UPDATE!

Washington Medical Commission
Vol. 8, Fall 2018

Message From The Chair

Alden Roberts, MD, MMM, FACS

It is my privilege to announce, with great admiration, that Dr. Warren Howe has recently completed his two year term as Chair of the Medical Commission. He has been a fantastic chairman and his achievements and leadership while chair have been an inspiration for all of us on the Medical Commission. Fortunately, he continues to serve as past-chair and to be a resource for all Medical Commission leadership. Under the chairmanship of Warren and those who have gone before him, the Washington Medical Commission (WMC) has become a national, innovative leader within the Federation of State Medical Boards.

Tradition has it that as the new chair of the Medical Commission, I should introduce myself. My background is in general surgery and hospital administration. I have been on the Medical Commission since 2015. I received my MD degree from LSU in New Orleans and did my residency at Los Angeles County-USC Medical Center. I originally practiced in Burbank, CA, then moved to Vancouver, WA in 1990. I received a certificate in Medical Ethics from UW in 1994, received a Master's degree in Medical Management from Carnegie Mellon University in 2011, and completed the Advanced Training Program in Quality from Intermountain Health in 2012. In 2007, I became Chief Medical Officer at the hospital where I worked.

The mission of the Washington Medical Commission is to promote patient safety and enhance the integrity of the profession through licensing, discipline, rule making and education.

Few MDs and PAs receive sanctions by The Medical Commission, and most sanctions are intended to help the practitioner practice better, and safer, in the future.

Our mission is backed up by state law, the Washington Administrative Codes (WAC's). These require a greater degree of public transparency than many states require, and allow the Medical Commission only limited responses to health care related problems. We receive approximately 1800 complaints per year, 40% of which are opened for an investigation, and 91% of those are closed without further action. Few physicians and PAs receive sanctions by the Medical Commission, and most sanctions are intended to help the practitioner practice better, and safer, in the future. Rarely, practice

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UPCOMING MEETINGS

Educational Conference
October 5-6 (see page 9)

WMC Policy Meeting
November 15

WMC Business Meeting
November 16

Regular Meeting
January 17-18

More information including locations and times

Message From the Chair

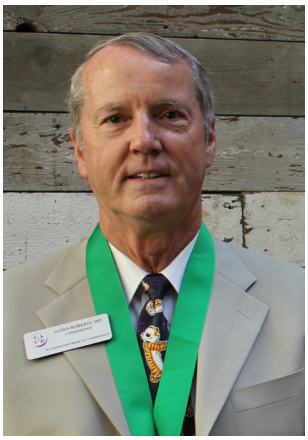
restriction or license revocation is required to assure patient safety. A major part of promoting patient safety is to assure there are enough qualified physicians and PAs to care for the citizens of this state. As such, the purpose of the Medical Commission cannot be punishment, as that drives problems underground, produces physician and PA burnout, drives people out of practice or to other states and is contrary to our vision of advancing the optimal level of medical care.

The Medical Commission vision is "advancing the optimal level of medical care for the people of Washington State". Our vision requires utilization of a just culture, which is the basis of true quality improvement. A just culture requires the assurance of accountability on the part of both individuals and institutions and attempts to use human factor analysis to design safe, reliable systems of care. Medical error, and even adverse outcomes, can only be reduced through a team based approach to medical care with a leveling of the medical hierarchy. To this end, the Medical Commission established a memorandum of understanding with the Foundation for Healthcare Quality, who certifies the Communication and Resolution Program (CRP). This important project provides a mechanism for assessing and resolving situations in which an unanticipated outcome or medical error has occurred, without finding fault or assessing blame, and by using a systemic approach to achieve a just outcome and quality improvement. Certification by the Foundation for Healthcare Quality assures that the process is achieving its goals. This encourages improved medical care at the local level.

CRP does not address gross negligence or behavioral problems. These problems are also best addressed locally, but the Medical Commission can, and does, address these problems. Inability to function as part of a team or disruptive behavior has been shown to seriously interfere with safe patient care and must be addressed.

