Medical Quality Assurance Commission
Update!

www.doh.wa.gov/medical Vol. 8, Spring 2018

Message from the Chair

Warren B. Howe, MD
Chair, Congressional District 2

There is a fresh breeze blowing across the landscape of efforts to reduce medical error, improve patient safety and better manage medical discipline in Washington. The underlying processes are termed "Communication and Resolution Programs (CRPs)," and your Medical Commission has become very interested and involved in studying their potential applications and benefits in fulfilling the Medical Commission's mission.

> **"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes".**
> **- Dr. Lucian Leape (2000)**

CRPs are defined as "a principled, comprehensive and systematic approach to responding to patients who have been harmed by their healthcare." [1] The model has evolved out of the concept of "Just Culture," which recognizes that competent professionals can and will make mistakes in complex situations and should not be punished for actions, omissions or decisions made by them, or triggered by systems issues as long as gross negligence, impairment, recklessness, willful violations of procedure, purposely destructive acts, etc. are not involved. Dr. Lucian Leape, Harvard School of Public Health professor, told Congress in 2000 that, "The single greatest impediment to error prevention in the medical industry

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NOTICE:

The Summer 2018 edition of Update! will be the last printed edition. To ensure that you continue to recieve news and updates from the Medical Commission, Sign up to have the newsletter delivered to your email inbox at: https://goo.gl/D9tq9c

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Mission

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

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is that we punish people for making mistakes". So, preferably, such occurrences should be openly evaluated and lessons learned thereby used to reduce the chance of recurrence.

CRPs require transparency with patients regarding adverse events, candid analysis of the event, and implementation of action to prevent recurrence. Implicit in the CRP process is immediate and ongoing emotional support for patient, family and the involved care team. An offer of financial and/or other restitution to affected patients may be appropriate. Current belief is that employment of the CRP process, in contrast to the "deny and delay" tactics that characterize the contemporary "legal" approach to adverse events, is much more likely to contribute to patient safety while responding with greater alacrity to the patient needs and distress generated by the adverse event.

Your Medical Commission is vitally interested in how the CRP process may eventually impact medical discipline in Washington. The Seattle-based Foundation for Health Care Quality (FHCQ) has recently instituted a "CRP Certification Pilot" to which cases of patient harm that have been dealt with using CRP principles can be submitted for review by a panel of physicians, risk managers and patient advocates.[2] Cases reviewed and judged to have met the standard for appropriate application of the CRP elements will be "CRP Certified." Some, perhaps most, of those cases will also come to the Medical Commission attention either because a complaint is submitted or because monetary payment triggers mandatory reporting. The Medical Commission will evaluate these cases, comparing what action it determines is necessary in the interest of patient safety, with the action that actually occurred in the CRP process. If experience shows that the outcomes of CRP and CRP certification equal or exceed what the Medical Commission would require, increasing weight may be given to the CRP certification report in adjudicating and perhaps closing cases. The Medical Commission has recently been working on the first submitted CRP-certified case.

Many on the Medical Commission believe that the CRP process has great promise for improving patient safety and for mitigating the often serious sequelae associated with adverse medical events. The possibility that litigation and the lodging of some formal complaints may be reduced by the process is a hoped for but, as yet, unproven outcome. The Medical Commission is, at present, evaluating each complaint submitted according to its statutory policies, and is determined to maintain its unwavering emphasis on protection of patient safety. Whatever value that may accrue from increasing application of the CRP process will probably become clear as we continue our collaboration with FHCQ and the CRP pilot. Of course, cases inappropriate for the CRP process will, when submitted to the Medical Commission, continue to be evaluated and resolved according to existing policy.

At present, the "formal" CRP process is only available within relatively large healthcare institutions, which have the resources to implement it effectively. However, the principles involved: transparency, communication, event analysis and action to prevent recurrence, emotional support and financial restitution (when appropriate) can be applied in any practice setting. It is definitely good to discuss this with your professional liability carrier before taking any specific steps toward implementation.

