Medical Quality Assurance Commission
Update!
www.doh.wa.gov/medical
Vol. 7, Winter 2017

Message from the Chair

Warren B. Howe, MD
Chair, Congressional District 2

From time to time, with seemingly increasing frequency, your Medical Commission receives complaints that require it to consider the term "disruptive physician (or physician assistant)" in relation to a respondent. Disruptive behavior is defined in the AMA Code of Ethics as personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. Such behavior can take varied forms: aggressive (yelling, angry outbursts, publicly berating medical team members, etc.), passive aggressive (antagonistic emails, deprecating remarks, incessant complaining, inappropriate jokes and comments, etc.) or passive (tardiness, non-compliance with rules, meeting avoidance, etc.), and usually involves some combination of these. In practice, it may better be defined in the eyes of the beholder; as Justice Potter Stewart famously said on being asked to define obscene material, ". . . .I know it when I see it." Disruptive behavior is increasingly cited in the literature as a threat to patient safety, largely because it disrupts effective communication within the healthcare team and inhibits "subordinate" team members from voicing safety or procedural concerns. A physician who engages in a recurring pattern of such behavior is therefore engaging in unprofessional conduct that can result in discipline by the Medical Commission.

Labeling a physician or PA "disruptive" is challenging. The rare emotional outburst, triggered by a sincere concern about patient care, does not constitute "disruption," although it may merit a word of caution to the offender. Regulatory agencies have repeatedly cautioned that such labeling should not be used to silence practitioners who criticize systems and/or institutions for good or reasonable cause in a socially acceptable manner. It is recognized, however, that truly disruptive practitioners, whose behavior is rooted in personality or character flaws, may seek to excuse their behavior, when challenged, as an attempt on their part to support quality patient care.

By the time a problem practitioner reaches Medical Commission jurisdiction, patient harm has probably already occurred and any intervention is likely to acquire "official" trappings. Since 2009, the Joint Commission has recognized the importance of early and consistent intervention and has addressed practitioner behavior in its standards. Their standards require: code of conduct policies, consistent and equitable enforcement of behavioral expectations across the entire staff, and implementation of defined processes for managing disruptive behavior when it occurs. The Federation of State Medical Boards has taken a similar position. Unfortunately, many medical practices and institutions fail to take appropriate steps as soon as disruptive behavior is suspected or identified, a time when intervention is more likely to have beneficial effect. *Continued on pg. 2*

In This Issue.....

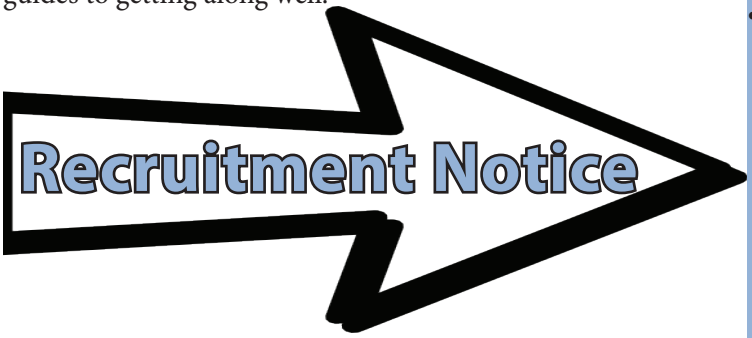
Mission

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

Continued from page 1

Your Medical Commission suggests that the "disruptive practitioner" be identified and engaged with at the earliest possible time in his/her career. This would start with individual physicians or physician assistants evaluating their own risk for being labeled "disruptive" and modifying behavior as appropriate. A quick online search under "avoid being labeled a disruptive physician" will produce a gold mine of interesting and useful resources to guide this process. Practices, especially the large ones, and all hospital staffs should have carefully crafted policies regarding behavioral standards. They should institute ongoing routines for regularly evaluating staff members' behavior, processing filed complaints, and they should establish firm guidelines for dealing with identified problems in a forthright and consistent manner. Desirable behavior can be the subject of reinforcement by periodic staff education, which is likely to be as important as punishment or remedial action for transgression, although both approaches are necessary. Involvement of available resources such as the Washington Physicians Health Program (WPHP) can be very helpful, especially in making the distinction between behavior resulting from serious psychopathology and that resulting from personality disorder, behavioral habit or other factors (e.g. gender, culture, religion, social influences) triggering the objectionable behavior. Thorough evaluation of practitioners appearing to be disruptive should be the rule. Helping a "disruptive" physician or physician assistant to recognize and overcome the problem is difficult and often frustrating, but it is rewarding when successful in that it preserves a valuable medical career while reducing the stress in those with whom the affected practitioner interacts, all while enhancing patient care and safety.