Each year, in October, the Medical Commission puts on an educational conference. This year's conference will occur on 5-6 October 2018 and is titled "Engaging Patients (in their medical care): The Road Ahead." This activity has been approved for *AMA PRA Category 1 Credit* ™ More information and registration can be found on our website.

I am humbled and honored to assume the role of Medical Commission Chair. Following in the rather large footsteps of previous chairs such as Drs. Warren Howe, Michelle Terry, Richard Brantner and Mimi Pattison is a very humbling experience indeed. In addition, it is a pleasure to work with the amazing staff of the Medical Commission.



Under the executive directorship of Melanie de Leon, they provide the operational and legal activities that allows the commissioners to perform their duties. Without their efforts, little of value would be accomplished.

Thanks to you all.
Alden Roberts,
MD, MMM, FACS

Washington Medical Commission - Fall 2018

Medical Commission Members

Alden W Roberts, MD Chair	John Maldon, 1st Vice Chair	Charlotte Lewis, MD 2nd Vice Chair
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Charlie Browne, MD	Bruce Hopkins, MD	Claire Trescott, MD
Jason Cheung, MD	Warren Howe, MD	Mimi Winslow, JD
Jimmy Chung, MD	Peter Marsh, MD	Yangling Yu, Ph.D
Karen Domino, MD	Kathleen O'Connor	

Update! Editorial Board

James Anderson
William Brueggemann Jr.
Bruce Hopkins
Mimi Winslow

Have something for us? Send it to the Managing Editor

Technical Assistance and Common Sense

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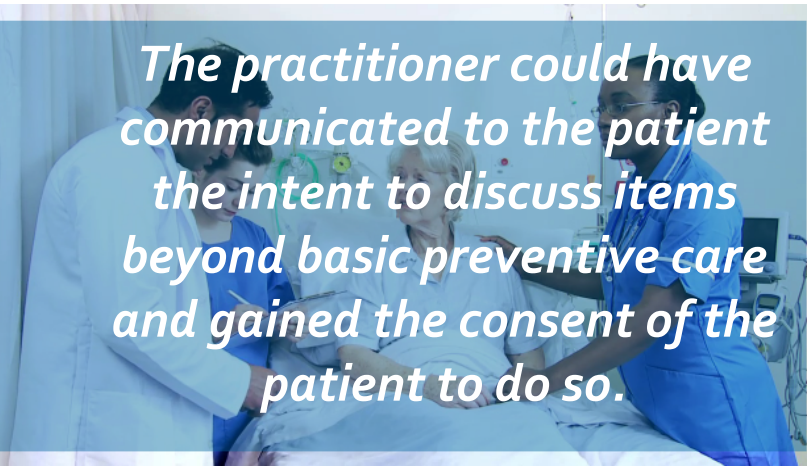
Micah Matthews, MPA
Deputy Executive and Legislative Director

Every so often in my work with elected officials, the non-standard scenario comes up that requires research and troubleshooting. This is usually the result of a constituent not knowing where to turn for assistance. These inquiries commonly, and appropriately, come to the WMC, where they are generally dealt with outside of the complaint or discipline process through what we call technical assistance. One such situation popped up this August and presents a teaching moment



The Scenario: A primary care practitioner completing a preventive checkup on a late middle aged patient. During the encounter the practitioner begins to ask the patient questions relating to having a will and other items generally consistent with advanced care planning, which seemed appropriate. While the patient took this as a little odd and did not really wish to discuss the matter with the practitioner, they apparently shrugged it off and the visit continued. All seemed fine until later that month when the patient received a bill with the $200+ charge for advanced care planning. In the mind of the patient, answering a question about having a will did not qualify them for such a charge, especially one that their insurance was making them cover. So what, if anything, did the practitioner do wrong?

The likely answer is no one is in the wrong. The advanced planning code is an allowable charge and in this case is likely a reasonable discussion to have with the patient. However, as in so many scenarios that come before the WMC, effective communication is a factor. While not all practitioners will know what triggers an enhanced billing code, most practitioners are aware when they deviate from a standard preventive visit. In this case, the practitioner could have communicated to the patient their intent to discuss items beyond basic preventive care and gained the consent of the patient to do so.

