

UPDATE!

Washington Medical Commission Vol. 9, Winter 2019

Message From The Chair: Licensing Fee Increase

Alden Roberts, MD, MMM, FACS

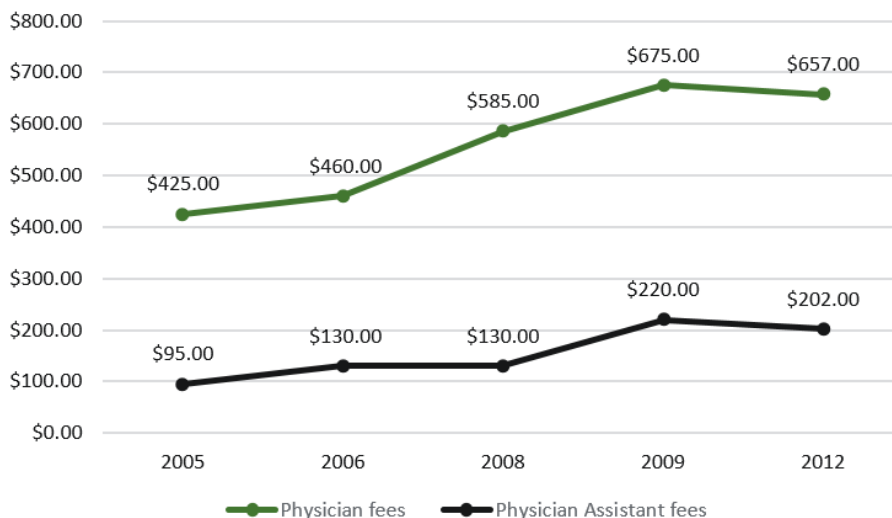


There is, understandably, considerable concern regarding the proposed license fee increase for the Washington Medical Commission (WMC). I will try to present here the process and the rationale from which the proposed increase was developed.

Background

The last license renewal fee increase was in 2009, and increased the renewal fee by \$90. The last review of license fees with the Department of Health was in 2014, and no change was indicated at that time. A Washington Physician Health Program (WPHP) assessment, as well as an assessment for Heal WA, are included in the license renewal fees but are unrelated to the fee increase by the WMC. The WMC is aware that there have been other state and federal initiatives that affect the business of practicing medicine, but these do not alter the financial requirements of the WMC.

Fee History



Proposed License Renewal Fee Increases

Physician Fee Increase

The proposed fee increase for physicians would make the two year license renewal fee \$956. The current license renewal fee is \$657 for two years, or \$328.50 per year. The proposal results in a \$299 increase for the two year renewal, or \$149.50 per year. It is a 45.5% increase in the biennial renewal fee.

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WMC Mission

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

Message From the Chair

PA Fee Increase

The proposed physician assistant two year renewal fee is \$379, or \$189.5 per year. The current physician assistant license renewal fee for two years is \$202, or \$101 per year. The proposal represents an 87.6% increase in the biennial renewal fee. Consideration was given to tying PA license fees to a percentage of physician license fees, but the WMC chose not to do so at this time.

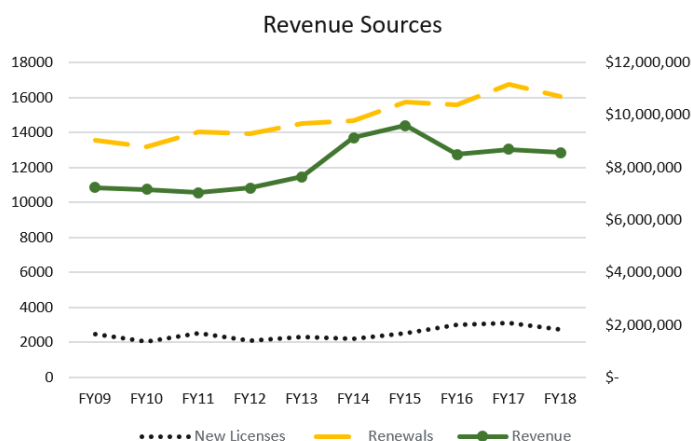
Why This Fee Amount?

