WASHINGTON

# Medical Commission

Licensing. Accountability. Leadership.

# Policy Committee Meeting

July 24, 2025

# Policy Committee Meeting

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Washington Medical Commission (WMC) meetings. This agenda is subject to change. The WMC will take public comment at this meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

**Virtual via Teams Webinar: Registration link can be found below.**
***Commissioners and staff will attend virtually.***
**Physical location: 111 Israel Rd SE, TC2 Room 166, Tumwater, WA 98501**

## Thursday, July 24, 2025

### Open Session

| 4:00 pm | Agenda | |
|---|---|---|
| To attend virtually, please **register** here: WMC Policy Committee | | |
| The goal of this meeting is to create an open and welcoming forum for public input, allowing anyone to review, comment on, and suggest changes to the WMC's policies, guidance documents, procedures, and interpretive statements. We strongly encourage members of the public, healthcare professionals, and other interested parties to share their perspectives, as their feedback plays a vital role in shaping clear and effective policies. | | |
| **Organizers:** Kaddijatou Keita, Policy Manager | | |
| **1** | **Guidance Document: A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety (GUI2014-02)**<br>*Review and discuss proposed revisions to the document as part of its scheduled four-year review process.* | Pages 4-12 |
| **2** | **Guidance Document: Medical Professionalism**<br>*Review and discuss proposed revisions to the document as part of its scheduled four-year review process.* | Pages 13-17 |
| **3** | **Procedure: Interactive and Transparent Development of Evidence-based Policies and Guidelines (PRO2018-02)**<br>*Review and discuss proposed revisions to the document as part of its scheduled four-year review process.* | Pages 18-20 |
| **Public Comment**<br>*The public will have an opportunity to provide comments about the items on this agenda. If you would like to comment, please use the Raise Hand function. Please identify yourself and who you represent, if applicable. If you would prefer to submit written comments, please email medical.policy@wmc.wa.gov by 5 pm on **July 21, 2025**.* | | |
| **Policy: Interested Parties Meeting**<br>About one month before a Policy Committee meeting, the WMC hosts a Policy: Interested Parties meeting. These meetings offer an opportunity for individuals to provide input and suggest revisions to WMC policies, guidance documents, procedures, and interpretive statements. The next Policy: Interested Parties meeting is scheduled for 10 a.m. on Thursday, September 25, 2025. This meeting | | |



PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | **WMC.wa.gov**

is held virtually and you may register to attend here: WMC Policy: Interested Parties

## Future Topics for Discussion

The following items are next up for review. Feel free to provide comments regarding these items at medical.policy@wmc.wa.gov.

| 2026 | |
|---|---|
| **1** | Guidance Document: Practitioner competence (GUI2018-02) |
| **2** | Guidance Document: Overlapping and simultaneous surgeries (GUI2018-03) |
| **3** | Guidance Document: Reentry to Practice guideline (GUI2019-01) |
| **4** | Guidance Document: Reentry to Practice for suspended licenses guideline (GUI2019-02) |
| **5** | Guidance Document: Informed Consent and Shared Decision-Making (GUI2022-01) |
| **6** | Guidance Document: Ownership of Clinics by Physician Assistants MD2015-06 |
| **7** | Guidance Document: Medical marijuana authorization guidelines |
| **8** | Policy: Discrimination in Healthcare (POL2022-01) |
| **9** | Policy: Self-Treatment or Treatment of Immediate Family Members (POL2022-02) |
| **10** | Policy: Terminating the Practitioner-Patient Relationship (POL2022-03) |



PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | **WMC.wa.gov**

# Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

# A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety

*"~~We need to quit blaming and punishing people when they make mistakes and recognize that errors are symptoms of a system that's not working right, and go figure out and change the system so no one will make that error again, hopefully.~~ We have to change the culture, so everyone feels safety is his or her responsibility, and identifies hazards before someone gets hurt."*

**-Lucian Leape, MD**
Adjunct Professor of health policy, Harvard School of Public Health
Co-Founder, National Patient Safety Foundation

## Purpose

The Washington Medical Commission (Commission) adopts this Guidance Document to collaborate with the Washington health care system to reduce medical error[i] and enhance patient safety. This document replaces previous Commission policies to provide a more comprehensive approach to the Commission's efforts to reduce medical error.[ii]

## Background

Medical errors continue to be a leading cause of death in the United States.[iii,iv] In its seminal report, *To Err is Human: Building a Safer Health System,* the Institute of Medicine (IOM) studied other high-risk industries that have taken a systems approach to improving safety.~~,~~ They~~and~~ concluded that the most effective way to reduce error and improve patient safety is not to blame individuals, but to create an environment that encourages organizations to identify errors, evaluate causes, and take appropriate actions to prevent future errors from occurring.[3,v,vi]

Leading national patient safety advocates such as Lucian Leape, MD, have proposed going beyond the IOM's recommendations and building momentum for a "just culture" in medicine-- a culture that is open, transparent, supportive and committed to learning; a culture centered on teamwork and mutual respect, where every voice is heard and every ~~worker~~ member is empowered to prevent system breakdowns and correct them before they occur; where patients and families are fully engaged in their care; and where caregivers share information openly about hazards, errors and adverse events.[vii, viii,ix,x,xi] Communication and Resolution Programs have shown great promise in providing a structure to employ these principles to reduce medical error.

