid" analgesics in the post-operative period, tramadol was found to have similar morphine-sparing effects to acetaminophen and less than that caused by NSAIDs or alpha2 adrenergic receptor agonists [2]. Further, unlike acetaminophen, adding tramadol to morphine did not provide a significant analgesic benefit [2, 25]. This should factor strongly into a prescriber's risk/benefit analysis given the generally safer profile for truly nonopioid drugs like acetaminophen and NSAIDs in most patients.

Is Tramadol an Opioid or a Nonopioid Analgesic? Yes!

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WPHP Report

WASHINGTON Medical Commission
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Chris Bundy, MD, MPH
Executive Medical Director, Washington Physicians Health Program

Prior to the COVID-19 pandemic, widespread professional burnout, dissatisfaction, and disillusionment were symptomatic of an ailing healthcare system. We were all aware of this - hardly a day went by without another headline about the crisis of physician burnout. Systemic drivers of professional distress had been identified and responsibility assigned. Medical educators, regulators, organizations, leaders, administrators, even the affected clinicians themselves, took turns accepting blame for causing or perpetuating the problems. Those of us involved in physician health and well-being advocated for change and tried to convince ourselves that momentum was building. However, little progress was made. The chronic systemic dysfunction was too entrenched and widespread, efforts to intercede were sporadic and fragmented both within and across health care organizations and stakeholder entities. The inertia was not for lack of caring among of those in charge – revolutionary change was needed, and the game was rigged against it.

COVID-19 produced a shockwave across the health care system that has resulted in unprecedented challenges and rapid adaptations. Regulations and payment issues that previously hindered widespread adoption of telehealth services disappeared "virtually" overnight to support care delivery under social distancing. Reuse of personal protective equipment, unthinkable in the pre-COVID era, became critical in the face of undependable supply chains. At the point of crisis, many of the usual bureaucratic encumbrances to efficient and effective work in medicine were set aside so that physicians and other health professionals, whose status and influence had been progressively eroded over the prior two decades, could right the ship.

Our health care workforce has, without doubt, responded to this call heroically, reflecting a deep repository of altruism, compassion, selfless commitment and expertise that is our greatest health care asset. Were it otherwise, our health care infrastructure might well have collapsed under the weight of the crisis. After all, the pandemic placed tremendous emotional and psychological pressure on professionals who, by all pre-COVID accounts, appeared to be at the breaking point. Yet we did not falter, we rose mightily to the challenge and continue the fight under severe resource threats with no clear end in sight. As society moves toward relaxing social distancing and re-opening the economy it can be easy to forget that, for health care workers, the battle goes on.

As of this writing the CDC reports 27 COVID-related deaths among U.S. health care personnel with over 9,200 infected and at least 700 hospitalized due to infection. Countless others have sustained acute mental health injuries that require immediate care and support. Many others will have delayed reactions emerging in the weeks and months ahead. Finally, there are those who have been financially harmed as the result of restrictions on "non-essential" care and stay at home orders. Clinics have been shuttered and those that have survived, especially safety net programs, are facing existential threats that generate chronic stress and uncertainty. However, the pandemic has not been without some bright spots that may serve as clues to workforce sustainability.

In a recent New England Journal of Medicine article, Hartzband and Groopman observe that there appears to have been a paradoxical amelioration of burnout during COVID-19. They argue that this can be explained by the restoration of the "three pillars" of intrinsic motivation (autonomy, competence and relatedness) as the health care system rallied behind its caregivers.[1] It might seem like we have more pressing concerns than addressing burnout. While there may be some truth to that, there is also an opportunity inside of the disruptive change wrought by COVID-19 to reform the system to better promote proactive workforce sustainability. As we pause to take a breath on "the other side of the curve" we can appreciate that the pandemic has shown us that the system can be reset; that what has helped us survive the crisis may sustain us in the siege ahead.