The WMC looked at all cost drivers based on recent history, projected growth rates in the number of licensees, and the requirement to grow and maintain a reserve. The WMC is required by law to maintain a reserve of 12.5% of its budget. This reserve functions as a business continuity insurance that cannot be accessed without legislative permission. The legislature can allow us to use these reserves to cover cost overruns related to workload issues. The WMC cannot use these reserves to conduct normal operations, and the WMC is required to replenish these reserves if they are tapped. WMC reserves are forecast to be negative this year.

The State Auditor's Office performed an audit of our fees and the health professions fund. The proposed fee increases were undertaken in part due to the audit recommendations. It represents the minimum increase necessary to cover costs and to achieve the required reserves within the next 6 years. This is the cost of professional self-regulation and is required by statute.

Revenue

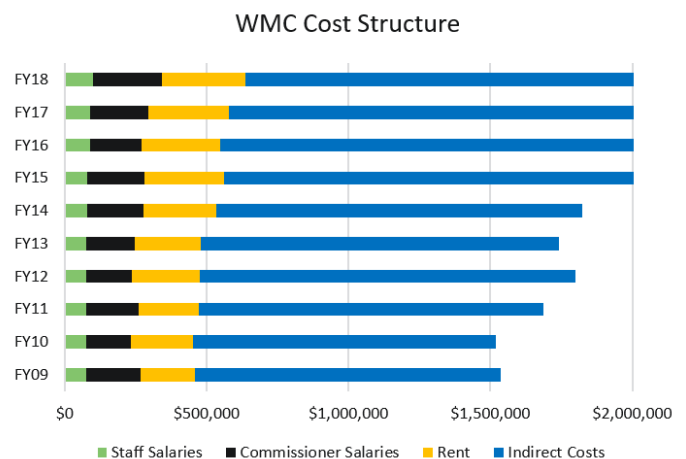
The Washington Medical Commission derives its entire revenue from license fees, with less than .001% from disciplinary actions. It has only two ways to increase revenue. The first is by licensing more practitioners; the second is by increasing fees. Growth in the number of practitioners licensed did not meet the forecasted rate, leaving a fee increase as the only option to increase revenue. WMC receives no money from general state funds.



Expenditures

The culture surrounding healthcare is changing. WMC had a 52% increase in the number of complaints. The cost of judges has gone up 195%. Adjudicative Clerk's Office expenses are up 100%. Attorney General costs are up 76%. This is related to an increase in legal activity and an across the board rate increase, and was non-negotiable for WMC.

The below graph is a representation of the cost structure over time. Indirect costs are charged to us by the Department of Health. They represent services, such as FBI background checks, that are shared with other Department of Health entities. These indirect costs, which are non-negotiable, represent 25% of WMC budget and are up 98%. Rent is up 54%, salaries of commission staff are up 33% under the rules of collective bargaining, and commissioner activity is up 50%. Commissioners are paid at the statutory rate of \$31.25 per hour and that this rate remains unchanged. WMC has no control over any of these costs.



Cost Reduction Activities

The WMC has engaged in a number of cost reduction activities. Some of these include the following:

- WMC has become a paperless organization. This resulted in a cost savings of over \$250,000 by eliminating paper newsletters and case files.
- Switching CME providers has resulted in a \$40,000 savings.
- LEAN methodology and electronic forms have decreased staff work time per case.
- Elimination of commission meetings around the state has decreased travel expenses.
- Staff size has been held constant over the last few years. Three positions were eliminated, a few were

Message From the Chair

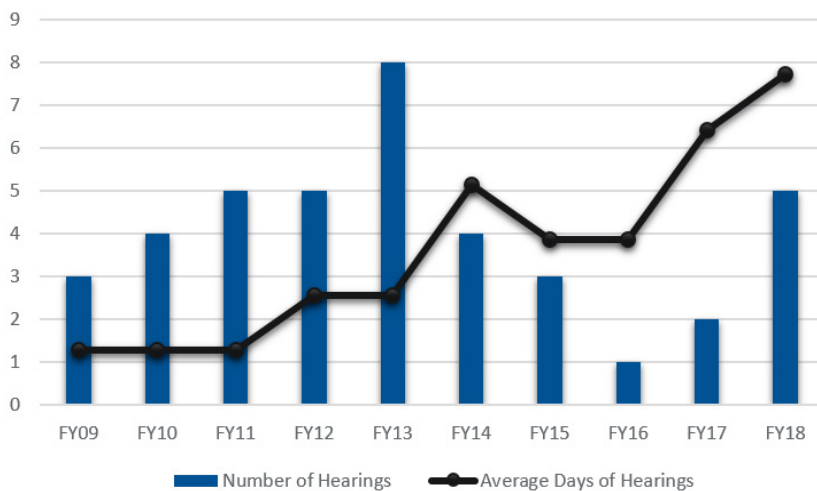
held vacant for several months, and some positions were reallocated for other purposes. No new permanent staff positions have been created since 2016. Those that were created at that time were created because of an increase in workload due to unfunded mandates.

