WASHINGTON

Medical Commission

Licensing. Accountability. Leadership.

Policy Committee Meeting

January 2, 2025

Policy Committee Meeting

WASHINGTON Medical Commission
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In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Washington Medical Commission (WMC) meetings. This agenda is subject to change. The WMC will take public comment at this meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Virtual via Teams Webinar: Registration link can be found below.
Commissioners and staff will attend virtually.
Physical location: 111 Israel Rd SE, TC2 Room 166, Tumwater, WA 98501

Thursday, January 2, 2025

Open Session

4:00 pm	Agenda	
To attend virtually, please **register** here: WMC Policy Committee		
The goal of this meeting is to provide an opportunity for anyone to comment on and suggest changes to the WMC's policies, guidance documents, procedures, and interpretive statements. The WMC encourages open discussion on the items listed on the agenda.		
Organizers: Kyle Karinen, Executive Director & Micah Matthews, Deputy Executive Director		
1	**Proposed Policy: Clinical Experience Assessment** *Discussion of proposed policy which has completed DOH Secretary review*	Pages 4-10
2	**Proposed Guidance Document: Communicating Diagnostic Test Results and Time Critical Information to Patients and Practitioners** *Review and discussion of proposed document which combines two current Guidance Documents:* • Communicating Diagnostic Test Results to Patients, GUI2016-02 • Direct Communication of Time Critical Patient Medical Information Between Health Care Practitioners, GUI2021-01 *If this proposed document is recommended as a replacement for the two documents listed above, the Policy Committee would need to recommend their rescission.*	Pages 11-14
3	**Guidance Document: Processing Complaints Against Licensees Enrolled in the Washington Physicians Health Program** *Review and discussion of current document and proposed revisions.*	Pages 15-18
4	**Guidance Document: Completion of Death Certificates by Physicians and Physician Assistants** *Review and discussion of current document and proposed revisions.*	Page 19
Public Comment *The public will have an opportunity to provide comments about the items on this agenda. If you would like to comment, please use the Raise Hand function. Please identify yourself and who you represent, if applicable. If you would prefer to submit written comments, please email medical.policy@wmc.wa.gov by 5 pm on* ***December 27, 2024****.*		

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Future Topics for Discussion	
The following items are next up for review. Feel free to provide comments regarding these items at medical.policy@wmc.wa.gov.	
1	Guidance Document: A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety (GUI2014-02)
2	Policy: Elective Educational Rotations (POL2020-01)
3	Guidance Document: Sexual Misconduct and Abuse (GUI2017-03)
4	Policy: Practitioners Exhibiting Disruptive Behavior (MD2021-01)
5	Procedure: Interactive and Transparent Development of Evidence-based Policies and Guidelines (PRO2018-02)
6	Interpretive Statement: Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants (INS2023-03)
7	Interpretive Statement: Opioid Prescribing & Monitoring for Patients (INS2023-04)

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Policy

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Title:	Clinical Experience Assessment		POL2024-01
References:	RCW 18.71.472		
Contact:	Washington Medical Commission		
Phone:	(360) 236-2750	E-mail:	medical.commission@wmc.wa.gov
Supersedes:	NA		
Effective Date:			
Approved By:	Karen Domino, MD ,Chair		

Policy

It is the policy of the Washington Medical Commission (Commission) to consider the attached Clinical Experience Assessment (CEA) as the clinical assessment adopted by the Commission to determine the readiness of international medical graduates to apply and serve in residency programs according to RCW 18.71.472.

Introduction

In 2020, ~~the Washington State Legislature chose to extend the responsibilities of the International Medical Graduate (IMG) Assistance Work Group with the passage of~~ Senate Bill 6551; ~~thus, creating the IMG Implementation Workgroup (Workgroup). The bill also~~ required that the Washington Medical Commission (Commission) "adopt a clinical assessment to determine the readiness of international medical graduates to apply and serve in residency programs and adopt a grant award process for distributing funds" pursuant to appropriation by the legislature and donations received from public and private entities. ~~After meeting monthly throughout 2022, t~~The Workgroup voted to propose the following Clinical Experience Assessment (CEA) form, Attachment A, which meets the requirement set forth by the legislature.