In our medico-legal world, patient consent drives many of the healthcare decisions we see daily. There are so many documentation requirements on informed consent that a simple surgery can require reams of paper. In all things, patients have the right to say no, just as practitioners have the right to refuse to treat. Both the patient and practitioner must understand the risks inherent in failing to not provide the requested information or engage in planning discussions. As the treatment relationship develops potential gaps in care or assessment should be discussed.

In this scenario, as the WMC does not entertain billing disputes, the simplest solution would be for the clinic to recognize that the patient did not expect or consent to the planning discussion and waive the fee. That sort of common sense solution prevents phone calls from legislators to me on constituent issues and one off policy bills. In reality, a little communication and grace will go a long way in satisfying both parties.

Have you experienced a similar situation where technical assistance would have been beneficial?

Email us and we may publish it in a future edition of Update! for others to learn from.

Physician Impairment and the WPHP: Questions and Answers

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Chris Bundy, MD, MPH

Executive Medical Director, Washington Physicians Health Program

Since 1986 the Washington Physicians Health Program (WPHP) has served as the legally qualified professional support program in Washington for licensed physicians and physician assistants. We are a small, independent, physician-led, non-profit organization that is contracted with the Department of Health to provide assessment, treatment referral, post-treatment monitoring and advocacy for professionals with health conditions that may impair their ability to safely practice. This is largely possible through laws in Washington that allow WPHP to work with professionals confidentially and without notification or involvement of the licensing authority. We endeavor to assist our colleagues, who are often suffering silently, obtain help before a career and/or life altering event occurs. A referral to WPHP is a courageous act of compassion for a colleague whose life and career may be at risk.

Q: What is impairment?
A: Impairment is defined as the inability to practice with reasonable skill and safety to patients as the result of a physical or mental health condition. Impairment is a functional classification related to illness, but the presence of illness, in itself, does not mean an individual is impaired. Clinical competence is often confused with impairment. Impairment, by definition, results from an underlying illness. In the absence of impairing illness, performance problems related to competence are outside of the scope of WPHP's mission and expertise.

Q: How common is impairment?
A: No one knows the true prevalence of physician impairment. Estimates suggest 1-2% of health care providers may fall into the category of impairment at some point in the course of a year. Impairing conditions such as substance, mood and anxiety disorders appear to occur at least as frequently in physicians if not more frequently. However, physicians are less likely to seek help for such problems on their own due to fear, shame, stigma and denial.

Q: Do I really have to call someone if I am worried about a colleague who may be impaired?
A: Per Washington Administrative Code (WAC 246-16-235), if you hold a clinical license through DOH and you have knowledge "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," you are legally and ethically obligated to make a report for the safety of your colleague and for the safety of the patients they treat. Note that you do not have to know whether the colleague is impaired, you simply must have knowledge that your colleague may be impaired. It is WPHP's role to determine whether and to what extent actual or potential impairment exists.

Q: Whom do I call, if I am worried that a colleague is impaired?
A: If your colleague is an MD or a PA, you can fulfill your obligation by calling one of two agencies. You can call the Medical Commission, or you can make a report to the Washington Physicians Health Program at 1-800-552-7236. Someone at WPHP is available to take your call 24 hours per day, 365 days per year.

Q: What happens if I make a report with the Medical Commission?
A: The Medical Commission will be obligated to review the case and likely open an investigation of your colleague for "unprofessional conduct" for practicing medicine while potentially impaired due to an untreated or undertreated illness. For unavoidable reasons, this has a high likelihood of resulting in disciplinary sanctions for your colleague, including public disclosure of any disciplinary action. There is also a high likelihood that the Medical Commission will have empathic concern for the well-being of your colleague and strongly encourage your colleague to self-refer to WPHP for immediate clinical help.

