



UPDATE!

Message From The Chair

Alden Roberts, MD, MMM, FACS

It occurs to me that the workings of the Washington Medical Commission (WMC), are a mystery to many of you. Let me try to clarify who we are and how we function in our disciplinary role.

The WMC is composed of 21 commissioners appointed by the governor, with some input from the Commission itself. There are 13 physician commissioners of a variety of specialties and subspecialties. One physician commissioner is chosen from each of the ten congressional districts and there are 3 at large physician commissioners. There are two PA-C commissioners and 6 public members. There is a staff of about 54 people, including departments of licensing, legal services, investigations, compliance, and a variety of other support services. We have access to additional "Pro Tem" members who provide subspecialty assessment and can also function in many other commission duties. WMC also has access to other physician experts to whom we can send cases for evaluation.

We license over 30,000 physicians and about 4,000 PA-C's. WMC

funding comes entirely from license fees, which have been unchanged for nearly 10 years (although fees will have to change in the near future).

The WMC is a complaint-driven organization, which means we only pursue discipline in response to complaints received. However, our mission is to promote patient safety and enhance the integrity of the profession. If, in the course of an investigation, we encounter problems with care outside of what the complainant alleges, the WMC may address those issues as well. This would include substandard care that was delivered by a different provider from the "Respondent" (the physician or PA against whom the complaint was filed), in which case we can initiate our own complaint related to that provider. However, we do not go out looking for problems. For those concerned about a WMC investigation being triggered by the data regarding your prescribing patterns that you are now receiving from the Prescription Monitoring Program (PMP), don't be. We do not receive these reports, we do not wish to receive them, and the data alone doesn't provide enough information for a regulatory body to appropriately assess the care provided. The WMC received approximately 1800 complaints last year and we are not interested in expanding that based on a report from the PMP.

For those concerned about a WMC investigation being triggered by the data regarding your prescribing patterns from the Prescription Monitoring Program (PMP), don't be.

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UPCOMING MEETINGS

WMC Policy Meeting
January 17th

WMC Business Meeting
January 18th

Regular Meeting
March 7th - 8th
Tumwater, WA

Regular Meeting
April 11- 12
Tumwater, WA

[More information](#) including locations and times

Message From the Chair

Every week, complaints received by the WMC are entered into our database and sent to a Case Management Team (CMT). The commissioners on CMT change each week, but the team is composed of 3 to 4 commissioners (one of whom is a public member), representatives of the investigative staff, the legal staff, and other members of the WMC staff. Each commissioner on the CMT for that week reviews and assesses all of the 25-30 complaints that have been brought to the team. Sometimes, we have only the complaint to look at. Sometimes, we have an entire chart included. When I sit on the CMT, it takes me 2-4 hours to go through all of these complaints. The CMT is conducted via phone conference where each case is discussed and a decision is made whether or not to open the case for investigation. The decision to open a case for investigation is made solely by the commissioners; the staff is supportive and answers legal and technical questions that the commissioners may ask. About half the complaints discussed at a CMT are closed as being "below threshold" (BT) for investigation. Wait! Only half of the complaints received get opened for investigation?? What's that about?

All complaints that come to the commission are taken seriously, but there are a number of reasons why a complaint may not go forward for investigation. The most common reason for not authorizing a complaint for an investigation is that even if the allegations in the complaint are true, no violation of the law has occurred. In other words, whatever was being complained about was actually within standard of care. This accounts for 66% of BT complaint closures.

Other reasons for not authorizing an investigation into the allegations of a complaint include:

- The complaint is about a communications issue.
- The complaint is a billing issue.
- The complainant meets the definition of a "whistle blower" and doesn't wish to be identified. If by opening the case and pursuing an investigation, the identity of the complainant might be revealed to the respondent (the physician or physician assistant about whom the complaint was filed) against the complainant's wishes, investigation cannot proceed.
- Insufficient information was provided to move forward with an investigation.
- The issue has already been dealt with elsewhere.
- The WMC doesn't have jurisdiction over the matter.
- The complaint isn't really about a MD/PA and needs to be referred to another program or agency, such as the agency that licenses the hospital where the MD/PA works.

