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 the Policy: Interested Parties 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, September 25, 2025

Open Session

10:00 am	Agenda	
To attend virtually, please **register** here: WMC Policy: Interested Parties		
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 the public to provide comments on the items on this agenda. To participate, please use the Raise Hand function or add your comments to the chat. Be sure to identify yourself and your affiliation, if applicable. If you prefer to submit written comments, please email them to medical.policy@wmc.wa.gov by 5 p.m. on **September 22, 2025**.		
Organizer: Kaddijatou Keita, Policy Manager		
1	**Guidance Document: Practitioner Health** *Review and discuss proposed revisions to the document as part of its scheduled four-year review process.*	Pages 3-5
2	**Guidance Document: Reentry to Practice** *Review and discuss proposed revisions to the document as part of its scheduled four-year review process.*	Pages 6-8
3	**Guidance Document: Reentry to Practice for Practitioners with Suspended Licenses** *Review and discuss proposed revisions to the document as part of its scheduled four-year review process.*	Pages 9-10
4	**Guidance Document: Informed Consent and Shared Decision-Making** *Review and discuss proposed revisions to the document as part of its scheduled four-year review process.*	Pages 11-17
5	**Open Forum** Interested parties are invited to share ideas for new policies or suggestions for reforming existing ones. Each speaker will have a two-minute comment period. Written comments are also welcome; please see below for details.	
The items on this agenda will be discussed at the next Policy Committee meeting, which is scheduled for 4:00 pm on October 30, 2025. This meeting is held virtually and you may register to attend here: WMC Policy Committee		

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.	
2026	
1	Guidance Document: Overlapping and simultaneous surgeries (GUI2018-03)
2	Guidance Document: Ownership of Clinics by Physician Assistants MD2015-06
3	Guidance Document: Medical marijuana authorization guidelines
4	Policy: Discrimination in Healthcare (POL2022-01)
5	Policy: Self-Treatment or Treatment of Immediate Family Members (POL2022-02)
6	Policy: Terminating the Practitioner-Patient Relationship (POL2022-03)

Practitioner Health

Assessment Framework

Physicians and physician assistants (PAs) have a duty to undergo an ongoing assessment of their health and competence to practice medicine, which involves a life-long process over the course of their careers. The Washington Medical Commission (WMC) recommends physicians and PAs participate in regular health evaluations as part of their ongoing professional responsibility. These health evaluations should include, physical, psychological, cognitive, screening, and substance use components and assessments should be individualized to the job-specific demands of the physician or PA's practice such as eyesight and manual dexterity evaluations for those performing surgical procedures.

The WMC recommends that physicians and PAs begin regular health evaluations upon completion of their first certification cycle (ABMS for physicians or NCCPA for physician assistants). If a physician or PAs does not have a certification cycle,[1] they should initiate a health evaluation upon completing their postgraduate training. These initial evaluations may serve as a baseline metric for future comparison during the physicians or PA's career.

Physicians and PAs who participate in recertification may find it convenient to do these assessments in conjunction with their recertification process, which generally occurs every seven to ten years. The WMC generally recommends physicians and PAs increase the frequency of these evaluations --to coincide with the increase in risk of developing limitations-- as they age. Those with chronic conditions or with disabilities that might impair safe practice should consider increasing the frequency of their assessments, regardless of age, to better enable monitoring of status changes.

Age	Minimum Recommended Frequency of Health Evaluations
25-54	Health evaluations every 5-7 years
55-64	Health evaluations every 2-5 years
65-74	Health evaluations every 2 years

[1] A practitioner may not have a certification cycle if the practitioner has a lifetime certification or if the practitioner pursued certification, but did not attain certification.

≥75	Health evaluations every year

Practice Modification

With enough time in practice, a physician or PA will eventually encounter a point when their skills begin to decline. Such decline might be due to a physical limitation such as hearing loss or a tremor, or a cognitive limitation associated with normal aging or early dementia. Age or health-related decline in practice performance may impact a practitioner's ability to practice safely. Other causes of impairment, such as untreated mental illness and/or substance use disorder, also may create a risk of harm to patients. Regardless of etiology, it is important for the physician or PA, and those in their practice setting, to recognize signs of impairment and intervene in support of the health of the physician or PA and the safety of the patients under their care.