**Commented [MM1]:** Unclear if this is an accurate statement at this point.

Despite the efforts of many organizations across the country to develop initiatives to enhance patient safety, progress has been slow and insufficient.[7,8] Medical errors remain vastly underreported.[xii,xiii,xiv] Traditional malpractice and disciplinary systems are thought to impede progress by discouraging the reporting of errors, contributing to a culture of blame and a "wall of silence" in health care that inhibits learning and prevents systems change that is critical to reducing error.[14,xv,xvi] Dr. Leape calls on regulators to become a force for error reduction rather than a force for error concealment. [15]

The Commission is committed to its statutory mandate to protect the public through licensing, discipline, rule-making, and education. The Commission recognizes the limitations of the traditional disciplinary process to reduce error in a rapidly evolving health care delivery system. As health care becomes more patient-centered, team-based, and transparent,[xvii] a new regulatory model is needed, one that focuses less on punishment and more on improving systems and preventing error.[xviii] The Commission believes that a more effective regulatory approach is ~~to~~ working directly with entities in the health care system to foster open communication with patients to~~,~~ proactively prevent or reduce medical error and increase patient safety. [xix]

The Commission answers Dr. Leape's call to become a force for error reduction rather than concealment through the following activities:

- Endorsing just culture principles. The Commission encourages institutions, hospitals, clinics and the health care system to adopt a just culture model to reduce medical error and make systems safer. Likewise, the Commission will use just culture principles in reviewing cases of medical error.
- Entering into a Patient Safety Collaboration with the Foundation for Health Care Quality to support and develop Communication and Resolution Programs throughout the state of Washington and to develop a process to handle such cases.
- Collaborating with the Foundation for Health Care Quality to develop a state-wide system to disseminate lessons learned from unanticipated outcomes and medical errors, fostering a learning culture in our state and making the entire health care system safer.

**Commented [MM2]:** Has this actually occurred?

By taking these steps, the Commission collaborates with the health care system to reduce medical error, become a more effective regulator, and better meet its mandate to protect the public. This policy replaces previous Commission policies to provide a more comprehensive and effective approach to the Commission's efforts to reduce medical errors.[xx]

## The Commission Endorses a Just Culture Model for the Health Care System

"Just culture" is a term describing an approach to reducing error in high-risk and complex industries by recognizing that errors are often the result of flawed systems, and that blaming individuals for human error does not make systems safer. A just culture describes an environment where professionals believe they will be treated fairly and that adverse events will be treated as opportunities for learning. A just culture encourages open communication so that near misses can serve as learning tools to prevent future problems, and adverse events can be used to identify and correct root causes. It holds individuals accountable for the quality of their choices and for reporting errors and system vulnerabilities, and holds organizations accountable for the systems they design and how they respond to staff behaviors.[xxi,xxii,xxiii]

In *To Err is Human*, the IOM detailed the efforts of high-risk industries, most notably aviation, in applying these principles with remarkable success.[iii,xxiv] The report called for applying these principles to health care, observing that health care is decades behind other high-risk industries in its attention to ensuring safety and creating safer systems.[iii] A just culture in healthcare recognizes that medical errors often involve competent providers in flawed systems, and encourages greater voluntary event reporting, open communication, learning and improvement of systems. [18,21,xxv] A just culture has no tolerance for reckless or intentional disregard of safe practices. In those instances, discipline is required. Since the IOM report, many healthcare organizations have adopted a just culture model in their systems and have experienced the benefits of increased event reporting and decreased medical error.[xxvi,xxvii,xxviii]

The Medical Commission endorses just culture principles and encourages institutions, hospitals, and clinics to adopt these principles to improve the health care system in the state of Washington.[xxix] As the healthcare delivery system becomes more patient-centered, team-based, and transparent, the employment of a just culture model is critical to making meaningful improvement in patient safety.

### The Patient Safety Collaboration to Support Communication and Resolution Programs

In 2013, the Commission and the Foundation for Health Care Quality (Foundation) signed a Statement of Understanding to form a Patient Safety Collaboration. (Attachment A) -The purpose of the collaboration is for the Commission and the Foundation to work together to help the medical profession reduce medical error by supporting and promoting communication and resolution programs (CRPs). The collaboration also sets forth a process by which the Commission will handle cases that go through a CRP process.

Communication and Resolution Programs

CRPs promote a patient-centered response to unanticipated outcomes: -when a patient is harmed by medical care, providers should be able to tell the patient exactly what happened, what steps will be taken to address the event, and how similar outcomes will be prevented. CRPs are a stark departure from the long-standing deny and defend posture following unanticipated outcomes.[xiii,xxx,xxxi]

CRPs are characterized by open and prompt communication; support for involved patients, families, and care providers; rapid investigation and closure of gaps that contributed to the unanticipated outcome; proactive resolution; and collaboration across all involved stakeholders. CRPs are based on just culture principles, and recognize that most medical errors are caused not by incompetent providers, but rather by the interaction between competent providers who have made a simple human error and faulty healthcare systems, processes, and conditions.

A CRP involves the following steps:

- Immediate reporting of unanticipated outcomes, both to the patient and family, and to the institution;
- Immediate internal investigation to determine the factors that led to the event;
- Communicating the findings of the investigation to the patient and the patient's family;

- Apology to the patient and, when appropriate, an offer of compensation, waiver of costs, or non-financial resolution;
- A change to the system to prevent the event from re-occurring; and
- Shared learning within and outside the institution.