If a complaint is closed BT, you will receive a letter notifying you that you had a complaint filed, but that it has been closed. That ends things, with two exceptions. First, the Complainant can submit additional information and request a re-evaluation of the complaint, in which case we start over. And second, the complaint is listed as having been closed BT on future complaint intake forms that may be filed against the Respondent. Commissioners are required by law to consider previous complaints. While this isn't usually a problem, if a number of similar complaints have been filed against the Respondent in a short period of time or if the number of complaints is far outside the "norm" for complaints against other physicians in a similar specialty, the pattern of complaints could possibly result in the opening of an investigation.

So, what happens to the other half of the cases seen in CMT that ARE opened for investigation? A lot! At this point, you have entered the section of the complaint process map that looks like the wiring diagram for a Boeing 767. Unfortunately, investigations into a complaint can be disruptive to your practice and emotionally difficult, even if, as in the vast majority of cases, your case is subsequently closed without any disciplinary action. It turns out that only 11.5% of authorized investigations (6% of complaints received) actually result in disciplinary action; but the process involved in reaching final decision is tedious, time consuming, and stressful for all parties involved. What happens after a case is opened for investigation will be my topic for the next issue of UpDate!



Executive Director's Report



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Melanie de Leon, JD, MPA Executive Director

Our demographics data indicates that about 5 percent of you are in a solo practice. National data indicates that the number of physicians wanting to go into solo practice is on the decline. What's driving the decline of solo and small practices? According to our research, the shift from small to large practices reflects what is called a "cohort effect"—younger doctors are 2.5 times less likely than older doctors to be in solo practice, and so as solo practitioners retire they are not being replaced. Younger physicians appear to prefer larger practices for the more predictable income and work-life balance they can offer.

According to a 2016 survey from the Physicians Foundation, more than 70 percent of physicians say patient relationships are the most satisfying aspect of medical practice, while nearly 60 percent say regulatory/paperwork burdens is least satisfying. But is the paperwork the only burden felt by the solo practitioner?

Information presented in a recent seminar by the Coalition for Physician Enhancement, indicated that isolation may be leading to disengagement by solo practitioners and this loss of engagement contributes to physician burnout.

What's the regulator's role in developing a culture of engagement in professional practice? In 1999, Buckingham and Coffman wrote a book entitled, "First, Break All the Rules". In this book, the authors asked 6 questions:

1. Do I know what is expected of me at work?
2. Do I have the resources I need to do my work right?
3. At work, do I have the opportunity to do what I do best every day?
4. In the last week, have I received recognition, praise or acknowledgement for doing good work?
5. Does my manager seem to care about me as a person?
6. Is there someone at work who encourages my personal and professional development?

We want to make sure the Medical Commission is meeting the needs of this special population. I encourage you to take 3 minutes and answer our [short survey](#). This will help us plan future events and educational opportunities.

Stephanie McManus Public Relations and Legislative Liaison

Meet your New Public Information Officer

You may not have realized but the Washington Medical Commission added a new position in September, the position of Public Relations and Legislative Liaison. That's me, Stephanie McManus. I am excited to join the WMC team representing leaders in the medical field and regulators who actively protect and educate the public.

You might be asking yourself, "What does a public information officer do?" As a public information officer it is my job to tell the world about the WMC. Some of what I do for example is to [write press releases](#), create [social media](#) posts, craft [website](#) content, and talk with reporters about how we license MDs and PAs; the [disciplinary actions](#) we've taken to protect the public; our [new opioid rules](#) and much more. In this role I'd love to hear from you! Do you have a story you think we should tell? Do you hear from patients or have an idea of your own and think, "I wish someone would tell the press about this." [Email me](#) any time with your thoughts and ideas. A big idea the WMC has with my coming on board is to let people know we are resource before there is a problem. We aren't a faceless agency. We care about practitioners and patients.