Physicians and PAs should also be aware of the detrimental effects of burnout, a psychological response to chronic work-related stress, which may similarly impact their ability to practice safely. Burnout may be experienced as irritability, low frustration tolerance, exasperation, fatigue, dreading work, callousness toward patients, interpersonal conflicts, diminished social functioning, and existential doubts about career or life choices. If signs of burnout are present, the WMC recommends that practitioners take active measures to address issues related to burnout (both cause and effect) as quickly as possible. This may involve identifying contributing sources of burnout in the practice environment and working collaboratively with leadership to mitigate these issues. In certain cases, burnout may involve mentally or physically burdensome responsibilities that need modifications to not only alleviate burnout, but also to minimize the health risks they may impose on physicians or PAs and their patients.

The Washington Physicians Health Program (WPHP) can provide further evaluation and assistance to physicians and PAs when there is concern that a health condition may threaten the safe practice of medicine. Regardless of the cause (skills decline, mental illness, substance use disorder, or burnout), the WMC recommends physicians and PAs consider altering their practices when practitioner responsibilities become mentally or physically burdensome or present a risk to patients. Physicians and PAs may consider practice modifications, such as reducing or eliminating overnight call schedules, mandating call recovery periods, shifting into part-time practice, reducing office hours, and/or eliminating certain procedures. The WPHP encourages physicians and PAs to reach out should they seek further evaluation or assistance in identifying reasonable practice modifications.

Conclusion

The WMC encourages all physicians and PAs to undergo regular health evaluations to gauge their ability to practice safely over the course of their careers. Additionally, throughout their careers, physicians and PAs should self-monitor and seek evaluation if they develop signs of skills decline, cognitive impairment, mental illness, or substance use disorder. Further, physicians and PAs should monitor for signs of burnout and mitigate issues related to burnout as they arise.

With appropriate consideration of current health, burnout, and ability status, physicians and PAs can usually modify their practices, as necessary, to extend fruitful and satisfying careers. The WMC strongly supports all physicians and PAs in proactively evaluating their health and competence on a regular, career-long basis, and

utilizing results to adapt their practice as needed to maintain patient safety. The WPHP can provide further evaluation and assistance to practitioners to help ensure safe practice.

Number:	GUI2018-02
Date of Adoption:	April 13, 2018
Reaffirmed / Updated:	May 27, 2022
Supersedes:	N/A

Guidance Document

WASHINGTON Medical Commission
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Reentry to Practice

Introduction

Purpose

To help ensure and advance patient safety and quality of care, the Washington Medical Commission (Commission) provides this guideline to assist physicians and physician assistants who take a temporary leave from practice to successfully reenter the safe practice of medicine

Background

A growing number of physicians and physician assistants (collectively "practitioners") take a leave from the clinical practice of medicine at some point in their careers. The break from practice may be for any number of reasons, the most common being the birth of a child, child care, caring for an ill family member, personal health, military service, humanitarian leave, and a change in career path. With the projected national physician shortage and considering the public's investment in education and training physicians, practitioner reentry is becoming increasingly important to the health care delivery system.

While reentry can be complex and challenging, there is evidence that practitioners who participate in a supportive structured educational program were generally successful in returning to practice.[1] Successful reentry to the safe practice of medicine requires the combined efforts of various stakeholders, such as regulators, specialty boards, hospitals, health plans, potential employers and preceptors. Recognizing that reentry to the practice of medicine is becoming an increasingly common part of a practitioner's career, the Commission creates this guideline to assist practitioners to successfully navigate a return to the practice of medicine in the state of Washington.

Definition(s)

Practitioner reentry is defined as the return to clinical practice in an area or scope of practice for which one has been trained, certified or licensed after an extended period of time away from clinical practice. A practitioner returning to clinical practice in an area or scope of practice in they have not been previously trained or certified or in which they have not had an extensive work history is not considered a reentry practitioner for the purpose of this guideline.

[1] Grace ES, Korinek EJ, Weitzel LB, Wentz DK. Physicians reentering clinical practice: Characteristics and clinical abilities. Journal of Continuing Education in the Health Professions. 2011;31(1):49-55.

Guidance

Planning ahead before leaving clinical practice

A practitioner considering taking a temporary leave from clinical practice should consider taking some or all of the following steps to help ease the transition back to the practice of medicine.

