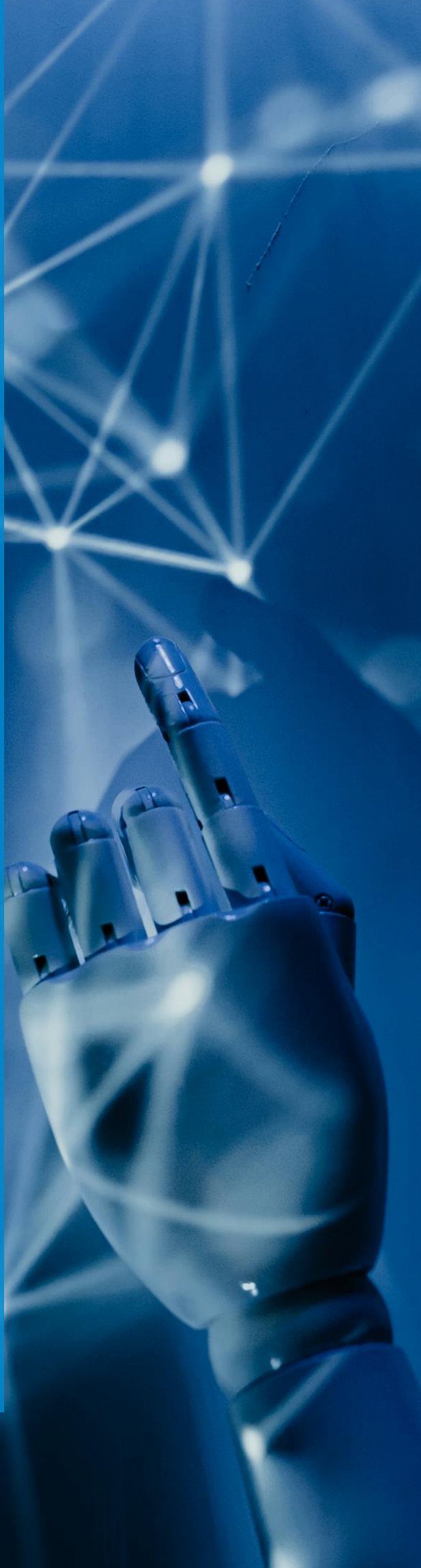
WASHINGTON
Medical Commission
Licensing. Accountability. Leadership.

UPDATE!

Spring 2024 - Vol. 14

In This Issue



Message from the Chair

WASHINGTON Medical Commission
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The 'Brave New World' of AI in Health Care

Karen Domino, MD, MPH

In mid-January, I was privileged to attend the Federation of Medical Boards Symposium on Artificial Intelligence (AI) in Health Care and Medical Regulation held in Washington, DC. AI has been so prominent in the news since last year with the release of Chat GPT. AI use in health care is increasing at an exponential rate. The WMC wants to understand how AI in medicine is evolving and how recommendations by the AI device or algorithm may result in misdiagnosis or an adverse outcome.

The conference was incredibly exciting and illuminating with presentations by national regulators from The Office of the National Coordinator for Health Information Technology (ONC), AI developers, physician AI superusers, and attorneys/regulators. I was not aware radiologists already extensively use AI to improve diagnosis and prioritize workflow when on call in busy emergency rooms with mostly negative studies. Having shared the "Seeing Waldo" books with my children, I have always been impressed at how difficult it is to see Waldo, but once you find him, it is easy. Now I can easily understand how AI helps alert radiologists to a potential abnormality, for which they can then focus using their clinical judgement. In addition, predictive models for sepsis, need for critical care after surgery or medical admissions, and prediction/treatment of hemodynamic instability use AI. Other reputed benefits of AI include:

1) better and earlier diagnosis;
2) personalized treatment beyond oncology;
3) better prediction of diseases and need for more intensive hospital care;
4) management of time consuming tasks including billing, scheduling and documentation/charting;
5) remote monitoring and telehealth;
6) improved patient engagement;
7) cost reduction and resource optimization, and
8) improvements in medical education, research, and drug discovery and development.