As you can see there are two sections to my title. I am also the Legislative Liaison. Most people don't know that the state legislature attempts to pass several thousand bills each year. A lot of these can impact the practice of medicine – sometimes for the better, sometimes for the worse. My job is helping the WMC navigate and keep track of what proposed legislation could do and protect the interests of MDs/PAs and patients. As you are likely aware, if a law passes that impacts our arena we use the rule making process to determine how we apply and enforce the law. If this sounds complicated, that's because it is. If you have any questions about legislation, your lawmaker or how you can be involved, send me a message!



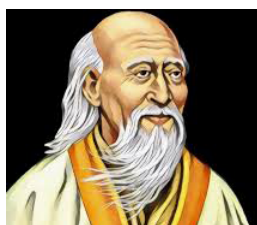


Theresa Schimmels, PA-C Physician Assistant Member

"Honesty is the best policy."
-Benjamin Franklin,
statesman



to communicate. Inability to communicate leads to misunderstanding. Misunderstanding leads to hurt feelings, frustration, and eventually anger which often leads to a complaint to the medical commission.



"Treat those who are good with goodness, and also treat those who are not good with goodness. Thus goodness is attained. Be honest to those who are

honest, and be also honest to those who are not honest. Thus honesty is attained."
-Lao Tzu, philosopher

What do all of these quotes have to do with medicine? They are all linked with the common theme of honesty or doing the right thing.

So often as a Commissioners we see providers take a shortcut during care for a patient. Such things as copy and pasting from an old chart note with out of date patient data, or not performing a "time out" procedure before starting surgery, can have devastating consequences on the outcome of a patient's care. It may cause patient harm. It may be out of the "standard of care". It also damages our reputations as providers which can undermine our ability to care for others.

Communication is often the key. We, as providers, are so pressured to see more, do more in less time that it's amazing how much we **ARE** able to accomplish! Unfortunately, we spend less time with patients, less time in face-to-face communication, which is so vital in medicine.

We may understand the concepts of that simple, uncomplicated, non-life threatening disease through our education and experience treating it. Patients, though, are left out of the language of medication, confused or frightened by Latin medical terms that they don't understand. And lack of understanding leads to inability

Mistakes are made. We all do it! None of us are perfect (in case you needed a reminder). Being honest and up front about medical errors with your patient, your staff and colleagues can go a long way in rectifying a problem. It often leads to new policies or procedures that can increase patient safety and diminish the likelihood that the same mistake repeats itself. It also can affirm to the patient that you tried your best and that you care about their health and wellbeing.

As medical providers, we have a responsibility to make sure that we are honest in all that we do with our patients, and those that work with and for us. We need to make sure we communicate clearly and openly that which others do not understand. It's about standing for the principles upon which we, as providers, are held to. To quote Hippocrates, "Now if I carry out this oath, and break it not, may I gain for ever reputation among all men for my life and for my art; but if I break it and forswear myself, may the opposite befall me." Or, as Benjamin Franklin said: "Honesty is the best policy."



Who can obtain an informed consent from the patient?



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Mimi Winslow, JD Public Member

In a recent publicized Pennsylvania case, *Shinal v Toms*, a patient had surgery for recurrence of a nonmalignant brain tumor. After the initial consultation with the surgeon, in which Dr. Toms advised her of risks associated with surgery and reviewed a less aggressive approach and a more aggressive approach, Mrs. Shinal did not reach a decision about which approach she wanted. Her subsequent preoperative interactions were with a Physician Assistant (PA). She had questions which the PA answered by phone. The PA also did the preoperative history and physical, provided pre surgical information, and obtained her signature on the consent form. On appeal from a jury verdict for the doctor, the Pennsylvania Supreme Court ruled that the duty to obtain informed consent belongs solely to the physician and is non-delegable. Such a delegation would deprive the patient of the opportunity to engage in dialogue with the chosen health care provider. The Court and a two-way exchange between cannot be confident that the benefits, likelihood of success and

Can a physician rely on someone else to disclose vital information and obtain informed consent?

stated that without direct dialogue provider and patient, the physician patient comprehends the risks, alternatives.