- Maintain an active license;
- Maintain board certification;
- Keep up with continuing medical education activities; and
- Take advantage of opportunities to stay involved in practice in a limited context. This can include part-time volunteer medical work during the leave from practice.

Reentering Clinical Practice

The Commission encourages practitioners who have been inactive for 24 months or more to complete a reentry program prior to entering clinical practice. Practitioners who are inactive for 12 to 24 months should consider completing an informal reentry program.

Reentry Programs

The length, activities and cost of reentry programs vary. Reentry programs should be comprehensive but practical and flexible enough to address a variety of situations and specialties. Reentry programs should be evidence-based and consistent with lifelong learning expectations for all practitioners. At the very least, reentry programs should include reflective self-assessment, as well as assessment of medical knowledge and skills and performance in practice by qualified preceptors.

A list of reentry programs can be found at the end of this guidance document under Resources.

Practice Mentors

If the reentry program calls for a practitioner to use a practice mentor upon a return to practice, the practitioner should ensure that the mentor is appropriately qualified and practices in the same clinical area as the practitioner seeking reentry. The practice mentor should have the capacity to serve as a practice mentor, including sufficient time for mentoring, and an active and unrestricted medical license under no active discipline. The practice mentor may require financial compensation or incentives for work associated with practice mentoring.

Substance Use Disorders and Mental or Physical Impairment

A practitioner who has a mental or physical condition or a substance abuse disorder that currently affects or could affect the ability to practice with reasonable skill and safety should meet with the Washington Physicians Health Program and follow all recommendations before reentering the practice of medicine.

Funding

The Commission recognizes that reentry programs may be expensive and that funding will likely be borne by the practitioner, presenting a barrier for some practitioners. The Commission encourages academic medical centers to look for ways to cover some of the cost of reentry programs through research opportunities and generation of revenue through professional fee billing. Federal, state and local funding driven by physician shortages may become a funding source. Potential employers, including community hospitals and large group practices, may be willing to offset individual physician reentry costs in exchange for later service. Practitioners with disabilities may consider applying to the State of Washington Department of Social and Health Services, Division of Vocational Rehabilitation, as another potential source of funding.

Resources

American Medical Association Resources for Physicians Returning to Clinical Practice

Drexel University College of Medicine Physician Refresher/Re-Entry Program

Physician Retraining & Reentry at UC San Diego School of Medicine

The Center for Personalized Education for Physicians (CPEP) Reentry to Clinical Practice Program

KSTAR/Texas A&M Rural and Community Health Institute

Lifeguard Re-Entry/Reinstatement at Foundation of the Pennsylvania Medical Society

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Number:	GUI2019-01
Date of Adoption:	May 17, 2019
Reaffirmed / Updated:	November 18, 2022
Supersedes:	Reentry to Practice, MD2015-10, November 6, 2015

Guidance Document

WASHINGTON Medical Commission
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Reentry to Practice for Practitioners with Suspended Licenses

Introduction

Purpose

The Washington Medical Commission (Commission) provides this guidance to assist physicians and physician assistants (collectively "practitioners") who have been out of practice a period of time due to a suspended license to demonstrate that they have the knowledge and skills to successfully reenter the practice of medicine.

Background

To protect public health, the Commission may find it necessary to suspend the license of a physician or physician assistant. The suspension may be the result of unprofessional conduct or a physical or mental impairment. At some point the practitioner may seek reinstatement of his or her license to practice. In addition to fully satisfying the requirements of the disciplinary order, the practitioner may have to demonstrate that they have the knowledge and skills necessary to practice medicine with reasonable skill and safety. Evidence shows that practitioners who have been out of practice for a period of time experience a decline in their medical knowledge and skills.

Guidance

The Commission may require a practitioner with a suspended license to demonstrate clinical competence by completing a reentry program prior to entering clinical practice. When determining whether completion of a reentry program is required, the Commission will carefully review all the circumstances in each individual case.

The length, activities and cost of reentry programs vary. Reentry programs should be comprehensive but practical and flexible enough to address a variety of situations and specialties. Reentry programs should be evidence-based and consistent with lifelong learning expectations for all practitioners. At the very least, reentry programs should include reflective self-assessment, assessment of knowledge and skills, and performance in practice.

Practitioners should be aware that some reentry programs will not admit practitioners with licenses under suspension or discipline. A list of reentry programs can be found at the end of this guidance document under Resources.