While some of these cost saving measures are ongoing, others represent a one-time cost savings. Unfortunately the escalating costs in the areas outside of WMC control will continue beyond any possibility that the economies of cutbacks can be effective.

Closing Thoughts

WMC members spent a considerable amount of time in the last nine months discussing this proposal. A workgroup was created to evaluate options and determined that the current proposal reflected a financially responsible course to comply with regulations using the minimum fee increase possible. Their recommendation was presented to the entire WMC and was approved. Had we not proposed this increase, an increase would have been mandated for us by the Secretary of Health.

Average Length of Hearing



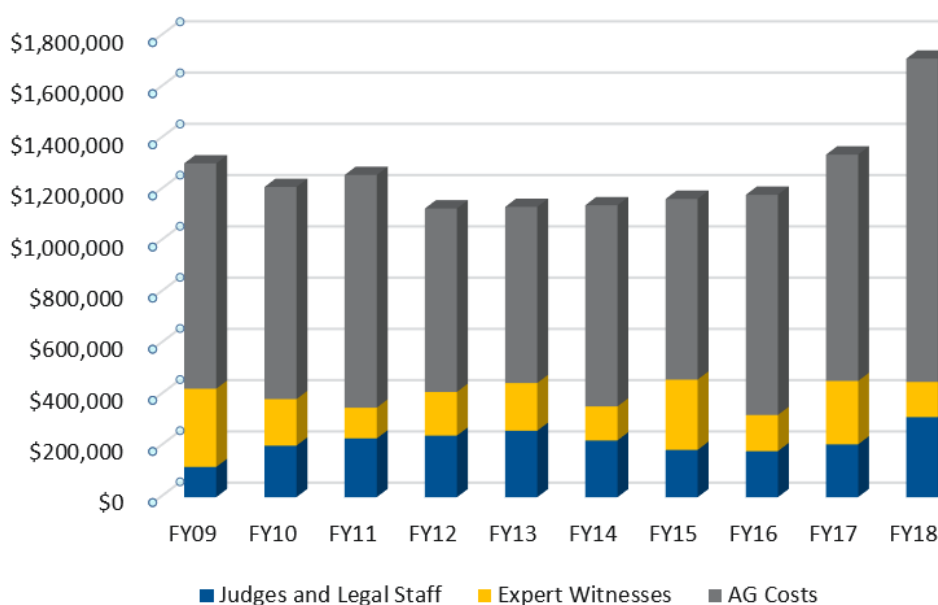
Many of the recent WMC cost increases caught us by surprise. Four years is too long a time period between reviews. Review of licensing fees needs to occur every two years due to unexpected and substantial circumstances. WMC staff leadership is working closely with Department of Health budget analysts to develop better forecasting tools so a more consistent, informed and on-going assessment of WMC finances is possible. Further, both internal and external organizations who provide services and bill WMC for their work will be provided quarterly budgets to work within and to notify WMC if these budgets are exceeded, so that escalating costs can be addressed quickly.

There have been several high profile cases that were extremely expensive over the last four years. Legal expenses have amplified because of increased respondent legal representation, legal maneuvering and the overall scale of legal activity, to which the WMC must respond if it is to appropriately protect the public. It seems unlikely that these issues

will diminish in the future. As such, I believe the fee increase, as presented, is well thought out and represents the minimum increase necessary to achieve financial stability for the organization.

Fee increases are never popular. Perhaps we could have identified a looming problem two years ago and increased fees at that time; perhaps not. Regardless, I believe our fees would have ended up at this level. This increase represents the level of revenue that our current and projected future expenses dictate. We appreciate your attention and your support of self-regulation of the profession.