The Washington State Medical Association's Care for the Caregiver During COVID-19 Outbreak has a wealth of resources to address the toll the crisis is taking on individuals and health care teams. In addition, WSMA has been a national leader in system reforms to reduce burnout and promote professional fulfillment through their Healthy Doctors, Healthier Patients initiative. Physicians Insurance has also created a COVID-19 Resource Library with documents and links to support the practical challenges clinicians are facing in this rapidly changing environment. Finally, the Washington Physicians Health Program is here to support individuals and organizations effectively navigate through the strains of the pandemic. With over 30 years of experience in this area, our mission has never been more critical, and we stand ready to serve.

What is clear amidst all this uncertainty is that we cannot and should not go back to the way it was before COVID-19. A revolutionary opportunity is upon us to reshape health care so that we may protect the national treasure that is our health care workforce.

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Policy & Guideline Update

WASHINGTON Medical Commission
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Michael L. Farrell, JD
Policy Development Manager

WMC publishes new guidelines on medical records, medical marijuana authorizations, reaffirms other policies and guidelines

The WMC develops policies and guidelines to help practitioners to practice good medicine by clarifying legal obligations and encouraging the use of best practices. Here are a few notable policies and guidelines the WMC issued in the past year.

Combining two old documents, the WMC issued a new guideline with helpful recommendations on a number of issues in the evolving world of medical records. This guideline includes advice on proper documentation, the length of time medical records should be retained, the use of electronic medical records, a patient's right to access their records, storage and disposal, and the handling of records when closing a practice. An appendix contains a brief history of the development of the medical record, as well as examples of complaints the WMC has received regarding electronic medical records.

The WMC also issued a new guideline to help practitioners navigate the murky medical and legal issues involved in authorizing the use of medical marijuana (cannabis). The guideline clarifies the legal requirements and responsibilities of the practitioner. It also describes best practices for evaluating a patient, formulating a treatment plan, maintaining medical records, as well as warning practitioners of the dangers of authorizing marijuana for minors. The guideline recommends that practitioners complete at least three hours of continuing medical education on authorizing medical marijuana and provides a link to a Department of Health web page with more information.

The WMC also reviewed and reaffirmed existing guidelines, policies and interpretive statements. This includes reaffirming a guideline on treating partners of patients with sexually transmitted chlamydia and gonorrhea, which encourages practitioners to follow "Sexually Transmitted Diseases Treatment Guidelines" issued by the CDC. The WMC also reaffirmed an interpretive statement permitting physician assistants to order patient restraint and seclusion. Last, the WMC reaffirmed two guidelines on reentry to practice. The first is designed for practitioners who have been out of the workforce temporarily and provides advice on successfully returning to the practice of medicine. The second guideline advises practitioners with suspended licenses on the necessary steps to reenter the practice of medicine, which may include the completion of a formal reentry program and the use of a practice monitor.

All WMC processes are available on our website and we can be contacted if you have any questions.

PMP EHR Integration Requirement Waived until 9/30/2021

The COVID-19 pandemic has taken an unprecedented toll on Washington's health care system over the last several months. Health care providers have been consumed with planning for and responding to the surge of patients needing critical care due to COVID-19. Although we are seeing hopeful signs that the spread of COVID-19 has slowed, the pandemic is not over. This public health emergency will continue to require the full focus of health care entities in Washington for some time to come.

In light of this, the Secretary of Health is exercising his authority under RCW 70.225.090(2)(b) to grant a nine month waiver from complying with the requirement in RCW 70.225.090(2)(a) for opioid prescribers to use electronic health records (EHRs) that are integrated with the state Prescription Monitoring Program (PMP) by January 1, 2021. This waiver applies to all facilities, entities, offices, and provider groups subject to the integration requirement and is being effected in light of the burdens placed on our state's health care entities because of the exceptional circumstances of the COVID-19 outbreak in Washington State.

This waiver will expire on September 30, 2021. After that time, all health care entities subject to the EHR/PMP integration requirement must have integrated EHRs in compliance with RCW 70.225.090(2)(a) or another waiver issued by the Department of Health. For more information, please contact the Prescription Monitoring Program at PrescriptionMonitoring@doh.wa.gov.