The Commission will have complete discretion to determine whether the practitioner has satisfactorily completed a reentry program and is competent to reenter clinical practice. If the Commission permits a practitioner to reenter clinical practice, the Commission may impose additional restrictions or limitations on the practitioner's practice to protect the public, including approval of practice monitors.

The Commission recognizes that reentry programs may be expensive and that funding will likely be borne by the practitioner, presenting a barrier for some practitioners. The Commission encourages academic medical centers to look for ways to cover some of the cost of reentry programs through research opportunities and generation of revenue. Federal, state and local funding driven by physician shortages may become a funding source. Potential employers, including community hospitals and large group practices, may be willing to offset individual physician reentry costs in exchange for later service. Practitioners with disabilities may consider the State of Washington Department of Social and Health Services, Division of Vocational Rehabilitation, as another potential source of funding.

Resources

American Medical Association Resources for Physicians Returning to Clinical Practice

Drexel University College of Medicine Physician Refresher/Re-Entry Program

Physician Retraining & Reentry at UC San Diego School of Medicine

The Center for Personalized Education for Physicians (CPEP) Reentry to Clinical Practice Program

KSTAR/Texas A&M Rural and Community Health Institute

Lifeguard Re-Entry/Reinstatement at Foundation of the Pennsylvania Medical Society

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Number:	GUI2019-02
Date of Adoption:	April 12, 2019
Reaffirmed / Updated:	November 18, 2022
Supersedes:	Reentry to Practice for Suspended Licenses, MD2015-11, November 6, 2015

Informed Consent and Shared Decision-Making

Introduction

Informed consent to medical treatment is a fundamental part of the practitioner-patient relationship. It is a process of communication, and not merely signing a form. Informed consent involves a dialogue between the practitioner and the patient[1] by which information is exchanged concerning the risks, benefits, and alternatives of the tests or treatments being recommended. The obligation of a practitioner to obtain informed consent from a patient is rooted in the recognition of patients' autonomy. Patents who have decision-making capacity have the right to make decisions regarding their care, even when their decisions contradict their providers' recommendations. The practitioner "must supply the patient with material facts the patient will need to intelligently chart that destiny with dignity."[2]

The Washington Medical Commission (WMC) issues this policy to provide guidance to allopathic physicians and physician assistants to ensure that patients are being adequately informed of the risks, benefits, and alternatives of proposed tests and treatments, such that patients can make informed care decisions that best reflect their goals and preferences in entering the care agreement. This policy serves to ensure that practitioners and patients understand their role in the processes of informed consent and shared decision-making.

Elements of the Informed Consent Process

A valid process of informed consent has four elements:

1. **Voluntariness**. A patient's decision must be free from coercion or undue influences. For example, if a decision is instead made under duress from a clinician, family member, or other third party, a patient's decision is not voluntary and, as such, informed consent cannot be obtained.

2. **Disclosure.** The practitioner must share all information that "a reasonably prudent person in the position of the patient" would find significant for the patient to make an informed decision,[3] including the nature, character, and anticipated results of the proposed test/treatment; material risks inherent to the proposed test or treatment; and alternative courses of action, including no action, and the benefits and risks of those alternatives.

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[1] The term "patient" in this policy includes a person with a power of attorney for health care when the patient is incapacitated.

[2] *Miller v. Kennedy,* 11 Wn. App. 272, 281-82, 522 P.2d 852 (1974), *aff'd per curium*, 85. Wn.2d 151 (1975). For a comprehensive review of the legal aspects of informed consent, see Washington Health Law Manual, 4th ed., Chapter 2A.3 (2016).

[3] RCW 7.70.050(2)

3. **Understanding.** The practitioner must ensure that the patient has not only been informed but also understands and appreciates the nature of the proposed test/treatment, in addition to associated risks, benefits, and alternatives. The practitioner has a duty to ensure that informed consent is obtained using a form of communication (e.g., language) that the patient understands. Understanding can be difficult to ascertain with certainty. One way to gauge understanding is for the practitioner to ask the patient to state in their own words what they just discussed and what they understood. The practitioner should be aware that cultural differences can significantly impact understanding.

4. **Capacity.** The practitioner must ensure that the patient has the ability to engage in reasoned deliberation (e.g., comparing the risks and benefits of the procedure with personal life goals). A patient who lacks the ability to engage in reasoned decision-making lacks the capacity to give informed consent.