However, other messages from the conference were concerning. There is limited precedent in regulation in health care related AI for clinical predictive models and devices that predict hemodynamic instability and recommend treatment. In addition, FDA regulation of the devices may be insufficient due to device approval without peer reviewed publication and treatment as an approved "similar" device without AI would need. AI incorporates all "published" literature on the internet, without regard to quality of the research. Most AI results do not prioritize higher levels of evidence. Therefore, a case report or an opinion without peer review on a website has the same impact for AI recommendations as a guideline based on systematic review published in a journal after peer review. More concerning, AI may treat medical misinformation similar in quality to published, peer reviewed scientific evidence.

Physicians and physician assistants using current open market AI technologies for diagnosis and care of patients lack a comprehensive understanding of the building blocks that produce AI recommendations. Future health-related AI will improve dramatically with adoption of quality safeguards. Health care systems and providers should carefully evaluate their AI technologies to avoid unnecessary risk to their practice and the patient. Please continue to use your clinical experience and judgement in addition to any device, diagnostic, or predictive AI model. If you have an open complaint with the WMC, where you relied upon devices that utilize AI technologies, please let your investigator know so we can factor this into our assessments.

Executive Director Report

WASHINGTON Medical Commission
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Kyle Karinen, J.D., LL.M

This last quarter has been a whirlwind for the Commission. There are three topics I will address:

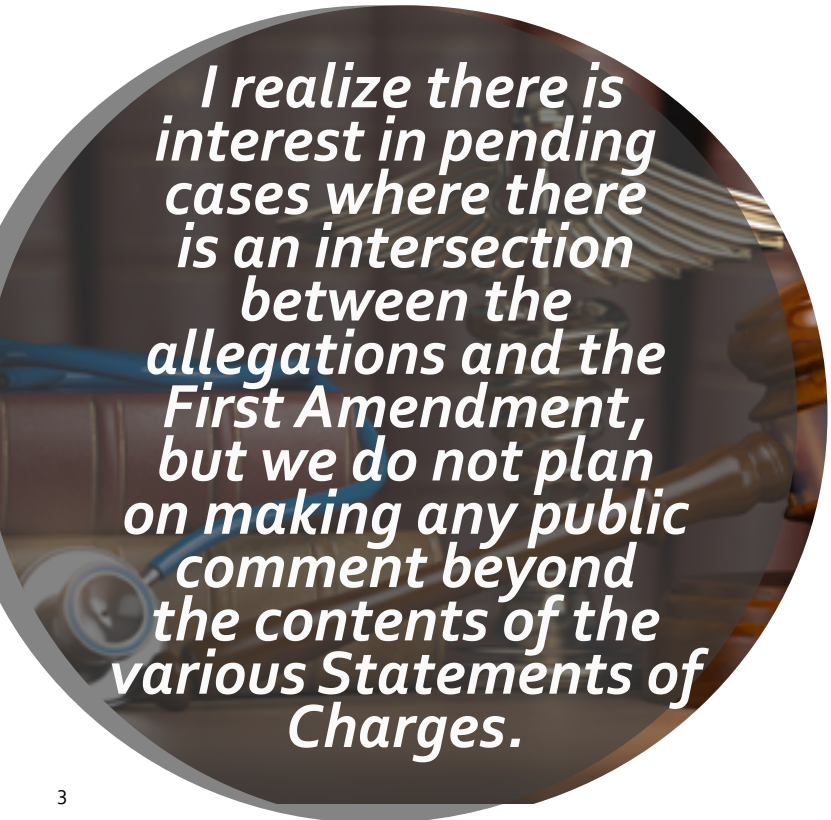
1) briefly, the previous legislative session that just concluded with the Governor's signature on March 29 for both the revisions to the biennial budget as well as the creation of a new profession that will be licensed and regulated by the Commission;

2) recent media coverage involving the Commission; and

3) another round of fraud targeted at physicians and physician assistants.

Legislative Session

I commend everyone interested in the finer details of the most recent legislative session, a piece by Deputy Director Micah Matthews that appears on page 7. As he outlines, although this session was the shorter version, there were no less than five major pieces of legislation that will have lasting impacts on the practice of physicians and physician assistants. The policy staff was at the Capitol Campus on a near-daily basis to work with legislators, other sections of the Department of Health, other executive branch agencies, and interested parties. Additionally, during the session, the Commission's policy staff endeavored to keep licenses apprised of what was happening and my hope is that you were able to engage with us if you were interested in doing so. The continued evolution of the medical profession was once again evident in the majority of these bills.



