

## Message from the Chair

**Warren B. Howe, MD**

**Chair, Congressional District 2**

It seems as if every journal I read these days contains an article about “physician burnout” – the topic is also prominent in the lay press. Small wonder, since the statistics are chilling: approximately 50% of physicians report burnout symptoms (e.g. loss of enthusiasm for work, cynicism, diminished or absent sense of personal accomplishment) and 300-400 U.S. physicians, the equivalent of two or more medical school classes, commit suicide annually. The suicide rate in male physicians is 1.41 times greater than the general male population and the rate for female physicians is 2.27 times greater. The reported burnout rate is steadily rising with no end in sight. Something is very, very wrong and it threatens the soul of our profession, not to mention the safety and welfare of our patients. Your Medical Commission endorses the concern about burnout, raised by so many voices speaking for and about medicine.

Many factors have been implicated in burnout: bureaucratic pressures, loss of professional autonomy, long hours, stressful work, insufficient income, increasing computerization, burdensome recertification obligations, etc. Some of these, such as long and stressful hours, have always been characteristic of medical practice while others are of more recent origin. My opinion is that physicians with burnout are experiencing a mismatch between the motivations and expectations that attracted them to the medical profession, and the reality they experience daily. I volunteer as an alumni interviewer for prospective undergraduates at my alma mater, many of whom identify themselves as “pre-med”. Their invariable response to my “why” question is “I want to help people” or some variation of that theme. I suspect it was and is the same for the vast majority of today’s medical practitioners. But currently there is a lot that comes between the doctor and the patient: computer screens, dysfunctional EMRs, endless paperwork, arcane government and insurance regulations, administrators, productivity norms, and insufficient time to spend with increasingly complex patients to name a few. Dedication loses out to the need to get through the day, and the motivational fire that shaped an excellent practitioner is gradually smothered.

Burnout does not just injure the physician; there are adverse effects on patient care quality attributed to it, including higher error rates, increased malpractice risk, lower patient satisfaction, increased physician and staff turnover.

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## Mission

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

So what to do about burnout? It seems unlikely that the stressors inherent in contemporary medicine will go away. Some modification may be possible, such as: improving the functionality of EMR's, eliminating and/or revising onerous regulations, encouraging measures that promote physician autonomy in the clinical arena, reducing paperwork and eliminating externally-imposed physician tasks that are unrelated to direct patient evaluation and care. But the overall impact of all of this is likely to be small; medicine has always been and will remain a demanding and intense profession. Most experts agree that improved compensation may help somewhat but does little to change the dynamics underlying burnout. The antidote to burnout probably "does not lie in incentivizing physicians with money or restructuring systems to minimize stress on physicians – it lies in finding earnest professional fulfillment."<sup>1</sup> Burnout reduction requires proactive steps. All practitioners, even those who don't feel "burned out" now, should pursue self-education about burnout and potential lifestyle changes that may mitigate this threat to their wellbeing. There is excellent CME available, and books by physician-authors who have "specialized" in helping colleagues with burnout. An Internet search using "physician burnout" or a similar phrase will reveal myriad avenues to consider.

If you identify significant burnout symptoms in yourself, or a colleague, the situation is critical. Seek help or provide support and do not try to "go it alone". Trusted colleagues and sometimes family members may provide help and guidance. Some healthcare institutions have formalized and useful employee assistance programs.

In our state there is a marvelous resource, the Washington Physicians' Health Program (WPHP), which is partially supported by your license fees. Its website (<http://wphp.org>) highlights the many avenues of support it can provide, and a call (206-583-0127), which can be anonymously and/or confidentially made, will initiate contact with a clinical coordinator with whom a practitioner experiencing burnout or fearing that a colleague may be so afflicted can discuss the situation and potential interventions. Unless there is identifiable risk of patient harm, the Medical

Commission is not notified of such interactions, or of treatment programs practitioners may undertake. The Medical Commission is well acquainted with many circumstances in which WPHP has saved careers and even lives through its beneficial responses to practitioner contacts.

By all means, take burnout seriously. It jeopardizes your career, your family and potentially your life. But it can be prevented, mitigated or successfully treated with timely and appropriate action.