The question of whether there is a relationship between "burnout" and "disruptive behavior" has been raised, without a definitive answer. I suspect such interplay exists. Interpersonal relationships are a critical component of happy and successful lives and careers. Surely, in all our relationships with patients, family and colleagues, fundamental principles such as, "Do unto others as you would have them do unto you" serve as our most reliable guides to getting along well.



Executive Director's Report: Welcome to Washington!

Melanie de Leon, JD, MPA
Executive Director

As of November 13th, the Washington Medical Commission began issuing reciprocal allopathic physician licenses through Interstate Medical Licensure Compact (the Compact). This means that physicians licensed in a state belonging to the Compact can become licensed in Washington very quickly.

Washington became the 20th state to join after enacting the legislation in 2017. The Compact began issuing licenses in April 2017 and issued 384 physician licenses as of October 20, 2017.

Under the Interstate Medical Licensure Compact, applicants may select a State of Principal License upon which to base their qualifications for Compact entry and select reciprocal licenses from other participating states. At this time, the Washington Medical Commission can only issue reciprocal licenses and cannot be designated as a State of Principal License or issue a Letter of Qualification. These features will be available at a later date.

The Department of Health (DOH) is currently accepting applications to fill upcoming vacancies on the Washington State Medical Quality Assurance Commission (commission). The commission helps make sure physicians and physician assistants are competent and provide quality medical care.

We are looking for people willing to study the issues and make decisions in the best interest of the public. Our member selection reflects the diversity of the profession and provides representation throughout the state. The commission has openings for:

- One physician representing Congressional District 3
- One physician representing Congressional District 5
- One physician representing Congressional District 9
- One physician-at-large
- One physician assistant
- Three public members

The physician applicants for Congressional Districts 3, 5, and 9 will also be considered for the physician-at-large position. Additional information and a link to the governor's application can be found at: http://go.usa.gov/c2XrH. Applications must be received by **April 6, 2018.**

If you have questions about serving on the commission, please contact Daidria Amelia Underwood, Program Manager, at daidria.underwood@doh.wa.gov, or call (360) 236-2727.

ESHB 1427 Rule-making update from the Workgroup

Claire Trescott, MD, Congressional District 6
Alden Roberts, MD, 1st Vice Chair

House Bill 1427 was adopted in May of 2017. In it, the legislature requested that the Department of Health (DOH) improve the rules of opioid prescribing. They took note of the fact that opioid overdose deaths were occurring at a rate of two per day in Washington State and that we had seen a doubling of the death rate from 2010 to 2015. They felt that medically prescribed opiates were contributing to the opiate epidemic and, for this reason, more needs to be done to ensure proper prescribing, use of opiates and expanded access to treatment.

This bill requires that we adopt a new set of rules by January of 2019, and a task force has been created to rewrite the opiate rules and expand their scope.

We have been asked to obtain input from physicians, PAs, osteopathic physicians, osteopathic PAs, podiatrists, dentists, ARNPs, and pharmacists. The task force is composed of two voting members from each board or commission, except for Pharmacists, who are present but don't have a vote.

The legislature asks that we expand the use of the Prescription Monitoring Program (PMP). We will be required to give access to the PMP to more individuals and groups. These groups may use it for quality improvement at their organization, and for some legal activity. One specific new activity will be using the PMP to inform prescribers whenever one of their patients experiences an overdose. A task force subgroup is looking at the implications of this expansion.