Lack of capacity can take many forms. One form involves statutory criteria, which are required to determine lack of capacity (e.g., as declared by a court or by certain types of health care providers) regarding advance directives.[4] Outside of specific legal criteria, there are scenarios when patients may lack capacity to make reasoned medical decisions, such as the following two examples.

Health literacy is one example. Many patients may not understand complex medical information. Practitioners should explain medical information using plain language that a patient can understand. A patient who is confused by the medical terminology may be able to provide informed consent when these complex terms are explained using more basic terminology.

Another example involves a patient overwhelmed by complexity or volume of information at hand. An overwhelmed patient may lack the capacity to provide informed consent. This may create a challenge for practitioners, as it can be difficult to adequately explain all pertinent risks, benefits, and alternatives without overwhelming the patient. Practitioners should focus on explaining all concepts that a reasonably prudent patient would likely need to know to make an informed decision in a manner that promotes dialogue and understanding.

If a practitioner believes that a patient does not have the mental capacity necessary to make an informed decision, the practitioner may consider recommending the patient have a court-ordered guardian ad litem appointed before proceeding with any elective treatment.

Capacity is not an all-or-nothing phenomenon; a patient may have the capacity to make some decisions but not others.[5] The American Medical Association Code of Medical Ethics Opinion 2.1.2 provides excellent guidance to a practitioner who encounters an adult patient who seemingly lacks decision-making capacity.[6]

Shared Decision-Making

[4] RCW 71.32.110
[5] "The Limits of Informed Consent for an Overwhelmed Patient: Clinician's Role in Protecting Patient and Preventing Overwhelm," AMA Journal of Ethics, Vol. 18, no. 9:869-886 (September 2016).
[6] AMA Code of Medical Ethics Opinion 2.1.2.

Washington became the first state to codify shared decision-making as an alternative to traditional informed consent. The statute, RCW 7.70.060 was first amended in 2012 and then again in 2022. The statute states that shared decision-making is a process in which a practitioner discusses with the patient, or his or her representative, information to make a decision that aligns with the patient's values and goals.

Both the Robert Bree Collaborative in Washington State and the National Institute for Health and Care Excellence have issued excellent guides to implementing shared decision-making into a practitioner's medical practice. As noted in the 2019 Bree Collaborative, "Shared decision making is a key component of patient-centered care, 'a process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences.'"[7]

Shared decision-making takes the traditional notion of informed consent a step further by encouraging practitioners and patients to undertake, not just an informed, but an active role in complex medical decisions that affect the patient's health. Shared decision-making requires a high-quality communication between a practitioner and a patient, and in some cases family members or others, about risks, benefits, values, and goals.

The goal of shared decision-making is to help patients arrive at informed decisions that respect what matters most to them.[8]Shared decision-making is especially useful in complex cases where a patient is faced with multiple options and high stakes decisions need to be made in a narrow window of time, such as the decision-making regarding which treatments to undergo when cancer is diagnosed.[9] Shared decision-making is appropriate for treatments that are (patient) preference-sensitive and either have (1) high-quality scientific evidence supporting more than one option, which may include no treatment, or (2) a lack of evidence and/or no clinical consensus on what is the best option.[10] The practitioner may encourage the patient to have a patient advocate involved in this process.

Shared decision-making is, however, not appropriate when there is clear evidence of a net benefit, or harm. For example, generally, a clear net benefit of immunization against measles, mumps, and rubella (MMR) excludes MMR vaccination as a shared decision-making opportunity, as does the clear net harm of using antibiotics to treat a common cold.[11]

Shared decision-making can sometimes be assisted with patient decision aids. Certified by one or more national certifying organization[12], the tool provides a balanced presentation of the condition and treatment options, benefits, and harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes.[12] A decision aid can be in any format, including written,

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[7] Dr. Robert Bree Collaborative, Shared Decision Making, 2019, at 3. (hereinafter Bree Collaborative paper) https://www.qualityhealth.org/bree/topic-areas/shared-decision-making/

[8] "The Limits of Informed Consent for an Overwhelmed Patient: Clinician's Role in Protecting Patient and Preventing Overwhelm," AMA Journal of Ethics, Vol. 18, no. 9:869-886 (September 2016).

[9] "Development of a Program Theory for Shared Decision-Making: a realist synthesis," Waldron, et al., BMC Health Services Research 20:59 (2020).