CRPs emphasize provider accountability. Providers must report unanticipated outcomes as soon as they occur, participate in efforts to understand whether the unanticipated outcome was due to medical error or system failure, and participate in efforts to prevent recurrences. CRPs do not tolerate reckless or intentional disregard of safe practices. CRPs have been used in a number of institutions and systems across the country with early success, and have the support of the Joint Commission and the Agency for Health Care Quality and Research. [14,30,31,xxxii]

The Foundation for Health Care Quality

The Foundation is a non-profit organization that administers quality improvement programs of which CRP is one. The Foundation uses clinical performance data as a tool, working with providers and hospitals to adopt evidence-based practices and improve patient safety.[xxxiii] The Foundation also houses the Washington Patient Safety Coalition, a collaboration of patient safety leaders who share best practices to improve patient safety and reduce medical errors.

~~In 2011, the Foundation received a grant from the Agency for Healthcare Research and Quality to form HealthPact. HealthPact is a program designed to improve communication in health care by (1) training healthcare providers to communicate better with each other and with patients, (2) working with stakeholders to create an ongoing learning community and implement best practices in their respective institutions, and (3) developing CRPs.~~

**Commented [MM3]:** My understanding is the grant is no longer active, so consider deleting this section.

The CRP Certification Process

The collaboration between the Commission and the Foundation led to the creation of an additional step in the standard CRP process: the formation of a CRP Event Review Board. This Board serves as a neutral panel to review and certify CRP events outside of the Commission. The Board is composed of individuals from across the health care spectrum, including patient safety advocates, risk managers, insurers, and physicians.

When an unanticipated outcome occurs and an institution completes a CRP process, the institution may request an independent review by submitting an application for certification to the Board. The Board reviews the application and all relevant records and documents, and determines whether all key elements of the CRP process have been satisfied, particularly that the systems changes are appropriate and effective. If all the elements are fully satisfied, and patient safety has improved as a result, the Board will send a report back to the institution stating that the event is certified. This step provides an additional level of objective quality review of the CRP process.

The Commission's Coordination with the CRP Process

When the Commission receives a complaint against a provider~~,~~ and learns that the provider is participating in a CRP process, the Commission will exercise its discretion to decide whether to place the case on hold pending timely completion of the CRP process. The Commission will not place a case on hold if the provider's continued practice presents a risk to patients or if the Commission is concerned that patient safety will not be adequately addressed by the CRP. In such a case, the Commission will conduct a prompt investigation and take appropriate action to protect the public.

If the Commission places a CRP case on hold and then receives a report that the event has been certified, the Commission will exercise its discretion to determine whether to investigate the matter or to close the case. If the Commission determines that the CRP process has timely and thoroughly enhanced patient safety, including individual and system-level improvements, the Commission may close the case as satisfactorily resolved. If not, the Commission will promptly investigate the case and take appropriate action, if warranted.

The CRP process is limited to cases of human error. The CRP Event Review Board will not certify cases involving reckless or intentional conduct, gross negligence, sexual misconduct, boundary violations, patient abuse, drug diversion, criminal activity, and other unethical or unprofessional behavior.

CRPs Benefit Patients and Families, Providers, and the Commission

The use of CRPs is a drastically different approach to medical error than the traditional system ~~of~~ which can result in secrecy, denial and defensiveness. CRPs intend to provide patients with what they need after an unanticipated outcome: ~~-~~open and honest communication about what occurred, emotional first aid, accountability, an apology, remediation and compensation. Ultimately, CRPs have the potential to reduce medical errors and improve patient safety if adopted by Washington health care institutions.~~-~~

CRPs benefit providers by reducing the barriers to reporting medical errors. CRPs offer a safe environment for providers to disclose unanticipated outcomes, have an honest discussion with the patient and the patient's family, and work to improve systems, without undue fear of malpractice suits, professional discipline or personal embarrassment.[xxxiv] CRPs promote a non-punitive, learning culture to improve patient safety.

For the Commission, CRPs remove the limitations inherent in the traditional disciplinary process:

- Reports of medical errors to the Commission are often delayed for years by the malpractice system, limiting the effectiveness of the Commission's response to complaints.[xii] The CRP process requires prompt reporting and patient-centered action allowing for early resolution of medical errors. This expedited process will allow the Commission to ~~address~~ consider errors much sooner than under the current system.
- The Commission has no jurisdiction over institutions, such as hospitals or clinics. When a medical error occurs, the Commission can ~~discipline~~ remediate the individual provider but is unable to

directly influence the institution to make system changes to ensure the error is not repeated. The collaboration requires the individual provider and the institution to change the system to prevent future patient harm.

- The Commission ~~has no good~~ mechanism for sharing lessons learned so that licensees and institutions can prevent errors from occurring is limited and not ideal. The collaboration requires shared learning across and among institutions.

The collaboration allows the Commission to have a greater effect on patient safety than the traditional disciplinary process and thereby improve its ability to protect the public.

Furthermore, medical errors that do not cause harm --"near misses"-- seldom come to the attention of the Commission. This collaboration strongly encourages internal reporting of near misses to help identify potential system problems and implement system fixes before patients are harmed. By promoting early reporting of all unanticipated outcomes, as well as near misses, a wider range of errors will be identified and corrected before Commission action becomes necessary.[xxxv]

The Commission encourages all institutions, clinics, and practices in the state of Washington to develop a CRP program, make it available to all physicians and physician assistants, have events certified by the CRP Event Review Board, and join in the effort to foster open communication, reduce medical error and improve patient safety in our state.[xxxvi]

## The Collaboration to Develop a State-Wide System for Dissemination of Lessons Learned from Medical Error

**Commented [MM4]:** Did/Does this actually happen? It is written in future tense and I don't recall if it actually got implemented before funding ran out.

