Message from the Chair

WASHINGTON Medical Commission
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Medical Board Complaints

John Maldon

When providing consulting services to a large multi-disciplinary physician group, the most overwhelming event and emotional response I heard from any physician was their reaction to receiving a medical board complaint. The first question I heard was "am I going to lose my license"? Followed by "who complained, what is the complaint and what do I do"? Receiving a complaint usually caused a loss of sleep and questions about whether the physician should continue to practice. Complaints were viewed as their competence being questioned and without exception a physician's confidence to practice medicine was significantly shaken.

Understanding the basis of a complaint, what it means to the physician and how to lessen the chance of future complaints are starting points to learning how to cope with the complaint and finding reassurance for their practice mindset.

Complaints can come from a number of sources. Patients and patient families are the most common sources of complaints. Complaints can also be made by attorneys representing patients, co-workers, fellow providers, ancillary medical sources, malpractice insurers and other regulatory agencies.

Complaints can range from a misdiagnosis, failure to diagnose, failure to timely diagnose, medication management, patient abandonment to related care issues involving billing issues, not providing copies of medical records and rude staff.

Receiving a complaint can have significant consequences. Complaints become a permanent record of regulatory boards. Complaints are public records that can be viewed by anyone.

Complaints resulting in discipline are reported to the National Practitioner's Data Bank. If licensed in multiple states, physicians must report disciplinary cases to each jurisdiction. Each jurisdiction may take disciplinary action based on the complaint even though the complaint did not occur in that jurisdiction. There is the potential of losing medical board certification. There may be a reputational impact with credentialing by insurers, practice groups and institutions.

Many physicians view educational disciplinary sanctions as helpful to their practice while others view the process as punishment. Whether viewed negatively or positively, disciplinary action taken by boards and commissioners can take the form of remedial education requiring specific CME, formal education courses, writing papers and presentations to practice or institutional staff.

Egregious conduct or care violations will likely result in more severe actions that might include competency testing, practice restrictions, license suspensions or license revocation.

Physicians should know that there are many complaints filed that have no merit. They may not reach the threshold for an investigation or the complaint may be investigated but found to be without merit and closed. Unfortunately, these complaints remain part of the permanent record but are identified in a way that the complaint was closed without merit.

While there is no absolute way to avoid a medical board complaint, there are thought processes that can be employed during patient visits that may lessen the likelihood of a complaint being registered by a board. While sounding simplistic, keeping up to date on treatment modalities is basic to providing care. Referring patients to specialty care at the appropriate time is important to keep in mind. Referring patients to other providers when diagnoses and treatment may be beyond expertise is another consideration.

And lastly, the number one complaint preventative measure, communications. Know your patient, be

a good listener, be attentive, be empathetic, be compassionate be certain the patient knows the diagnosis and treatment plan. Make sure to ask the patient if they have questions at the conclusion of the visit. Offer to answer questions that might come up after the patient has gone home and has had time to think about the office visit.

What should a physician do if a board or commission complaint is received? First and foremost never ignore a contact from a board investigation representative. Board notification of a complaint requires immediate attention.

Generally, the physician should contact their immediate supervisor or medical director to let them know about the complaint and to obtain advice on what to do next. If there is a risk management office, representatives in the office may provide an attorney that specializes in managing board complaints on behalf of physicians. It is customary for medical organizations to pay the cost of retaining an attorney to defend board complaints in full or up to some monetary limit.