CRP, a relatively recent arrival in the arena of responding to incidents of patient harm, is based on age-old principles involving "just culture" and concern for others. In the not-distant future we may view it as a pivotal breakthrough in improving patient safety and fostering sound health care delivery. Stay tuned!

1. Collaborative for Accountability and Improvement, UWMC 2017
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5134339/pdf/HESR-51-2569.pdf

Remember to report malpractice payments

Mike Farrell, JD, Policy Manager

The Medical Commission is aware that some hospitals may not be reporting malpractice settlements to the Medical Commission. The Medical Commission reminds hospitals, and every institution or organization providing malpractice insurance, that they are required to report to the Medical Commission malpractice settlements or payments, in excess of $20,000, that are based on damages alleged to have been caused by a physician's negligence. The reports must be made within 60 days of the date of the settlement or verdict. Failure to comply can result in a fine. You can find the full text of the statutory requirement at https://go.usa.gov/xn6Hs.

Executive Director's Report: Your Medical Commission - behind the scenes…

Melanie de Leon, JD, MPA
Executive Director

While every state in the union has a medical board, fourteen states also have a separate board for osteopathic physicians – Washington is one of those states. The Washington Medical Commission only has jurisdiction over allopathic physicians and physician assistants. Osteopathic physicians and physician assistants come under the jurisdiction of the Board of Osteopathic Medicine and Surgery.

The Washington Medical Commission is the third largest medical board in the nation, with 21 governor-appointed Commissioners. There are two other boards with the same number of commissioners – New Jersey and Connecticut. New York has the largest board with 24 commissioners and Maryland is the second largest with 22 commissioners.

The Medical Commission employs staff to help support its statutory mission and strategic vision. These are the folks that renew your license, investigate complaints, facilitate rulemaking and work on a myriad of other tasks to implement the strategic goals set by the Commissioners. Every two years, the Medical Commissioners develop a strategic plan that they use to establish the direction of the Medical Commission and outline measurable goals for the next two years.

Goals we are currently working on:

- Developing a more user friendly website for both practitioners and the public.
- Interactive webinars on the website that will provide CME credits.
- All electronic licensing applications and renewals.
- Shorten the time to investigate and review complaints.
- Develop and deploy public service announcements.

The strategic plan can be found here: http://go.usa.gov/xn6HA

WPHP Launches Mindfulness Tele-Training for Health Professionals!

Chris Bundy, MD, MPH
Executive Medical Director, WPHP

In 2014, the Washington Physicians Health Program (WPHP) partnered with Mindfulness Northwest to help address the growing problem of burnout in the health professions with our Mindfulness for Health Professionals (MHP) training program. Through this 5-week series of in-person workshops, health professionals and their spouses across Washington experienced a 10% increase in mindfulness, 20% reduction in perceived stress, and substantial improvements in burnout factors (11% reduction in emotional exhaustion, 14% less depersonalization, 7.8% more efficacy). Outcomes were great, feedback was glowing, and requests for more courses kept coming in. However, we also experienced a paradoxical decline in registrations over time and by 2016 felt it was time to re-evaluate how the program might better serve health professionals in Washington.

Through informal feedback and common-sense, we speculated that time and travel to attend the sessions might be substantial barriers to participation. To overcome these barriers, Mindfulness Northwest has developed an innovative program providing all the benefits of MHP, including the opportunity to interact and learn from peers, online through video tele-conference technology. In addition, we have partnered with the Washington State Medical Association to offer AMA PRA Category 1 Credit™ for the course. We hope that the added incentive of Continuing Medical Education (CME) credit, combined with the convenience of group participation from work or home, will increase the opportunity for physicians from across the state to participate in this highly effective program.

Extensive research has shown that mindfulness training, and the Mindfulness-Based Stress Reduction curriculum on which MHP is based, can have significant positive impacts on participants' job satisfaction; relationships with patients, co-workers and administration; and their focus and creativity at work. After participating in the MHP program, professionals are able to:

- Employ formal and informal mindfulness training techniques in both preventive and responsive ways in high stress situations.