[10] Dr. Robert Bree Collaborative, Shared Decision Making, 2019, at 3. https://www.qualityhealth.org/bree/topic-areas/shared-decision-making/

[11] Bree Collaborative paper, at 4.

[12] RCW 7.70.060(4)(a).

electronic, audio-visual, or web based. A decision aid is not essential for shared decision-making to occur, but studies have shown that patients who engaged in shared decision-making with a decision aid had a greater knowledge of the evidence, understood better about what mattered to them, had more accurate expectations of the risks and benefits, and participated more in the decision-making process.[13] The commission recommends that any use of patient decision aid be documented in medical record.

Generally, shared decision-making is associated with improved patient satisfaction, improved health outcomes, and better appropriateness of care.[14] When patients participate in decision-making and understand what they need to do, there are benefits to patients: they are more likely to follow through on their treatment plans,[15] there is a reduction in the chance of "preference misdiagnosis,"[16] and there is a reduction in health care disparities.[17] Shared decision-making may also benefit practitioners by improving doctor-patient relationships, improving communication, and providing certain legal protections to practitioners.

Practitioners should document shared decision-making in the patient's medical record as follows:

- A description of the services that the patient and provider jointly have agreed will be furnished;
- A description of the patient decision aid or aids that have been used by the patient and provider to address the needs for (a) high quality, up-to-date information about the condition, including risk and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes; (b) clarification to help patients sort out their values and preferences; and (c) guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process;
- A statement that the patient or his or her representative understand: the risk or seriousness of the disease or condition to be prevented or treated; the available treatment alternatives, including nontreatment; and the risks, benefits, and uncertainties of the treatment alternatives, including nontreatment; and
- A statement certifying that the patient or his or her representative has had the opportunity to ask the provider questions, and to have any questions answered to the patient's satisfaction, and indicating the patient's intent to receive the identified services.[18]

The Informed Consent Process Cannot be Delegated

[13] Spatz E, Krumholz H, Moulton B, The New Era of Informed Consent: Getting to aa Reasonable-Patient Standard Through Shared Decision Making, Viewpoint, JAMA Vol 315, No 19, May 17, 2016.
[14] Bree Collaborative paper at 4, citing Arterburn D, Wellman R, Westbrook E, Rutter C, Ross T, McCulloch D, et al. Introducing decision aids at Group Health was linked to sharply lower hip and knee surgery rates and costs. Health Aff (Millwood). 2012 Sep;31(9):2094-104; and Stacey D, Légaré F, Col NF, Bennett CL, Barry MJ, Eden KB, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev. 2014 Jan 28;(1):CD001431.
[15] Shared Decision-Making Fact Sheet, HealthIT.gov, National Learning Consortium (December 2013).
[16] C Brach, "Making Informed Consent an Informed Choice," Health Affairs bog April 4, 2019.
[17] Bree Collaborative paper, at 4-5, citing as an example the increasing rates of total knee replacement for black patients with osteoarthritis to rates closer to those of white patients.
[18] RCW 7.70.060.

Obtaining informed consent is an interactive process that is integral to the practitioner-patient relationship and cannot be delegated to others. For elective procedures, the treating practitioner is the one primarily responsible for the process of obtaining a patient's informed consent. At the end of that process, the treating practitioner may rely on ancillary personnel to obtain a patient's signature on a consent form. However, the practitioner is responsible for any act or statement made by the ancillary personnel when obtaining the patient's signature.[19] The practitioner retains responsibility for obtaining consent and for communications regarding consent.

Exceptions

There are certain situations in which informed consent is not required. For example, in an emergency when immediate treatment is necessary to preserve life or to prevent serious deterioration of a patient's condition, and the patient is unable to make an informed decision and a surrogate is not available, consent is not required.[20] Informed consent is also not required to detain a child without the consent of the parents when there is an imminent danger to the child,[21] when a patient is involuntarily committed to a psychiatric unit or facility under the Involuntary Treatment Act,[22] or when disclosure of information would be detrimental to the patient's best interests.[23]

Additionally, a patient may choose not to be informed about the details of a proposed treatment, including risks, benefits, and alternatives. A patient may also refuse treatment, or withdraw consent to treatment, no matter how unreasonable. In these scenarios, the practitioner should accept a patient's wishes and document their decision in the medical record.[24] The practitioner should consider having the patient confirm these types of decisions by documenting them in writing.