The task force is looking at improving the rules for prescribing in ways that reduce the likelihood of patients becoming inadvertently addicted. This will involve exploring proper prescribing in the following areas:

- Patients under the age of 25;
- Prescribing for acute pain episodes;
- Dental prescribing;
- Perioperative opiates;
- Opiates in pregnancy;
- Geriatric opiate prescribing;

The legislature also specifically requested that we increase access to treatment throughout the state, including medically assisted treatment. We are also required to look at current community barriers and address them with new regulations. At the same time, they would like to see standard rules for treatment programs to adhere to in order to gain certification.

We are having meetings every month in locations throughout the state to gather input from professionals and from individuals. We have experts involved in these meetings as speakers and as regular contributors. So far, we have had one meeting in Olympia, one in Spokane and one in Yakima. There appears to be significant interest in this topic and the public offers a much needed perspective. We encourage anyone interested to come to our future meetings and give input. A list of the upcoming meeting locations, dates and times can be found at the opioid rules website: http://go.usa.gov/xnrez. You can also provide feedback on this rule making process at https://go.usa.gov/xnWV7.

Attend a 1427 Rule-making Workshop!

When	Where
January 8, 2018 8:30 a.m. to 3:30 p.m.	Vancouver Ft. Vancouver Regional Library District 1007 E. Mill Plain Blvd. Vancouver, WA 98663
February 9, 2018 8:30 a.m. to 3:30 p.m.	Everett Community College Jackson Conference Center 2000 Wilderness Auditorium Tower Street Everett, WA 98201
March 14, 2018 8:30 a.m. to 3:30 p.m.	Tumwater (Olympia) Labor & Industries Department 7273 Linderson Way S.W. Tumwater, WA 98501

For Updates, Agendas and Minutes, have email alerts sent directly to you as information becomes available. Sign up here http://go.usa.gov/xnreu!

Updated Guideline for Retaining, Storing and Disposing of Medical Records

Mike Farrell, JD
Policy Manager

Ever wonder how long you are required to retain medical records? What about storing records or disposing records? What do you do with records when closing a practice? The Medical Commission recently updated its guidelines to provide answers to these questions.

How long should medical records be kept?
While no law in Washington requires a physician or physician assistant to retain a patient's records for a specific period of time, the Medical Commission concurs with the Washington Medical Association that you should consider retaining patient records for at least:

- Ten years from the date of a patient's last visit, prescription refill, test or patient contact;
- 21 years from the date of a minor patient's birth;
- Six years from the date of a patient's death;
- Indefinitely if you have reason to believe the patient is incompetent, there are problems with the patient's care, or the patient may be involved in litigation.

How should records be stored?
Records, whether in electronic or paper format, should be stored to allow for lawful access and in a place that maintains confidentiality. You can contract with a third party to act as custodian of the records.

How should records be destroyed?
When retention is no longer required, records should be destroyed by secure means. The Medical Commission has disciplined practitioners for leaving records in sheds and garages, and for abandoning them in storage facilities. It is important to give patients an opportunity to claim their records or have them sent to another practitioner before they are destroyed.

What about closing a practice?
When closing your practice, you still have an obligation to make records available to patients and other providers. Ideally, you should notify active patients and patients seen within three years at least 30 days prior to closing your practice. You should provide notice by individual letter to patients at the last known address, or electronically (if that is how you normally communicate with patients), and by placing a notice in the newspaper.
The notice should include:

- The name of the responsible entity to contact to obtain the records or request transfer of the records;
- How the records can be obtained or transferred;
- The format of the records, whether paper or electronic;
- How long the records will be maintained before they are destroyed; and
- The cost of recovering or transferring records.

These recommendations for notifying patients when closing a practice do not apply if you are leaving a group practice in which another provider will assume care of the patients, or if you are a specialist who does not have ongoing relationships with patients.

For additional recommendations, see the complete guidelines on "Retention of Medical Records" at https://go.usa.gov/xnKQq.