Learning from medical errors is crucial to improving patient safety. To facilitate and enhance learning, the Commission and the Foundation have committed to collaborating to develop a state-wide system to disseminate lessons learned from medical error cases to health care providers and institutions.

The collaboration will consist of the following: -The collaboration will give the Foundation two additional sets of data about medical errors: (1) the CRP Event Review Board will submit information on cases that go through the certification process, and (2) the Commission will submit de-identified reports of medical error cases that come from complaints.

The Foundation will analyze the information to determine trends in the root causes of medical errors and lessons learned from these cases, and will combine this information with data from other Foundation programs such as the Clinical Outcomes Assessment Program (COAP), the Surgical Care Outcomes Assessment Program (SCOAP), and the Obstetrics Clinical Outcomes Assessment Program (OB-COAP) to create a comprehensive picture of medical errors, their causes, and lessons learned across the state.

On at least a bi-monthly basis, the Foundation will produce a written briefing on medical errors for distribution to healthcare workers across the state that identify key steps they can take to improve patient safety. The distribution of this briefing will be closely coordinated with the Patient Safety Coalition, another Foundation program, along with the Washington State Medical Association and the Washington State Hospital Association. Depending on the nature of the medical errors that are highlighted in the briefing, the distribution of this material may be targeted to specific providers.

The Foundation will produce a written briefing on medical errors on a quarterly basis for distribution to healthcare institutions across the state emphasizing patterns of medical errors and lessons learned. The Foundation will closely coordinate the distribution of this briefing with the Washington State Hospital Association. In the event that a lesson learned has potential immediate impact on patient safety, the Foundation will issue an emergency briefing on the subject to both healthcare providers and institutions using the distribution channels described above.

## Conclusion

Medical errors continue to pose a serious threat to patient safety. The Commission is firmly committed to its mandate to protect the ~~public, but~~public but recognizes the limitations of the disciplinary process in the evolving health care delivery system. The Commission believes that a more effective approach is to collaborate with the health care system to develop a more patient-centered response to medical error and improve patient safety.

The Commission believes that by endorsing just culture principles, collaborating with the Foundation for Healthcare Quality to support and develop CRPs, and collaborating with the Foundation to develop a system to disseminate lessons learned from medical error statewide, the Commission will help to reduce medical errors, become a more effective regulator, and better meet its mandate to protect the public.

| | |
|---|---|
| Number: | GUI2014-02 |
| Date of Adoption: | January 29, 2014 |
| Reaffirmed / Updated: | March 2, 2018 |
| Supersedes: | None. |

[i] Medical Error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Institute of Medicine 2000. Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System*. Washington DC: National Academy Press; 2000.

[ii] In 2011, the Commission adopted a policy to address wrong-site, wrong-procedure, and wrong-person surgery: Preventing Wong Site, Wrong Procedure and Wrong Person Surgery, MD20111-08. In 2012, the Commission adopted a policy to reduce medical error by providing case information to hospitals and other entities: Reducing Medical Errors: Developing Case Commission Case Studies for Hospitals and other Entities MD2012-04. In 2014, the Commission adopted a policy endorsing just culture principles: Endorsement of Just Culture Principles to Increase Patient Safety and Reduce Medical Errors MD2014-06.

[iii] Institute of Medicine 2000. Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System*. Washington DC: National Academy Press; 2000.

[iv] James, John T., PhD, (2013). A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care, *Journal of Patient Safety, 9,* 122-128.

[v] Institute of Medicine 2001. Committee on Quality of Health Care in America. *Crossing the Quality Chasm*. Washington DC: National Academy Press; 2001.

[vi] Sentinel Event Statistics Released for 2014, the Joint Commission. April 2015: "In 2014 the leading root causes and contributory factors are examples of cognitive failures. Cognitive failure is preventable and safety-critical industries take a systems view. Health care organizations must focus on factors that influence errors and operationalize strong corrective actions aimed at improving working conditions and eliminating all preventable injury, harm and death." Ronald Wyatt, M.D., M.H.A., medical director, The Joint Commission. Accessed at http://www.jointcommission.org/assets/1/23/jconline_April_29_15.pdf