What is the law in Washington? Can a physician rely on someone else to disclose vital information and obtain informed consent? The issue includes not only surgical procedures but also other treatments such as colonoscopies and cancer treatments.

It is clear that a physician in Washington State, as in Pennsylvania, cannot delegate the legal duty to obtain informed consent to another. Washington statute requires that patients must be informed of the material facts they need to make decisions about their care. RCW 7.70 provides that a health care provider, including physicians and physician assistants, can be liable for an injury resulting from health care that involves a breach of the duty to secure informed consent.

But can the physician have staff aid in performing the physician's duty? Unlike the *Shinal v Toms* ruling, it appears that there is no such explicit prohibition in Washington statute or case law on others assisting the physician in obtaining informed consent. But the provider has the primary responsibility for obtaining consent, and will be responsible for what ancillary staff do or fail to do as part of the consent process. Drawing the line between assistance and impermissible delegation is the difficult issue.

Several commentators have suggested that physicians expand and particularize consent forms to provide more detail including stating risks and their sequelae clearly; require patients to choose among alternatives; and strive to be present when the patient signs the consent, to give the opportunity for additional questions. It is also suggested that attention be paid to documenting any discussion by assistive staff prior to their obtaining the written consent.

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Physician Burnout and Distress: Is the Health Care System Impaired?



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Chris Bundy, MD, MPH

Executive Medical Director, Washington Physicians Health Program

Impairment is defined as the inability to practice with reasonable skill and safety due to a health condition. Among health professionals, a variety of health conditions (and their treatments) can cause impairment. Illness is not impairment. Illness exists on a continuum of severity while impairment is a functional classification that implies the inability of an ill person to perform specific activities. Illness typically pre-dates impairment, often by many years, and most health professionals who become ill can function effectively in the initial stages of illness due to their extensive training and dedication. Early identification and treatment of illness can prevent progression to impairment and protects patient safety [1]. Historically, the concept of impairment has been applied to safety-sensitive health care workers. Perhaps the time has come to evaluate whether the health care system itself is impaired – and the impact that might have on patient safety.

There is an extensive and evolving literature demonstrating the relationship between physician distress and poorer health care outcomes for patients [2-4]. Not only do healthy physicians provide better care, but it has become stunningly clear that professional burnout and psychological distress negatively impact safe and effective care.

Despite increased awareness and numerous well-intentioned calls to action from all quarters of organized medicine, little progress has been made to combat the epidemic of physician burnout and distress that has infected the US health care system. Experts have speculated that uncertainty among organizational decision-makers is at least partly to blame for this anemic response. One source of uncertainty stems from the invisibility of the economic costs of physician burnout. Given limited resources, what is the return on investment in physician well-being? Another source of uncertainty is rooted in pessimism about whether anything really can be done to alleviate a problem of this scope and complexity. In response, the national dialogue has increasingly focused on making the business case for physician well-being and identifying key steps organizations can take in to strategically impact the drivers of physician burnout and distress [5].

The changing discourse has resulted in two important conceptual shifts. The first is recognition that the key targets for reducing burnout live at the level of the organization not the individual. We have spent far too much time focused on the wrong target, blaming the victims of burnout and encouraging them to develop more resilience. This is not to say that health-promoting behaviors should be de-emphasized. On the contrary, personal wellness should be a core value within the culture of medicine, woven into our identity starting in medical school and supported by the organizations we serve across the career span. But burnout interventions aimed at improving personal wellness will never do more than provide better shelter from the storm. The second (and related) conceptual shift is that the organizational correlates to burnout have negative downstream effects on patient safety and care quality.