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- Recognize the three primary components of burnout and implement mindfulness practices to reduce risk of burnout along these axes

- Identify helpful and unhelpful thought patterns when they arise, and apply mindful problem solving, emotional regulation, and meaning-focused coping strategies, both at work and at home

- Be more present, compassionate and engaged with patients in ways that promote better patient experiences and outcomes

- Disconnect from work and transition more effectively to home and leisure activities that promote rejuvenation

Some may believe that mindfulness techniques are primarily useful for those experiencing burnout. While it is true that mindfulness does ameliorate burnout, the benefits extend well beyond burnout and are applicable to all. Like physical exercise, mindfulness-based practices are "exercise for the brain" that produce characteristic changes in brain structure and function when practiced over time. Furthermore, there is evidence that meditation, a core component of mindfulness practice, may protect against grey matter loss associated with aging. One need not be suffering from burnout to benefit from MHP.

"Clearly, we cannot "make healthcare great again" through personal resilience alone. Developing wellness cultures and improving practice efficiency will take time and the coordinated effort of many stakeholders."

Stanford University's Physician Wellness Model identifies 3 target domains to promote professional fulfillment: 1) Wellness Culture (appreciation, peer support, and values alignment, mediated through effective leadership), 2) Personal Resilience (diet, exercise, healthy relationships, and mindfulness), and 3) Efficiency of Practice (clinically useful EHRs, enhanced workflows, elimination of administrative burdens, etc.). Clearly, we cannot "make healthcare great again" through personal resilience alone. Developing wellness cultures and improving practice efficiency will take time and the coordinated effort of many stakeholders. Personal resilience interventions, on the other hand, deliver relatively rapid results through individual commitment to dedicated practice. Our modest aim is to provide an effective, time-efficient, and accessible resource for professionals seeking shelter in the storm. Please consider joining us for our inaugural course in June or one of the subsequent courses offered quarterly over the next year. Mindfulness is only a few clicks away!

WPHP Mindfulness for Health Professionals: June 2018
In partnership with Mindfulness Northwest and the Washington State Medical Association
Course Schedule:
5 meetings: 4 regular class sessions and one extended session.
4 Tuesday evenings 6 pm- 8:30 pm: June 5 – July 3rd (no session June 19th).
Extended session: Sunday June 24, 1 pm - 7 pm.
Instructor: Tim Burnett, Executive Director and Guiding Instructor at Mindfulness Northwest.
Location: Offered live online through Zoom video conferencing. https://www.zoom.us/

Course Fee: $365
Fee includes all 5 meetings, CME, a downloadable manual and guided meditation audio tracks. Payment plans and need-based scholarships are available during registration.

Registration:
https://www.mindfulnessnorthwest.com/MHP-Online
Phone: 360-830-6439, ext. 0.

Continuing Education:
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Washington State Medical Association and Mindfulness Northwest. The WSMA is accredited by the ACCME to provide continuing medical education for physicians.

The WSMA designates this live activity for a maximum of 14 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity meets the criteria for up to 14 hours of Category I CME credit to satisfy the relicensure requirements of the Washington State Medical Quality Assurance Commission.

ESHB 1427 Rule-making update from the Workgroup

Alden Roberts, MD, 1st Vice Chair

The 9th and final meeting of the Washington State Department of Health Joint Task Force for Opioid Prescribing and Monitoring occurred on March 14 in Tumwater, WA. A draft of the proposed rules will be produced and sent to the prescribing boards and commissions for evaluation and possible modification, additional public comment will occur, following which "new" rules will be approved by no later than January 1, 2019. These rules will be enacted following a period of education. However, there are some important concepts that I think need to be understood as this process moves forward.