[vii] Leape L, Berwick D, et al., Transforming Healthcare: a Safety Imperative, *Qual. Saf. Health Care*, 2009; 18:424-428. Waterson P, *Patient Safety Culture*. Ashgate 2014.
[viii] Safe Practices for Better Healthcare—2010 Update, National Quality Forum, page 7. http://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare_%E2%80%93_2010_Update.aspx accessed 3-9-15.
[ix] Marx D. *Whack a Mole: The Price We Pay for Perfection*. By Your Side Studios: 2009.
[x] Marx D. *Patient Safety and the "Just Culture": A Primer for Health Care Executive.* New York, NY: Columbia University: 2001.
[xi] Waterson P, *Patient Safety Culture*. Ashgate 2014.
[xii] Studies show that disclosure of medical errors occurs in approximately 30% of cases. Wu A, Boyle D, Wallace G, Mazor K, Disclosure of Adverse Events in the United States and Canada: an Update and a Proposed Framework for Improvement, *J. Public Health Research,* 2013; 2:e32:186-193.
[xiii] James J., A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. *J. Patient Saf.* 2013;9(3) 122-128.
[xiv] Bell SK, Smulowitz P, Woodward A, Mello M, Duva A, Boothman R, Sands K, Disclosure, Apology, and Offer Programs: Stakeholders' Views of Barriers to and Strategies for Broad Implementation. *Millbank Quarterly* 2012;90(4): 682-705.
[xv] The Commonwealth Fund, Q&A with Lucian Leape, http://www.commonwealthfund.org/publications/newsletters/states-in-action/2010/jan/january-february-2010/ask-the-expert/ask-the-expert accessed 4-28-15.
[xvi] Sage WM, Medical Liability and Patient Safety, *Health Law*. 2003;22(4):26-36.
[xvii] In March 2015, the Robert Wood Johnson Foundation issued a report on the importance of implementing a team-based model: Lessons from the Field: Promising Interprofessional Collaboration Practices, Robert Wood Johnson Foundation report 2015, available at http://www.rwjf.org/content/dam/farm/reports/reports/2015/rwjf418568 .
[xviii] In January 2015, the National Patient Safety Foundation's Lucian Leape Institute issued a report on the importance of transparency: Shining a Light: Safe Health Care Through Transparency, available at http://c.ymcdn.com/sites/www.npsf.org/resource/resmgr/LLI/Shining-a-Light_Transparency.pdf .
[xix] This approach is consistent with the Commonwealth Fund scorecard: "Aiming Higher: Results from a Scorecard on State Health System Performance, 2014: "The Scorecard also reminds us, however, that improvement is possible with determined, coordinated efforts. The most pervasive gains in health system performance between 2007 and 2012 occurred when policymakers and health system leaders created programs, incentives, and collaborations to raise rates of children's immunization, improve hospital quality, and lower hospital readmissions. These gains illustrate that state health system performance reflects a confluence of national policy and state and local initiatives that together can make a difference for state residents." http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard
[xx] Since 2011, the Commission has adopted three policies on medical error: Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery MD2011-08; Reducing Medical Errors: Developing Commission Case Studies for Hospitals and other Entities MD2012-04; and Endorsement of Just Culture Principles to Increase Patient Safety and Reduce Medical Errors MD2014-06. The Commission rescinds these policies with the adoption of this more comprehensive policy.
[xxi] Marx D. Patient Safety and the "Just Culture": A Primer for Health Care Executives New York, NY: Columbia University; 2001. Available at http://www.safer.healthcare.ucla.edu/safer/archive/ahrq/FinalPrimerDoc.pdf
[xxii] Latter C, And Justice For All, *Prevention Strategist,* Winter 47-53.
[xxiii] Griffith K, Column: The Growth of a Just Culture, *The Joint Commission Perspectives on Patient Safety,* 9(12), 8-9.
[xxiv] The success of the Aviation Safety Reporting System is attributed to three factors: reporting is safe (pilots are not disciplined if they report promptly), simple (a one-page report is made), and worthwhile (experts analyze the reports and disseminate recommendations to the pilots and the FAA). Leape L, , Reporting of Adverse Events, *N Eng J Med.* 2002;347:1633.
[xxv] Boysen PG, Just Culture: A Foundation for Balanced Accountability and Patient Safety, *The Ochsner J.* 2013;13:400-406.
[xxvi] Petschonek S, Burlison J, Development of the Just Culture Assessment Tool: Measuring the Perceptions of Health-Care Professionals in Hospitals, *J Patient Safety* 9(4): 190-197.
[xxvii] Wachter RM, Pronovost PJ Balancing "no blame" with accountability in patient safety. *N Eng J Med.* 2009;361:1401-1406.
[xxviii] The National Quality Forum endorsed a just culture approach as part of a patient safety program. See Safe Practices for Better Healthcare—2010 Update. https://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare_%E2%80%93_2010_Update.aspx
[xxix] The Medical Commission encourages health care systems to implement a Just Culture into their organizations by integrating the following key elements:

1. Create working health care teams with open communication among team members, recognizing that patients and their family members are active members of the health care team.
2. Encourage each member of the healthcare team to immediately internally report unanticipated outcomes, near misses, and hazardous conditions.

3. Promptly inform the patient and family of unanticipated outcomes, and keep patient and family fully apprised of the process.
4. Apply thorough analysis within facilities to identify factors that contribute to adverse events.
5. Inform the patient and family of the findings of the analysis. If the analysis reveals a medical error, notify the family of the remedial action to be taken, including apologizing for the medical error.
6. Take prompt action with adequate resources to fix system flaws and ensure individual remediation to prevent future patient harm.
7. Share improvements and learning between facilities and with pertinent specialty organizations so that other facilities can improve their systems and prevent future harm.
8. Maintain ongoing staff training to support implementation of all Just Culture elements.