<https://www.theatlantic.com/health/archive/2012/08/the-root-of-physician-burnout/261590/>

## NOTICE OF RECRUITMENT

**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 1
- One physician representing Congressional District 7
- One physician assistant
- One public member

To determine what congressional district you live in, please visit <http://go.usa.gov/c2XCw>.

The Commission consists of 21 members appointed by the governor. It meets about eight times a year, usually on Thursday and Friday. There is an expectation to review multiple disciplinary cases between meetings, and additional meetings or hearings are often necessary. Additional information regarding commission membership and a link to the governor's application can be found at: <http://go.usa.gov/c2XrH>.

Please take the time to review the valuable information on commission membership available at the above website. Applications, along with a current resume, must be received by **April 28, 2017**.

If you have any questions about serving on the Commission, please contact Daidria Underwood, Program Manager, at Post Office Box 47866, Olympia, Washington 98504-7866, by email at [daidria.underwood@doh.wa.gov](mailto:daidria.underwood@doh.wa.gov), or call (360) 236-2727.



# County Profile: Benton

On June 29-30th, 2017 the Medical Commission will be holding its meeting at the Red Lion Hotel Kennewick Columbia Center in Benton County. In anticipation of our visit to beautiful Kennewick, The Medical Commission is putting the spotlight on the licensees of Benton County. Benton County is located in Southeastern Washington. As of the 2010 Census is has a population of 175,177.

As of July 2016, the Medical Commission received 25,803 demographic censuses. Over 50% of Benton County physician and physician assistants have returned their census to the Medical Commission. Here is what we have learned about Benton County licensees.

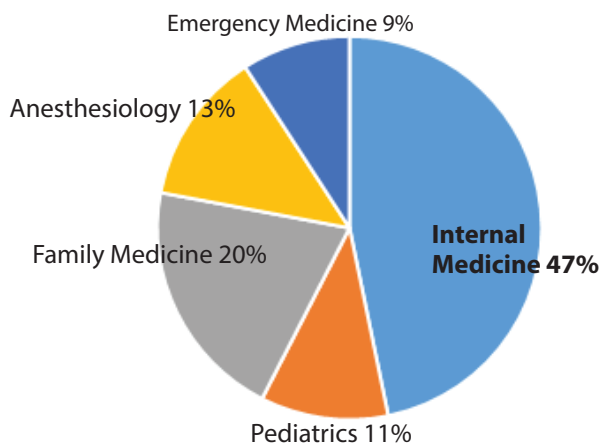
## Physician (MD)

- ▶ 64% of the physician population is male, which is lower to the statewide percentage of 67% of physicians being male.
- ▶ 43% of the practicing population is between the age of 31 and 51. 48% is between 52 and 72 years of age.
- ▶ 33% of the population are employees of a hospital or clinic while 26% work for a single specialty group.
- ▶ Almost 2.7% of practicing physicians use telemedicine in their practice. This is below the state average of 11% utilizing telemedicine.
- ▶ On average, a Benton County MD will spend 44 hours per week in clinical practice. This is higher than the state average of 35 hours.

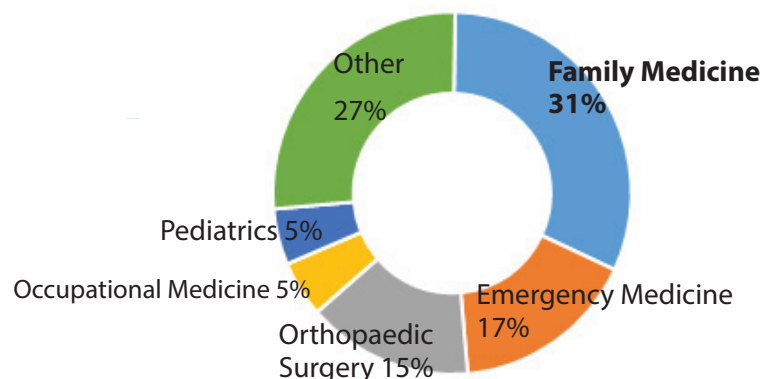
## Physician Assistant (PA)

- ▶ Physician assistants in Benton county have an almost even split of males and females practicing, with 55% of males making up the PA population.
- ▶ Physician Assistants tend to be younger overall, with 64% of Benton county PAs being between 31 and 51 years of age.
- ▶ 96% of the PA population in Benton county is certified in their respected fields.
- ▶ 24.5% of the population have more than once supervising physician.
- ▶ 8% of PAs in Benton County practice telemedicine.
- ▶ On average, Benton county PAs spend 38 hours per week devoted to clinical practice. This is in line with the state average of 37 hours per week.