Media

The Commission was, as they say, "in the news" over the past month or so. In short, I will be continuing the general policy of my predecessor: the Commission will not discuss the substance of pending disciplinary matters. There may be times when members of the media or other interested parties contact our Public Information Officer in an effort to better the administrative hearing process or something similar. I think there is an obligation on the Commission's part to answer those procedural or general questions. However, our Public Information Officer takes great pains to not comment on the substance of the underlying charges in those instances – I am sure members of the media get tired of hearing that "the Statement of Charges speaks for itself", but it really does. A typical Statement of Charges addressing clinical issues is reviewed in detail by at least two clinicians and three attorneys prior to being filed. After being filed, the administrative hearing process begins. At that point, there is a mandate for the Commission to provide a hearing that is free from additional comment so that a physician or physician assistant can expect a hearing on the substance of the charges. This general principle also applies in instances where the Commission (or in the most recent instance, commission staff) have been sued. The Commission must allow the civil litigation to proceed without comment because it relates to underlying pending disciplinary litigation. I realize there is interest in pending cases where there is an intersection between the allegations and the First Amendment, but we do not plan on making any public comment beyond the contents of the various Statements of Charges.

Fraud

Several weeks ago, one of the Commission's staff contacted me early in the morning. She was on another line with a physician who had been contacted by "someone from the Commission." The physician was told that they needed to wire $20,000 to a bank account in Hong Kong or their license would be immediately suspended due to several violations of federal controlled substance law. The initial letter that the physician received was on letterhead that contained the WMC logo and was purportedly signed by me. The physician headed to their bank in order to make the transfer, but paused and decided to call the Commission before taking the next steps. As an initial matter, I want to say that my heart goes to those who have been intended victims of these sort of fraud attempts. To hear out of the blue, that you have committed illegal acts, given very little notice to remedy the situation at great expense, must be a harrowing experience. Unfortunately, fraudsters do not seem to be decreasing.

Executive Director Report

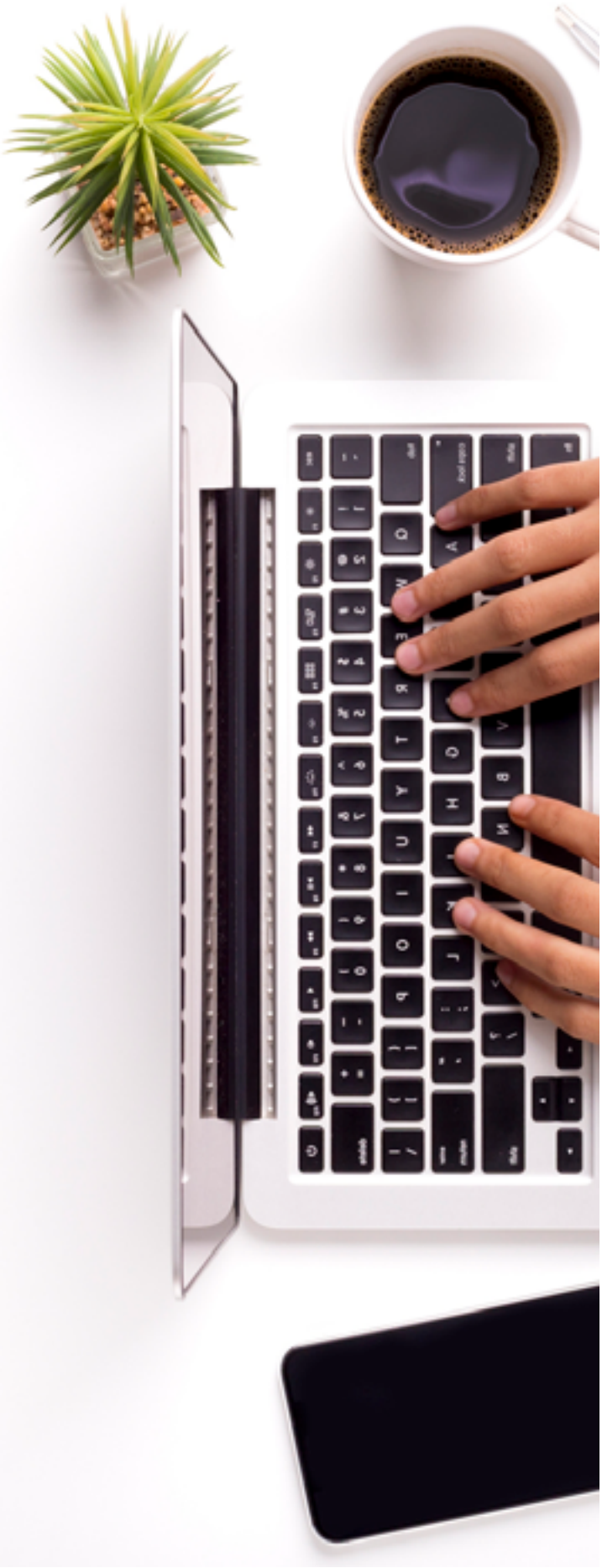
The Commission sends out, unfortunately, regular notices about these attempts via its email service. (As an aside, I highly recommend subscribing to the Commission's email list. The letter that was sent to this physician was easily identified as fraudulent to any commission staffer, but was sophisticated enough that it could have easily been seen as legitimate. I am taking the opportunity to highlight a couple of items here to hopefully aid future targets to the same realization this physician found their way to.