~~Policy~~Instructions

Purpose of the CEA Form. The CEA is intended for physician assessors working with IMGs to prepare them for residency and to determine their overall readiness for residency training. The CEA is not an element of application for residency nor is it a qualification for residency.

Assessment of Residency Preparedness. The CEA is to be used to assess what level of "entrustment" seems appropriate for the IMG to enter a residency and to aid the IMG in successfully gaining a residency position.

Frequency of Assessment. The CEA is to be used as a quarterly assessment tool throughout the program until a passing score on all competencies has been attained, signifying residency readiness.

Monitoring of the CEA Form's Effectiveness. As funding and staffing capabilities permit, the Workgroup should develop a monitoring system to track effectiveness and limitations involving the use of the CEA.

Once developed, the Workgroup is to begin tracking progress and challenges of IMGs who utilized the CEA form, identify where additional education or targeted trainings may be needed, and adjust to optimize the effectiveness of IMG pre-residency training, and of the CEA form itself.

Retention. The CEA form should be retained until [residency placement/6 years/?] and be made available upon request.

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Clinical Experience Assessment

Name: Date:

Ranking Guidelines		
1	"I did it."	The licensee required complete guidance or was unprepared or not competent; I had to do most of the work myself.
2	"I talked them through it."	The licensee was able to perform some tasks competently but required repeated directions.
3	"I directed them from time to time."	The licensee demonstrated some independence and competence and only required intermittent prompting.
4	"I was available just in case."	The licensee functioned fairly independently and competently and only needed assistance with nuances or complex situations.
5	"Not observed."	The licensee was not seen or observed completing this task.

1. Gather a History and Perform a Physical Examination					
1	2	3	4	5	Task
					Obtain a complete and accurate history in an organized fashion.
					Demonstrate patient-centered interview skills.
					Demonstrate clinical reasoning in gathering focused information relevant to a patient's care.
					Perform a clinically relevant, appropriately thorough physical exam pertinent to the setting and purpose of the patient visit.

2. Prioritize a Differential Diagnosis Following a Clinical Encounter					
1	2	3	4	5	Task
					Synthesize essential information from previous records, history, physical exam, and initial diagnostic evaluations to propose a scientifically supported differential diagnosis.

1	2	3	4	5	Task
					Prioritize and continue to integrate information as it emerges to update differential diagnosis, while managing ambiguity.
					Engage and communicate with team members for endorsement and verification of the working diagnosis that will inform management plans.
3. Recommend and Interpret Common Diagnostic and Screening Tests					
1	2	3	4	5	Task
					Recommend first-line cost-effective screening and diagnostic tests for routine health maintenance and common disorders.
					Interpret results of basic studies and understand the implication and urgency of the results.
4. Enter and Discuss Orders and Prescriptions					
1	2	3	4	5	Task
					Compose orders efficiently and effectively verbally, on paper, and electronically.
					Demonstrate an understanding of the patient's condition that underpins the provided orders.
					Recognize and avoid errors by attending to patient-specific factors, using resources, and appropriately responding to safety alerts.
					Discuss planned orders and prescriptions with team, patients, and families.
5. Document a Clinical Encounter in the Patient Record					
1	2	3	4	5	Task
					Prioritize and synthesize information into a cogent narrative for a variety of clinical encounters (admission, progress, pre- and post-op, and procedure notes; informed consent; discharge summary).
					Follow documentation requirements to meet regulations and professional expectations.
					Document a problem list, differential diagnosis, and plan supported through clinical reasoning that reflects patient's preferences.