Our health care system is ailing. In an analysis by the Commonwealth Fund, the U.S. health system spends far more on health care yet ranks dead last in overall performance (including health outcomes for patients) compared to other high-income countries [6]. Costly, inefficient, and lagging, our health care system is now generating unprecedented rates of burnout among its workers. Burnout, the final common pathway of systemic dysfunction, creates a vicious, self-reinforcing cycle of performance decline. A recent meta-analysis by Panagioti and colleagues is sobering. Across 47 studies and 42,473 physicians, burnout was associated with 2-fold increased odds for unsafe care, unprofessional behaviors and low patient satisfaction. The depersonalization (callousness) dimension of burnout showed the strongest link with these outcomes, while the association between unprofessionalism and burnout was highest across studies of residents and early-career physicians [7].

Like alcohol on the breath of a physician at work, burnout and distress are ominous signs of an impaired health care system. We have progressed beyond the early stages of a systemic illness that is now placing patients (and health professionals) at risk. Recognizing and addressing impairment is most often impeded by denial. Denial is not deception, it is an unconscious defense that permits us to ignore truths that are too painful to acknowledge.

Physician Burnout and Distress

With patient safety in the balance, we do not have the luxury of our uncertainty or collective denial. We have a moral imperative to take action.

In 1999, the Institute of Medicine (IOM) released *To Err is Human: Building a Safer Health System* [8]. In the 2 decades that followed, health care organizations invested enormous resources to build a massive safety and quality infrastructure. This robust response was not the result of some deep fiscal analysis, it was simply the right thing to do for our patients under the disinfecting light of the IOM's denial-busting report. Efforts aimed at addressing "physician wellness" perpetuate our denial and are a distraction from what is, ultimately, a patient safety and care quality issue. We can and should use our existing quality and safety infrastructures to intervene on our impaired system, address the drivers of professional burnout and dissatisfaction that reside within the environment of care and begin the recovery process. The only resource we really need is the will to act.

1. Public Policy Statement: Physician Illness vs. Impairment. Federation of State Physician Health Programs. 2008 https://www.fsphp.org/assets/docs/illness_vs_impairment.pdf
2. Wallace JE, Lemaire JB, Ghali WA. Physician wellness: a missing quality indicator. *Lancet*. 2009
3. Dewa CS, Loong D, Bonato S, Trojanowski L. The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. *BMJ Open*. 2017
4. Hall LH, Johnson J, Watt I, Tsipa A, O'Connor DB. Healthcare staff wellbeing, burnout, and patient safety: a systematic review. *PLoS One*. 2016
5. Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. *JAMA Int Med*. 2017
6. Schneider EC, Sarnak DO, Squires D, Shah A, Doty MM. Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care. <https://interactives.commonwealthfund.org/2017/july/mirror-mirror/>
7. Panagioti M, et al. Association between physician burnout and patient safety, professionalism, and patient satisfaction: A systematic review and meta-analysis. *JAMA Int Med*. 2018
8. Kohn LT, Corrigan JM, Donaldson MS, editors. *To err is human: building a safer health system*. Washington, DC: National Academy Press, Institute of Medicine. 1999



New Opioid Prescribing and Monitoring Rules are Effective January 1st.

The Medical Commission has been busy with the implementation and education requirements needed for the rules around opioid prescribing and monitoring as required by [ESHB 1427](#).

We have accomplished the following in our efforts to educate providers and the public about the changes to opioid prescribing that are effective January 1, 2019:

- We have presented at over 20 organizations and events;
- We have issued over 200 CME credits that meet the requirement as outlined in the rules;
- We have created information materials and a dedicated webpage;
- We have held 3 Twitter town halls to answer general questions;

But we are not done yet! We are still scheduling informational sessions and webinars into the New Year. If you would like to discuss having a medical commission representative speak to your organization about the new opioid rules, please [contact us](#).

Be on the lookout for:

- Self-paced webinars for CME credit;
- Opioid prescribing guide to be mailed;

We are here to help.

We are a resource.

Use us!