Special Considerations for Surgery or Invasive Procedures

When a practitioner proposes a surgery or an invasive procedure, the need for informed consent, or shared decision-making, is amplified. Barring an urgent or emergent situation, dialogue between the practitioner and the patient to discuss the proposed procedure, including the risks, benefits, and alternatives, should generally take place well in advance. Patients are naturally apprehensive and vulnerable on the day of a procedure, and may be reluctant or unable to ask questions, and engage fully in the decision-making process. Thus, for non-urgent procedures, having an informed consent discussion in advance optimizes a patient's ability to consider the information, ask questions, and seek advice from another practitioner, friend, or family member, prior to consenting.

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[19] Washington Health Law Manual, 4th ed., Chapter 2A.3 (2016). *See also, Shinal v. Toms*, 640 Pa. 295, 162 A.3d 429 (2017) (Pennsylvania court rules that the physician must obtain informed consent himself).
[20] RCW 7.70.050(4).
[21] RCW 26.44.056(1).
[22] RCW 71.05 (adults) and RCW 71.34 (minors aged 13-17). See also Washington State Health Care Authority, "The Involuntary Treatment Act," December 2021.
[23] *Holt v. Nelson*, 11 Wn. App. 230, 523 P.2d 211 (1974), *rev denied*, 84 Wn.2d 1008 (1974).
[24] RCW 7.70.060(1)(b).

Unexpected operative findings may be encountered during a procedure or surgery that require additional procedure(s) for which there is no consent. If these findings are significant and the patient is under anesthesia, an attempt should be made to obtain consent from appropriate patient representative . If that is either not appropriate or not possible, surgical judgment justifying the necessity of the additional procedure(s) for which there is no consent must be clearly documented. At the appropriate time following the procedure, the additional procedures performed, and the rationale shall be discussed with the patient.

Another special consideration in obtaining consent includes the names and roles of practitioners to whom the patient consent to a procedure. The practitioner should advise the patient of the names of any other practitioners who will perform surgical interventions or other important parts of the procedure, including anesthesia.[25] The primary surgeon may not know who will be involved in the procedure at the time informed consent is obtained, in which case, the primary surgeon should advise the patient that other practitioners may be involved and explain their planned scope of involvement in the procedure. The primary surgeon or practitioner should also discuss any applicable overlapping procedures.

The WMC issued a guideline on Overlapping and Simultaneous Elective Surgeries in 2018, in which the WMC recommended that the primary attending surgeon 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.[26]

A surgeon should not allow a substitute surgeon to perform the procedure without the patient's consent.[27] According to the AMA Principles of Medical Ethics, patients are entitled to accept or refuse the care of a substitute practitioner,[28] and a patient is only able to do this with prior knowledge of its occurrence.

Regulations and Requirements of Other Regulators and Organizations

In addition to Washington statutes regarding informed consent and shared decision-making, it is important to remember that there may be additional requirements of other regulators or organizations. Healthcare organizations or regulatory bodies may have their own regulations or

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[25] The Center for Medicare and Medicaid Services has a detailed example of a well-designed informed consent process for surgical procedures. A-0392 Surgical Services, Interpretive Guidelines §482.51(b)(2). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-17.pdf

[26] Washington Medical Commission Guideline GUI2018-03, "Overlapping and Simultaneous Surgeries," adopted July 13, 2018.

[27] AMA Code of Ethics Opinion 2.1.6, *available at* https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf

[28] AMA Code of Ethics Opinion 2.1.6, *available at* https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf

requirements that also must be followed. For example, a physician needs to honor Department of Health facility regulations, Department of Social and Health Services regulations, Joint Commission requirements, and Center for Medicare and Medicaid requirements regarding consent and shared decision-making. The practitioner is responsible for compliance with all applicable statutes, regulations, and requirements to help ensure that quality patient care is provided in the state.

Conclusion

Informed consent and shared decision-making are integral to a healthy practitioner-patient relationship. Evidence suggests that following these recommendations, as well as reviewing the resources cited, will enhance communication, improve practitioner-patient relationships, decrease legal risk, and result in better overall patient care.

Number:	GUI2022-01
Date of Adoption:	May 27, 2022
Reaffirmed:	N/A
Supersedes:	N/A