

# Policy: Interested Parties 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](mailto: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 535, Tumwater, WA 98501**

**Thursday, January 29, 2026**

## Open Session

**10:0 AM**

## Agenda

To attend virtually, please **register** here: [WMC Policy Committee](#)

The goal of this meeting is to create an open and welcoming forum for public input, allowing anyone to review, comment on, and suggest changes to the WMC's policies, guidance documents, procedures, and interpretive statements. We strongly encourage members of the public, healthcare professionals, and other interested parties to share their perspectives, as their feedback plays a vital role in shaping clear and effective policies.

**Organizers:** Kaddijatou Keita, Policy Manager

|          |   |             |
|----------|---|-------------|
| <b>1</b> | <b>Guidance Document: Ownership of Clinics by Physician Assistants</b><br><i>Review and discuss proposed revisions to the document as part of its scheduled four-year review process.</i>             | Pages 3-4   |
| <b>2</b> | <b>Policy: Self-Treatment or Treatment of Immediate Family Members (POL2022-02)</b><br><i>Review and discuss proposed revisions to the document as part of its scheduled four-year review process</i> | Pages 5-6   |
| <b>3</b> | <b>Policy: Terminating the Practitioner-Patient Relationship (POL2022-03)</b><br><i>Review and discuss proposed revisions to the document as part of its scheduled four-year review process.</i>      | Pages 7-8   |
| <b>4</b> | <b>Guidance Document: Overlapping and Simultaneous Surgeries</b><br><i>Review and discuss proposed revisions to the document as part of its scheduled four-year review process.</i>                   | Pages 9-10  |
| <b>5</b> | <b>Policy: Discrimination in Healthcare (POL2022-01)</b><br><i>Review and discuss proposed revisions to the document as part of its scheduled four-year review process</i>                            | Pages 11-14 |

## 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](mailto:medical.policy@wmc.wa.gov) by 5 pm on **January 28, 2025**.

## 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](mailto:medical.policy@wmc.wa.gov).

### 2026

- |          |   |
|----------|---|
| <b>1</b> | Guidance Document: <a href="#">Medical marijuana authorization guidelines</a> |
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## Ownership of Clinics by Physician Assistants

### Purpose

The Washington Medical Commission (WMC) sets forth its position on physician assistants owning clinics and hiring their sponsoring physician.

### Introduction

Physicians and physician assistants face numerous ethical challenges every day in their practice. The ability to avoid ethical pitfalls is built on a foundation of the training that physician assistants and physicians receive during their education, as well as the ongoing continuing education process physician assistants and physicians engage in throughout their career. With ethical conundrums never far away, such attention to professionalism and ethical conduct is essential to provide high-quality, sensitive, and respectful care to patients. In an average clinical day for a physician assistant or physician, the clinician faces an almost uncountable array of decision-points related to ethical and professional care. These include documentation, billing, interactions with colleagues and staff, the selection of words and phrases to be used when talking with patients, interactions with vendors and the public, dealing with inquiries about patient information from a variety of sources, use of social media, and navigating potentially complex and pressured decision making about screening, exam and plans of care. All of these are areas where lack of attention to detail and sub-par decision-making can lead to ethical breaches and patient harm, and safe physician-physician assistant practice requires constant vigilance.

As with the above areas of risk, the interactions between physicians and physician assistants are also a possible area in which ethical and professional lapses can compromise patient care. In rare cases, physicians and physician assistants work in settings where the physician assistant is the owner of the clinic or business, and employs the supervising physician.

Most clinics and medical facilities are not owned by either physicians or physician assistants, but instead by a variety of other organizations. Such organizations hire physicians to lead the medical practice, and it would clearly be an ethical breach for such a facility to dictate medical practice to a medical employee, just as it would be an ethical violation for a physician assistant owner to undermine

the decision-making authority of an employed supervising physician. Solid grounding in ethical and professional principles is what prevents such situations from occurring.

Such is the case in the uncommon setting where a physician assistant owns a practice and hires a physician who is then the supervising physician. These situations require standard ethical and professional principles to assure quality care for patients. Physician assistant ownership does not change the legal requirements for physician assistants and physicians. The ethical practice of physician assistants and physicians requires knowledge of, adherence to, and compliance with these rules and laws, regardless of the ownership of the business. Failure to adhere to these laws risks harm to the public and disciplinary action against physicians and physician assistants.