Q: What happens if I make a report to WPHP instead of the Medical Commission?
A: You have fulfilled your legal obligation to make a report. WPHP now has an obligation to assess your colleague as soon as possible to "rule-out" that they are impaired, or to get them adequately treated if WPHP "rules-in" impairment. For patient safety reasons, your colleague will have a reasonable, but limited, time frame in which to respond and comply with WPHP's clinical evaluation. They may be directed to take extended medical leave if impaired or at substantial risk for impairment and

complete sufficient treatment before they can return to work under WPHP monitoring. If they are non-compliant with this process, WPHP has the legal obligation to make a report to the Medical Commission as appropriate. You have given your colleague a chance to receive confidential help without being identified to the Medical Commisison, facing the risk of disciplinary action for trying to practice while impaired by illness.

Q: Once I've made a report to WPHP, under what circumstances does WPHP report my colleague to the Medical Commission?
A: If WPHP is significantly concerned that your colleague is suffering from an impairing health condition and he or she does not follow WPHP recommendations, we are obligated to notify the Medical Commission. We work very hard to help clients avoid this contingency. We feel that clients do best when internal motivators are engaged, rather than externally leveraged through a possible Medical Commission referral.

Q: How frequently does the WPHP report my colleague to the Medical Commission?
A: These events are rare. At this time, 94% of the physicians being actively monitored by WPHP are unknown to the Medical Commission. Over half that are known to the Medical Commission were referred by the Medical Commission to WPHP when an investigation revealed a potentially impairing health condition. Usually these are cases in which no one called WPHP when concerns of impairment came to light and eventually someone called the Medical Commission instead. In less than 3% of cases is WPHP required to notify the Medical Commission about a potentially impaired professional.

Q: What happens if I don't call anyone and make a report?
A: When impairment is suspected, not making a report prolongs the unacceptable exposure of patients to the risk of unsafe care from the potentially impaired provider. Failing to act also needlessly jeopardizes the career of a colleague that can be easily saved through therapeutic treatment for their illness. Finally, if it is shown that you knew there was a concern for impairment and failed to act, you may be exposed to legal risk from the Department of Health or a malpractice suit.

Q: What if the "impaired" physician in question is my patient?
A: You may still have an obligation to make a referral to WPHP or the Medical Commission, although your concern has to reach a higher threshold. Per WAC 246-16-235, you do not have to make a report until your physician-patient "poses a clear and present danger to patients or clients." You have to weigh this obligation versus your legal obligations under HIPAA if your patient is not willing to consent to you disclosing their identity in a report to WPHP. You may always contact WPHP anonymously for guidance on whether to report a physician or PA patient.

Q: Are there any possible "impairment" situations in which I cannot fulfill my legal reporting obligation by calling WPHP instead of the Medical Commission?
A: Yes, there are two. Any behaviors falling under the definition of sexual misconduct (WAC 246-16-100) cannot be reported to WPHP and stay confidential. These incidents must be directly reported to the Department of Health. Any situation in which there is concern for impairment and there is known patient harm stemming from the suspected impairment, a direct report to the Department of Health is required. In these situations, a report to WPHP is not a substitute for reporting to the Department of Health. WPHP will advise accordingly should such circumstances come to light.

Q: In the absence of patient harm, why is the law set up to allow reporting of suspected impairment to WPHP "as a substitute for reporting to the Department" and the Medical Commission?
A: In order to maximize patient safety, the law is set up to encourage early identification, assessment and treatment of providers who are thought to be impaired. Allowing physicians to self-report to WPHP or to be reported by their employer or colleagues to WPHP rather than to the Medical Commission serves this purpose. It encourages use of WPHP as a therapeutic alternative to discipline for providers who need help and can be rehabilitated. Having a chance to avoid the threat of discipline serves as a powerful motivator for such physicians to commit to intensive treatment and recovery programs.

Q: If I need to make a report, is there any disadvantage to me or to my colleague if I call the WPHP rather than the Medical Commission?
A: No. If we feel you are not fulfilling your obligation by calling us and this is one of those rare cases in which a call to the Medical Commission or DOH is mandatory, we will explicitly clarify this for you.

Rulemaking Efforts

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Daidria Underwood
Program Manager

Engrossed Substitute House Bill 1427

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

This was a collaborative rulemaking with the other boards and commissions within the Department of Health. A one-day Task Force meeting was held each month from September 2017 to March 2018 in various locations around the state. More information.