6. Provide an Oral Presentation of a Clinical Encounter					
1	2	3	4	5	Task
					Present personally gathered and verified information, acknowledging areas of uncertainty
					Provide an accurate, concise, well-organized oral presentation.
					Adjust the oral presentation to meet the needs of the receiver.
					Demonstrate respect for patient's privacy and autonomy.
7. Form Clinical Questions and Retrieve Evidence to Advance Patient Care (*only level 3 required)					
1	2	3	4	5	Task
					Combine curiosity, objectivity, and scientific reasoning to develop a well-formed, focused, pertinent clinical question (ASK).
					Demonstrate awareness and skill in using information technology to access accurate and reliable medical information (ACQUIRE).
					*Demonstrate skill in appraising sources, content, and applicability of evidence (APPRAISE).
					*Apply findings to individuals and/or patient panels; communicate findings to the patient and team, reflecting on process and outcomes (ADVISE).
8. Give or Receive a Patient Handover to Transition Care Responsibility					
1	2	3	4	5	Task
					Document and update an electronic handover tool and apply this to deliver a structured verbal handover, using communication strategies known to minimize threats to transition of care
					Provide succinct verbal communication conveying illness severity, situational awareness, action planning, and contingency planning.
					Demonstrate respect for patient's privacy and confidentiality.

9. Collaborate as a Member of an Interprofessional Team					
1	2	3	4	5	Task
					Identify team members' roles and responsibilities and seek help from other members of the team to optimize health care delivery.
					Include team members, listen attentively, and adjust communication content and style to align with team-member needs.
					Establish and maintain a climate of mutual respect, dignity, integrity, and trust; prioritize team needs over personal needs to optimize delivery of care; and help team members in need.
10. Recognize a Patient Requiring Urgent or Emergent Care and Initiate Evaluation and Management (*only level 3 required)					
1	2	3	4	5	Task
					Recognize normal and abnormal vital signs as they relate to patient- and disease-specific factors as potential etiologies of a patient's decompensation.
					Recognize severity of a patient's illness and indications for escalating care.
					*Initiate and participate in a code response and apply basic and advanced life support.
					Upon recognition of a patient's deterioration, communicates situation to attending physician.
11. Obtain Informed Consent for Tests and/or Procedures					
1	2	3	4	5	Task
					Describe the key elements of informed consent: indications, contraindications, risks, benefits, alternatives, and potential complications of the intervention.
					Communicate with the patient and family to ensure that they understand the intervention including pre/post procedure activities.

12. Perform General Procedures of a Physician (*only level 3 required)					
1	2	3	4	5	Task
					*Demonstrate technical skills required for the procedure.
					Understand and explain the anatomy, physiology, indications, contraindications, risks, benefits, alternatives, and potential complications of the procedure.
					Completes expected procedures and keeps log book signed by mentor
13. Identify System Failures and Contribute to a Culture of Safety and Improvement (*only level 3 required)					
1	2	3	4	5	Task
					Identify and report actual and potential ("near miss") errors in care using system reporting structure (event reporting systems, chain of command policies).
					Participate in system improvement activities in the context of learning experiences (rapid- cycle change using plan–do–study– act cycles, root cause analyses, morbidity and mortality conference, failure modes and effects analyses, improvement projects).
					Engage in daily safety habits (accurate and complete documentation, including allergies and adverse reactions, medicine reconciliation, patient education, universal precautions, hand washing, isolation protocols, falls and other risk assessments, standard prophylaxis, time-outs).
					Admit one's own errors, reflect on one's contribution, and develop an individual improvement plan.

Guidance Document

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Communicating Diagnostic Test Results and Time Critical Information to Patients and Practitioners

Introduction

Effective communication is a critical component of medical care. Quality patient care requires that study results are conveyed in a timely fashion to those responsible for treatment decisions and those patients or guardians who must make informed choices. Communication should:

a) Be tailored to satisfy the need for timeliness;
b) Identify and communicate clearly the critical nature of the findings
c) Identify responsibility to inform the patient;
d) Encourage health care practitioner communication; and
e) Minimize the risk of communication errors.

Various factors and circumstances unique to a clinical scenario may influence the methods of communication between those caring for the patient. Timely receipt of the report is as important as the method of verification and delivery method.

The Washington Medical Commission issues this guideline to emphasize the responsibility of all practitioners to identify and responsibly communicate Time Critical Medical Information (TCMI) in a timeframe and manner that assures the usefulness of the information for quality patient care. This guideline also recognizes the shared responsibility of administrators, referring practitioners, treating practitioners and interpreting practitioners to design and use support systems to document the timely communication and receipt of TCMI.