1. The Commission will never ask you to wire money to it under any circumstance. Period. Licensing fees can be handled through the Department of Health's (DOH) online licensing portal. Or you can come to the Tumwater location for the DOH and pay in person. In the very few instances when disciplinary actions occur and money is owed to the Commission, we only accept payment through the mail. (More on this below.) We do not accept cryptocurrency.

2. The Commission will never tell you that you must immediately pay a fine in order to avoid having your license suspended due to alleged misconduct. The Commission receives thousands of complaints each year and generally authorizes less than half for investigation. In almost every instance, you will be notified via postal mail that a complaint is being investigated. In addition to this notification, in almost every case, you will be given an opportunity to address the specific allegations that were raised by one of the Commission's investigators. In short, you will not receive a demand for money in letter form out of the blue. That is simply not how the Commission operates.

3. The Commission does enforce federal law. There are limited instances where the Commission may cite underlying federal laws, but the Commission works under the Uniform Disciplinary Act chapter of Washington State law.

If you ever have a question about any of these pernicious fraud attempts, please do not hesitate to contact the Commission via phone or email. As mentioned, our contact information is available on the Commission's website. I invite anyone reading this and has ideas about how we can further disseminate this message to your physician or physician assistant colleagues to mitigate these fraud schemes, please call me at (360) 236-4810, I would love to talk to you.



"Primum Non Nocere"

Ed. C. Lopez PA-C

It's Friday afternoon in the office, its' 4:15 PM, you're running behind on your schedule, you have already reached your minimum required patient volume threshold for the week and yet you still have a patient to see in room 3 when you walk in to find a 67 year old Mr. Magillacutty sitting up in a chair red faced and showing signs of shallow breathing with a nasal cannula oxygen in place. You go to the computer to sign on to open his chart, then briefly introduce yourself and ask the patient "what's wrong with you today sir?" The lady in the room answers that "he hasn't been able to catch his breath since this morning so we brought him in to find out if you could tell us what's wrong?" And then she adds, "oh yes… I'm his wife Betty."

As you turn to review his medical record in the EMR, you find that his intake BP was recorded to be 179/98 with a heart rate of 92, a respiratory rate of 24 and a room air saturation of 88% which prompted the nurse to place him on some oxygen for comfort. You then grab your stethoscope, perform a cursory lung examination, and think you hear an expiratory wheeze. You turn to Mr. Magillacutty to inform him that it sounds like an asthma flair and order him an albuterol inhaler and an SVN Treatment while in clinic, electronically prescribe him a home dose of tapering oral steroids, as well as an inhaled metered dose steroid and a rescue inhaler, encourage him to take his blood pressure medicine and assure him that he's going to improve with this regimen. You then tell the nurse that he can be released after his treatment.