## Primary Practice (MD)



## Primary Practice (PA)



# Washington Physician Health Program (WPHP) Report: Cognitive Performance in Physicians: What's Age Got to Do with It?

**Chris Bundy, MD, MPH**  
**Medical Director, WPHP**

Our population is getting older with the proportion of physicians over age 60 approaching 25%. The aging of the physician workforce has raised concern and controversy. On one hand, physician retirement represents a major threat to an adequately supplied physician workforce with implications for access to services and quality of care. On the other hand, some physicians may wish to work beyond the time when they can safely practice. While calls for age-based cognitive screening might appear to be a reasonable strategy to protect patient safety, such measures may be unfairly discriminatory and insufficient to protect patient safety.

**“If our overarching goal is to prevent patient harm through early detection of cognitive impairment in physicians, older physicians may be too narrow a target.”**

Concerns about older physicians are understandable because cognitive performance declines with normal aging [1] and advancing age is the greatest risk factor for neurodegenerative disorders. In addition, Choudhry and colleagues 2005 meta-analysis demonstrated an inverse relationship between age and all quality outcomes assessed in 52% of the included studies. The authors suggest that “older physicians may need quality improvement interventions that are generally applicable to all physicians” [2].

In contrast, factors such as genetic vulnerability, lifestyle, personality type/stress response, and medical comorbidity create substantial inter-individual variability in cognitive aging. For example, Drag and colleagues found that nearly 80% of surgeons aged 60-64 performed within the range of younger surgeons on all tasks measured, as did 40% of those aged 70 or older. 45% of retired senior surgeons performed within the range of the younger surgeons on all tasks. The authors speculate that some surgeons might have chosen to stay in practice with the benefit of objective evidence of their intact cognitive abilities [3]. On average, cognitive performance declines with age, but we should not assume an individual physician is performing below his or her peers based on age alone.

If our overarching goal is to prevent patient harm through early detection of cognitive impairment in physicians, older physicians may be too narrow a target. In a study of 267 physicians referred for practice concerns, 24% had levels of cognitive difficulty warranting further neuropsychological assessment. In another study by Turnbull and colleagues, 38% of physicians with performance concerns demonstrated moderate to severe cognitive impairment on neurocognitive testing sufficient to explain their poor performance [5]. There was no difference in age between the cognitively impaired and intact groups in these studies. Brooks and colleagues found that age and referral question were poor predictors of cognitive difficulty among their 124 cases with cognitive impairment [6]. Finally, in a recent pilot study at WPHP, we found that 23% of referrals screened positive for cognitive impairment and half of those demonstrating impairment were age 60 years or younger. Together, the data consistently suggest that selectively screening older physicians for cognitive impairment may be a somewhat arbitrary and ineffective quality improvement effort.

If we are truly serious about protecting patient safety, then we should at least consider the merits of routine cognitive screening for all physicians as an alternative to age-based screening. Other safety-sensitive professions, such as airline pilots, air traffic controllers, police officers, and firefighters, undergo routine health screening to ensure safety. As a general health measure, cognitive screening may be a good place to start. The brain, exquisitely sensitive to insult, may be the “canary in the coal mine” for a variety of health conditions that could negatively impact practice performance. Proactive screening has the potential detect health problems before patients are put at risk while improving the health of the physician and their likelihood of cognitive recovery. Furthermore, the prospect of routine cognitive screening might encourage healthier lifestyle choices and better health care engagement by physicians who tend to neglect self-care and seek medical treatment reluctantly. In short, it is consistent with the professional value of maintaining personal wellness. We have found that evidence of cognitive problems powerfully motivates physicians to attend to their personal health and engage with effective medical care. In the vast majority of cases, cognitive dysfunction resolves with effective treatment of the underlying condition and the physician can safely return to practice.