Rulemaking Efforts

WASHINGTON Medical Commission
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Amelia Boyd

Program Manager

Chapter 246-919 WAC
The CR-101 for Chapter 246-919 WAC was filed with the Office of the Code Reviser (OCR) on January 2, 2018 as WSR #18-02-079.

The WMC is considering updating the chapter to more closely align with current industry standards and provide clearer rule language for licensed allopathic physicians. In addition, RCW 43.70.041 requires the WMC to review its administrative rules every five years to ensure that regulations are current and relevant.

Rule amendments being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

On July 12, 2019 the WMC approved initiating the next step in the rulemaking process, Proposed Rule Making (CR-102). A rules hearing is tentatively scheduled for Wednesday, August 19, 2020. At this time, this hearing will be only accessible virtually.

Clinical Support Program
The CR-101 for WAC 246-919-XXX Physicians and WAC 246-918-XXX Physician Assistants was filed with the OCR on February 22, 2018 as WSR #18-06-007.

The WMC is considering creating two new rule sections, and revising related rule sections as appropriate, to establish a clinical support program (program), its criteria and procedures for allopathic physicians and physician assistants. The intent of the program is to assist practitioners with practice deficiencies related to consistent standards of practice and establish continuing competency mechanisms that will protect patients proactively through a plan of education, training and/or supervision. The WMC may resolve practice deficiencies through the program at any point in a practitioner's period of licensure.

The program would allow for quick identification of issues requiring clinical support, through practitioner or employer inquiry, referral, and including complaints that may not rise to the level of a license sanction or revocation. These issues could be resolved with voluntary participation from the allopathic physician or physician assistant in the program. The WMC is considering education, training, supervision, or a combination of the three as part of the program. Issues appropriate for clinical support would likely include but are not limited to practice deficiencies such as a failure to properly conduct a patient assessment or document treatment. This also allows an allopathic physician or physician assistant a structured process to quickly improve his or her clinical skills.

Finally, participation in this program places the WMC in an active patient safety role.

At their business meeting on July 12, 2019, the WMC approved initiating the next step in the rulemaking process, Proposed Rule Making (CR-102).

Telemedicine
The CR-101 for Telemedicine was filed with the OCR on September 17, 2019 as WSR #19-19-072. The WMC will consider rulemaking to address the practice of physicians and physician assistants engaging in telemedicine with Washington patients. Possible subjects the WMC may address are: What, if any requirements for licensure; recordkeeping requirements; establishing a patient-practitioner relationship; prescribing issues; and standard of care. Regulating the use of telemedicine would place the WMC in an active patient safety role.

Exclusions – Opioid Prescribing
The CR-101 for amending the exclusions sections in both the MD (WAC 246-919-851) and PA (WAC 246-918-801) chapters to expand the types of patients who are exempt from certain provisions of rule when being prescribed opioid drugs was filed with the OCR on March 25, 2020.

As part of the WMC rule making for ESHB 1427, enacted in 2017 and codified as RCW 18.71.800, the WMC received comments regarding adhering to the opioid prescribing rules for patients admitted to long-term acute care (LTAC) and nursing homes is onerous. Specifically, the rules require a history and physical as well as a check of the prescription monitoring program (PMP) be completed prior to prescribing opioids. It has been stated that patients transferred to LTACs and nursing homes had a history and physical while in the previous facility and that practitioners in LTACs and nursing homes can rely on that assessment.

Inpatient hospital patients are currently exempt from the opioid prescribing rules. The Commission recognizes that patients in LTACs and nursing homes are similarly situated to hospital patients receiving inpatient treatment.

Rulemaking Efforts

Since the rules related to ESHB 1427 became effective January 1, 2019, the WMC has continued to receive comments related to LTAC and nursing home patients. To address this issue, the WMC filed an interpretive statement: "Exempting Patients in Nursing Homes and Long-Term Acute Care Hospital from the Opioid Prescribing Rules." While the interpretive statement has helped to curb the comments and concerns from prescribers, the WMC feels this important exemption should be in rule. Furthermore, this could allow us [to] rescind the interpretive statement.