[xxx] Mello M, Senecal S, Kuznetsov Y, Cohn J, Implementing Hospital-Based Communication-and-Resolution Programs: Lessons Learned in New York City. Health Affairs 2014; 33(1): 30-38.
[xxxi] Mello M, Boothman R, McDonald T, Driver J, Lembriz A, Bouwmeester D, et al., Communication-and-Resolution Programs: the Challenges and Lessons Learned from Early Adopters. Health Affairs. 2014; 33(1): 20-29.
[xxxii] Mello M, Gallagher T, Malpractice Reform—Opportunities for Leadership by Health Care Institutions and Liability Insurers. *N. Eng. J. Med.* 2010;362(15):1353-1356.
[xxxiii] The Foundation has the following programs: 1. Clinical Outcomes Assessment Program (COAP), which collects data submitted by all 35 hospitals in the state where cardiac interventions are performed, then producing a quarterly report to the hospitals, and documenting statistically significant improvements in quality, as well as establishing standards by peer consensus and holds institutions accountable for performing to those standards. 2. Surgical Care and Outcomes Assessment program (SCOAP), which involves the surgical community working with stakeholders to create a framework which defines metrics, tracks hospital performance, and reduces variability and errors in surgical care. 3. Obstetrics Clinical Outcomes Assessment Program (OB COAP), the obstetrics version of COAP. 4. The Washington Patient Safety Coalition, which consists of diverse groups working together to improve patient safety through the sharing of best practices related to patient safety. 5. HealthPact, which seeks to transform communication in healthcare, recognizing that poor communication is a fundamental cause of most preventable injuries. 6. The Bree Collaborative, established by the Washington State Legislature, consist of stakeholders appointed by the Governor and is tasked with annually identifying three health care services with high variation in the way care is delivered, that are frequently used, and do not lead to better care or patient health, or have patient safety issues. The group then develops evidence-based recommendations to send to the Health Care Authority to guide the care provided to Medicaid enrollees, state employees and other groups. http://www.qualityhealth.org/
[xxxiv] Statement on Medical Liability Reform, Bulletin of the American College of Surgeons, March 1, 2015 (CRPs "show the most promise for promoting a culture of safety, quality and accountability; restoring financial stability to the liability system; and requiring the least political capital for implementation.") Available at http://bulletin.facs.org/2015/03/statement-on-medical-liability-reform/
[xxxv] Krause Ph.D., Thomas R and Hidley, M.D., John, *Taking the Lead in Patient Safety,* John Wiley & Sons, Inc. , 2009 Near-miss reporting is recognized as one of several leading indicators for healthcare safety (p. 42) "Virtually every patient injury is preceded by lower-level decisions and outcomes that increase the likelihood of a safety failure. The catastrophic outcome – a sentinel event, serious injury, or death—can be seen as the tip of an iceberg embedded in a larger architecture of behaviors, practices, and outcomes that made the greater loss predictable." (p. 189) ". . . the companies setting the benchmark for industry safety often have the highest rates of reported near misses because they do not penalize the reporting of near misses and do not directly reward the reduction of incident rates. Instead, they welcome the information stemming from near misses, quickly digest its implications, and act immediately to reduce the likelihood of repeated exposures to hazard." (p. 221) "When a single serious event occurs, it can be inferred with high probability that many related but less severe events have occurred previously. To prevent medical errors and adverse events, small events and their precursors must be taken as seriously as large ones." P. 38
[xxxvi] The AHRQ has provided grants to other sites around the country to implement CRPs. The Collaborative for Accountability After Patient Injury consists of leading experts on medical error to exchange ideas and support the growth and spread of CRPs.

Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

# Medical Professionalism

## Introduction

In 2002, the American Board of Internal Medicine Foundation, the American College of Physicians-American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine developed a Charter on Medical Professionalism, and published it simultaneously in the Annals of Internal Medicine and The Lancet.[1] The Charter on Medical Professionalism is designed to reaffirm the medical profession's commitment to patients and to the health care system by setting forth fundamental and universal principles of medical professionalism.

The Washington Medical Commission (WMC) largely adopts the Charter on Medical Professionalism (Charter), as guidance for Washington physicians and physician assistants in fulfilling their professional responsibilities to their patients and to the public. [2]

## Charter on Medical Professionalism

### Preamble

Professionalism is the basis of medicine's contract with society. Professionalism demands placing the best interests of patients above those of the practitioner[3], setting and maintaining standards of competence and integrity, and providing scientifically accurate advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and the public. Public trust in practitioners depends on the integrity of both individual practitioners and the profession as a whole.

At present, the medical profession is confronted by an explosion of technology, evolving practice conditions, and heightened regulatory obligations. As a result, practitioners find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all practitioners, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle

[1] "Medical Professionalism in the New Millennium: A Practitioner Charter." Annals of Internal Medicine, 2002;136(3):243-246, *available at* http://annals.org/aim/article/474090/medical-professionalism-new-millennium-practitioner-charter

[2] This Guidance Document is not identical to the previous Charter on Medical Professionalism. The WMC has edited that previous document in order to conform to state laws and rules. For example, in many places in this document, the WMC has replaced the word "shall" with the word "should," so as not to create mandates outside of the rule-making process.

[3] In this guidance document, the WMC uses the term "practitioner" to refer to both allopathic physicians and physician assistants.

ways. Despite these differences, common themes emerge and form the basis of this Charter in the form of three fundamental principles, and as a set of definitive professional responsibilities.

## Fundamental Principles

1. *Principle of primacy of patient welfare*. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the practitioner–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.
2. *Principle of patient autonomy.* Practitioners should respect patient autonomy. Practitioners should be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical principles and do not lead to demands for inappropriate care.
3. *Principle of social justice*. The medical profession should promote justice in the health care system, including the fair distribution of health care resources. Practitioners should work actively to eliminate discrimination in health care, whether based on race, gender, gender identity, sexual orientation, socioeconomic status, ethnicity, religion, or any other social category.

## A Set of Professional Responsibilities

*Commitment to professional competence*. Practitioners should be committed to lifelong learning and to maintaining the medical knowledge and clinical and team skills necessary to deliver quality care. More broadly, the profession as a whole must strive to see that all of its members are competent[4] and must ensure that appropriate mechanisms are available for the profession to accomplish this goal.