# Commission Issues Guidelines on Simultaneous or Overlapping Surgeries

**Mike Farrell: Policy Manager**

**Mark Johnson, MD: Congressional District 1**

Is it reasonable that only older physicians should submit to cognitive screening when the evidence suggests that cognitive dysfunction is largely unrelated to age in those who ultimately develop practice problems? As Choudhry points out, “older physicians may need quality improvement interventions that are generally applicable to all physicians.” This implies that we should have broadly applicable standards of cognitive performance for all physicians to which older physicians are equally accountable. In the end, physician age may simply be a convenient target for a larger, more complex issue that would be easier to ignore.

What’s age got to do with cognitive performance in physicians? Something certainly, but perhaps not as much as we might think.

#### References

1. Schaie K. Intellectual Development in Adulthood: The Seattle Longitudinal Study. New York: Cambridge University Press, 1996.
2. Choudhry N, Fletcher R, Soumerai S. Systematic review: The relationship between clinical experience and quality of health care. *Ann. Intern. Med.* 2005; 142:260-273.
3. Drag L, Bieliauskas L, Langenecker S, Greenfield L. Cognitive functioning, retirement status, and age: Results from the cognitive changes and retirement among senior surgeons study. *J. Am. Coll. Surg.* 2010; 211; 303-307.
4. Korinek L, Thompson L, McRae C, Korinek E. Do Physicians Referred for Competency Evaluations Have Underlying Cognitive Problems? *Academic Medicine*, Vol. 84, No. 8, August 2009.
5. Turnbull J, Cunningham J, Unsal A, Norman G, Ferguson B. Competence and cognitive difficulty in physicians: A follow-up study. *Acad. Med.* 2006; 81:915-918.
6. Brooks E, Gendel M, Parry A, Humphreys S, Early S. Challenging cognitive cases among physician populations: Case vignettes and recommendations. *Occup. Med.* 2016; 67:68-70.

## Stay Informed!

The Medical Commission maintains four email listserves to deliver relevant information to your inbox. Sign up today and keep up-to-date!

Newsletter:	<a href="http://go.usa.gov/dGk">http://go.usa.gov/dGk</a>
Minutes and Agendas:	<a href="http://go.usa.gov/dGW">http://go.usa.gov/dGW</a>
Rules:	<a href="http://go.usa.gov/dGB">http://go.usa.gov/dGB</a>
Legal Actions:	<a href="http://go.usa.gov/dGK">http://go.usa.gov/dGK</a>

As a result of national news reports last year highlighting the practice of simultaneous surgeries, the American College of Surgeons revised their guidelines in the area. Using these guidelines, the Medical Commission recently issued its own guidelines to ensure that Washington surgeons who perform overlapping or simultaneous elective surgeries do so in a patient-centered and transparent manner.

The guidelines first provide general principles:

- The primary attending surgeon’s sole focus must be to provide the best care to the patient.
- The primary attending surgeon is personally responsible for the patient’s safety and welfare throughout the surgery.
- The primary attending surgeon should participate in the surgical huddle or time out before the first incision is made.
- In general, the primary attending surgeon should be in the operating suite or be immediately available for the entire surgical procedure. If the primary attending surgeon is not present or immediately available, another attending surgeon should be assigned as immediately available.

The guidelines then recommend that the primary surgeon inform the patient in advance of the surgery of:

- Who will participate in the surgery, including residents, fellows, physician assistants and nurse practitioners who are directly supervised by the surgeon;
- When the primary attending surgeon will be absent for part of the surgery; and
- Who will continue the surgery when the primary attending surgeon leaves the operating room;

Finally, the guidelines recommend the surgeon document the following information in the surgical record:

- The absence of the primary attending surgeon for any part of the surgery;
- The time the primary attending surgeon enters and leaves the operating suite; and
- The name of the temporary primary operator in the primary attending surgeon’s absence;