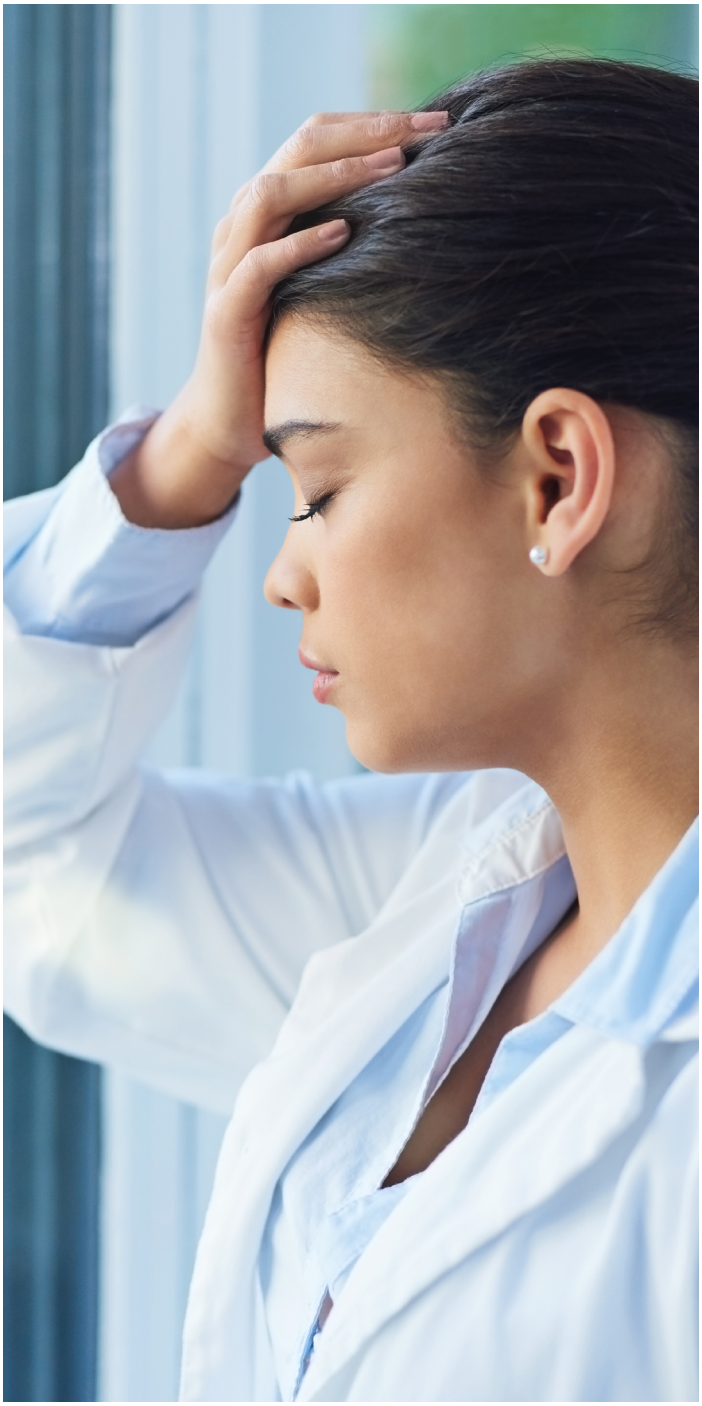
If in private practice, contact your malpractice insurance carrier. Most malpractice insurance policies provide coverage for retaining an attorney to defend regulatory complaints.

If none of the above resources are available, it is recommended physicians seek the advice of counsel. Board disciplinary authority is embedded in statute and case law that may be beyond the expertise of physicians. Legal counsel will know the law and provide advice and a response to the complaint that is in the best interests of the physician.

If there is some merit to the complaint, it is usually best to attempt to resolve a board complaint than contest the complaint. Most complaint resolutions can be negotiated to conclusion. The alternative is going to hearing that can be a painful experience. There may be financial costs both legal and from being away from the practice. Emotional costs are not quantifiable but need to be considered when contesting a board complaint. A negotiated solution to the complaint is generally the best path to finalize the complaint.

The above is intended to be a general overview of board complaints and how the process works. Physicians and their counsel need to assess each individual complaint to develop an appropriate strategy to address the complaint.

"Understanding the basis of a complaint, what it means to the physician and how to lessen the chance of future complaints are starting points to learning how to cope with the complaint and finding reassurance for their practice mindset.