Five Things to Think About in Utilizing PAs to Meet the Demands of the Growing Opioid Epidemic

Jim Anderson, PA-C, MPAS, DFAAPAA

1. **We must change the way we talk about this disease.** Opioid-use disorder (OUD) should be viewed as a chronic illness. Methadone and other medications need to be seen as useful for treating OUD. Similar to patients with hypertension, congestive heart failure, diabetes, other chronic diseases, those suffering from OUD may require long-term treatment. I think it is important for medical providers to utilize medical language, such as "positive" or "negative" tests (instead of "clean" or "dirty), and we should all make a very strong effort to avoid saying the word "addict." The connotations are very negative, so it will really help decrease the stigma that is so common in addiction.

2. **The field is flooded with misinformation and misperceptions.**
The opioid epidemic is complex and multi-factorial in nature, and pain management is a difficult area of medical practice. Most people who use opioids do not become addicted. Most data indicates that 75-85 percent of patients who take prescription opioids for pain do not become addicted. That still leaves a lot of people who do, but it's nowhere near as high as some providers would guess.

3. **There is an unfounded fear and stigma around opioids.**
   There is an ongoing belief among some medical providers that OUD is reflective of weakness or personal shortcomings. Like all chronic diseases, OUD is certainly multi-factorial in causes, including personal choices and behaviors. But this is also true of hypertension, congestive heart failure, diabetes and other chronic diseases.

   While medical professionals know that buprenorphine can work very well for OUD, there is still a lingering and often unspoken fear of addiction and the medicines used to treat them. DEA X Waivers allow PAs and NPs to prescribe buprenorphine for the treatment of OUD. These waivers have stringent limitations on the number of patients PAs and NPs can treat. These seemingly arbitrary limitations are a way to placate those who still don't believe that medication-assisted treatment (MAT) is appropriate, and who think methadone and buprenorphine are "just trading one addiction for another." And because there is still such skepticism, I think regulators feel the need to "chip away" at the issue. One way they can do that is start low with the X waiver. To me, this is regrettable, with so many people dying from the opioid epidemic. But if this is the only way to start getting PAs and NPs involved in stemming this epidemic, then we'll take it.

4. **There is great opportunity for PAs in addiction medicine.**
   Opportunities exist for PAs in a variety of addiction medicine settings, ranging from prescribing in primary care and community settings to increased opportunities in opioid treatment programs, often known as methadone clinics. Generally speaking, the most common addiction medicine opportunities for PAs are in detox/rehab settings (inpatient and outpatient), primary care settings, and opioid treatment programs.

   It is worthwhile to PAs to pursue the X Waiver, allowing PAs to prescribe buprenorphine for treatment of OUD. The 24-hour certification curriculum is available free and online (https://goo.gl/r7oB8W) and is a great way to wade into OUD and familiarize yourself with addiction medicine. I found it very educational and informative.

5. **Get involved.**
   This is an important time in addiction medicine and medication-assisted treatment, and PAs can really help. I am currently working on a project in conjunction with the PA Foundation (https://goo.gl/tkaAMY) and the National Institute on Drug Abuse. The project regards increasing the utilization of PAs in opioid treatment programs by educating PAs about the process to gain approval from state and federal agencies to allow PAs to practice in such settings. Additionally, I've worked with AAPA on a "how to" resource, advising PAs and opioid treatment programs on receiving an exemption from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to dispense methadone and buprenorphine.

   Many states are taking the default position that both the supervising physician and the PA must have the X waiver, which allows medical professionals to prescribe buprenorphine. AAPA, in conjunction with the American Academy of Nurse Practitioners and American Society of Addiction Medicine, recently formed a workgroup and came up with some very helpful recommendations (https://goo.gl/MibWxo) for state medical boards who oversee PAs, MDs, and NPs to remove barriers in PAs and NPs ability to prescribe buprenorphine.

   I recommend that all PAs interested in or currently practicing addiction medicine consider contacting the Medical Commission and reaching out to your state PA chapter. If we urge the adoption of this interpretation, we can remove barriers, increase the number of PAs in addiction medicine, and increase the number of patients we can treat. We can all be part of the solution for opioid-use disorders.

Cannabis use among Physicians: How High are the Stakes?