First and foremost, patients need to be taken care of. A decision to stop treating patients in pain is potentially harmful, just as is providing bad care. Second, physicians and PA-C's aren't the problem in the opioid epidemic. Nor are osteopaths, dentists, podiatrists or advanced registered nurse practitioners, all of whom are represented on the Joint Task Force. A few practitioners do contribute to the problem, but even if all physicians practiced within some defined best practice, we would still have a serious opioid problem. Finally, the rules surrounding opioid prescribing, both now and in the future, define a minimum standard, below which we begin doing more harm than good. They are not, and cannot be, "best practices." Those practitioners who have received disciplinary action under the current rules were practicing well below the standard of care and received scrupulous due process prior to sanction.

Appropriate pain management is poorly understood by the medical community, including consumers, providers, insurers and pharmaceutical companies. My training on pain management as a surgeon consisted of being required to use a triplicate pad or provide a hard copy. Good data regarding pain management is finally beginning to appear: studies continue and practice recommendations are still being developed. There are large areas that clearly need improvement. For example, following a recent surgery, I was discharged with a prescription for 60 oxycodone 5mg tablets. I used 2. Were those remaining 58 disposed of properly? Did my kids get them (well, no, my youngest is 32 and doesn't live here)? Did I have an open house where someone stole them and sold them on the streets? Bad outcomes from poor pain management may be life-changing or life ending events for patients. Rather than not prescribing opioids for pain, or for that matter inappropriate use of opioids for pain, we would serve our patients better if we actually learned how to treat pain better, including our use of opioids. Treating pain effectively and safely is an important part of patient care.

House Bill 1427, which has mandated the current pain rule development, attempts to address some of the problems for which we, as physicians and PA-C's, have responsibility. There is other legislative action currently in process that could affect us. Doing nothing isn't an option. The Joint Task Force final draft will be coming out shortly and will be available on the Medical Commission website (https://go.usa.gov/xnJyS). There will be new rules relating to the treatment of acute pain (lasting up to 6 weeks), preoperative pain (also lasting up to six weeks), and subacute pain (pain lasting from 6-12 weeks). There will be new requirements regarding Prescription Monitoring Program review and registration. There will be a few changes regarding the treatment of chronic pain. I encourage all practitioners to become familiar with the new proposed rules when they become available and to let the Medical Commission know of changes that should be considered. Some medical offices have chosen to ban the prescribing opioids from their practice, but this is not a good answer as it leaves a large group of patients without access to care. A far better response is for practitioners to educate themselves on how to best treat patients in pain and how we can avoid inadvertently contributing to the problem.

"Appropriate pain management is poorly understood by the medical community, including consumers, providers, insurers and pharmaceutical companies."

Stay up-to-date with the Medical Commissions rulemaking by signing up for email alerts at https://goo.gl/pw8j6g

Rough Waters Ahead for "Independent Practice" for Physician Assistants?

James Anderson, PA-C
Physician Assistant Member

PAs have been around for about fifty years, after being birthed by the midwives of our profession, also known as MDs. We've always had a close and formal connection to MDs, which has made us unique in the medical world.

Over the years, there have been several efforts to begin to put a little more space between PAs and MDs, including several efforts to have our professional association, the American Academy of Physician Assistants, endorse a different title. Many PAs, young and old alike, have chafed under the word "assistant," often feeling that this misrepresents and belittles our profession and the work we do.

I get this, but I've never shared that concern. I've always felt that our connection to MDs is one of our strengths, setting us apart from our "mid-level" colleagues in other professions. And up until recently, this has been the stance of the AAPA. Efforts to pass resolutions calling for a name-change in the AAPA House of Delegates have repeatedly failed.

"They have been effective political strategists, and have made significant gains in garnering and organizing support for their vision of PAs practicing without a requirement to have a formal connection with an MD."

Still, inroads have been made by the advocates for increased autonomy. They have been effective political strategists, and have made significant gains in garnering and organizing support for their vision of PAs practicing without a requirement to have a formal connection with an MD. To me, that's independent practice, and it's something many MDs and MD associations such as the AMA have worried about since the inception of PAs. And up until recently, their worries have been ill-founded.