You return to your office where you realize that it's after 5:00 PM closing time, while you are not caught up on your charting, you did surpass your minimum required patient volume quota and remember that the camping group you planned to join was leaving at 6:00 PM. You decide that the charting can wait till after the weekend on Monday, so you grab your backpack and head out the clinic door looking forward to some much-needed down time for the weekend.

You return on early Monday morning to another full clinic day on your schedule, attempt to catch up on last Friday's patient records and by 9:15 have completed the previous Friday's patient visit notes in the EMR. After a usually busy Monday morning. you return to your office by 12:30 PM to grab a brief lunch and receive an inter-office message that the local hospital E.D. had called to let you know that Mr. Magillacutty had gone to the hospital E.D. early Saturday morning with acute air hunger, dyspnea and tachycardia. He was found to have had an acute myocardial infarction with associated congestive heart failure resulting in an emergent cardiac catheterization and found to have significant culprit coronary artery disease. He underwent Coronary Bypass surgery on that morning and now was in critical condition in the Cardiac ICU. You realized that you had likely missed an important diagnosis and felt awful. You realized the afternoon patients were waiting and thus you promptly returned to your duties.

Approximately a month later, you receive a notification that a patient's family member has filed a formal complaint with the Washington Medical Commission (WMC) about your care with a patient alleging that the care that you provided violated RCW 18.130.180 (4), which charges in part, "Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed", with instructions about the investigatory and potential adjudication process.

While this case, if bearing any resemblance to any real case is purely coincidental and refers to no prior or pending cases, nonetheless, incidents like this do occur more often than they should. This fictional narrative is intended to highlight and possibly dissect some of the reasons why this may happen to any of us despite our education, our years of experience, our evidence of clinical competence, our personalities, or our specific clinical practice settings.

> ***"Healthcare delivery today has made a significant paradigm shift over the last decade and not only on how care is delivered, but also the why and by whom it is delivered […].***

"Primum Non Nocere"

What is important for all of us to understand, is that healthcare delivery today has made a significant paradigm shift over the last decade and not only on how care is delivered, but also the why and by whom it is delivered as well as how it is paid and reimbursed for it's services. Here are some current facts for us to consider:

- By 2025 it is projected that the demand for Physicians in the United States will exceed supply by 46,000 to 90,000 which comprises a shortage of 12,500 to 31,100 primary care physicians in the United States.
- As of Jan, 2021, PAI data indicates that 423,800 physicians, nearly 70% of the U.S. physician workforce, were employed by a hospital or corporate entity
- Consistently the last 4 years of statistical data reveals that 32% of Physicians are in office based Primary care.
- As of April 2022, the average number of patients seen by Primary Care Physicians each week was 110.
- The U.S. spends more on health care than does any other nation on earth by a combination of payments by employers covering their employees and dependents, government sponsored payments for the elderly, the disabled and some of the poor but there are still 26 million or (7.9%) of Americans uninsured …a record low as of Sept 2023.
- The number of private equity acquisitions of physician practices has grown six-fold between 2012 and 2021. Some markets have been highly penetrated by private equity, with a single private equity firm holding more than 30% in one or more physician specialties.
- As of January 2022, there were 160,000 Certified PA's and growing. Nearly 35% of PA's work in Primary Care. Overall PA's see nearly 75 patients per week in Primary Care while those working in Dermatology and Pediatrics see an average of 100 patients per week.

For all of these reasons and more, resulting in increased demands on PA's and Physicians delivering front line Primary Care today as employed providers, these demands result in time constraints particularly due to EMR demands and ever increasing volumes, resulting in increasing stress, work dissatisfaction, burn out, depression, lack of practice ownership, cutting corners to keep up and delivering partial or frankly sloppy care because there are only so many hours in each day. And while all of these factors seem to be true in our lives, we cannot as professionals allow this sense of a clinical "creeping compromise" to enter into our professional lives in the name of "corporate and private equity efficiency or productivity". Remember our pledge and commitment to our patients and to our profession when we entered it, "Primum Non Nocere- the Latin for, "First do no harm".