Discipline Related Expenditures



Executive Director Report: Licensing – How is it so complex?



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Melanie de Leon, JD, MPA Executive Director

Our goal is to achieve same day license renewals and drastically shortened times to approve initial licensing applications while satisfying the need for public protection. What are some of the barriers to this lofty but common sense goal? Here is a look at the issues and how we are working to resolve them:

Issue	Resolution
<p>The System:</p> <p>The current licensing system was procured in 2008 and is no longer maintained by the vendor, so we cannot upgrade its capabilities or add on new customer-friendly features. It's old. It's clunky. It's not user friendly. It's what we have.</p>	<p>While we will be getting a new system (in 3-4 years), we need to do something now to reduce licensing times. We have begun scrutinizing all of our processes to see where and how we can streamline and see if we can at least add some customer-friendly services that are not part of the old system in the interim.</p>
<p>The Renewal Application:</p> <p>We added eight questions to the renewal application November 2018 to gather some information from the licensee population. These questions added complexity to the application for both the licensee and the Commission staff who review them.</p>	<p>We are re-examining the need for these questions and how we can move forward with a more streamlined renewal process.</p>
<p>Requirements for Initial Licensing:</p> <p>We currently require initial license applicants to provide work history, five years' worth of hospital privilege information, a photo and much, much more. These requirements add complexity, lead times and confusion to the application process.</p>	<p>We are examining everything we ask the applicant to provide for their initial license to see if we can streamline the process, eliminate some of those requirements or procure the information in way that does not require the applicant to provide it.</p>

We know that some stakeholders expressed frustration with our licensing times – we are frustrated too. We want to license physicians and physician assistants as quickly as possible with the least amount of steps, paperwork, staff time and frustration for you. We also take seriously our need to appropriately scrutinize applications with an eye for public protection. This is a work in progress and we are committed to making a real difference for you.

Online Delegation Agreements Are Now Available.
Completing the new online form for delegation agreements will allow PA's same-day provisional approval to practice. Access the free online form [here](#).

WPHP Report: Setting the Record Straight, Part 2



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Chris Bundy, MD, MPH

**Executive Medical Director, Washington Physicians Health Program
President-Elect, Federation of State Physician Health Programs**

Introduction

In Part 1 of “Setting the Record Straight,” I explored some of the challenges and rewards of working in the field of physician health. Chief among these challenges is my worry for colleagues who may avoid physician health program (PHP) assistance or have difficulty engaging collaboratively with the PHP due to inaccurate or misguided information. Unacceptably high rates of physician distress, burnout, and suicide, superimposed on a national addiction and mental health epidemic, make the potential harms of misinformation more serious, and real, than ever. In this installment of “Setting the Record Straight,” we will look more closely at some of the common questions I receive about the Washington Physicians Health Program (WPHP). The goal here is to empower physicians with accurate information so they may make informed decisions should they find themselves, or a colleague, in difficulty.

How is WPHP funded?

70% of WPHP’s operating budget is supported by license surcharge paid by all licensees of the professional groups we serve. Surcharge funding is critical to our ability to provide high quality services at a lower cost to participants while avoiding undue influence from extramural funding sources. The remaining 30% comes mostly from monitoring fees paid by program participants. Participants who do not require monitoring do not pay program fees and are only charged for initial toxicology testing. A small portion of our funding comes from donations, mostly from current or former participants, which are used to provide need-based financial assistance to other participants. WPHP has a strict conflict of interest policy that prohibits accepting gifts or financial support from entities (including evaluation or treatment centers) that have a business interest in WPHP activities.

Is WPHP part of the Washington Medical Commission (WMC)?

No, and this is often an area of confusion. WPHP is an independent, non-profit, physician-led organization contracted with the Department of Health to provide assessment, treatment referral, post-treatment monitoring and advocacy for medical professionals with health conditions that may impair their ability to practice safely. Enabling legislation permits WPHP to assist physicians and physician assistants confidentially without the involvement of the WMC. This therapeutic alternative to discipline promotes early intervention and treatment of health problems before patients are put at risk.