But recently two developments have some MD colleagues very concerned. An organization representing the effort to move toward autonomy has made big inroads into the AAPA, resulting in a push toward unhitching ourselves from our MD colleagues. First came the decision by the AAPA to propose that we stop saying "physician assistant," and to just say "PA"[1]. This has clearly been a result of the advancement of the name-change, independent practice proponents.

Second came the success of a resolution at last year's AAPA House of Delegates, supporting the adoption of a concept originally called "Full-Practice and Responsibility,"[2] later changed to the more catchy "Optimal Team Practice (OTP)."[3] For many MDs, the sticking points of both is this statement, from the Full Practice document on the AAPA site: Support the elimination of provisions in laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician in order to practice. Advocate for the establishment of autonomous state boards, with a voting membership comprised of a majority PAs, to license, regulate, and discipline PAs.

My guess is that changing the name to "Optimal Team Practice" was an attempt to de-emphasize the independent practice component. OTP proponents will quickly move to a talking point which underscores the belief that team-based care is superior, etc. But this doesn't appear to be placating MDs and MD organizations who are extremely concerned about this effort. The AMA is creating resources for state associations to oppose the OTP effort, particularly as it comes up in individual states. Many PA chapters and individuals are reporting strong push-back from their MD colleagues, with some noting concerns that the OTP effort by PAs has the potential to undermine the strong PA-MD partnerships that have been developed over the last 50 years.

It's important to note that creating AAPA policy does little to implement any new concept. Instead, it is simply a statement of philosophy of the PA professional association. While it is an important statement to the medical community, such uncoupling of PAs and MDs can only happen in individual state legislations, something that remains a formidable obstacle for those proposing this change in physician assistant practice.

1) https://goo.gl/yJ7SzA
2) https://goo.gl/UTZkm5
3) https://goo.gl/7jCYzD

Commission Rule-Making Efforts

Daidria Amelia Underwood
Program Manager

Engrossed Substitute House Bill 1427
This bill was passed by the legislature on May 16, 2017. The bill is concerning opioid treatment programs and mandates the Commission adopt rules for both allopathic physicians and physician assistants. On June 30, 2017 the Commission approved moving forward with rulemaking to adhere to the mandate. They also approved reviewing the allopathic physician and physician assistants' current pain management rules as part of this rulemaking effort. With that approval the CR-101 (https://go.usa.gov/xnJyv) was filed as WSR #17-17-156 with the Office of the Code Reviser on August 23, 2017.

This will be a collaborative rulemaking with the other boards and commissions within the Department of Health. For more information, please visit www.doh.wa.gov/opioidprescribing

To learn more about ESHB 1427 please visit the bill summary page: https://go.usa.gov/xnJyd

Chapter 246-919 WAC
The CR-101 (https://go.usa.gov/xnJyw) for Chapter 246-919 WAC was filed with the Office of the Code Reviser on January 2, 2018 as WSR #18-02-079.

The Commission 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 Commission 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: https://go.usa.gov/xN9qC.

Reminder: Suicide Prevention Training – ESHB Bill 1424
The CR-103 for allopathic physicians (WSR #17-07-043) and allopathic physician assistants (WSR# 17-07-044) was filed with the Office of the Code Reviser on March 8, 2017. These rulemaking documents were filed pursuant to the requirements under Engrossed Substitute House Bill 1424 (Chapter 249, Laws of 2015), that require allopathic physicians, allopathic physician assistants, and other health care providers to complete a one-time training in suicide assessment, treatment, and management to help lower the suicide rate in Washington State. Allopathic physicians will find their requirements for this training at WAC 246-919-435 (https://go.usa.gov/xN8hJ). Allopathic physician assistants will find their requirements for this training at WAC 246-918-185 (https://go.usa.gov/xN8hS). Frequently asked questions regarding both of these rules can be found on our website at http://go.usa.gov/cJ98G.

More Information
For continued updates on rule development, interested parties are encouraged to join the Commission's rules GovDelivery at: https://goo.gl/79Cnuw.