You can find the guidelines here: <https://go.usa.gov/xXYU4>

## Commission Rule-Making Efforts

### Daidria Underwood Program Manager

#### Suicide Prevention Training – Engrossed Substitute House Bill 1424

The supplemental CR-102 for allopathic physicians was filed with the Office of the Code Reviser on October 18, 2016 (WSR# 16-21-089) and the supplemental CR-102 for allopathic physician assistants was filed with the Office of the Code Reviser on October 13, 2016 (WSR# 16-21-055). 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. The CR-102 hearing for both allopathic physicians and physician assistants was held December 1, 2016. As there was not a quorum at that hearing, the proposed language was brought to the full Commission at their January 13, 2017 business meeting, where it was approved. The final step in the rulemaking process, the CR-103, is currently in progress. Frequently asked questions regarding both of these rules can be found on our website at <http://go.usa.gov/cJ98G>

#### Temporary Permits

A statement of inquiry CR-101 for WAC 246-919-390 and WAC 246-919-395 was filed with the Office of the Code Reviser on June 20, 2016. The WSR # is 16-13-106. The Commission is considering amending rules regarding temporary permits in order to be consistent with current practice, modernize language, and clarify requirements. A rules workshop was held September 7, 2016 and draft language was reviewed at that meeting. The draft language is currently under review. A rules hearing will be held in early 2017.

#### Office-Based Surgical Settings

A statement of inquiry CR-101 for WAC 246-919-601(5) was filed with the Office of the Code Reviser on September 27, 2016. The WSR # is 16-20-025. The Commission is considering amending rules regarding office-based surgical settings to modernize language, clarify requirements, and possibly amend the list of entities that accredit facilities, where surgery is performed. A rules workshop was held November 2, 2016. The draft language is currently under review. A rules hearing will be held in early 2017.

#### Clinical Support (formerly Technical Assistance)

A statement of inquiry CR-101 for Chapters 246-919 WAC and 246-918 WAC was filed with the Office of the Code Reviser on September 6, 2016. The WSR # is 16-18-081. The Commission is considering establishing a clinical support program to resolve practice deficiencies that may not rise to the level of a license sanction or revocation through a plan of education, training, and/or supervision for allopathic physicians and physician assistants. A rules workshop was held November 2, 2016 where it was determined additional research will need to be done. Another workshop will be held in mid-2017.

#### More Information

For continued updates on rule development, interested parties are encouraged to join the Commission's rules listserv at: <http://go.usa.gov/dGB>

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## Exploring Health Equity: Resources from the Commission

The Health Equity Work Group of the Medical Quality Assurance Commission has a resource page intended to provide tools and information for MDs and PAs to help address racial and other health inequities. Currently being featured on the site (<https://go.usa.gov/xXBQQ>) is the Disparities Policy page from the Kaiser Family Foundation.

The current page includes some fascinating reporting and data about health coverage by race and ethnicity, looking at changes under the controversial Affordable Care Act. Also of interest is the report about health and health care for black patients, with some troubling comparisons of care of black and white patients.

Those of us on the MQAC Health Equity Work Group hope you will take a look at some of the resources, and share some with us that you may know about for us to include on our resource page.

**14%** of women in Washington did not see their doctor last year, due to cost.

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# Licensee Spotlight

## Marc Pellicciaro, MD

I'm a psychiatrist with addiction medicine subspecialty training. Currently, I am the Medical Director of residential treatment at Lakeside-Milam Recovery Centers in Kirkland. I help people through the process of acute withdrawal and guide them into a drug and alcohol free lifestyle.

After graduating from University of Washington Medical School, I trained in anesthesia, psychiatry, and addiction medicine. Although my past clinical experiences are far-reaching, my current role of treating those suffering from addiction is the most rewarding clinical position I have ever practiced.

I now live in Bellevue with my lovely wife Olena. For leisure, we enjoy visiting the various majestic sites throughout the USA, healthy activities, and cooking (and eating) Italian food. On a daily basis, I am grateful to be a physician and thankful that I am able to work in a profession that lets me help people every day and give back to the community.