Similarly, patients deserve to receive their test results and an adequate explanation of the results in a timely manner. Failure to do so can cause unnecessary worry and lead to serious consequences for the patient.

The term "test results" in this guideline refers to diagnostic test results. In response to a provision in the 21st Century Cures Act, the Department of Health and Human Services completed a federal rule in 2022 mandating patient access to their health records in electronic format while also prohibiting the practice of information blocking. With the near instant patient access to test results, it becomes essential that practitioners are not only notifying patients of results, but proactively reaching out to make sure there is a clear understanding on the part of the patients. Communication with the patient regarding the implications and the next steps suggested or required by the results should be prioritized for continuity of care.

Guidelines for Practitioner-to-Practitioner Communication

Practitioners who provide TCMI should, in a collaborative fashion with interested parties, identify TCMI and establish transmission and verification policies for TCMI in order to assure timely care and patient safety. Communication of information is only as effective as the system that conveys the information. There is a reciprocal duty of information exchange. The referring practitioner or treating practitioner shares the responsibility for obtaining results of studies ordered. Formulating transmission and verification of test results requires the commitment and cooperation of administrators, referring practitioners, and interpreting practitioners. Practitioners should identify and communicate who will be responsible for informing the patient. In reporting TCMI, the practitioner should expedite the delivery of a TCMI (preliminary or final) in a manner that reasonably assures timely receipt and verification of transmission of the results.

Guidelines for Practitioner-to-Patient Communication

All practitioners should have an effective system that will ensure timely and reliable communication of test results to patients and appropriate follow-up. While the system will vary depending on the type of practice, the Commission recommends that it be in writing and, at a minimum, contain the following elements:

1. Clear definitions to distinguish between test results that are routine and test results that are critical.
2. A mechanism by which the ordering physician is notified of the receipt of critical test results from the diagnosing physician, if not the same practitioner.
3. A process to communicate the test results to the patient in a timely manner—whether in writing, electronic, telephonic or in person (depending on preference indicated by the patient)—that ensures the patient receives the test results.

a. Communication should be in a format and in language that is easily understood by the patient to include communicating at an accessible education level.

b. The medical record should reflect who made the communication, how the communication was made, and when the communication was made.

c. Communication should comply with the privacy requirements of the Health Insurance Portability and Accountability Act and Washington State law.

4. Confirmation that the patient received the test results. Verification of receipt should be documented in the medical record.
5. Clear instructions to the patient to enable the patient to contact the practitioner and ask questions about the test results and schedule a follow-up appointment with the practitioner. The instructions should be documented in the medical record.
6. If the test results indicate that treatment may be necessary, the ordering practitioner should discuss potential options with the patient and initiate treatment.
7. When the ordering practitioner is unavailable, there must be a qualified designee who will assume responsibility to receive test results, notify the patient, and initiate appropriate clinical action and follow up.
8. The system should not depend solely on the attentiveness of human beings but be backed up by technology or processes that prevent test results from being missed, lost or inadequately communicated to the ordering physician or to the patient.

Additional Guidance and Scenarios

Situations that may require non-routine communication

1. **Findings that suggest a need for immediate or urgent intervention**:

   Generally, these cases may occur in the emergency and surgical departments or critical care units and may include diagnostic evidence of a malignancy including new suggestive imaging findings, pneumothorax, pneumoperitoneum, or a significantly misplaced line or tube, critical time sensitive laboratory values, and pathology results that may represent critical or potentially life-threatening medical information.

2. **Findings that are conflicting with a preceding interpretation of the same examination and where failure to act may adversely affect patient health:**

   These cases may occur when the final interpretation is contradictory with a preliminary report or when significant discrepancies are encountered upon subsequent review of a study after a final report has been submitted.

3. **Findings, including imaging studies and laboratory results, that the interpreting physician reasonably believes may be seriously adverse to the patient's health and are unexpected by the treating or referring physician:**

   These cases may not require immediate attention but, if not acted on, may worsen over time and possibly result in an adverse patient outcome.