Let us always remember that the patient is why we do what we do. Let's keep our perspective on always providing only the best care and communication with our patients and their loved ones even when the external pressures are looming over us from employers, payors and Wall Street. If we do this, we can never be faulted for failing our patients or their families. Remember the words of one of our founding fathers of Medicine, *"The good physician treats the disease, the great physician treats the patient who has the disease." Dr. William Osler*

Connect your patients to WIC via new online WIC Interest Form

The WA State Department of Health recently launched an online WIC Interest Form and Washington WIC Clinic Locator. Individuals, health care providers, and community-based organizations can use the simple online form to refer to the Washington WIC Nutrition Program (Women, Infants, and Children Nutrition Program). The WIC Clinic Locator allows people to easily search for and connect with a local WIC Clinic.

WIC is for eligible people who are pregnant, recently delivered a baby, breast and chest feeding, and infants and children under age five. Dads, grandparents, foster parents, or other guardians may apply for WIC for their children.

WIC helps improve the health of adults and children through:

- Monthly benefits to buy healthy food
- Nutrition education
- Personalized breast and chest feeding support
- Health screenings and referrals
- And so much more

Please use the WIC Interest Form and WIC Clinic Locator to easily connect your patients to WIC!

- WIC Interest Form short URL: doh.wa.gov/WICRefer
- WA WIC Clinic Locator short URL: doh.wa.gov/FindWIC

Questions? Contact Monica Escareño, DOH Office of Nutrition Services, Outreach Coordinator

2024 Legislative Session Wrap Up

WASHINGTON Medical Commission
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Micah Matthews, MPA
Deputy Executive and Legislative Director

With the conclusion of the 2024 Legislative Session on March 7, the WMC begins the simultaneous work of policy landscape evaluation, implementation of new statutory requirements, and consideration of policy proposals for the 2025 session. A part-time legislature does not equal part time policy work for WMC staff. Despite not initiating any legislation, the WMC saw a significant impact to its regulatory work in 2024. Bills of note for our physician and physician assistant licensees are as follows:

House Bill 1300: Fraud in Assisted Reproduction

- This bill makes it a crime for practitioners to implant their own genetic materials in patients. It also bans the practice entirely under the Uniform Disciplinary Act and classifies it as unprofessional conduct.
- The WMC completed our first case regarding fraud in assisted reproduction in November 2023. This bill clarifies the legal landscape for all practitioners in the assisted reproduction field, which is a welcome change.
- Bill report: 1300-S.E SBR APS 24 (wa.gov)

House Bill 2041: Physician Assistant Collaborative Practice

- This bill moves PAs from a supervision model to the collaborative practice model, removes responsibility for WMC to maintain the practice agreement portal in favor of providing a model collaborative agreement, and clarifies legal liability for acts performed by the PA.
- Additionally, for PAs fresh out of training or switching specialties, a period of supervised practice (similar to what exists now for PAs) is required for a defined period of time.
- A third tier of practice experience is recognized for PAs who have worked in a single specialty for 20,000 hours in rural areas that does not require their collaborating physician to be practicing the same specialty as the PA.
- Bill report: 2041-S.E SBR APS 24 (wa.gov)

House Bill 1917: Adopting the Physician Assistant Compact

- The WMC will be an inaugural member in the PA Compact. The compact activates once seven states adopt the legislation. WA will be number four with several other states pending adoption this year.
- The compact model is like the Physical Therapy Compact model with a privilege to practice being issued as opposed to a license.
- With the adoption of Virginia on April 5, the PA Compact went live and activated an 18 month timeline to stand up the Compact Commission
- Bill report: 1917 SBR APS 24 (wa.gov)

Senate Bill 5184: Concerning Licensure of Anesthesiology Assistants

- This bill creates the new (to WA) profession of Certified Anesthesiology Assistants (CAAs) under the regulatory authority of the WMC.
- CAAs must practice under the direct supervision of a qualified anesthesiologist up to a 4:1 ratio.
- The WMC must conduct rulemaking prior to launching the profession. This will be an estimated 18-month process. Sign up here to receive rulemaking notifications, Look for this profession to launch January 2026.
- Bill report: 5184 SBR HA 24 (wa.gov)

2024 Legislative Session Wrap Up

Senate Bill 5838: Establishing an AI Task Force, by request of the Attorney General

- Brings together state agencies and leaders to develop recommendations consistent with NIST standards and other noted national expertise.
- The focus is initially on state use of AI and prevention of discrimination.
- Bill report: 5838-S2.E SBR HA 24 (wa.gov)