*Commitment to honesty with patients*. Practitioners should ensure that patients are adequately and honestly informed before the patient has consented to treatment, and also after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on their course of therapy. Practitioners should acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide opportunities to develop and apply appropriate risk management strategies that should improve patient care, not only for patients who have been injured but also to prevent future harm moving forward.

*Commitment to patient confidentiality*. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to prevent disclosure of patient information unless disclosure is legally necessary. This commitment extends to discussions with persons acting on a patient's behalf when obtaining a patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than

---

[4] Professional competence refers to "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served." Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002; 287(2):226-235), *available at* https://jamanetwork.com/journals/jama/article-abstract/194554?casa_token=nY5Pp29vutgAAAAA:fUtkGd2lVdq0e1p1T61lgKV1MYyhQNxUHoO4aEOxeZL21IchaFYoxgdHGC-nwjX0YNQJkhYTK9k6

ever given the increasing availability of genetic information and the widespread use of electronic information systems for compiling patient data. However, practitioners recognize that their commitment to patient confidentiality must occasionally yield to overriding legal requirements that protect public health and safety (for example, when patients endanger themselves or others).

*Commitment to maintaining appropriate relations with patients*. Given the inherent vulnerability and dependency of patients, certain relationships between practitioners and patients must be avoided. Practitioners should avoid exploiting patients for personal financial gain, or other private purpose. For example, state law prohibits practitioners from engaging in sexual or romantic relationships with current patients. This includes behaviors such as soliciting a date or kissing a patient in a romantic or sexual manner.[5] State law also prohibits romantic or sexual relationships with former patients if the practitioner uses or exploits the trust, knowledge, influence or emotions derived from the professional relationship, or uses or exploits privileged information to meet the practitioner's personal or sexual needs.[6] Practitioners should also abide by any ethical restrictions regarding romantic or sexual relationships with former patients that are applicable to their specialties.[7]

*Commitment to improving quality of care*. Practitioners should be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Practitioners should actively participate in the development and application of better quality of care measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Practitioners, both individually and through their professional associations, should take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

*Commitment to improving access to care*. Medical professionalism demands that the objective of all health care systems is the availability of a reasonable and adequate standard of care that is accessible to all patients. Practitioners should individually and collectively strive to reduce barriers to equitable health care. Within each system, the practitioner should help eliminate barriers to access which are often based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine without concern for the self-interest of the practitioner or the profession.

*Commitment to a just distribution of finite resources*. While treating individual patients, practitioners should provide health care that is based on the standard of care which considers cost-effective management and limited resources. When medically necessary resources are scarce, such as during a pandemic, practitioners are encouraged to follow guidance from the Washington State Department of Health and local health departments to prioritize the needs of the public when there are not enough resources for all patients. Otherwise, practitioners should be committed to working with other practitioners, hospitals, and payers to develop and implement guidelines focused on the delivery of cost-effective care. While a practitioner, at times, may be tempted to "overtest" and "overtreat" to decrease their risk of medical malpractice claims, the

---

[5] WAC 246-919-630, 246-918-410. See also RCW 18.130.180(24).
[6] WAC 246-919-630(3). For additional guidance, see the WMC Guidance Document on "Sexual Misconduct and Abuse," GUI2017-03.
[7] For example, the American Psychiatric Association takes the position that sexual activity with a current or former patient is unethical. American Psychiatric Association: The principles of medical ethics (with annotations especially applicable to psychiatry), section 2. Arlington, VA: American Psychiatric Association, 2013. https://www.psychiatry.org/psychiatrists/practice/ethics. Accessed May 7, 2019.

practitioner's professional responsibility involving appropriate resource allocation requires scrupulous avoidance of superfluous tests and procedures. Providing unnecessary services not only exposes patients to avoidable harm and expense but also diminishes the resources available for others.

*Commitment to scientific knowledge*. Much of medicine's contract with society is based on integrity and the appropriate use of scientific knowledge, technology, and evidence-based medicine. Practitioners should uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence, practitioner experience, and effective communication.

*Commitment to maintaining trust by managing conflicts of interest.* Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including pharmaceuticals, laboratory services, medical equipment, and insurance companies. Practitioners should recognize, disclose to the public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determines the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

*Commitment to professional responsibilities*. As members of a profession, practitioners are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should define and organize the educational and standard-setting process for current and future members. Practitioners have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment, offering constructive feedback to peers, and accepting external scrutiny of all aspects of their professional performance. Part of professionalism is being aware of conscious and unconscious bias and that practitioners must sure to treat all patients with compassion, equity, and respect.

## Summary

The practice of medicine in the modern era faces unprecedented challenges in virtually all cultures within our society. These challenges center on disparities in our health care system, an inability to meet the legitimate needs of patients due to insufficient resources, the increasing dependence on market forces to transform health care systems, and the temptation for practitioners to forsake their traditional commitment to the primacy of patient interests for their own personal gain. To maintain the fidelity of medicine's social contract, the WMC believes that practitioners must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve our health care system for the welfare of society. The WMC adopts this Charter on Medical Professionalism to encourage such dedication among practitioners and the profession in general, and to assure the public that the WMC upholds ideals of professionalism in the State of Washington.

| | |
|---|---|
| Date of Adoption: | January 19, 2018 |
| Revised/Reaffirmed: | May 27, 2022 |
| Supersedes: | N/A |

Procedure

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

# Interactive and Transparent Development of Evidence-based Policies

## Introduction

The Washington Medical Commission (Commission) develops policies[i] to encourage the medical profession to improve the delivery of medical care and enhance patient safety.[ii] The Commission wishes to better engage the public and the profession by creating an interactive, consistent, and transparent procedure to obtain input to develop evidence-based policies.[iii] This document describes the procedure the Commission uses to develop evidence-based policies.