Chapter 246-919 WAC

The CR-101 for Chapter 246-919 WAC was filed with the Office of the Code Reviser on January 2, 2018 as WSR #18-02-079.

The WMC is considering updating the chapter to more closely align with current industry standards and provide clearer rules language for licensed allopathic physicians. In addition, RCW 43.70.041 requires the WMC to review its administrative rules every five years to ensure that regulations are current and relevant.

Rule amendments being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards. For more information on this rule, please visit our rulemaking site.

Clinical Support Program

The CR-101 for WAC 246-919-XXX Physicians and WAC 246-918-XXX Physician Assistants was filed with the Office of the Code Reviser on February 22, 2018 as WSR #18-06-007.

The WMC is considering creating two new rule sections, and revising related rule sections as appropriate, to establish a clinical support program (program), its criteria and procedures for allopathic physicians and physician assistants. The intent of the program is to assist practitioners with practice deficiencies related to consistent standards of practice and establish continuing competency mechanisms that will protect patients proactively through a plan of education, training and/or supervision. The WMC may resolve practice deficiencies through the program at any point in a practitioner's period of licensure.

The program would allow for quick identification of issues requiring clinical support, through practitioner or employer inquiry, referral, and including complaints that may not rise to the level of a license sanction or revocation. These issues could be resolved with voluntary participation from the allopathic physician or physician assistant in the program. The WMC is considering education, training, supervision, or a combination of the three as part of the program. Issues appropriate for clinical support would likely include (but are not limited to) practice deficiencies such as a failure to properly conduct a patient assessment or document treatment. This also allows an allopathic physician or physician assistant a structured process to quickly improve his or her clinical skills.

Finally, participation in this program places the WMC in an active patient safety role. For more information on this rule, please visit our rulemaking site.

More Information

For continued updates on rule development, interested parties are encouraged to join the WMC rules GovDelivery.

FOR INFORMATION AS IT HAPPENS, LIKE THE MEDICAL COMMISSION ON FACEBOOK AND TWITTER

@WAMEDCOMMISSION

New Guidelines for Practitioners Authorizing Medical Marijuana

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Michael L. Farrell, JD
Policy Development Manager

The Washington Medical Commission recently issued new guidelines for practitioners who authorize medical marijuana, or medical cannabis. The Medical Commission worked with the Board of Osteopathic Medicine and Surgery, the Nursing Care Quality Assurance Commission, and the Board of Naturopathy to develop uniform guidelines for all practitioners with authority to authorize medical marijuana.

The new guidelines cover the following topics:

- The patient history and physical examination,
- The treatment plan,
- Ongoing treatment,
- Maintenance of health records, and
- Treating minor patients or patients without decision-making capacity

The guidelines also recommend that practitioners issuing authorizations for medical marijuana complete a minimum of three hours of continuing education related to medical marijuana.

Practitioners should be aware that the legislature recently revised the law governing medical marijuana. The new provisions took effect on July 1, 2018:

- All authorizations are required to be printed on authorization tamper-resistant paper containing the RCW 69.51A.030 logo, which refers to the law requiring the form and setting forth the authorization process. You can find the new authorization form here.
- An authorization for medical marijuana may be renewed only upon completion of an in-person physical examination.

You can find information for health care practitioners about authorizing medical marijuana here.

Hot Topics at WMC

ESHB 1427 Rulemaking

The Medical Commission adopted the final version of the rules required by ESHB 1427 on August 22. The effective date of these rules will be January 1, 2019. Sign-up for our email distribution list to have the rules emailed to you once the CR-103 has been filed.

ESHB 1427 Educational Tour

We know you have a lot of questions about the changes made to the opioid prescribing rules. We are currently scheduling speaking engagements to educate and answer any questions you may have prior to the effective date. Email us to request that WMC come speak to your organization.

Keep your Address Updated

The law requires each practitioner to maintain a current name and address with the WMC. If you have moved recently, take a moment to submit the contact information change form. If your name has changed, submit the appropriate documentation for name change via email.