Executive Director Report

WASHINGTON Medical Commission
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Policy Update

Melanie de Leon, JD, MPA

The integration of new technology, more informed and empowered patients and cultural shifts are changing the practice of medicine in ways not previously envisioned. As a result, the Washington Medical Commission (WMC) is constantly trying to keep up with these changes and develop policies, guidelines and interpretive statements to provide information and best practices that you may find useful in your practice. Each of these types of statements are used in specific ways by the WMC for specific reasons.

- Policy. A written description of the WMC's current approach to implement a statute or other provision of law, a court decision, or an order, including, where appropriate, the current best practice, procedure, or method of action based upon that approach. Policies adopted by the WMC are also be reviewed by the Department of Health's Office of the Secretary.
- Guidelines. A set of recommended practices designed by the WMC to inform practitioners about appropriate health care for specific circumstances. A guideline does not have the force of law but may be considered by the WMC to be the standard of care in our state.
- Interpretive Statement. A written expression of the opinion of the WMC as to the meaning of a statute or other provision of law, of a court decision, or of an agency order.

All WMC's policies, guidelines and interpretive statements can be found on the WMC website under the "Policies & Rules" tab. Here are excerpts from some policies and guidelines you may find informative:

Self-Treatment or Treatment of Immediate Family Members. The WMC believes that practitioners generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the practitioner is the patient; the practitioner's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Read the entire policy here.

Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice. The WMC provides this guidance to physicians and physician assistants (practitioners) on the appropriate documentation of a medical record; special considerations for maintaining an electronic health record; providing access to medical records; the retention, storage and disposal of medical records; and handling records when closing a practice. Read the entire guideline here.

Professionalism and Electronic Media. The WMC is charged with protecting the public and upholding the standing of the profession in the eyes of the public. Therefore, it offers this guideline to assist physicians and physician assistants (practitioners) in adhering to the standards of their profession in both their personal and professional lives. The public must be able to rely on practitioners maintaining appropriate practitioner-patient boundaries. This is an essential element of medical professionalism. Read the entire guideline here.

There are over 45 policies, guidelines and interpretive statements on our website. It is a great site to bookmark as we update this page regularly. Stay informed!

Rulemaking Efforts

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Amelia Boyd
Program Manager

Exclusions – Opioid Prescribing
The CR-102 for amending the Exclusions sections in both the MD (WAC 246-919-851) and PA (WAC 246-918-801) chapters to expand the types of patients who are exempt from certain provisions of rule when being prescribed opioid drugs was filed with the Office of the Code Reviser on February 22, 2022. The WSR #22-05-083.

The WMC is proposing exempting patients in long-term acute care (LTAC) facilities, nursing homes, residential habilitation centers (RHC), and residential treatment facilities (RTF) from the opioid prescribing rules. This change will allow physicians and physician assistants in these facilities to continue the patient's pain medications without having to perform a history and physical or wait for a history and physical to be completed on the patient.

As part of the WMC's rulemaking for ESHB 1427, enacted in 2017 and codified as RCW 18.71.800, the WMC received comments that adhering to the opioid prescribing rules for patients admitted to LTACs and nursing homes, is onerous. Specifically, the rules require a history and physical as well as a check of the prescription monitoring program (PMP) be completed prior to prescribing opioids. It has been stated that patients transferred to LTACs and nursing homes had a history and physical while in the previous facility and that practitioners in LTACs and nursing homes can rely on that assessment.

Inpatient hospital patients are currently exempt from the opioid prescribing rules. The WMC recognizes that patients in LTACs and nursing homes are similarly situated to hospital patients receiving inpatient treatment.

The WMC has also received a comment regarding patients in RHCs, that they are also similarly situated to LTAC and nursing home patients. We received a similar comment about RTFs, that stated RTFs are similar to RHCs except the stay at an RTF is usually short-term. As such, the WMC is also exempting patients in RHCs and RTFs.

In response to the filing, the WMC will conduct a public rules hearing on Wednesday, April 13, 2022, beginning at 2:30 pm. In response to the COVID-19 public health emergency, the WMC will not provide a physical location for this hearing to promote social distancing and the safety of the citizens of Washington State. A virtual public hearing, without a physical meeting space, will be held instead. For more information, including the registration link for the hearing as well as the proposed language, please visit our Rules in Progress page.