This model is only possible when the disciplinary authority trusts that WPHP will exercise its legal and ethical obligation to make a notification when a health professional or program participant poses a risk to patients. Effective collaboration between WPHP and the WMC is critical to maintaining the trust upon which our program depends. Unfortunately, such collaboration can lead some to assume there is little or no difference between the two organizations. However, closer analysis reveals a complementary truth; WPHP must also safeguard the trust of the professional community and participants we serve by making a report to the WMC only when necessary. We must use all means available to engage and collaborate with our participants, employers, credentialing entities, and other stakeholders to promote positive outcomes. Such efforts should serve the rehabilitative needs of our participants while averting the need to protect the public through professional discipline. That WPHP infrequently reports participants to the WMC, but will do so when necessary, suggests that we are effectively honoring our commitments to both.

How often does WPHP report a colleague to the disciplinary authority?

So far this year, a mandatory reporting requirement was triggered in only 4% of referrals under evaluation and 0.7% of monitoring participants. 92% of WPHP’s 319 current participants are unknown to their disciplinary authority. The vast majority of individuals who are known to their disciplinary authority were referred to WPHP by their Board or Commission as part of an investigation or disciplinary action and were, therefore, already known. Usually these are cases in which no one called WPHP when concerns of impairment came to light and eventually someone called their disciplinary authority instead.

Is WPHP really a voluntary program?

Yes. Participation in WPHP is completely voluntary. That said, for some it may not *feel* voluntary. In fact, there have been some who have gone so far as to describe PHP’s as coercive. To suggest as much reflects a misunderstanding of how PHP’s work as well as the social contract that governs medical practice [1].

WPHP offers a voluntary opportunity for confidential assistance to physicians who are worried about their health, their ability to safely practice or who want to avoid sanction by their employer, medical executive committee, or disciplinary authority. Participation in WPHP allows physicians to re-enter or remain in practice rather than

face these hardships. When physicians cannot or will not follow recommendations for rehabilitation, and pose a risk to patient safety, PHPs have mandatory reporting requirements to licensing boards and commissions and must withhold advocacy to workplaces. The use of mandatory reporting mechanisms in cases of suspected impairment recognizes that tying treatment adherence to future medical practice is highly effective at rehabilitating the professional *and* protecting public safety. However, it is ultimately physician workplaces and licensing bodies that mandate PHP participation; PHPs themselves cannot discipline or force physicians to participate. As such, WPHP cannot be considered coercive or non-voluntary.

Voluntary participation in a PHP is part of the broader social construct between physicians and their patients: the social contract. Physicians agree to practice in a professional manner in exchange for the privilege to practice interventions that would be illegal if conducted by other citizens. Unlicensed citizens are not permitted to do surgery, prescribe medications or conduct clinical evaluations without this privilege. The social contract is an agreement between professionals (physicians in this case) and governments (as public representatives) that secures a physician's privilege of practice in exchange for the benefit or right of citizens to expect safe care. The right of the state (via licensing authorities) to take action against the licenses of physicians on behalf of the public is not controversial. WPHP's fulfillment of its ethical, legal and professional obligations, pursuant to the American Medical Association *Code of Medical Ethics* [2-3] and applicable Washington statutes, is a critical societal interaction that serves to increase available options for physicians within the construct of the social contract between physicians and patients.

What mechanisms are in place to ensure WPHP's accountability to participants and the medical community?

WPHP is governed by a Board of Directors representing a broad range of stakeholders from across the medical and participant community. WPHP's Executive Director and Executive Medical Director are directly accountable to our Board for the execution of WPHP's mission. WPHP's Board of Directors and bylaws are, in turn, approved by the Executive Committee of the Washington State Medical Association (WSMA), ensuring WPHP's accountability to organized medicine in the state. WPHP provides WSMA with quarterly reports and an annual report to the WSMA House of Delegates.

WPHP is also accountable to the disciplinary authorities we serve through our contract with the Department of Health. Our contract specifies essential program elements as well as the special qualifications and expertise required for the evaluation and treatment of health professionals among the programs WPHP uses. Among other things, WPHP deliverables include quarterly statistical reporting and a detailed annual report to the Department of Health.