Engaging Patients: The Road Ahead

The WMC will be hosting a free conference October 5-6 in SeaTac to provide information and skill to better engage your patients. Patient engagement leads to higher scores on patient satisfaction surveys and lower readmission rates. This activity has been approved for *AMA PRA Category 1 Credit*™. Visit our website for more information and to register. You can also view our infographic for more details about patient engagement.

PA News:
Tick Tick Tick: Today's PAs in Action

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James Anderson, PA-C
Physician Assistant Member

I have knee problems, and I've seen a PA a couple of times over the previous years for knee injections. (Best thing I ever did, not sure why I waited so long!) It's always interesting being the patient instead of the PA, and it flips the dynamic in ways that can be fascinating. He and I have talked about this, about how it's always fun to be the patient and see another PA in action, and how we both, when patients, are unsure if, or when, to announce our PA-dom to the provider. We talk about how we don't want to act like big shots and make the provider feel like we are scrutinizing them, but how we also needn't hide this tidbit which might be a way to connect.

First comes the MA encounter, with my inevitable declining of the vitals. I've got my reasons, which we'll come to later. Savvy and experienced MAs always just smile and say "OK, fine!" probably glad that it's five minutes saved for them in their breakneck schedules. Sometimes if they are new, they appear shocked, and I try to ease them through the process by smiling and saying, "it's OK, just note in the chart that the patient declined."

Once in the exam room, I'm always struck with the order and cleanliness at this facility, always with some art to soften the medicinal ambience. There is never music on in the rooms, for which I am deeply grateful, as exam-room music usually makes me nervous.

My PA enters the room briskly, with a friendly yet businesslike demeanor. He takes the time to make sure that I know he remembers me, discussing a few details of our previous encounter. I really like this, as there is nothing more deflating than seeing someone you've seen before and having them not remember your last visit. We exchange the secret PA handshake (ha ha), and he's ready for action. But what I really like about his style, and something I always look for in a PA and other providers, is his artful mix of personal with medical, of chatting with scanning, and how, even though I am here for injections, he covers an amazing amount of ground. He's constantly on the move, getting his gear set up, with frequent exchanges of eye-contact and friendly chit-chat, just enough but not too much.

We get the injections out of the way, and I always expect it to it hurt way worse than it does. I ask him if he's ever had a knee injection, and he laughs and asks "no, how is it?" We laugh, and I tell him it's really not that bad, just in case he ever considers getting one.

As he's finishing up, he asks what I am doing to treat my knee pain besides injections. Then it's on to other topics. Is it time for a certain vaccination? What about that overdue test? When do you think you can take care of that? How about the dark lesion on your (bald) head? (Recent shaving accident, healing). Meds are reviewed, activity level discussed. And then he inquires, in very friendly and conversational manner, "what's up with your declining the vitals, I'm curious about that." I tell him that I take my BP regularly, tell him what it is (normal), and that it's always high at the clinic (White Coat HTN?), and reiterate that I do monitor it outside of here with quality gear. I also tell him that sadly, I do know how much I weigh. I tell him what my weight is, and how I find it stressful and humiliating to stand on a scale in the office and have an MA announce it aloud as I stare in shame down at the evil numbers on the scale.

He smiles and nods, says "sure, I get that, just want to make sure you are tracking these numbers and that we know what they are, so we can do our best to take good care of you." He kindly initiates a brief conversation about the benefits of weight loss for osteoarthritis, and I commit to addressing this. And my fingers weren't even crossed.

We finish up with his asking about my upcoming trip, and he tells me about a time he went to the same place, and how much he liked it. He also tells me a little story about his child, which I enjoyed. And that's that. EHR note complete, AVS in hand, "good to see you!" and a handshake and I'm on my way. Guess how long this well-crafted, thorough, friendly, artfully done medical visit and procedure took? How about twenty-three minutes. I marvel at this and compare it to a similar procedure I had in the 1970s, which took about 90 minutes, from start to finish, with much less skill, much less personal connection, and much more pain. This is the new practice of medicine to be sure, and it's not always perfect, but I still marvel at the pace changes in medicine and the ways that so many crafty and committed PAs and other providers have adapted as well as my PA has.