Chris Bundy, MD, MPH, Executive Medical Director, WPHP
Cynthia Morales, LMHC, Clinical Coordinator, WPHP

You are off duty, not on call and free of any patient-related responsibilities. You are at a semi-intimate social gathering and an acquaintance passes you a vaporizer and a knowing glance. You are pretty sure it is cannabis, less sure about what to do. Prior experience, personal values, perceived risks, anticipated enjoyment, desire for social acceptance and/or conviviality might all play a part in the decision you make in that instant. Would the professional implications or public perception of your choice even enter your mind? Would you be concerned that someone might view your use as troubling? As cannabis use becomes more common and socially accepted among US adults, physicians and PA's may be faced with a conflict between social permissiveness and conformance to the high expectations of medical professionalism. In our experience, cannabis legalization and unresolved controversies about the harmful effects of cannabis have led to confusion regarding the professional consequences of personal use.

Defending a right to use medicinal or recreational cannabis as the result of legalization fails to consider that cannabis remains a federally illegal, schedule I controlled substance. Violations of federal law are taken seriously by medical specialty boards, employers, and credentialing bodies regardless of state legal status. Medical staff bylaws often specifically prohibit the use of illegal controlled substances and may impose disciplinary action if cannabis use is detected through random or for-cause toxicology testing. Termination of employment as the result of medicinal cannabis use during non-work hours has been upheld in Colorado case law (Colorado Supreme Court, Coats vs. Dish Network, 2015). Professional liability carriers view cannabis use by health professionals as a serious underwriting risk. For these reasons (among others), health professionals should not confuse cannabis legalization with professional permissiveness toward personal use.

Health professionals may also be prone to underestimate the impact of cannabis use on cognitive function and thus their ability to practice safely after recent use. Inconsistent research data on the cognitive effects of chronic and/or past use has understandably made it difficult for health professionals to draw conclusions. However, cognitive dysfunction among current cannabis users is not controversial. In a 2017 review of over 10,000 cannabis research abstracts, the National Academy of Sciences concluded that current cannabis use is associated with deficits in learning, memory and attention that may be permanent in some cases [1]. In a 2009 review by Hall et al, abnormalities on EEG, PET and fMRI persisted hours and days after last cannabis use [2]. And, pilots have demonstrated significantly more impairment than controls in flight simulation 24 hours after smoking a single, low-potency 19 mg joint [3]. Thus, the cognitive effects of recent cannabis use may well translate to functional performance deficits, especially involving complex tasks like those encountered in typical medical practice.

While cannabis users may dismiss these concerns as prohibitionist propaganda, Bertha Madras, PhD, Harvard Professor of Psychobiology and internationally recognized expert on cannabis and cognition offers a sobering response, "This is not a war on drugs, it is the defense of our brains, the repository of our humanity." In our experience, health professionals referred to the Washington Physicians Health Program (WPHP) for cannabis-related concerns are often unfit for practice based on neurocognitive testing, regardless of whether they meet criteria for cannabis use disorder. Fortunately, nearly all have been able to safely return to practice following a period of sustained abstinence.

The issue is not about the legal status of cannabis or our right to self-determination in our private affairs, but the higher standard to which we are held (by ourselves and the public) for the privilege of practicing medicine. Personal health, safe practice, professional standing, and the public trust hang in the balance. Even for the occasional social user, dispelling a concern for cannabis-related impairment can be a costly and time-consuming process. Given these stakes, WPHP advises against use of cannabis among health professionals. It just isn't worth the risks.

WPHP is a confidential resource for questions about cannabis use (or other potentially impairing health conditions) among medical professionals and can provide resources and assistance for those who may be struggling with problematic use. We can be reached at 800-552-7236 or www.wphp.org.

References:
1.National Academies of Sciences, Engineering, and Medicine. 2017. The health effects of cannabis and cannabinoids: Current state of evidence and recommendations for research. Washington, DC: The National Academies Press.
2.Hall, W, Degenhardt, L. Adverse health effects of non-medical cannabis use. Lancet 2009; 374:1383-91.
3.Yesevage et al. Carry-over effects of marijuana intoxication on aircraft pilot performance: A preliminary report. AJP 1985; 142;1325-1329.