WPHP is accountable to our participants through annual and exit surveys that measure participant satisfaction, self-reported health, professional, and quality of life outcomes, as well as opportunities for improvement. WPHP also has a meaningful appeal process for individual participants who do not agree with WPHP's recommendations. Through the appeal process, participants are able to have their recommendations reviewed first by their clinical coordinator, then by a panel of clinical staff that were not involved in developing the recommendations under review and, finally, the Executive Medical Director. So far this year, only two cases have proceeded to final review by the Executive Medical Director and, in both cases, the recommendations were modified to the mutual satisfaction of WPHP and the participant.

WPHP will be among the first state physician health programs to undergo an external review by the Federation of State Physician Health Programs' (FSPHP) Program Enhancement and Effectiveness Review (PEER™). This national program, currently under development by the FSPHP, is intended to promote accountability, consistency and excellence among member PHPs. It is endorsed and supported by the American Medical Association, American College of Physicians, American Board of Medical Specialties, Federation of State Medical Boards, American Psychiatric Association and the American Osteopathic Association.

Finally, WPHP is accountable to the colleagues, employers, health care organizations, medical schools, graduate medical education programs, credentialing entities, and professional liability carriers that consult us. In short, WPHP operates under the tight scrutiny of our many stakeholders in order to effectively rehabilitate and advocate for program participants.

Conclusion

In WPHP's 33-year history, we have facilitated the rehabilitation and successful return to practice of over 1500 health professionals with impairing health conditions - roughly one-third of a large graduating medical school class each year. In addition, we have provided help and support to countless others who sought WPHP assistance but did not require monitoring-based advocacy. In Part 3 of "Setting the Record Straight," I will explore questions related to WPHP's evaluation and treatment referral process as well as WPHP satisfaction and outcomes data. I will continue to tell the story of how getting better works and how great better can be.

References:

Candilis P. Physician health programs and the social contract. *AMA J of Ethics*. 2016; 18: 77-81.

Physician Responsibilities to Impaired Colleagues. American Medical Association Code of Medical Ethics Opinion 9.3.2. Accessed 11/20/19 at <https://www.ama-assn.org/delivering-care/ethics/physician-responsibilities-impaired-colleagues>

Professional Self-Regulation: Physician Wellness. American Medical Association Code of Medical Ethics Opinion 9.3.1. Accessed 11/20/19 at <https://www.ama-assn.org/delivering-care/ethics/physician-health-wellness>

Rulemaking Efforts



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Amelia Boyd Program Manager

Substitute Senate Bill 5380 – Concerning opioid use disorder treatment, prevention, and related services.

[Substitute Senate Bill \(SSB\) 5380](#) was passed by the legislature on April 16, 2019. The bill is concerning opioid use disorder treatment, prevention, and related services and mandates that the WMC adopt rules for both allopathic physicians and physician assistants. A rules hearing was held on December 12, 2019 where the draft language was adopted. The rules will be effective January 1, 2020. For more information about these rules, please visit our [website](#).

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.

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, January 15, 2020.

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 WMC in an active patient safety role.

At their business meeting on November 15, 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 Office of the Code Reviser 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 commission 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 commission in an active patient safety role.

More Information

Please visit our [rulemaking site](#).

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



August 1, 2019 – October 31, 2019

Below are summaries of interim and final actions taken by the Medical WMC. 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 Medical WMC [website](#).

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Interim and Formal Actions				
Lee, Gerald MD00043750 King	Final Order	06/27/19	Sexual misconduct.	Suspension for at least 18 months with pre-conditions to petition for reinstatement.
McMahon, Ross MD00047181 King	Final Order - Default	08/20/19	Failure to cooperate with WMC investigation.	Indefinite suspension.
Reese, Susan MD60754962 Out of state	Final Order - Default	09/09/19	Failure to comply with a WMC order.	Indefinite suspension.
Smith, Brenda MD00037884 Whatcom	Final Order - Default	10/16/19	Patient abandonment and failure to maintain current address on file.	Indefinite suspension.
Informal Actions				
Anderson, David MD60367274 Out of state	Informal Disposition	10/04/19	Alleged misuse of alcohol, failure to report DUI and reckless driving conviction.	Undergo a health program evaluation and comply with all requirements, ethics coursework, written research paper, personal appearances, \$4,000 cost recovery, and termination no sooner than 3 years.
Asomaning, Rebecca MD00047870 Thurston	Informal Disposition	10/04/19	Alleged failure to apply age appropriate pediatric testing methods and delayed diagnosis.	Written research paper, preceptor oversight, practice reviews, personal appearances, \$1,000 cost recovery, and termination no sooner than 2 years.
Bowman, Jaime MD00045278 Spokane	Informal Disposition	08/22/19	Alleged failure to remove expired contraceptive device prior to placement of a new device.	Clinical coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
Carulli, Nicholas MD00037171 Clark	Informal Disposition	08/22/19	Alleged boundary violations and improperly allowing staff member to sign prescriptions.	Ethics coursework, prescribing coursework, written research paper, personal appearances, \$2,000 cost recovery, and termination no sooner than 1 year.