- I was born in New York city but I grew up on a farm in Wasilla Alaska, raising horses.
- I knew I wanted to practice medicine as a child. I was inspired by my late uncle who graduated from UW medical School and practiced family medicine in Alaska for over 40 years.
- While studying for the MCAT I worked as a chemist evaluating soil samples after the EXXON Valdez oil spill.
- In my practice I utilize my 22 years of experience and my addiction medicine subspecialty certification to help patients break the downward spiral of addiction and obtain sobriety.
- The one thing MDs and PAs should do in there practice is not let the hectic and demanding nature of our profession interfere with forming an alliance with the patient and remaining compassionate.
- Technology has changed the practice of medicine by broadening my ability to care for patients such as telepsychiatry in rural Alaska.
- During my free time I exercise and spend time with my wife, Olena.
- The most memorable trip I have ever taken was to Tonga at the age of 12, where my blond hair was the center of attention of the island.
- I want to explore the Ukraine and how medicine is practiced in Eastern Europe.
- My dream trip would be surfing in warm water on 4-6 foot glassy waves.
- I absolutely cannot live without Saturday naps.
- No one would ever suspect that I am the 1978 Anchorage karate champion.
- Friends would describe me as funny, smart, handsome....humble.
- I give back to my community by helping people with their sobriety.
- I would never throw out my 1990 UW medical school mug.
- I would like to meet Kelly Slater and Sigmund Freud.
- My first car was a 1976 Mustang, a real POS.
- I wish less complex insurance billing would come back into style.
- I wanted to be Captain Kirk when I grew up.
- If I have learned one thing in life, it is that, if you fall, get back up and turn the experience into intelligence.

We would like to learn about you!  
Go to <https://goo.gl/forms/8d4DH9JT0lJsF5cq1> or email [jimi.bush@doh.wa.gov](mailto:jimi.bush@doh.wa.gov) to request a questionnaire.

## Legal Actions

### November 1, 2016 - January 31, 2017

Below are summaries of interim suspensions and final actions taken by the 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 Commission website: <http://go.usa.gov/bkNH>

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
<b>Formal Actions</b>				
Craig, Gerald B. MD00044814 Walla Walla	Amended Agreed Order	11/04/16	Failure to effectively manage patients with non-cancer chronic pain.	The Amended Agreed Order eases a controlled substance prescribing restriction, and provides for a practice monitoring program.
Fox, Samuel F. MD00005293 Snohomish	Amended Agreed Order	01/19/17	Mismanagement of patient weight loss programs through excessive prescribing of Phentermine.	The Amended Agreed Order provides for surrender of license.
Tangredi, Raymond P. MD60248946 Out of State	Agreed Order	11/08/16	Oregon Medical Board Stipulated Order providing for an agreement to retire license while under investigation.	Surrender of license.
Yoon, Justin K. MD00037000 King	Agreed Order	01/13/17	Conviction of Class C felony – promoting prostitution - 2 <sup>nd</sup> degree.	Volunteer non-profit service, ethics course work, written research paper, personal appearances, and \$5,000 fine.
Zhuge, Wu MD60087703 Out of State	Agreed Order	01/17/17	Failure to obtain full informed consent to surgical procedure, negligence, failure to note changes in function and surgical complications, and failure to timely perform exploratory and corrective surgery.	Ethics and recordkeeping course work, written research paper, personal appearances, and \$5,000 fine.
<b>Informal Actions</b>				
Buchan, Jennifer B. PA10004759 King	Informal Disposition	01/17/17	Alleged: inability to safely practice as a physician assistant due to a health condition.	Surrender of license.
Friedman, Andrew S. MD00031061 King	Informal Disposition	01/17/17	Alleged: sexual misconduct.	Written research paper, maintain proper boundaries, quarterly personal statements, personal appearances, and \$1,000 cost recovery.
Hein, Lee C. MD00015144 Whatcom	Informal Disposition	01/13/17	Alleged: failure to effectively manage patients with non-cancer chronic pain and ADHD.	Pain management course work, registration in and use of prescription monitoring program, practice reviews, personal appearance, 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.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
<b>Informal Actions (continued)</b>				
Krane, BjornMD00044958 King	Informal Disposition	01/17/17	Alleged: failure to communicate critical time sensitive information during the course of surgery and failure to accurately document patient harm.	Ethics and communication course work, written research paper, personal appearance, and \$1,000 cost recovery.
McCann, Bessie MD00047162 Thurston	Informal Disposition	01/17/17	Alleged: failure to properly document, perform, and supervise cosmetic laser treatments.	Written research paper, written protocols governing laser treatments, implement compliance with laser device rules, practice reviews, personal appearances, and \$1,000 cost reimbursement.
Mielbrecht, Cheryl M. PA10005359 King	Informal Disposition	01/17/17	Alleged: inability to safely practice as a physician assistant due to substance abuse.	Surrender of license.
Scott, Charles M. MD00023490 Kitsap	Amended Informal Disposition	11/07/16	Alleged: failure to personally consult with patients that were being prescribed medications, failure to order appropriate lab work, and failure to comply with prior Informal Disposition.	Expanded prescribing restriction, expanded written research paper, practice reviews, personal appearances, \$1,000 cost reimbursement, and extended term of oversight.
Trotta, Thomas C. MD00023082 Benton	Informal Disposition	01/13/17	Alleged: failure to obtain pre-operative imaging studies, improper scheduling of complex surgical procedure at an outpatient ambulatory surgical center, and failure to properly note and repair surgical complications.	Written research paper, peer group presentation, quarterly quality review reports, personal appearances, and \$1,000 cost reimbursement.