For information as it happens, follow us!
@WAMedCommission

Medical Commission Meetings 2018 Medical Commission meetings are open to the public	
Date	**Location**
April 12-13	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
May 24-24	The Heathman Lodge 7801 NE Greenwood Drive Vancouver, WA 98662
July 12-13	Hotel RL Spokane at the Park 303 W North River Drive Spokane, WA 99201 (509) 777-6300
August 23-24	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
October 3-5	TBD Seattle, WA
November 8-9	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512

Legal Actions
November 1, 2017 - January 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 are updated quarterly and can be found with definitions on the Medical Commission website: http://go.usa.gov/bkNH

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Summary Actions				
Slater, Robert MD60229784 Clark	Ex Parte Order of Summary Action - Suspension	01/12/18	Allegations that Respondent has health issues that impact his ability to safely practice medicine.	Suspension.
Campbell, Jeffrey MD 60668354 Clark	Ex Parte Order of Summary Action - Suspension	01/24/18	Allegations that Respondent's license to practice medicine in the state of Kentucky was summarily suspended for alleged overprescribing of controlled substances and fraud.	Suspension.
Formal Actions				
Haverly, Jackson MD00030718 King	Final Order - Default	11/08/17	Respondent failed to comply with a Commission order. Respondent failed to respond and a default order was entered.	Suspension for no less than five years.
Najera, Alex MD00025470 Franklin	Agreed Order	11/02/17	Negligent management of chronic pain patients.	Controlled substance prescribing coursework, written research paper, utilization of PMP, practice reviews, personal appearances, and $2,500 fine.
Newell, David MD00021288 King	Agreed Order	01/18/18	Respondent was arrested on allegations involving patronizing a prostitute and entered a plea of guilty to a misdemeanor.	Reprimand, ethics coursework, written research paper, personal appearances, community service, and $2,000 fine.
Informal Actions				
Ahmed, Tariq MD00030967 Out of state	Informal Disposition	11/02/17	Alleged: ineffective communications with co-workers and patient, negligent recordkeeping, substandard clinical management of patients, and failure to consult with sponsor physician.	Practice restricted to medical disability examinations, neuropsychological evaluation, supervisor reports, personal appearances, and $1,000 cost recovery.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Caedenas, Richard PA60421280 Stevens	Informal Disposition	11/02/17	Alleged: failure to document critical patient communications, failure to appropriately communicate time critical information to a patient, and failure to diagnose or manage acute peritonitis.	Diagnostic coursework, written research paper, personal appearances, and $250 cost recovery.
Crane, Samuel MD60219174 Out of state	Informal Disposition	11/02/17	Alleged: negligent recordkeeping and mismanagement of a pain patient.	Controlled substance prescribing coursework, written research paper, health evaluation, personal appearances, and $1,000 cost recovery.
Duran, Wayne MD00020201 King	Informal Disposition	11/02/17	Alleged: gross misdemeanor violation related to domestic assault.	Written research paper, health evaluation, personal appearances, and $1,000 cost recovery.
Ennis, Gregory MD60105263 Pierce	Informal Disposition	01/18/18	Alleged: negligent management of chronic pain patients.	Controlled substance prescribing coursework, written research paper, peer group discussions, utilization of PMP, review and compliance with Commission pain management rules, practice reviews, personal appearances, and $500 cost recovery.
Hallock, Alexis MD00036935 King	Informal Disposition	01/18/18	Alleged: overprescribing of a controlled substance.	Controlled substance prescribing coursework, written research paper and protocols, utilization of PMP, personal appearances, and $1,000 cost recovery.
Jensen, Gordon MD60022074 Out of state	Informal Disposition	01/18/18	Alleged: false or misleading advertising.	Ethics coursework, cease misleading advertising, personal appearance, and $1,000 cost recovery.
Jones, Nila MD00040656 Clark	Informal Disposition	01/18/18	Alleged: inability to safely practice due to a health condition.	Practice restriction from treating patients, and opportunity to petition for modification in the future.
Kather, Natalie MD00047535 Thurston	Informal Disposition	11/02/18	Alleged: negligent prescribing of controlled substances and legend drugs.	Prescribing coursework, patient notices, practice reviews, and personal appearances.
Livingstone, E. Franklin MD00019551 Out of state	Stipulation to Practice under Conditions	11/02/17	Alleged: out of state order based on inappropriate comments and hugging.	Utilize chaperone when treating female patients, practice reviews, notice to employers, and compliance with out of state order.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Melendrez, Ricardo PA60715075 Benton	Stipulation to Practice under Conditions	01/18/18	Alleged: practice prior to becoming licensed.	Ethics coursework, written research paper, personal appearances, and $1,000 cost recovery.
Petersen, James PA60710620 Yakima	Stipulation to Practice under Conditions	01/18/18	Alleged: practice prior to becoming licensed.	Ethics coursework, written research paper, personal appearances, and $1,000 cost recovery.
Pham, Joseph MD00033980 Pierce	Informal Disposition	11/02/17	Alleged: wrong site laser procedure.	Written research paper, peer group presentation, personal appearances, and $1,000 cost recovery.
Phillips, Stephen MD00023939 King	Informal Disposition	12/13/17	Alleged: inability to safely practice due to a health condition.	Restriction from performing surgical procedures except as part of approved training, provide notice to patients, and opportunity to petition for modification in the future.
Reddy, Gayatri MD60025242 King	Informal Disposition	01/18/18	Alleged: failure to review diagnostic test results before initiating treatment.	Written research paper, peer group presentation, personal appearances, and $1,000 cost recovery.
Reese, Susan MD60754962 Out of state	Stipulation to Practice under Conditions	01/18/18	Alleged: inability to safely practice due to a health condition.	Approved place of practice, approved supervision by a board certified physician, employer reports, ongoing treatment, treatment provider reports, and personal appearances.
Smith, Thomas MD00016322 King	Informal Disposition	11/02/17	Alleged: negligent management of chronic pain patients.	Utilization of PMP, review and compliance with Commission pain management rules, practice reviews, personal appearances, and $500 cost recovery.
Straub, Catherine MD60220733 Chelan	Informal Disposition	11/02/17	Alleged: failure to diagnose and manage necrotizing fasciitis.	Written research paper, peer group presentation, personal appearances, and $1,000 cost recovery.