Chang, Michael MD60333198 Yakima	Informal Disposition	10/28/19	Alleged failure to conduct a complete physical evaluation and delayed diagnosis.	Self study, written research paper, written office protocol, peer group presentation, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
Hein, Lee MD00015144 Out of state	Modified Informal Disposition	10/22/19	Alleged ongoing negligent chronic pain management.	Permanent restriction from prescribing controlled substances, surrender of DEA registration, and personal appearances, and pre-conditions to petition for modification (other prior requirements noted as completed).
Howard, Sara PA60502824 Clark	Informal Disposition	10/04/19	Alleged failure to properly prep patient for superficial procedure and to take a thorough medication history.	Clinical coursework, written research paper, peer group presentation, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
Kakar, Mahmood PA10003149 Snohomish	Informal Disposition	08/22/19	Alleged failure to conduct a complete physical evaluation and delayed diagnosis.	Clinical coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
Laurino, James MD00024695 Benton	Informal Disposition	10/04/19	Alleged sexual misconduct, boundary violations, and patient abuse.	Voluntary surrender.
Millik, Filiz MD00041501 Pierce	Informal Disposition	08/22/19	Alleged inability to practice with reasonable skill and safety due to a health condition.	Compliance with physician health program requirements, personal appearances, and termination no sooner than discharge by health program.
Park, Sangkun MD00032417 Out of state	Informal Disposition	08/22/19	Reprimand and fine by the Oregon Medical Board in April 2018 for alleged boundary and ethics violations.	Compliance with Oregon Medical Board requirements, ethics coursework, restriction on entering business relationships with patients, personal appearances, \$1,000 cost recovery, and termination no sooner than completion of all requirements.
Perry, Johnathan MD00034127 Benton	Informal Disposition	08/22/19	Alleged failure to conduct a complete physical evaluation and delayed diagnosis.	Clinical coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than completion of all requirements.
Shirk, Tracey MD00034802 King	Informal Disposition	10/04/19	Alleged practice of medicine while under the influence of non-prescribed controlled substances.	Compliance with physician health program requirements, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than discharge by health program.
Travis, Dane MD00033916 King	Informal Disposition	10/04/19	Alleged sexual misconduct, boundary violations, and patient abuse.	Voluntary surrender.
VanDerBeck, Kenneth PA60646033 Out of state	Informal Disposition	10/04/19	Order entered by the Physician Assistant Board of California in November 2018 for alleged boundary and ethics violations.	Compliance with California Order, self reports, notice to the WMC if Respondent resumes practice in WA, personal appearances, \$1,000 cost recovery, and termination no sooner than 3 years.

Voss, Julie MD00033431 King	Informal Disposition	10/04/19	Alleged failure to supervise medical staff in performing a laser treatments.	Self study, written research paper, peer group presentation, personal appearances, \$2,000 cost recovery, and termination no sooner than 1 year.
Webb, Joseph PA60046817 Benton	Informal Disposition	08/22/19	Alleged failure to conduct a complete physical evaluation and delayed diagnosis.	Clinical coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than completion of all requirements.
Zugec, Mirko MD00037961 Spokane	Informal Disposition	09/30/19	Alleged failure to allow a patient the privacy to dress or undress.	Ethics coursework and \$1,000 cost recovery.

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.