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Engaging Patients in their Health Care

The Facts

$630 Million PER YEAR

Value - based incentives that depend on HCAHPS scores

9/10

patients cannot accurately remember discharge instructions by the time they get home

4/10

patients state they have problems with staff responsiveness

$26 Billion PER YEAR

Medicare dollars spent per year on readmitting patients

The Benefits (estimated)

$4 - $7M Recaptured Revenue

by avoiding one cancellation per day, per operating room

Patients are 30% Less Likely

to be readmitted when they understand post-hospital care instructions

Patients are 23% Less Likely

to be readmitted within 30 days when they receive a follow-up call

What Can You Do?

Join the WMC at their annual conference.
Topics to Include:

- Improving Overall Patient Care by Increasing Patient Engagement
- Strategies to Align Provider Compensation with Quality and Value
- Patient Reported Outcomes in Value Based Payments
- The New Opioid Prescribing Rules

Conference Details

Where: DoubleTree Seattle Airport

When: October 5-6

Cost: **FREE!**

CME: **Yes!**

This activity has been approved for *AMA PRA Category 1 Credit™*.

For more information and to register, visit:
https://wmc.wa.gov/education/annual-conference

Legal Actions

WASHINGTON Medical Commission
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May 1, 2018 - July 31, 2018

Below are summaries of interim suspensions and final actions taken by the Medical Commission. Statements of Charges, Notices of Decision on Application, Modifications to Orders and Termination Orders are not listed. We encourage you to read the legal document for a description of the issues and findings. All legal actions can be found with definitions on the Medical Commission website.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Formal Actions				
Compagno, John MD60070536 Out of state	Agreed Order	07/12/18	Respondent's license to practice medicine in Oregon was suspended based on a federal conviction of tax evasion.	License was previously summary suspended and has been expired for more than three years. No seeking of license reinstatement, renewal, or reactivation.
Delashaw, Johnny, Jr. MD00023061 Out of state	Corrected Final Order	07/13/18	Respondent engaged in a pattern of disruptive behavior in the work place that impacted patient safety.	Reinstatement of license, obtain a multi-disciplinary evaluation, fully comply with evaluation recommendations, fine of $10,000, personal appearances, restriction on supervising other physicians, modification no sooner than 3 years.
Duckworth, Garrett, Jr. MD00041802 Kitsap	Final Order - Default	06/20/18	Respondent health issues that impact his ability to safely practice medicine.	Indefinite suspension.
Earl, David MD00028611 Grant	Agreed Order	07/17/2018	Professional boundaries, negligent recordkeeping, mismanagement of chronic pain patients, and failure to comply with a WMC order.	Surrender of license.
Janes, Merle MD00026269 Spokane	Agreed Order	05/02/2018	Negligent recordkeeping and mismanagement of chronic pain patients.	Permanent restriction on prescribing opioids, benzodiazepines, and sedative/hypnotic medications, ensure pain patients have primary care providers, practice reviews, termination no sooner than 3 years.
O'Brien, John PA10003178 Thurston	Agreed Order	05/24/2018	Negligent recordkeeping and mismanagement of chronic pain patients.	Respondent has retired and agreed to cease practice. No seeking of license reinstatement, renewal, or reactivation.
Riegel, Daniel MD00026679 Snohomish	Agreed Order	05/24/2018	Negligent recordkeeping and mismanagement of chronic pain patients.	Prescribing privileges reinstated, comply with ongoing monitoring program, recordkeeping coursework, utilization of PMP, written research paper, employer reports, personal appearances, fine of $1,000, termination no sooner than 3 years.