Collaborative Drug Therapy Agreements
The CR-101 for creating rules related to Collaborative Drug Therapy Agreements was filed with the Office of the Code Reviser on July 22, 2020 as WSR #20-16-008.

One aspect of the practice of medicine is working with pharmacists to deliver drug therapy to patients. This coordination can take many forms, but the WMC's concern involves treating patients under a collaborative drug therapy agreement (CDTA).

These arrangements occur pursuant to a written agreement entered into by an individual physician or physician assistant and an individual pharmacist.

WMC Meetings and Events Full Schedule Rules in Progress	
WAC 246-918-801 Rules Hearing	April 13, 2022 2:30 pm Click Here to Register
WMC Policy Meeting	April 14, 2022 4:00 pm
WMC Business Meeting	April 15, 2022 8:00am
WMC Policy Meeting	May 26, 2022 4:00 pm
WMC Business Meeting	May 27, 2022 8:00am

Rulemaking Efforts

The Pharmacy Quality Assurance WMC has adopted a rule that governs CDTAs from the pharmacy perspective, however there are no statutes or rules that govern a physician's responsibilities under a CDTA. A rule is needed to define the roles and responsibilities of the physician or physician assistant who enters into a CDTA, any defined limit to the number of pharmacists who may have a CDTA with any one physician or physician assistant, and how the physician or physician assistant and pharmacist can best collaborate under these agreements.

Regulating the use of CDTAs would place the WMC in an active patient safety role. Rulemaking would provide clarity around this issue to help avoid potential discipline and increase patient safety. New sections being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

Workshops for this rulemaking are ongoing. Please visit our Rules in Progress page for the current schedule and draft language.

Senate Bill (SB) 6551 – International Medical Graduates

The CR-101 for creating rules related to integrating International Medical Graduates into Washington's healthcare delivery system was filed with the Office of the Code Reviser on August 6, 2020 as WSR #20-17-024.

SB 6551 permits the WMC to issue limited licenses to IMG. The bill also directs the WMC to establish requirements for an exceptional qualification waiver in rule as well as establish requirements for a time-limited clinical experience license for IMG applicants. Establishing these requirements would reduce barriers for IMG applicants obtaining residency positions in Washington.

The next step in the rulemaking process, the Proposal or CR-102, was approved at the WMC's November 19, 2021 Business meeting and is in the process of being drafted.

More Information

Please visit our rulemaking site and for continued updates on rule development, interested parties are encouraged to join the WMC's rules GovDelivery.

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WPHP Report: Physician Health Programs and the Equivalence Problem

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Chris Bundy, MD, MPH
Executive Medical Director, Washington Physicians Health Program

Over the last several years, many new players have entered the physician health and well-being space, offering an array of mental health, wellness, coaching, and other services aimed at health professionals who have been worn down by systemic drivers of burnout and a relentless global pandemic. While I am hopeful that these additional resources will be utilized and beneficial for our colleagues in distress, I am also concerned by the emergence of something I call the "equivalence problem." The equivalence problem is born of a mistaken belief that other organizations or individuals that assist (or want to assist) health professionals might be used as an alternative to physician health programs (PHPs).

At the June 2021 meeting of the American Medical Association (AMA) a report from Council on Judicial Affairs (CEJA) was passed that revised the AMA Code of Medical Ethics Opinion 9.3.2 to remove reference to utilization of PHPs for those impacted by risk of impairment. At the November 2021 meeting of the AMA House of Delegates (HOD) delegations from Pennsylvania, New York, and Wisconsin introduced Resolution 23 in an effort, among other things, to restore the reference to PHPs in 9.3.2.