## Correction to newsletter legal actions: Winter 2016

We apologize for a typo in the Winter 2016 newsletter regarding the name of a practitioner with an informal disposition date 10/12/2016. The name published should have read "**Davis, Frederick B.**" ...not **Chung, Crystal**. Please see below for the amended informal action. We apologize for any confusion or inconvenience.

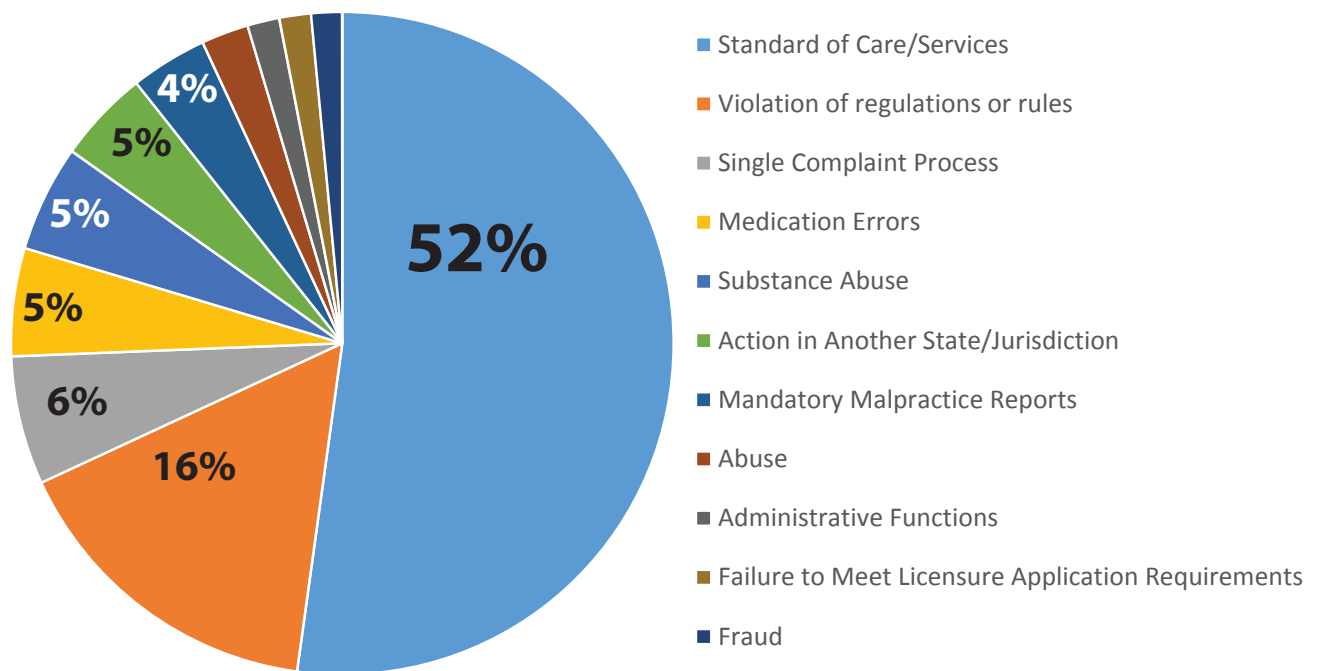
Davis, Frederick B. MD00010139 King	Informal Disposition	10/12/16	Alleged: Enabled at risk patient to possess excessive medication and failure to properly maintain treatment records.	Course work, written research paper, written protocol re prescribing to at risk patients, utilize PMP, practice reviews, personal appearances, and \$500 cost reimbursement.
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# Annual Investigative Statistics