Slater, Robert MD60229784 Clark	Agreed Order	07/12/2018	Failure to cooperate and illicit use of controlled substances.	Indefinite suspension.
Soffe, Pierre MD00037953 Spokane	Agreed Order	05/02/2018	Respondent health issues that impact his ability to safely practice medicine.	Reinstatement of license, comply with ongoing monitoring program, personal appearances, fine of $1,000, termination no sooner than 3 years.
Travers, Michael MD00028342 Chelan	Agreed Order	05/24/2018	Negligent recordkeeping and mismanagement of chronic pain patients.	Permanent restriction on prescribing Schedule II controlled substances, Schedule III narcotics, and Schedule IV benzodiazepine medications, personal appearances, satisfactory completion of board review course, and fine of $1,000.
Informal Actions				
Broeren, Sandra MD60275108 Out of state	Informal Disposition	07/12/18	Alleged negligent recordkeeping.	Recordkeeping coursework, written research paper, utilization of PMP, personal appearances, $1,000 cost recovery, and termination no sooner than 1 year.
Carlson, Bruce MD00011806 Out of state	Informal Disposition	05/24/18	Alleged prescribing restriction by the Oregon Medical Board.	Comply with Oregon Board order, provide notice prior to practicing medicine in WA, $1,000 cost recovery, personal appearances, and modification consistent with Oregon Board.
Grassman, Eric MD00042087 King	Informal Disposition	05/24/18	Alleged health issues that impact ability to safely practice medicine.	License expired. No seeking of license reinstatement, renewal, or reactivation.
Larrabee, Wayne, Jr. MD00017636 King	Informal Disposition	07/12/18	Alleged wrongful alteration of patient medical record and failure to obtain appropriate patient consent for surgery.	Ethics coursework, recordkeeping coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than 18 months.
Madsen, Paul MD00020444 King	Informal Disposition	07/12/18	Alleged negligent recordkeeping and prescribing of phentermine.	Restriction from dispensing controlled substances, utilization of PMP, recordkeeping coursework, personal appearances, $1,000 cost recovery, and termination no sooner than 4 years.
McDermott, Tiffany MD00034970 King	Informal Disposition	05/24/18	Alleged failure to diagnose and treat post-surgery complications	Clinical coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than 1 year.
Oguakwa, Ifesinachi MD60138693 King	Informal Disposition	05/24/18	Alleged ethical violation and directing treatment without prior patient contact, obtaining history, or performing exam.	Ethics coursework, review telemedicine guidelines, written research paper, personal appearances, $600 cost recovery, and termination no sooner than 1 year.
Ozanne, Roy MD00045646 Island	Informal Disposition	07/12/18	Alleged delay in referring an elderly patient for emergency care.	Ethics coursework, infection coursework, review telemedicine guidelines, written research paper, personal appearances, $2,00 cost recovery, and termination no sooner than 2 years.

Overfield, William MD00012650 Pierce	Informal Disposition	07/12/18	Alleged improper hugging and personal contacts with a patient outside of the clinical setting.	Voluntary surrender following retirement from the practice of medicine.
Padilla, Nyree MD60675021 Out of state	Informal Disposition	07/12/18	Alleged misrepresentation or concealment of a material fact in obtaining a license in another state.	Ethics coursework, comply with Illinois order, notice to WMC prior to practicing in WA, $1,000 cost recovery, and termination to mirror Illinois Board.
Pang, Nancy MD00040925 Pierce	Informal Disposition	05/24/18	Alleged negligent recordkeeping.	Clinical coursework, written research paper, peer group presentation, personal appearances, and $1,000 cost recovery, and termination no sooner than after at least one appearance.
Stiens, Steven MD00030880 King	Informal Disposition	07/12/18	Alleged negligent recordkeeping.	Recordkeeping coursework, practice reviews, personal appearances, $1,000 cost recovery, and termination no sooner than 2 years.
Turner, William MD00025446 Cowlitz	Informal Disposition	05/24/18	Alleged failure to comply with regulation requiring a delegating physician be on clinic premises for initial treatment of laser skin treatment patients.	Ethics coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than eighteen months.

Stipulated Findings of Fact, Conclusions of Law and Agreed Order: a settlement resolving a Statement of Charges. This order is an agreement by a licensee to comply with certain terms and conditions to protect the public.

Stipulated Findings of Fact, Conclusions of Law and Final Order: an order issued after a formal hearing before the Commission.

Stipulation to Informal Disposition (STID): a document stating allegations have been made, and containing an agreement by the licensee to be subject to sanctions, including terms and conditions to resolve the concerns raised by the allegations.

Ex Parte Order of Summary Suspension: an order summarily suspending a licensee's license to practice. The licensee will have an opportunity to defend against the allegations supporting the summary action.