Methods of communication

Communication methods are dynamic and varied. It is important, however, that non-routine communications be handled in time to provide the appropriate care to the patient. Communication by telephone or in person to the treating or referring practitioner or representative is appropriate and assures receipt of the findings. There are other forms of communication that provide documentation of receipt which may also demonstrate communication has been delivered and acknowledged. The system of communication must identify a responsible person and method to confirm that TCMI was received by an appropriate person involved with the patient's care and by the patient. Merely posting the results in the electronic medical record may not be sufficient in situations where time is critical to a safe and positive outcome.

Documentation of non-routine communications

Documentation of communication of TCMI is best placed contemporaneously in the patient's medical record. Documentation preserves a history for the purpose of substantiating certain findings or events. Documentation may also serve as evidence of such communication, if later contested.

Resources

Information Blocking, Centers for Medicare Services, Department of Health and Human Services, rule from 45 CFR Part 171, accessed October 30, 2024. Information Blocking | HealthIT.gov

Communicating Test Results to Providers and Patients, Department of Veterans Affairs, Veterans Health Administration, VHA Directive 1088. October 7, 2015. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=10366

Hanna D, Griswold P, Leape L, Bates D, Communicating Critical Test Results: Safe Practice Recommendations, Journal of Quality and Patient Safety, Feb 2005: Volume 31 Number 2, 68-80. https://www.ncbi.nlm.nih.gov/pubmed/15791766

Elder N, McEwen T, Flach J, Gallimore J, Management of Test Results in Family Medicine Offices, *Ann Fam Med.* 2009 Jul;7(4):343-351. https://www.ncbi.nlm.nih.gov/pubmed/19597172

Number:	GUI2025-xx
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Supersedes:	GUI2016-02, GUI2021-01

Guidance Document

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Processing Complaints Against Licensees Enrolled in the Washington Physicians Health Program

Introduction

The Washington Medical Commission (Commission) provides this guidance document to (1) explain how it handles complaints against physicians and physician assistants (hereafter licensees) who may be impaired by ~~drugs or alcohol (also known as a substance use disorder)~~a health condition and are enrolled in the Washington Physicians Health Program (WPHP), and to (2) enhance consistency and fairness in decision-making in such cases.

The Commission promotes patient safety and enhances the integrity of the profession through licensing, discipline, rule-making and education. To fulfill its mission to enhance patient safety, the Commission reviews and investigates complaints that licensees have engaged in unprofessional conduct or have ~~mental or physical conditions~~ health conditions that affect their ability to practice medicine with reasonable skill and safety.

Commented [CB1]: Mental conditions are physical (brain) conditions, separating them perpetuates stigma. Better to say psychiatric and non-psychiatric health conditions if you want to make a distinction. Preferable to just say heath conditions

The Uniform Disciplinary Act, Chapter 18.130 RCW, sets forth the process by which a disciplinary authority like the Commission may impose disciplinary sanctions upon a licensee who commits unprofessional conduct or has a ~~mental or physical~~health condition that renders the licensee unable to practice with reasonable skill and safety. RCW 18.130.160 states that when a disciplinary authority imposes sanctions, the first priority is to protect the public. Only after the public is protected may the disciplinary authority include requirements designed to rehabilitate the licensee.

RCW 18.130.175 provides that if the disciplining authority determines that the unprofessional conduct may be the result of ~~substance use disorder~~a health condition, the disciplining authority may, in lieu of discipline, refer the license holder to a ~~substance use disorder monitoring~~physician health program approved by the disciplining authority. The licensee must sign a waiver allowing the program to notify the disciplinary authority if the licensee fails to comply with the program or is unable to practice with reasonable skill and safety.

Commented [CB2]: Since this policy was written, statute was revised to apply to any health condition

Commented [CB3]: "Physician health program" is now recognized in statute and differentiated from voluntary substance use disorder monitoring program

The Washington State Department of Health has contracted with the WPHP as the approved ~~substance abuse monitoring~~physician health program for a number of healthcare professions, including physicians and physician assistants. The WPHP is an independent, nonprofit organization that facilitates the rehabilitation of licensees who have ~~physical or mental~~health conditions that could compromise public safety. The conditions include substance use disorder and other behavioral health disorders, as well as ~~physical~~ non-psychiatric medical conditions and cognitive disorders. The Commission fully supports the work of the WPHP and notes that it has had remarkable success in rehabilitating licensees and helping them to manage their illnesses and practice medicine safely.