Possible changes to team practice for Physician Assistants? Let's talk about it!

Theresa Schimmels, PA-C
Physician Assistant Member

The American Academy of Physician Assistants defines Optimal Team Practice (OTP) as: "Optimal team practice occurs when PAs have the ability to consult with a physician or other qualified medical professional, as indicated by the patient's condition and the standard of care, and in accordance with the PA's training, experience, and current competencies. The evolving medical practice environment requires flexibility in the composition of teams and the roles of team members to meet the diverse needs of patients. Therefore, the manner in which PAs and physicians work together should be determined at the practice level". https://goo.gl/q8nzLc

For 50 years, the MD-PA relationship has been a team approach to healthcare, even before we started recent talk about the "medical home" and "team based healthcare". Basically, the OTP is saying that the value of the physician assistant-doctor relationship needs to continue with the ability of the MD/DO and the PA to decide at the site of practice the degree of delegation and supervision. A new PA may need multiple chart reviews and physician on site whereas a PA that has practiced for years may see patients without direct contact with the physician and rare chart reviews. Again, this is what the OTP addresses.

Another aspect of having PA's actively involved in the licensure and discipline. Per the AAPA article quoted above: "If regulation is administered by a multidisciplinary healing arts or medical board, it is strongly recommended that PAs and physicians who practice with PAs be full voting members of the board." Here at the WA DOH Medical Quality Assurance Commission (Medical Commission) we have two Physician Assistant Commissioners. We, Jim Anderson, PA-C and myself, are actively promoting and protecting PA members through the licensing and disciplinary processes of the Medical Commission. Washington continues to be on the leading edge of PA regulation as we move into the future of medicine and healthcare policy.

I highly value and respect the education of the doctors I work with, knowing that my education and experience brings a valuable dynamic to our practice. I am constantly being told I don't work for them but with them. And it's true! I have a fair amount of autonomy as my supervising physician knows that if I have a question or concern, I'll go find him/her. The trust I bring from that relationship extends to patient care, where patients place their trust in me.

Washington is on the verge of being another dynamic frontrunner in national healthcare as we look to increase access, reimbursement, and strengthen the MD-PA relationship. Patient care and safety is the bottom line. I think Optimal Team Practice is the future of physician assistant practice. We'll get there with the support of you, the PA's of Washington, and you, the physicians with whom we team as we work, side by side, as colleagues, caring and treating and protecting patients.

Medical Commission Meetings 2018 Medical Commission meetings are open to the public	
Date	**Location**
January 18-19	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
March 1-2	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
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
August 1, 2017 - October 31, 2017