## Guideline

Physician assistants and physicians who work in a setting in which the physician assistant owns a clinic and employs his or her supervising physician should:

1. Understand that the primary duty of an owner or employee of a clinic is to provide high quality care to patients.
2. Understand the ethical challenges that can arise in such a relationship, particularly the reluctance to address or report unprofessional conduct or impairment.
3. Fully abide by the law regulating physicians and physician assistants, [Chapter 18.71 RCW](#), [Chapter 18.71A RCW](#), [Chapter 246-918 WAC](#), and [Chapter 246-919 WAC](#).
4. Fully abide by the mandatory reporting laws, [RCW 18.130.080](#), [RCW 18.130.070](#), [RCW 18.71.0195](#), [WAC 246-16-220 et seq.](#), [WAC 246-919-700 et seq.](#), particularly the laws requiring reporting of other license holders, to wit:
  - a. A license holder must report knowledge of a conviction, determination or finding that another license holder has committed an act of unprofessional conduct. [WAC 246-16-235\(1\)](#).
  - b. A license holder must report that another license holder may not be able to practice his or her profession with reasonable skill and safety due to a mental or physical condition. [WAC 246-16-235\(2\)](#). When there is no patient harm, this report may be made to one of the approved impaired practitioner or voluntary substance abuse programs.
  - c. A license holder, corporation, organization, health care facility, and state and local governmental agency that employs a license holder must report to the WMC when an employed license holder's services have been terminated or restricted based on a final determination that a license holder has either committed an act of unprofessional conduct or may not be able to practice with reasonable skill and safety as a result of a mental or physical condition. [RCW 18.130.080\(1\)\(b\)](#).
5. Understand that the failure to comply with the law may subject the physician assistant and the physician to discipline.

# Policy Statement



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|-----------------|---|--|
| Title:          | Self-Treatment or Treatment of Immediate Family Members | POL2022-02   |
| References:     | <a href="#">RCW 18.130.180(6)</a>                       |  |
| Contact:        | Washington Medical Commission                           |  |
| Phone:          | (360) 236-2750  | E-mail: <a href="mailto:medical.commission@wmc.wa.gov">medical.commission@wmc.wa.gov</a> |
| Supersedes:     | MD2013-03   |  |
| Effective Date: | March 4 2022  |  |
| Approved By:    | John Maldon, Chair (signature on file)                  |  |

The Washington Medical Commission (WMC) believes that practitioners generally should not treat themselves or members of their immediate families.<sup>1</sup> Professional objectivity may be compromised when an immediate family member or the practitioner is the patient; the practitioner's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered.

Practitioners may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the practitioner is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients.

When treating themselves or immediate family members, practitioners may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a practitioner's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the practitioner.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another practitioner or decline a recommendation for fear of offending the practitioner. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, practitioner may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified practitioner available, practitioners should not hesitate to treat themselves or family members until another practitioner becomes available. In addition, while practitioners should not serve

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<sup>1</sup> This policy is taken largely from the American Medical Association [Code of Ethics Opinion 1.2.1](#).

as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Documentation of these encounters should be included in the patient's medical records.

Except under the limited circumstances described above, practitioners should not access the medical records of themselves or their family members. Practitioners can always access records through the appropriate use of a patient portal.

Practitioners should be aware that [RCW 18.130.180](#)(6) prohibits practitioners from prescribing controlled substances to themselves. The Commission strongly discourages practitioners from prescribing controlled substances to their family members.

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# Policy Statement



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|                 |   |  |
|-----------------|---|--|
| Title:          | Terminating the Practitioner-Patient Relationship | POL2022-03   |
| References:     | None  |  |
| Contact:        | Washington Medical Commission                     |  |
| Phone:          | (360) 236-2750                                    | E-mail: <a href="mailto:medical.commission@wmc.wa.gov">medical.commission@wmc.wa.gov</a> |
| Effective Date: | March 4 2022                                      |  |
| Approved By:    | John Maldon, Chair (signature on file)            |  |

The Washington Medical Commission (WMC) recommends that practitioners take appropriate steps to properly terminate the practitioner-patient relationship.

A practitioner-patient relationship is established when the practitioner agrees to advise, diagnose or treat a patient and the patient agrees that the practitioner will advise, diagnose or treat the patient. Once a practitioner-patient relationship has been established, a practitioner is ethically and legally obligated to provide services until the relationship is terminated.