Most of the licensees enrolled in the WPHP have entered ~~voluntarily~~ confidentially and are unknown to the Commission. As long as the licensee complies with the requirements of the program and is safe to practice under monitoring, the WPHP will not report the licensee to the Commission. Many of these licensees complete treatment and monitoring and go on to practice medicine safely for the remainder of their careers.

While uncommon, ~~S~~some licensees experience ~~a relapse~~illness recurrence or return to substance use while being monitored by the WPHP. ~~Most licensees notify the~~ WPHP assists licensees in addressing recurrence and/or return to use and ~~may~~ will recommend that the licensee cease practice if the illness recurrence or return to substance use poses a risk to patient safety. ~~and come back into compliance with the requirements of the program~~. Some licensees will require additional treatment and then have an opportunity to return to clinical practice under active monitoring by the program, while others may need intensification of health monitoring or treatment services without the need to discontinue clinical practice. ~~Relapse~~Illness recurrence or return to substance use, ~~by~~ in itself, is not an indication that a licensee is not capable of practicing medicine safely. The WPHP has demonstrated an ability to accurately assess licensees who have suffered illness recurrence or return to use ~~a relapse~~ and determine appropriate interventions including whether and when they are safe to continue or return to practice.~~practice~~. The Commission relies on WPHP to determine whether a licensee who has ~~relapsed~~ illness recurrence or return to use should be reported to the Commission as unsafe to return to practice.

When the Commission receives a complaint that a licensee has committed unprofessional conduct or is impaired, and during the investigation the Commission learns that the licensee has signed an agreement~~contract~~ with the WPHP and is compliant with the requirements of the program, the Commission must decide whether to impose discipline or to close the case under RCW 18.130.175. This decision will depend on the facts and circumstances of each case.

The Commission adopts this guidance document to explain how it handles cases against impaired or potentially impaired physicians, and to help ensure consistency and fairness in decision making in these cases. Consistent with its statutory mandate, its mission statement, and the expectation of the public, the Commission will take necessary action to protect the public from licensees who commit unprofessional conduct or are unable to practice with reasonable skill and safety due to a ~~mental or physical~~health condition condition.

Guidance

The Commission may take disciplinary action for certain behavior regardless of the licensees health status or involvement in WPHP~~whether or not the licensee is in current compliance with a WPHP contract~~. The rationale for ~~taking action~~acting against licensees who fall into these categories is not only to protect the public, but to hold licensees accountable for their conduct. The Commission believes that disciplinary action should be determined on a case by case basis, taking into consideration the specifics of the circumstances. The presence of an impairing or potentially impairing health condition and/or involvement in WPHP may or may not mitigate against disciplinary action depending on the nature and specifics of the complaint. ~~a licensee enrolled in the WPHP should be accountable for his or her conduct to the same extent that a non-impaired licensee is accountable for his or her conduct~~.

The Commission may take action in the following circumstances:

1. **A licensee harmed a patient, regardless of whether the harm is due to impairment.** This may include negligent care such as a missed diagnosis, poor judgment or improper technique. It will also include reckless or intentional behavior such as abuse, sexual contact, or assault.

Commented [CB4]: All participants in WPHP are voluntary, though by convention, we classify those under order from the Commission as "mandated" participants. Confidentiality is the more appropriate construct here.

Commented [DB5]: Dr. Bundy edit.

Commented [CB6]: RCW 18.71.300 now uses the term "health condition" per statute change in 2022

2. **A licensee's behavior presented a risk of harm to a patient or to the public, regardless of whether it is due to impairment.** This may include treating a patient or being on call while under the influence of drugs or alcohol, or engaging in behavior unrelated to patient care such as driving erratically, leaving the scene of an accident, or exhibiting threatening behavior.

3. **A licensee engaged in acts of moral turpitude or dishonesty.** This may include any type of dishonest behavior, sexually inappropriate behavior with patients or non-patients, and behavior that lowers the standing of the profession in the eyes of the public.