The WMC has also received a comment regarding patients in Residential Habilitation Centers (RHC) that they are also similarly situated to LTAC and nursing home patients. As such, the WMC may also consider exempting patients in RHCs.

Stem Cell Therapy

The CR-101 for creating rules related to Stem Cell Therapy was filed with the OCR on April 21, 2020 as WSR #20-09-132.

The WMC has received complaints from licensees, stakeholders, and the public about the use of stem cells. The complaints have been regarding the advertising related to stem cell therapy, practitioners using non-FDA approved stem cell therapy, as well as concerns stem cell therapy not being within a practitioner's scope of practice. Regulating the use of stem cell therapy would place the WMC in an active patient safety role. Rulemaking would provide clarity around this emerging medical technology and procedure to help avoid potential discipline and increase patient safety. New sections being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

For more information about these rules, please visit our website.

More Information

Please visit our rulemaking site.

For continued updates on rule development, interested parties are encouraged to join the WMC Rules GovDelivery.

Clarification - Additional Requirements for COVID-19 Testing

Provider reporting is required for all notifiable conditions, not just COVID-19, however, due to the unprecedented volume of reporting required for COVID-19, and our need for more timely electronic data, DOH is heavily focused on prioritizing eCR Now (for COVID-19) as a model for eCR. The good news is that onboarding with eCR Now will make later work to send data for all notifiable conditions much easier and can be automated in the same way by your EHR vendor. eCR is for all notifiable conditions, but we're prioritizing COVID-19 case reports right now. More information can be found here and email eCR@doh.wa.gov with interest and questions.

Legal Actions

WASHINGTON Medical Commission
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February 1, 2020 – April 30, 2020

Below are summaries of interim and final actions taken by the Washington Medical Commission (WMC) that were reported to the Federation of State Medical Boards between February 1, 2020 and April 30, 2020. Statements of Charges, Notices of Decision on Application (with exceptions), Modifications to Orders (with exceptions), and Termination Orders are not listed. We encourage you to read the legal document for a description of the issues and findings. All legal actions can be found with definitions on the WMC website.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Interim and Formal Actions				
Nguyen, Dung X. MD00024150 Pierce	Agreed Order	02/27/20	Improper storage of medication and unsterile conditions.	Voluntary surrender.
Shuey, Jackie PA10004350 Pierce/King	Agreed Order	04/17/20	Failure to diagnose cerebral trauma, failure to consult with physician despite persistent unresolved symptoms, and failure to properly supervise nursing staff.	Requirement to practice with another clinician present, boundaries coursework, maintain professional certification, written research paper, supervisor reports, personal appearances, $3,000 cost recovery, and termination no sooner than four years.
Washington, William MD00046967 King	Final Order	01/19/20	Failure to adequately examine, diagnose, or treat a patient with a post-op infection.	Requirement for direct oversight by a proctor and restriction from practicing emergency medicine subject to modification, clinical skills assessment and follow all recommendations, medical records coursework, and $5,000 fine.
Informal Actions				
Banks, Casondra PA60340752 Skagit	Informal Disposition	11/14/19	Alleged substandard recordkeeping and prescription.	Medical records coursework, treatment of scalp infections coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Dagan, Benigno MD00036169 Pierce	Informal Disposition	04/17/20	Alleged negligent management of corticosteroid therapy and alleged failure to consult with rheumatology specialist.	Rheumatology coursework, written research paper, practice reviews, personal appearances, $2,000 cost recovery, and termination no sooner than three years.