A practitioner may decide to terminate the relationship for a number of reasons, including dismissing patients who are violent or verbally abusive, non-compliant with a treatment plan, fail to show up at appointments, intentionally misuse prescription medications violate chronic pain agreements. A patient may also decide to terminate the relationship and seek care from another provider. Regardless of the reason, the WMC recommends that practitioners act professionally and take appropriate steps as to properly terminate the practitioner-patient relationship.

To properly terminate the practitioner-patient relationship, the practitioner should provide notice to the patient that the practitioner-patient relationship has been terminated. The notice should include the following elements:

1. A statement that the practitioner-patient relationship is terminated;
2. A statement that the practitioner will continue to provide emergency treatment and access to services for a reasonable time, such as 30 days from the date of the notice, to allow the patient to secure care from another practitioner, except where the patient has displayed disruptive or threatening behavior toward the practitioner, office staff or other patients; and
3. An offer to transfer records to a new practitioner upon the patient's signed authorization to do so, or providing the records directly to the patient, unless excluded by RCW 70.02.090.

There is no legal requirement for a practitioner to provide a reason for the termination of the relationship, but the practitioner may choose to do so depending on the circumstances. Under

appropriate circumstances, the practitioner may choose to provide the patient with physician referral sources.

The notice should be sent in one of the following ways:

1. A letter sent via certified mail, return receipt requested, to the last address for the patient on record, with a copy of the letter, the certified return receipt, and the mail delivery receipt maintained in the patient record; or
2. An electronic message sent via a HIPAA-compliant electronic medical record system or HIPAA-compliant electronic health record system that provides a means of electronic communication between the health care entity and the patient, is capable of sending the patient a notification that a message has been received is in the patient's portal, and is capable of notifying the sender that a message has or has not been viewed. If the electronic message is not viewed within ten days, the practitioner should send a letter as recommended, above.

Following these recommendations will help a practitioner meet the ethical and legal obligations to a patient, and help avoid a complaint to the WMC that a practitioner abandoned a patient.

## Overlapping and Simultaneous Elective Surgeries

### Purpose

The Washington Medical Commission issues this guidance document to ensure that surgeons who perform overlapping elective surgeries do so in a patient-centered and transparent manner. Simultaneous or concurrent surgery is not appropriate.

### Definitions

**Overlapping surgery.** The practice of the primary surgeon initiating and participating in another operation when he or she has completed the critical portions of the first procedure and is no longer an essential participant in the final phase of the first operation. These are by definition surgical procedures where key or critical portions of the procedure are occurring at different times.

Overlapping surgery occurs in two circumstances. The first is when the key or critical elements of the first operation have been completed and there is no reasonable expectation that there will be a need for the primary attending surgeon to return to that operation. A second operation is started in another operating room while a qualified practitioner performs non-critical components of the first operation allowing the primary surgeon to begin the second operation. The second circumstance is when the key or critical elements of the first operation have been completed and the primary attending surgeon is performing key or critical portions in another room. The primary attending physician must assign immediate availability in the first operating room to another attending surgeon.

**Critical or key portions of an operation.** The “critical” or “key” portions of an operation are those stages when essential technical expertise and surgical judgment are necessary to achieve an optimal patient outcome. The primary attending surgeon should determine the critical or key portions of an operation.

**Simultaneous or concurrent surgery.** Surgical procedures when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time.

### Guidance

#### A. General principles

1. The primary attending surgeon’s sole focus must be to provide the best care to the patient.
2. The primary attending surgeon is personally responsible for the patient’s safety and welfare throughout the surgery.
3. The primary attending surgeon should participate in the surgical huddle or time out before the first incision is made.
4. In general, the primary attending surgeon should be in the operating suite or be immediately available for the entire surgical procedure. Prior to the procedure, a backup attending surgeon

should be identified and immediately available. Immediately available means the surgeon is reachable through a paging system or other electronic means, and able to return immediately to the operating room.

5. A primary attending surgeon's involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is inappropriate.

## B. Informed Consent

The primary attending surgeon must inform the patient of the circumstances of the overlapping or simultaneous surgery, including:

1. Who will participate in the surgery, including residents, fellows, physician assistants and nurse practitioners who are directly supervised by the surgeon;
2. When the primary attending surgeon will be absent for part of the surgery; and
3. Who will continue the surgery when the primary attending surgeon leaves the operating room.
4. Who the backup attending surgeon will be, if one has been identified prior to the surgery.