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.

The Testosterone Therapy Conundrum

Thomas Fairchild, MD
Pro Tem Member

Steroids can be a patient's salvation but can carry significant risk. Testosterone therapy (T-Therapy) has a significant role for hypogonadal males, but testosterone and other PEDs (performance enhancing drugs) are frequently abused.

Ideally, T-Therapy would always occur under medical supervision. Those days are gone. Natural and synthetic testosterones are readily available over the internet. We must face the fact that the internet, social media, influential friends and advocates many times have more influence over medical decisions than a provider. Despite these handicaps, we must do our best to advise patients on the appropriate medical use of these drugs, and to advocate for appropriate regulation.

Testosterone Therapy Indicated
Certain disease states require T-Therapy, due to lack of adequate endogenous production. There is little argument that testosterone is beneficial in some of these situations:

- Testicular failure due to trauma, mumps orchitis, bilateral testis cancer i.e. primary hypogonadism.
- Sellar abnormalities or other disruptions to the pituitary-hypothalamic axis-i.e. secondary hypogonadism.
- Measurement of testosterone and supplementation may be appropriate in: Type 2 diabetes; low trauma fracture in young men; infertility; COPD; end-stage renal disease; HIV-associated weight loss; and treatment with drugs that alter testosterone production, such as glucocorticoids and opioids.

Testosterone Therapy Contraindicated
Medically, exogenous testosterone therapy is contraindicated when endogenous testosterone levels are normal. Side effects associated with high testosterone include acne, mood swings, hypertension, testicular atrophy, elevated hemoglobin levels, premature closure of the epiphyses in younger males, and possibly cardiovascular disease. Despite these risks, exogenous testosterone supplementation occurs in many settings.