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**
Formal Actions				
Dang, Hung MD60034194 King	Final Order	09/29/17	Respondent refused to aid and consult with fellow physicians while acting as an on call specialist.	Ethics coursework, written research paper, supervisor reports, personal appearances, and $5,000 fine.
Delgado, Daniel MD60220369 Pierce	Agreed Order	08/10/17	Respondent displayed conduct that lowers the standing of the profession in the eyes of the public.	Reprimand, successfully complete terms of court ordered oversight, ethics coursework, Community service, written research paper, personal appearances, and $2,000 fine.
Dillinger, Donald MD00017867 Snohomish	Final Order	08/23/17	Negligent management of chronic pain patients.	Permanent restriction from treating chronic pain patients, no more than three days of opioid medication prescribing in the treatment of non-chronic pain, utilization of PMP, practice reviews, written research paper, recordkeeping coursework, personal appearances, and $5,000 fine.
Duggal, Narinder MD00036603 Kitsap	Final Order	10/23/17	Sexual misconduct, inadequate recordkeeping, negligent management of chronic pain patients, and negligent primary care of patients.	Suspension, clinical skills assessment, multi-disciplinary evaluation, probation upon reinstatement, boundaries and recordkeeping coursework, restriction from treating female patients and practicing as pain management specialist, self-reports, practice reviews, personal appearances, and $10,000 fine.
Faires, Penny MD60014000 King	Agreed Order	08/10/17	Negligent diagnosis and treatment of symptoms consistent with cauda equine syndrome.	Suspension, clinical skills assessment, and clinical practice monitoring.
Jack, Christopher MD60001446 King	Agreed Order	08/10/17	Negligent diagnosis and treatment of symptoms consistent with cauda equine syndrome, and inadequate recordkeeping.	Written research paper, neurologic emergencies coursework, practice reviews, personal appearances, and $2,500 fine.
Mustafa, Syed MD00034219 King	Agreed Order	08/10/17	False advertising, misrepresentation, aiding and abetting the unlicensed practice of medicine by persons enrolled in a non-accredited residency program.	Commission-approved public disclosure re legal status of training program and training materials, notification of training program enrollees, restriction on how training program is publicly represented personal appearances, and $5,000 fine.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Formal Actions (Continued)				
Robins, Edwin MD00035964 Spokane	Agreed Order	10/10/17	Negligent management of patients seeking reproductive fertility treatments and employment of an underqualified staff person.	Clinical skills assessment, ethics and reproductive medicine coursework, laboratory inspections, practice reviews, personal appearances, and $4,000 fine.
Schapera, Anthony MD00031432 Out of state	Final Order – Failure to Appear	10/10/17	Failure to comply with a Commission order.	Indefinite suspension.
Zilz, Nathan MD00033914 King	Agreed Order	10/10/17	Disciplinary action by Arizona Medical Board.	Restriction on reinstatement or reactivation of expired license, and personal appearances.
Informal Actions				
Abdullah, Bisher MD00035982 King	Informal Disposition	08/11/17	Alleged negligent failure to adequately document patient care and diagnoses.	Recordkeeping and professionalism coursework, written research paper, practice reviews, personal appearances, and $1,000 cost recovery.
Agan, William PA10005277 King	Informal Disposition	08/10/17	Alleged diversion of controlled substances.	Health program monitoring, ethics coursework, personal appearances, and $1,000 cost recovery.
Bliss, Erika MD00041541 King	Informal Disposition	08/10/17	Alleged negligent management of chronic pain patients.	Controlled substance prescribing coursework, written research paper, utilization of PMP, review and compliance with Commission pain management rules, practice reviews, personal appearances, and $1,000 cost recovery.
Carter, Thomas MD60263627 Out of state	Informal Disposition	08/10/17	Alleged professional conflicts in the counseling and representation of patients in a relationship, and alleged failure to comply with a court order.	Surrender of license.
Chamberlain, Marc MD00048128 King	Informal Disposition	08/10/17	Alleged informal dispensing of a legend drug to patients, and alleged negligent failure to thoroughly read and convey radiology report interpretation to a patient.	Surrender of license.

Practitioner Credential and County	Order Type	Date	Cause of Action	Medical Commission Action
Informal Actions (Continued)				
Fajardo, Renato MD00030962 King	Informal Disposition	08/10/17	Alleged negligent failure to perform adequate testing of a patient at risk for tuberculosis.	Surrender of license.
Green, Candace MD00044357 Benton	Informal Disposition	08/10/17	Alleged negligent management of chronic pain patients.	Controlled substance prescribing coursework, written research paper, utilization of PMP, review and compliance with Commission pain management rules, practice reviews, and personal appearances.
Johnson, Bryan MD00026794 Whitman	Informal Disposition	08/10/17	Alleged negligent management of a chronic pain patient.	Controlled substance prescribing coursework, written research paper, utilization of PMP, peer group presentation, practice reviews, personal appearances, and $1,000 cost recovery.
Kinane, Thomas MD00019971 Out of state	Informal Disposition	10/10/17	Alleged negligent failure to perform adequate workup and follow-up of a patient with a lung mass.	Diagnosis and treatment of lung mass coursework, written research paper, and personal appearances.
Lupton, Patricia PA60638457 Pierce	Informal Disposition	10/10/17	Alleged negligent recordkeeping.	Recordkeeping and time management coursework, ethics coursework, written research papers, 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.

What would you like to see in your newsletter? Email medical.newsletter@doh.wa.gov with comments and suggestions. We look forward to hearing from you!