## Investigations Totals as of December 31, 2016

The Medical Commission reviews every report that is received. Reports are reviewed by a panel of at least three Commissioners to determine if they warrant an investigation. This panel are referred to as the Case Management Team (CMT) and generally meets every week. The following statistical report is a snapshot of the reports that are received and the results of authorized investigations.

### Reports Recieved by Case Nature



**98.99%**

of reports are brought before CMT within 21 days to determine if an investigation is warranted.

Source of Reports	2016
Individual	1,115
WA Agency	114
WA Association	4
Institution	53
Insurance	65
Law Enforcement	10
Other Medical Board	74
Other	5

# Investigation Totals

■ 2014 ■ 2015 ■ 2016

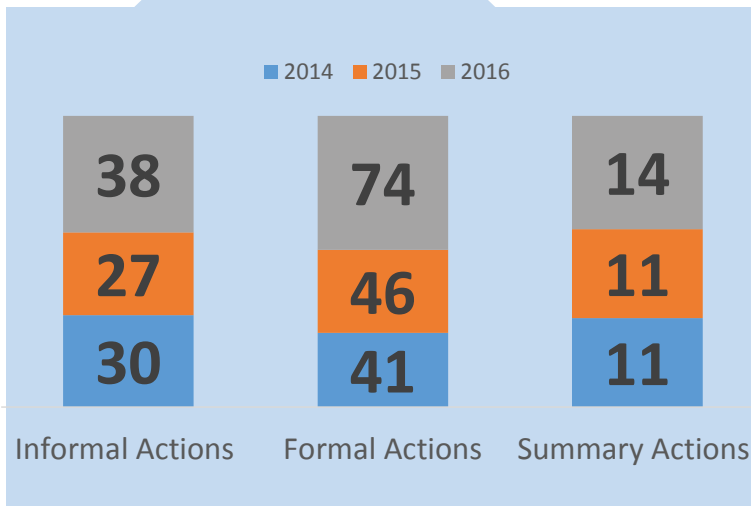
Reports received **1515** **1526** **1480**

Investigations opened **900** **862** **683**

Investigations closed **815** **775** **737**

Investigations that resulted in disciplinary action **71** **73** **112**

## Final Dispositions



## Commission options for discipline include:

- Educational program or coursework
- Chaperone Requirement
- Referral to WPHP
- Probation
- License Limitations
- Suspension
- Revocation
- Practice Mentor
- Practice Reviews

Medical Commission Meetings 2017		
Medical Commission meetings are open to the public		
Date	Activity	Location
April 6-7	Regular Meeting	Capital Event Center (ESD 113) 6005 Tye Drive SW, Tumwater, WA 98512
May 18-19	Regular Meeting	Radisson Hotel Seattle Airport 18118 International Blvd Seattle, WA 98188
June 29-30	Regular Meeting	Red Lion Hotel Kennewick Columbia Center 1101 N Columbia Center Blvd. Kennewick, WA 99336
August 10-11	Regular Meeting	Capital Event Center (ESD 113) 6005 Tye Drive SW, Tumwater, WA 98512
October 4-6	Educational Conference	Radisson Hotel Seattle Airport 18118 International Blvd Seattle, WA 98188
November 2-3	Regular Meeting	Capital Event Center (ESD 113) 6005 Tye Drive SW, Tumwater, WA 98512



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**

### Washington State Medical Commission Newsletter–Spring 2017

Jimi R. Bush, MPA, Managing Editor: [jimi.bush@doh.wa.gov](mailto:jimi.bush@doh.wa.gov)

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