PA News: Legal Assistance



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Theresa Schimmels, PA-C Physician Assistant Member

Happy New Year! I hope you had a wonderful holiday season. To start off our new year, I wanted to educate you on an issue that comes up from time to time when we are speaking with a physician or physician assistant that we have taken action on.

After you've been contacted with a letter that a complaint against you is being investigated by the WMC, the appropriate thing to do is acknowledge receipt of the notification and contact your practice's risk manager. Often these qualified individuals can help direct you through the complaint process and will help contact your insurance carrier.

Did you know that most liability carriers/malpractice carriers will provide policy holders (you) with a degree of legal assistance during WMC investigations? Often, this is provided as part of your normal policy, without extra cost to you. Check with your carrier to clarify what kind of support is provided under your policy.

You may have the right to select your own legal counsel as well. Several carriers I researched allow you to select counsel. Having a working knowledge of attorneys in your area may be helpful. Even if you feel the complaint is frivolous, the professional advice provided by legal assistance through your liability carrier can be very helpful.

Contact your corporation, practice, or personal liability/medical malpractice carrier to find out more information as to what is covered with your policy.



**For information as it happens
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E-Prescribing Law and Rulemaking

Tracy West, JD

**Deputy Director, Pharmacy Quality Assurance Commission
Washington State Department of Health**

During the 2019 Legislative Session, the Legislature passed Substitute Senate Bill 5380, this bill amended RCW 69.50.312 which requires all controlled substance prescriptions to be electronically communicated unless the prescriber receives a waiver from the Department of Health (DOH). As the regulatory authority of the Controlled Substance Act, the DOH determined the waiver should be placed within the Pharmacy Quality Assurance Commission's (Pharmacy Commission) rule chapter.

The rule will establish the criteria for prescribers to receive a waiver from the DOH to exempt them from complying with the electronic prescribing mandate which goes into effect on January 1, 2021. This rule will address economic, technological and other exceptional circumstances that prohibit a prescriber from electronically prescribing.

The Pharmacy Commission authorized staff to file a CR 101 to begin the rule making process for this new rule. Staff will be working internally with other prescribing boards, commissions and secretary professions on the rules as well as the implementation of the waiver. Stakeholder meetings will also be held at future dates to discuss the rule language.

The Pharmacy Commission will not be responsible for reviewing these waiver requests. Waiver requests will be sent to the prescribing boards and commissions for their review.

2020 Notice of Recruitment



The Washington Medical 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, 2020 the Commission will have openings for:

- One physician representing Congressional District 6
- One physician representing Congressional District 8
- One Physician-at-Large

Determine what congressional district you live in [here](#).

The physician applicants for Congressional Districts 6 and 8 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.

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 20, 2020**.

If you have any questions about serving on the Commission, please contact Amelia Boyd, Program Manager, at Post Office Box 47866, Olympia, Washington 98504-7866, by email at amelia.boyd@wmc.wa.gov, or call (360) 236-2727.



Members and Meetings



WASHINGTON
Medical
Commission
Licensing. Accountability. Leadership.

Medical Commission Members

Chair: Alden W. Roberts, MD

1st Vice Chair: John Maldon

2nd Vice Chair: Claire Trescott, MD

James E. Anderson, PA-C

Toni L. Borlas

Charlie Browne, MD

Jimmy Chung, MD

Diana Currie, MD

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Harry Harrison, Jr., MD

Christine Hearst, CPMSM

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April Jaeger, MD

Charlotte W. Lewis, MD

Terry Murphy, MD

Scott Rodgers

Theresa Schimmels, PA-C

Robert H. Small, MD

Candace Vervair

Richard Wohns, MD

Yanling Yu, PhD

Update! Editorial Board

James E. Anderson, PA-C Micah Matthews, MPA

Harry Harrison Jr., MD Bruce Hopkins, MD

Candace Vervair Jimi Bush, Managing Editor

2020 WMC Meeting Dates

Date	Location
January 16 - 17	Hotel Interurban 223 Andover Park E Tukwila, WA 98188
February 27 - 28	The Heathman Lodge 7801 NE Greenwood Dr. Vancouver, WA 98662
April 9 - 10	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
May 14 - 15	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
July 9 - 10	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
August 20 - 21	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
October 1 - 3	TBD
November 12 - 13	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512

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.

[Email us](#) with your questions and comments.