Perhaps the riskiest group abusing these drugs are high school athletes. Getting big quickly is a competitive advantage for these young men, but long-term effects can be negative. These athletes many times hide their androgen use from medical professionals. Estimates suggest that 5% of high school males have tried androgens, and 2-3% use them regularly. Up to one third of individuals using androgens become dependent. Dependence on androgens can be associated with substance abuse and mental health disorders.

Testosterone Therapy in the Aging Male
The good news: Life expectancy for males (and females) continues to move higher, with the average male in 1950 living until 65 and improving to age 76.4 today. The bad news: Treating diseases of aging is expensive. Think joint replacements, cardiovascular interventions, brilliant ICU rescues by the critical care specialists, rehabilitation hospitals, pharmaceuticals, and higher standards of care for almost every disease.

Hypogonadism in the aging male is certainly not the cost issue of many of those expensive treatments noted above. On the other hand, the hormone replacement debate highlights some of the difficult choices facing aging individuals. This debate questions and the answers are uncertain: Male sexual function and frequency of intercourse decline with age and testosterone levels decline with age. Is this a disease to be treated or normal aging? Male sexual decline occurs at variable rates. Compare the 50yo couch potato to the 80yo Lothario. What is normal and abnormal?

Sex is only one part of life. According to many studies, testosterone supplementation has other benefits including improved mood, energy, muscle mass, strength, and prevention of osteoporosis and anemia. Should testosterone be used for these conditions in the aging male?

Risks of T-Therapy in the Aging Male
Cardiovascular risk with testosterone therapy remains controversial. Some studies have suggested an increased risk of cardiovascular events in aging males using testosterone. These are disputed by endocrinologists and urologists. The FDA has issued new warnings about the use of testosterone products in aging individuals that require warnings about possible increased risk of heart attack and stroke.

Testosterone supplementation is usually not advised in the early stages of diagnosis and treatment of prostate cancer. On the other hand, with successfully treated prostate cancer in a stable patient with hypogonadal symptoms, many physicians are willing to consider cautious supplementation.

Advice for Treating Aging Males with Hypogonadism:

1. Treat the patient not the blood test. If a patient's testosterone is low but they are not complaining about hypogonadal symptoms, avoid testosterone supplementation.
2. Before treatment, document at least two low total testosterone levels. Obtain a baseline pretreatment PSA.
3. Discuss treatment goals with the patient. Sexual performance may not improve but mood, energy and strength may improve.
4. Document counseling regarding cardiovascular risk.
5. Monitor therapy periodically with testosterone levels, PSA, CBC, and LFTs. Adjust therapy accordingly.
6. Consider terminating therapy in 3-6 months if no improvement is achieved.
7. If treatment is successful, patients will insist on continuation. Continue to monitor their care.

For more information about the topics discussed in this article, please utilize the following resources:

1. Testosterone Therapy and Cardiovascular Risk: Advances and Controversies. Mayo Clinic Proceedings, Vol 90, Issue 2, 2015, pp.224-251.
2. Testosterone Therapy in Men with Androgen Deficiency Syndromes: An Endocrine Society Clinical Practice Guideline. The Journal of Clinical Endocrinology and Metabolism, Volume 95, Issue 6, 1 June 2010.
3. FDA Drug Safety Communication: FDA evaluating Risk of Stroke, Heart Attack, and Death with FDA-approved Testosterone Products. January31, 2014.
4. UpToDate, 2017: 1. Androgen replacement in Men (The Basics). 2. Testosterone treatment of male hypogonadism. 3. Use of androgens and other hormones by athletes. 4. Overiew of approach to prostate cancer survivors. 5. Overview of testosterone deficiency in older men. 6. Frailty. 7. Treatment of male sexual dysfunction
5. AUA (American Urological Association): Hypogonadism—Medical Treatment. (https://university.auanet.org)

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