Resolution 23 passed by a very wide margin reflecting widespread support at the AMA for returning the reference to PHPs in 9.3.2. However, in lead up to the vote, reference committee testimony from a member of CEJA revealed that some among AMA's ranks believe that there are many resources to support physician well-being and that PHPs should not enjoy the privilege of special recognition in 9.3.2. The unfolding of these events reinforced concerns about the equivalence problem that had been gnawing at me for some time.

Recent revisions to the American Society of Addiction Medicine (ASAM) and the Federation of State Medic al Boards (FSMB) policies relating to physician health were strongly supportive of PHPs and the PHP model. However, these policies also contain statements acknowledging that physicians and other health professionals may seek care from "other clinicians with expertise" without oversight of the PHP. On the surface, this is not surprising or particularly problematic. We all want health professionals to get care when needed and PHPs certainly do not want or need to be involved with all physicians who are ill. That said, such language edges toward the equivalence problem.

"As is the case in Washington, a PHP may be the only legally authorized entity that may receive reports of impairment or potential impairment in lieu of a report to the disciplinary authority."

In a recent update to the AMA Advocacy Resource Center (ARC) Issue Brief: confidential care to support physician health and wellness. the Federation of State Physician Health Programs had an opportunity to define the characteristics of PHPs which set them apart from other resources available to healthcare professionals, such as medical association Physician Wellness Programs, private monitoring agencies, or treatment providers with expertise in caring for physicians. I think it is worthwhile to expand further on the factors which are unique to PHPs here:

1. Legal authority: As is the case in Washington, a PHP may be the only legally authorized entity that may receive reports of impairment or potential impairment in lieu of a report to the disciplinary authority.
2. Special accountability: Through statute, rule, or contract with the disciplinary authority, PHPs have special accountability and mandatory reporting obligations designed to protect the public. Non-PHP providers may also have mandatory reporting obligations but, in my experience, most clinicians who care for physicians and physician assistants are unfamiliar with their reporting obligations and consequences for failure to report are often lacking.
3. Trusted verification: PHPs are trusted by employers, credentialing entities, licensing boards, medical specialty boards, and others to provide objective and ongoing verification that a health professional is safe to practice. PHP program compliance is often a requirement of continued employment, medical staff privileges, or licensure. Non-PHP providers are often unwilling to provide opinions regarding safety to practice or unable to meet the reporting needs of the involved entity. Such entities may also be reluctant to act in reliance upon information received from non-PHP provider who is ethically bound to act in the interest of their patient and may not fully appreciate the entity's responsibilities to address patient safety risks.
4. No treatment or other role conflict: PHPs do not provide treatment to participants and, therefore, do not have a treatment relationship that could create a conflict of interest with their obligation to act in the interest of public safety. PHPs seek to balance the rehabilitative needs of the participant with protection of the public. Non-PHP providers have a primary obligation to the interest of their patient which may help health professionals feel more comfortable disclosing worsening symptoms or very private information but may also create reluctance to report an impaired health professional. PHPs offer another layer of confidentiality protection when treatment providers working with health professionals are faced with the dilemma of preserving therapeutic trust and protecting the public.
5. Care management: PHPs provide oversight, communication, and coordination of health care to promote effective and sustained remission of chronic illnesses. PHPs also receive functional information from employers and key supports which, along with other monitoring data such as toxicology testing, can optimize the care a participant receives from their treatment providers. Outside of PHPs, this level of care management is virtually unavailable to health professionals.

These five characteristics differentiate PHPs from the growing list of services to support physicians in need of assistance. Clinicians and wellness professionals who treat physicians outside of the purview of a PHP should:

1. Thoughtfully appraise their ability to provide assurance of safety to practice for professionals in their care and understand the legal and ethical requirements for protecting public safety within the context of the therapeutic relationship.
2. Understand the circumstances in which involvement with a PHP might offer a benefit such as need for advocacy in employment, credentialing, or licensing matters.
3. Utilize the added layer of confidentiality protection that PHPs offer when a reportable concern for impairment arises.
4. Familiarize themselves with their state PHP and consult (anonymously if needed) if concerns of impairment arise. Proactive collaboration and relationship building with the PHP can help facilitate an excellent outcome when one is faced with a health professional in difficulty.