Need a Speaker?
The Medical Commission is happy to present to your group or organization. Go to https://go.usa.gov/xnK6h for more information.

Commission Rule-Making Efforts

Daidria Amelia 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 Medical Commission adopt rules for both allopathic physicians and physician assistants. On June 30, 2017 the Medical 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 was filed as Washington State Register (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. There will be one task force meeting per month from September 2017 to March 2018 in various locations around the state. For more information, please visit www.doh.wa.gov/opioidprescribing. To learn more about ESHB 1427 please visit the bill summary page: http://go.usa.gov/xRwbE

Temporary Permits
On June 28, 2017 a rules hearing was held for WAC 246-919-390 and WAC 246-919-395 in Pasco, Washington. The rule was passed on June 30, 2017. The CR-103 was filed with the Office of the Code Reviser as WSR #17-18-098 on September 6, 2017. The purpose of the rule was to: repeal WAC 246-919-390, adopt amendments to WAC 246-919-395 and to clarify when a temporary practice permit may be issued to an applicant who is licensed in another state with substantially equivalent licensing standards to those in Washington. This adopted amendment allows the Medical Commission flexibility to add or delete states from an internal list without going through a rules process.

Office-Based Surgical Settings
On June 28, 2017 a rules hearing was held for WAC 246-919-601(5) in Pasco, Washington. The rule was passed on June 28, 2017. The CR-103 was filed with the Office of the Code Reviser as WSR #17-18-032 on August 28, 2017. The purpose of the rule was to clarify and update requirements for allopathic physicians performing office-based surgery in facilities that are accredited, or certified, by accrediting entities approved by the Medical Commission. The rule eliminated the list of accrediting entities and instead, will allow the Medical Commission the ability to add or delete accrediting entities based on criteria established in the adopted rule. This will also allow the Medical Commission to post on their web site and disseminate to providers and stakeholders a current list of approved entities whenever the list is amended. The rule also clarifies when a physician may perform procedures in a nonaccredited facility that is actively seeking accreditation, and identifies the physician's responsibilities should the facility not maintain their accreditation.

Military Spouse Temporary Permits – Physician Assistants
On June 28, 2017 a rules hearing was held for WAC 246-918-076 in Pasco, Washington. The rule was passed on June 30, 2017. A CR-103 was filed with the Office of the Code Reviser as WSR #17-18-097 on September 6, 2017. The purpose of the rule is to provide for temporary practice permits to be issued to military spouses or state-registered domestic partners who hold out-of-state credentials as allopathic physician assistants whose partners are the subject of a military transfer to Washington, and who meet the specific requirements under.

Reminder: Suicide Prevention Training – ESHB Bill 1424
The CR-103 for allopathic physicians was filed with the Office of the Code Reviser on March 8, 2017 as WSR #17-07-043. The CR-103 for allopathic physician assistants was filed with the Office of the Code Reviser on March 8, 2017 as WSR# 17-07-044. 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 more information on any of these rules, please visit our rulemaking site: https://go.usa.gov/xN9qC.
For continued updates on rule development, interested parties are encouraged to join the Medical Commission's rules email distribution list at: https://goo.gl/pw8j6g

Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866

The law requires each practitioner to maintain a current name and address with the department. Please submit address changes and appropriate documentation for name changes to:
medical.commission@doh.wa.gov

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Jimi R. Bush, MPA, Managing Editor: jimi.bush@doh.wa.gov

Medical Commission Contact Information

Applications:	A–K 360-236-2765
	L–Z 360-236-2767
Renewals:	360-236-2768
Complaints:	360-236-2762
	medical.complaints@doh.wa.gov
Complaint Form:	https://go.usa.gov/xNyBC
Legal Actions:	http://go.usa.gov/DKQP
Compliance:	360-236-2781
Investigations:	360-236-2759
Fax:	360-236-2795
Email:	medical.commission@doh.wa.gov
Demographics:	medical.demographics@doh.wa.gov
Website:	www.doh.wa.gov/medical
Public Disclosure Request:	PDRC@doh.wa.gov
Provider Credential Search:	http://go.usa.gov/VDT
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