Rulemaking Efforts



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Daidria Underwood Program Manager

Engrossed Substitute House Bill 1427

Engrossed Substitute House Bill (ESHB) 1427 was passed by the legislature on May 16, 2017. The bill is concerning opioid treatment programs and mandates that the WMC adopt rules for both allopathic physicians and physician assistants. On May 25, 2018 the WMC approved the proposed rule language. With that approval the CR-102 was filed as WSR #18-15-055 with the Office of the Code Reviser on July 16, 2018. The hearing for this rule was held on August 22, 2018. The rules are scheduled to be effective January 1, 2019.

For more information about these rules, please visit our [website](#). If you are part of a health care organization, hospital, association or patient group, request an educational presentation for your organization through the [Medical Commission Speaker's Bureau](#).

To learn more about ESHB 1427 please visit the [bill summary page](#).

Chapter 246-919 WAC

The CR-101 for Chapter 246-919 WAC was filed with the Office of the Code Reviser 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 rules 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.

For more information on this rule, please visit our [rulemaking site](#).

Clinical Support Program

The CR-101 for WAC 246-919-XXX Physicians and WAC 246-918-XXX Physician Assistants was filed with the Office of the Code Reviser 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 commission in an active patient safety role.

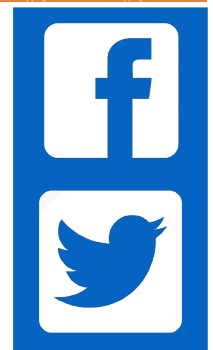
For more information on this rule, please visit our [rulemaking site](#).

More Information

For continued updates on rule development, interested parties are encouraged to join the WMC [rules GovDelivery](#).

FOR INFORMATION AS
IT HAPPENS, 'LIKE' THE
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Notice of Recruitment



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The Washington State Medical Quality Assurance Commission (Commission) is currently accepting applications to fill upcoming vacancies. The Commission helps make sure physicians and physician assistants are competent and provide quality medical care.

We are looking for people willing to study the issues and make decisions in the best interest of the public. Our member selection reflects the diversity of the profession and provides representation throughout the state. On July 1, 2019 the Commission will have openings for:

- One physician representing Congressional District 2
- One physician representing Congressional District 10
- One Physician-at-Large
- Two public members

Learn what congressional district you are in [here](#). The physician applicants for Congressional Districts 2 and 10 will also be considered for the Physician-at-Large position.

The Commission consists of 21 members appointed by the governor. It meets about eight times a year, usually on Thursday and Friday every six weeks. There is an expectation to review multiple disciplinary cases between meetings, and additional meetings or hearings are often necessary. Additional information regarding commission membership and a link to the governor's application can be found [here](#).

Please take the time to review the valuable information on commission membership available at the above website. Applications, along with a current resume, must be received by March 15, 2019.

If you have any questions about serving on the commission, please contact [Daidria Amelia Underwood](#), Program Manager, at Post Office Box 47866, Olympia, Washington 98504-7866, by email or call (360) 236-2727.



August 1, 2018 – October 31, 2018

Below are summaries of interim and final actions taken by the Medical Commission. Statements of Charges, Notices of Decision on Application, Modifications to Orders 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 Medical Commission [website](#).