Del Secco, Catherine PA10004561 King	Informal Disposition	02/27/20	Alleged provision of medical care without maintaining adequate records.	Boundaries coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Freezer, Jonathon MD60871372 Clallam	Informal Disposition	02/27/20	Respondent allegedly provided a non-patient with a letter stating a medical diagnosis that was based on their personal relationship.	Ethics coursework, written research paper, personal appearances, $1,600 cost recovery, and termination no sooner than after at least one appearance and completing other requirements.
Garnett, Michael MD00016667 Klickitat	Informal Disposition	04/17/20	Alleged failure to properly monitor a patient's lithium levels.	Written protocol, personal appearances, $1,000 cost recovery, and termination no sooner than after at least one appearance and completing other requirements.
Kincaid, Joseph MD00029893 Spokane	Informal Disposition	02/27/20	Entry into a diversion program for alleged possession of marijuana in Idaho.	Compliance with the Idaho diversion program, compliance with a health monitoring program in WA, personal appearances, conditional clinical skills assessment, $2,000 cost recovery, and termination no sooner than completion of diversion program and endorsement by health monitoring program.
Lavalle, Gregory MD60021446 Spokane	Informal Disposition	04/09/20	Alleged mismanagement of a patient's post-operative bleeding.	Postoperative monitoring and management coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than two years.
Meltzer, Richard MD00031769 Thurston	Informal Disposition	04/09/20	Alleged delay in diagnosing a known surgical complication.	Written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than after at least one appearance and completing other requirements.
Raekes, Julie MD00036517 Benton	Informal Disposition	02/27/20	Alleged mismanagement of a complex patient with an alcohol use disorder.	Medication management of sleep disorders coursework, written research paper, peer group presentation, personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Taylor, Douglas MD60088153 Thurston	Informal Disposition	02/27/20	Alleged failure to properly identify patient prior to starting procedure and to document a change of treatment plan.	Medical recordkeeping coursework, ethics coursework, written research paper, written protocol, peer group presentation, personal appearances, $1,000 cost recovery, and termination no sooner than one year.

Turner, Kevin MD0002688g Snohomish	Informal Disposition	02/27/20	Alleged failure to comply with a WMC order.	Voluntary surrender at retirement.
Turner, Josef MD60201428 Cowlitz	Informal Disposition	02/27/20	Alleged failure to properly assess a condition resulting in delayed treatment.	Clinical coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Whitaker, Malcolm MD00047269 Pierce	Informal Disposition	04/29/20	Alleged self-prescribing of a controlled substance.	Prescribing coursework, personal appearances, $2,000 cost recovery, and termination no sooner than one year.

Stipulated Findings of Fact, Conclusions of Law, and Agreed Order: A settlement resolving a Statement of Charges, and containing an agreement by the licensee to comply with certain terms and conditions to protect the public.

Stipulated Findings of Fact, Conclusions of Law, and Final Order: An order issued after a formal hearing before the Commission imposing certain terms and conditions to protect the public.

Stipulation to Informal Disposition (STID): A settlement resolving a Statement of Allegations., and containing an agreement by the licensee to comply with certain terms and conditions to address the Commission's concerns.

Ex Parte Order of Summary Action: An order summarily restricting or suspending a licensee's practice of medicine. The licensee has an opportunity to defend against the allegations supporting the summary action.

Members and Meetings

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Email us with your questions and comments.

2020 WMC Meeting Dates

Date	Meeting Type
July 9 - 4:00 PM	Virtual Policy Meeting
July 10 - 8:00 AM	Virtual Business Meeting
August 20 - 4:00 PM	Virtual Policy Meeting
August 21 - 8:00 AM	Virtual Business Meeting
November 12 - 4:00 PM	Virtual Policy Meeting
November 13 - 8:00 AM	Virtual Business Meeting

Policy meetings usually take place on the Thursday of the commission meeting at 4:00 pm.

Business meetings usually take place on the Friday of the commission meeting at 8:00 am.

Policy, business meetings and lunch time presentations are open to the public. Sign up to have the agenda emailed to you as it becomes available.

All upcoming meeting and workshops have been either canceled or been converted into a teleconference. Check our website for specific event details.

Follow us on Facebook for all upcoming webinars and special meetings.