The primary attending surgeon should provide this information well in advance of the surgery, providing the patient adequate time to consider the information, ask questions, and then to consent to the event as described or to find another surgeon.

## C. Documentation

The primary attending surgeon should document in the surgical record the following information:

1. The absence of the primary attending surgeon for any part of the surgery;
2. The time the primary attending surgeon enters and leaves the operating suite; and
3. The name of the temporary primary operator in the primary attending surgeon's absence.

## Resources

American College of Surgeons, Statement of Principles, revised April 12, 2016, Part II, D.

<https://www.facs.org/about-ac/s/statements/stonprin#anchor172771>

American Medical Association Code of Medical Ethics, Chapter 2: Opinions on Consent, Communication & Decision Making. <file:///H:/DATA/DOC/Projects/Simultaneous%20surgeries/code-2016-ch2.pdf>

Beasley GM, Pappas TN, Kirk AD. Procedure delegation by attending surgeons performing concurrent operations in academic medical centers: balancing safety and efficiency. *Ann Surg.* 2015; 261(6):1044-1045.

<http://www.massgeneral.org/News/assets/pdf/ProcedureDelegation.PDF>

Concurrent and Overlapping Surgeries: Additional Measures Warranted, A Senate Finance Committee Staff Report, United States Senate, December 6, 2016.

<https://www.finance.senate.gov/imo/media/doc/Concurrent%20Surgeries%20Report%20FINAL%20.pdf>

Mello M, Livingston E, Managing the Risks of Concurrent Surgeries. *JAMA.* 2016; 315(15):1563-1564.

<http://jama.jamanetwork.com/article.aspx?articleid=2505160>

Rickert J, A Patient-Centered Solution to Simultaneous Surgery, *Health Affairs Blog*, June 14, 2016.

<http://healthaffairs.org/blog/2016/06/14/a-patient-centered-solution-to-simultaneous-surgery/>

# Policy Statement



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|                 |  |  |
|-----------------|--|--|
| Title:          | Discrimination in Health Care          | POL2022-01   |
| References:     | None                                   |  |
| Contact:        | Washington Medical Commission          |  |
| Phone:          | (360) 236-2750                         | E-mail: <a href="mailto:medical.commission@wmc.wa.gov">medical.commission@wmc.wa.gov</a> |
| Effective Date: | March 4, 2022                          |  |
| Approved By:    | John Maldon, Chair (signature on file) |  |

## Policy

The Washington Medical Commission (WMC) is committed to establish and maintain an environment for patients and practitioners free of discrimination. The WMC sets the expectation for all licensees that everyone shall be treated with dignity, respect and provided with equal opportunities in the healthcare delivery system. For further discussion, see the WMC Position Statement “Racism in all its forms is a public health issue”.<sup>1</sup> To mitigate the impacts of discrimination and promote a culture of inclusion, the WMC adopts this policy to consistently apply the included framework to reports of discrimination.

## Key Terms

The following definitions are intended to provide a common understanding within this Policy and provide a context for discrimination in healthcare.

**Bias:** Tendency to favor one group over another; biases can be favorable or unfavorable and implicit or explicit.

**Discrimination:** Unfair treatment characterized by implicit and explicit bias, including microaggressions, or indirect or subtle behaviors that reflect negative attitudes or beliefs about a non-majority group. Discrimination in healthcare are differences in the quality of healthcare delivered that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.

**Explicit Bias:** The attitudes and beliefs we have about a person or group on a conscious level, that is we are aware and accepting of these beliefs, and they are usually expressed in the form of discrimination, hate speech or other overt expressions.

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<sup>1</sup> <https://wmc.wa.gov/sites/default/files/public/Newsletter/RacismInAllItsForms.pdf>

**Health disparities:** A health difference that is closely linked with social, economic, and environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group or other characteristics historically linked to discrimination or exclusion.

**Health inequities:** Systematic differences in the health status of different population groups. Health differences that are avoidable, unnecessary, and unjust.

**Implicit Bias:** subconscious feelings, perceptions, attitudes, and stereotypes that have developed as a result of prior influences and imprints. It is an automatic positive or negative preference for a group, based on one's subconscious thoughts. However, implicit bias does not require animus; it only requires knowledge of a stereotype to produce discriminatory actions.