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Summary Actions				
Boyd, Richard MD00016580 Yakima	Ex Parte Order of Summary Action - Restriction	08/01/18	Allegations that Respondent has a health condition that interferes with his ability to actively collaborate with coworkers and administrators when treating patients.	Previous WMC order was modified to restrict Respondent from going to or admitting patients at a particular medical center pending further proceedings.
Dienst, William, Jr. MD00025927 Pacific	Ex Parte Order of Summary Action - Suspension	08/17/18	Alleged multiple instances of negligent clinical care, and alleged substance use disorder.	Suspension
Pearson, Sean PA60610092 King	Ex Parte Order of Summary Action - Suspension	09/20/18	Alleged health issues that impact Respondent's ability to safely practice with reasonable skill and safety.	Suspension
Formal Actions				
Chotiner, Darren MD00049050 Kitsap	Agreed Order	10/04/18	Respondent was convicted of five counts of gross misdemeanor assault and one count of felony assault.	Voluntary surrender of license.
Clayton, Daniel MD60081909 Clark	Agreed Order	08/08/18	Respondent failed to disclose material facts to the WMC before signing a prior stipulation, failed to comply with that order, and misused alcohol and controlled substances.	Indefinite suspension.
Dillinger, Donald MD00017867 Snohomish	Amended Final Order	10/31/18	On August 25, 2017, Respondent's license was restricted and he was required to comply with other conditions, including minimum three years of oversight. Respondent subsequently decided to retire from practice.	Voluntary surrender of license.
Feinman, Jessica MD00042972 Out of state	Final Order - Waiver of Hearing	10/25/18	The Oregon Medical Board found that Respondent engaged in unprofessional or dishonorable conduct and she surrendered her Oregon medical license.	Indefinite suspension.
Hu, Chester MD00039238 Clark	Agreed Order	10/04/18	Respondent failed to properly monitor a pediatric dental patient after administering anesthesia or to delegate monitoring to an appropriately credentialed provider.	Comply with guidelines and checklists for monitoring and managing sedated pediatric dental patients, practice reviews, written research paper, peer group presentation, \$5,000 fine, personal appearances, and termination no sooner than 3 years.

Iversen, Larry MD00012070 Kitsap	Agreed Order	08/23/2018	Moral turpitude and conviction of gross misdemeanor assault with sexual motivation.	Surrender of license.
Informal Actions				
Detore, Miranda PA60610394 Spokane	Informal Disposition	08/23/18	Alleged misdiagnosis and delay in appropriate treatment for multiple patients.	EMS trauma coursework, infection management coursework, practice reviews, personal appearances, \$500 cost recovery, and termination no sooner than 18 months.
Duran, Wayne MD00020201 King	Informal Disposition	08/23/18	Alleged negligent recordkeeping and inappropriate prescribing of controlled substances to a patient.	Opioid and polypharmacy prescribing coursework, written research papers, utilization of PMP, peer group presentations, practice reviews, personal appearances, \$500 cost recovery, and termination no sooner than 3 years.
Erickson, Andrew MD60377449 Out of state	Informal Disposition	08/23/18	Alleged failure to properly assess patients for surgery, perform adequate informed consents, and take appropriate measures in light of preexisting conditions and religious beliefs.	Gallbladder surgery coursework, bloodless surgery techniques coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 12 months.
Goodman, Richard MD00023878 King	Informal Disposition	10/25/18	Alleged delayed diagnosis and insufficient supervision of fellow physician.	Evaluation and diagnosis of cancer coursework, training staff coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 12 months.
Haas, Jonathan MD60716362 King	Stipulation to Practice under Conditions	08/23/18	Alleged health condition.	Respondent is safe to practice subject to monitoring, quarterly reports, personal appearances, and termination no sooner than 3 years.
Hayes, Rutherford MD00029036 King	Informal Disposition	08/23/18	Alleged mismanagement of chronic pain patients.	Practice restrictions on treating pain, self-reports, practice reviews, personal appearances, \$1,000 cost recovery, and modification no sooner than 1 year.
Metzger, Chris MD00043066 Out of state	Informal Disposition	10/04/18	Alleged misuse of alcohol and controlled substances.	Monitoring and testing, quarterly reports, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
O'Rourke, Patricia MD00025963 Spokane	Informal Disposition	08/23/18	Alleged mismanagement of chronic pain patients.	Opioid prescribing coursework, written research paper, practice reviews, and termination no sooner than completing requirements and at least 1 practice review.
Rokosz, Norman MD00038687 Out of state	Informal Disposition	08/23/18	Alleged wrong level surgery.	Surgical error prevention coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 2 years.
William Stanley MD00036765 Snohomish	Informal Disposition	08/23/18	Alleged delayed diagnosis.	Diagnosis of internal bleeding coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 3 years.