4. **A licensee engaged in criminal activity regardless of the existence of a conviction.** This may include diversion of a controlled substance or legend drug, forging a prescription, or any other criminal activity. This would also include behavior that resulted in a conviction of a gross misdemeanor or a felony.

In all other circumstances, the Commission may~~, under RCW 18.130.175,~~ choose not to ~~discipline~~ take further action against a licensee if the licensee is enrolled in the WPHP, compliant with the program, and the Commission is assured that the public is protected. If the licensee is not enrolled in the WPHP, the Commission may choose not to take further action and instead refer the licensee to the WPHP under RCW 18.130.175. The procedure for the referral is as follows:

1. The staff attorney sends a letter to the licensee stating that the panel is referring the licensee to WPHP under RCW 18.130.175. The letter will state that the case will remain open until the Commission receives confirmation that the licensee has met with WPHP.
2. The staff attorney also sends a letter to WPHP informing them of the referral and asking WPHP to notify the staff attorney when the licensee has met with WPHP.
3. When WPHP receives the letter, WPHP will contact the staff attorney to get more information. After the licensee has met with WPHP, WPHP will notify the staff attorney that the meeting has taken place. If the licensee does not make an appointment with WPHP, or does not meet with WPHP, WPHP will notify the staff attorney.
4. When the staff attorney receives confirmation from WPHP that the licensee has met with WPHP, the staff attorney will bring the case back to the panel for closure. The panel may close the case with a unique closure. The closure letter should indicate that the reason for the closure is that licensee has been referred to WPHP under RCW 18.130.175, and that the Commission expects the licensee to comply with the program requirements.

~~if all of the following conditions exist:~~

~~the licensee is enrolled in the WPHP;~~

~~the licensee is compliant with the requirements of the program; and~~

~~the licensee's participation in the program will protect the public.~~

The Commission will rely on the WPHP to report to the Commission if the licensee fails to comply with the requirements of the program or if the licensee is unable to practice with reasonable skill and safety. If the Commission receives such a report, the Commission will immediately investigate the matter and take

necessary disciplinary action. If a licensee presents an immediate danger to the public, the Commission will suspend the license.

The above principles are designed to provide transparency to the public and WMC licenses. ~~It~~They also serve~~s~~ to guide the Commission in making decisions and are not meant to be ~~inflexible~~uncompromising. The Commission will use its judgment in each case to determine the course of action that first, best protects the public, and second, provides the opportunity to rehabilitate~~s~~ the licensee.

Number:	GUI2020-02
Date of Adoption:	February 12, 2016
Reaffirmed / Updated:	July 10, 2020
Supersedes:	MD2016-03

Guidance Document

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Completion of Death Certificates by Licensees

The Washington Medical Commission (Commission) adopted Guideline MD 2016-01, "Completion of Death Certificates by Physicians and Physician Assistants," in January 2016. The guideline supported the Washington State Department of Health (DOH) Guideline CHS D-10 "Completion of Death Certificates" based on RCW 70.58.170. The Commission rescinded this guideline on February 24, 2017, and urged all licensees to follow guidance issued by DOH for chapter 70.58A RCW.

RCW 70.58A.200 describes current death reporting and registering requirements.

Under WAC 246-490-200, Washington now requires electronic reporting through the (Washington Health and Life Event System) WHALES death registration module that replaces the Electronic Death Registry System (EDRS). Certifiers must use WHALES to register and complete a death record **within 5 days of the death**. For more information about enrolling in WHALES, contact Death.Registration@doh.wa.gov. Please note certifiers must access WHALES through an active Secure Access Washington (SAW) account. For more information about SAW, the secure single sign-on application, go to https://SecureAccess.wa.gov.

Additional information about death certification can be found at WHALES - Washington Health and Life Event System | Washington State Department of Health.

The Commission ~~rescinds its guideline and~~ urges all licensees to follow the guidance of the DOH Center for Health Statistics.

Number:	GUI2017-01
Date of Adoption:	February 24, 2017
Reaffirmed / Updated:	March 5, 2021.
Supersedes:	None.