## Procedure

**Step One: Determine the need for a policy**

Any Commission member, member of the medical profession, organization, or member of the public may ask the Commission's Policy Committee to consider developing a policy in a particular area of medical practice. In general, the Policy Committee will consider developing a policy for an issue that has broad application to practitioners or the public, to respond to an emerging problem, and to fulfill its regulatory charge to protect the public. The Policy Committee may decide that a policy is not necessary, or that the subject is more appropriately addressed by adopting a rule, which has the force of law.

**Step Two: Policy Committee**

If the decision of the Policy Committee is to develop a policy, the Policy Committee Chair may assign members to a work group to analyze the research and evidence, and to draft the policy. The workgroup will include one or more Commission members and may include subject matter experts on staff. The workgroup may also include subject matter experts outside the Commission.

The Policy Committee also reviews existing policies to ensure that they remain useful and ~~informative, and~~informative and reflect the current state of medical practice and the current view of the Commission.

**Step Three: Research and Obtain Evidence**

If the Policy Committee decides to develop a policy or guideline, the next step is to research the topic and obtain evidence that will inform the Commission's decision-making. The research may include:

- Reviewing complaints or other patient experiences related to the topic of the proposed policy.
- Conducting a literature review of the latest journal articles and studies.
- Reviewing the positions of appropriate stakeholders.
- Reviewing the positions of other state medical boards and the Federation of State Medical Boards.

- Identifying and researching relevant legal issues, consulting with the Attorney General's Office as needed.

**Step Four: Analysis and Drafting**

The work group will analyze the research and evidence, relevant law, and draft the policy. For existing policies, the workgroup will review feedback submitted to the Commission via the Commission web site or otherwise. The workgroup will create a first draft of the proposed policy.

**Step Five: Policy Committee Review**

In a public meeting, the Policy Committee will review the draft policy and proposes revisions. The Policy Committee presents the draft to the full Commission. The Commission provides feedback and then may approve posting the draft policy for public dissemination, including posting the draft on the Commission web site.

**Step Six: Solicit Feedback from Public and Profession**

Upon approval by the Commission, staff posts the draft policy to the Commission web site and invites members of the public and the profession to post comments on the proposed draft policy. The Commission will notify the public and the profession of the proposed policy by:

- Sending out notice of the draft policy on social media;
- Sending out notice of the draft policy to the Commission listserv;
- Sending the draft policy to stakeholders and interested parties

The Commission accepts comments on the proposed policy for 28 days. The Commission will have discretion to remove comments that do not contribute to a constructive discussion of the relevant issues.

**Step Seven: Policy Committee Review of Feedback**

In a public meeting, the Policy Committee reviews the feedback and comments from the public and the profession. The Policy Committee considers the extent to which the comments represent the expectations of the profession and are consistent with the Commission's mission to promote patient safety and our vision of advancing the optimal level of medical care for the people of Washington. The draft policy is revised accordingly.

**Step Eight: Secretary Review of Policy**

The Commission staff sends the proposed policy to the Secretary of the Department of Health for review and comment. Following the Secretary's review, the Policy Committee reviews and discusses the comments from the Secretary in a public meeting. The Policy Committee brings its recommendations to the full Commission. The full Commission reviews the proposed policy in a public meeting and may revise the policy. If the Commission revises the policy, the Commission sends the proposed policy back to the Secretary for review. Once the Commission approves a policy, the policy is filed with the Washington State Code Reviser and it is published in the Washington State Register.

**Step Nine: Final Review and Adoption**

Once the Policy Committee is satisfied with the proposed policy, it refers the draft to the full Commission with a recommendation to adopt the policy. The full Commission, in a public meeting, discusses the policy

and decides whether to adopt the final version. When the policy is final, the Commission publicizes it through its web site, social media channels, listserv, and newsletter.

**Step Ten: Policy Impact review**

After the policy is been adopted, in some instances, not all, we can outline how the policies will be monitored and communicated to ensure that it is understood and followed by our licensed practitioners , in providing care to patients.

**Emergency Exception**

In case of an emergency in which the development of a policy is required in a short time period, one or more of these steps may be waived.

Formatted: Indent: Left: 0", Tab stops: Not at 0.3"

Formatted: Indent: Left: 0"



Date of Adoption: ~~May 19, 2017~~

Date of Revision: ~~August 20,2021~~

[i] RCW 34.05.010(15) defines "policy statement" as "a written description of the current approach of an agency, entitled a policy statement by the agency head or its designee, to implementation of a statute or other provision of law, of a court decision, or of an agency order, including where appropriate the agency's current practice, procedure, or method of action based upon that approach." A policy is advisory only. RCW 34.05.230. Examples of Commission policy statements are "Complainant Opportunity to be Heard Through and Impact Statement," and "Practitioners Exhibiting Disruptive Behavior."

[ii] This procedure does not apply to the development of procedures, which merely establish the proper steps the Commission and staff take to conduct Commission business. Examples include "Consent Agenda Procedure" and "Processing Completed Investigations More Efficiently."

[iii] This process is largely based on the "consultation process" developed by the College of Physicians and Surgeons of Ontario. http://www.cpso.on.ca/Footer-Pages/The-Consultation-Process-and-Posting-Guidelines