WPHP supports and encourages physicians and other health professionals to proactively address health-related problems and obtain needed treatment. We hope that early intervention will prevent progression of illness and need for PHP involvement. We believe that there is "no wrong door" for a clinician in trouble and that there are many effective, non-PHP options available. However, we also know that to equate expert clinicians, wellness programs, and PHPs diminishes the unique value that each bring in their service to the profession. Communication, collaboration, and role clarity among all involved can help ensure that health professionals in need with get the right care, for the right reasons, at the right time.

Physician Assistant News

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All the Guidelines in the World

James Anderson PA-C

In today's medical practice there are practice guidelines, checklists, time outs, templates and error proofing EHRs. Whether they are friends or foes in our practice, they can never eliminate the inevitable gray areas. I found one definition that I really liked. Gray area: an ill-defined situation or field not readily conforming to a category or to an existing set of rules. Any of us in medical practice, whether PA or MD, must be prepared to make complex, high stakes medical decisions full of gray areas, advanced risk, and even the unknown.

I'm in my eighth and final year on the Washington Medical Commission, and it has been quite the personal ride. Frankly, while being intensely rewarding, it's been a heavy burden to be sure. Evaluating complaints that come to the WMC and making decisions about these complaints in ways that first and foremost protect the public is our most sacred duty. We are dedicated to this monumental task, whether we are commission members, attorneys, investigators, or administrative staff.

One thing I've relearned (I'm not sure how many chances I am given to relearn this!) is that the more I know, the less I know. The more I learn, the more I am reminded about the breadth of activity and humanity there is out there, including those who file complaints with the WMC, and those providers who are the focus of the complaints. The process is complicated and layered, even Byzantine at times. The more I have learned about the process, even with the most solid support structure possible on the commission, the heavier the weight has felt about the consequences of WMC decision-making.

It reminds me of the complexity of practicing medicine. No matter the field (mine is addiction medicine), there are an ever-expanding set of practice guidelines designed to promote safe, equitable, and consistent practice in our various settings. Sometimes it seems that they just keep coming, as if we create enough practice guidelines, then we won't have to think anymore, we can just go the internet, look up the guidelines, and push a button.

But of course, this will never happen, mostly because we are human. Look at some the most seemingly common-sense efforts to reduce error and promote safety. For example, the surgical time-out, which is part of the Universal Protocol mandated by the Joint Commission as a patient safety step in 2004.

In 2009, BMC published a piece called The 5th Anniversary of the "Universal Protocol" : Pitfalls and Pearls revisited. In its conclusion, it noted:

> **"The Universal Protocol was mandated by the Joint Commission 5 years ago with the aim of increasing patient safety by avoiding procedures at the wrong site or in the wrong patient. Despite widespread implementation, this standardized protocol has failed to prevent such severe 'never-events' from occurring.**

A more recent piece from the Journal of Patient Safety noted that "It is estimated that wrong-site surgery occurs in approximately 1 in 100,000 cases but could be as common as 4.5 in 10,000 cases dependent on the procedure being performed." And all of this despite the wide-spread use of surgical time-outs to prevent such 'never-events'.

This gets to the dangers, and the promise of 'gray areas' for medical providers. No amount of Universal Protocols or other practice guidelines will guarantee safe and even rational practice. In the end, it comes down to us, the medical providers, to use the safety tools we have, and to develop our own internal safety mechanisms, such as trusting our own anxiety, knowing our limits, living the power or collaborative and team- based practice, and listening to our patients.

When all of these things fail us as providers, Uniform Disciplinary Act violations occur, and complaints come to the WMC, we hope that we have the grace and wisdom to sort them out in fair and just ways that protect the public, and help providers become the best they can be. In such decisions, just as with our medical practices, we all remember that "gray areas" will be lurking around every corner, waiting to see how we will respond, and testing our ability to find a way to do what is safe, and what is right.

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

WMC Vision

Advancing the optimal level of medical care for the people of Washington State.