**Microaggression:** Brief and commonplace daily verbal/nonverbal behavioral, and environmental indignities whether intentional or unintentional that communicate hostile, derogatory or negative racial/ethnic, gender, sexual orientation, and religious slights and insults.

**Prejudice:** An unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason; a primary determinant of discriminatory behavior.

**Social determinants of health:** The conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

## Background

Discrimination is a social determinant of health that violates fundamental human rights and impedes access to quality and equitable healthcare. It is present across medical specialties and takes many forms. Discrimination in health care disparately impacts different population groups, including people of color, ethnic origin, religious beliefs, sexual and gender preferences, and other minorities.

The impacts of discrimination have been studied and documented-in the healthcare system. Discrimination is associated with both- increased incidences and adverse outcomes for a number of disease processes: such as the development of mental health issues , hypertension, cardiovascular disease, obesity, breast cancer, substance abuse, worse perinatal outcomes and pre-mature mortality.<sup>2</sup> It may trigger negative emotional reactions, leading to changes in health behaviors, such as avoiding medical care, decreased adherence to medical regimens, and engagement in high-risk behaviors.<sup>3</sup> There is an association between reports of discrimination

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<sup>2</sup> Williams, D.R., Mohammed, S.A. Discrimination and racial disparities in health: evidence and needed research. J Behav Med 32, 20–47 (2009). <https://doi.org/10.1007/s10865-008-9185-0>

<sup>3</sup> Aronson, J., Burgess, D., Phelan, S.M. and Juarez, L 2013: Unhealthy Interactions: The Role of Stereotype Treat in Health Disparities American Journal of Public Health 103, 50\_56, <https://doi.org/10.2105/AJPH.2012.300828>

and adverse cardiovascular outcomes, body mass index (BMI) and incidence of obesity, hypertension and nighttime ambulatory blood pressure, insomnia, engagement in high-risk behaviors and alcohol misuse.<sup>4</sup> Discrimination may lead to the development of inappropriate alterations of treatment regimens as has been seen with pain management, admission algorithms, and care management programs.<sup>5</sup>

## Framework

Discrimination violates the standard of care and is unprofessional conduct. If discriminatory behavior is identified in a report or investigation, the WMC will take appropriate action based on the severity of the conduct. Discrimination types include but are not limited to the following:

- Age
- Race
- Ethnic origin/ Place of origin
- Citizenship/ Immigration status
- Religion/ Ideology
- Sex
- Sexual orientation
- Gender identity/ Expression
- Language/ Accent
- Weight
- Socio-economic / Housing Status
- Relationship/ Marital arrangement
- Disability (including mental, physical, developmental or learning disabilities)
- Criminal Record
- Close relationship with a person identified by one of the above types

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<sup>4</sup> Lewis, T. T., Cogburn, C. D., & Williams, D. R. (2015). Self-reported experiences of discrimination and health: scientific advances, ongoing controversies, and emerging issues. *Annual review of clinical psychology*, 11, 407–440. <https://doi.org/10.1146/annurev-clinpsy-032814-112728>

<sup>5</sup> Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. *American journal of public health*, 105(12), e60–e76. <https://doi.org/10.2105/AJPH.2015.302903>

## WMC Action

Discrimination in health care violates the standard of care and presents a risk of harm to patients and is unprofessional conduct under RCW 18.130.180(4).

All WMC commissioners, attorneys and investigators are required to receive training to identify discriminatory behavior by health care practitioners and the understanding of its impact on the delivery of care.

Discriminatory behavior can encompass a broad continuum of behavior, ranging from unintentional behavior, to conduct taken with reckless disregard for the dignity of the patient, to deliberate discriminatory behavior. At one end of the continuum, the behavior may be remediated with education and guidance. At the other end of the continuum, when the behavior is deemed reckless or intentional, the WMC may consider stronger measures, such as a restriction of practice, a mental or physical examination, and letters of apology to the patient and others impacted. In serious cases, if the practitioner cannot be rehabilitated, the WMC may choose to revoke the practitioner's license to practice medicine in accordance with the Uniform Disciplinary Act 18.130 RCW to protect the public from harm.

Practitioners should be aware that discriminatory behavior may also violate both state and federal law, including the Washington Law Against Discrimination (Chapter 49.60 RCW), the Civil Rights Act of 1964, and the Americans With Disabilities Act.