Senate Bill 5481: Uniform Telehealth Act

- This is a bill by the Uniform Laws Commission, which establishes uniform telehealth policy in its own statute as opposed to insurance regulations. Put another way, telehealth requirements in law will finally be about the practice of a profession as opposed to payment. This may be one of the most significant bills impacting health care in this state passed this session.
- Establishes that care occurs at the time and location of the patient and that the telehealth standard is the same as the in-person standard.
- Requires a WA license to deliver telehealth from out of state to WA patients with several exceptions:
    - Peer-to-peer consults
    - Clinical specialist consults for assessment and diagnosis but not treatment
    - Continuity of care for patients in WA, temporarily
- If you recognize the license exemptions - it is because they have been the policy of the WMC since 2016. They are now the law for all licensed health professions in WA and any other state who adopts the uniform law.
- Bill report: 5481-S.E SBR HA 24 (wa.gov)

Transformative Role of AI in Medicine

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Mahlet Zeru, MPH
Equity and Social Justice Manager

In today's media landscape, whether you're scrolling through news updates or delving into print articles, the pervasive narrative surrounding Artificial Intelligence (AI) invariably emerges, depicting its profound impact on various aspects of our world. From discussions of how AI is "changing" and "revolutionizing" to "transforming" diverse functions, industries, careers, and professions, nowhere is this narrative more prominent than in the medical industry. AI is an umbrella term used to describe the use of computers and technology to simulate intelligent behavior and critical thinking akin to human capabilities.[1] With the integration of AI in health care, patient care and clinical outcomes have experienced significant improvements, and the delivery of health care services has undergone optimization, ushering in a new era of efficiency and innovation.

AI applications that have revolutionized medicine:

- Clinical Decision Support Systems (CDSS): AI enhanced CDSS offers evidence-based recommendations, guidelines, and alerts to health care providers at the point of care.[2] By integrating patient data, medical literature, and best practices, CDSS assist clinicians in making informed decisions, reducing diagnostic errors, and improving patient outcomes[3]. Under the categories of basic preventive reminders and drug interaction alerts in primary care, CDSS is used routinely 68% and 100% of instances when the practice is entirely EMR/her based.[4]
- Diagnostic Imaging Interpretation: AI algorithms are used to analyze medical imaging data, including X-rays, MRI scans[5], CT scans, and mammograms, to assist radiologists and clinicians in interpreting images, detecting abnormalities, and diagnosing diseases such as cancer, fractures, and cardiovascular conditions.[6] AI-driven image analysis tools can improve diagnostic accuracy, reduce interpretation time, and prioritize cases for review, leading to earlier detection and intervention.[7]
- Precision medicine: AI facilitates the development of personalized treatment plans based on individual patient characteristics, including genetic makeup, medical history, and lifestyle factors.[8] By analyzing large datasets and clinical research, AI algorithms predict treatment efficacy, identify disease biomarkers, and optimize therapeutic interventions for precision medicine approaches.[9],[10],[11],[12]
- Healthcare Predictive Analytics: Predictive analytics tools analyze patient data to identify patterns, trends, and risk factors associated with adverse health outcomes.[13],[14] These tools aid in anticipating patient deterioration, preventing hospital readmissions, and optimizing resource allocation for improved care coordination and delivery efficiency.[15],[16]
- Natural Language Processing (NLP): NLP algorithms process and analyze unstructured clinical text data, including physician notes, discharge summaries, and medical literature, to extract valuable information, insights, and trends.[17] NLP applications enable health care organizations to automate documentation processes, extract clinical data for research purposes, and improve information retrieval for evidence-based decision-making.[18],[19]
- Remote monitoring and telemedicine: AI-enabled telemedicine platforms and remote monitoring systems enable patients to access health care services remotely, facilitating virtual consultations, remote diagnosis, and chronic disease management.[20] AI algorithms analyze real-time patient data from wearable devices and remote sensors to detect early warning signs of health deterioration, enabling proactive interventions and personalized care delivery.[21],[22]
- Drug Discovery and Development: machine learning and computational modeling are increasingly being used in drug discovery, development, and marketing.[23] AI algorithms analyze vast molecular structures, quickly predict drug interactions, and identify potential therapeutic targets, accelerating the life cycle of pharmaceutical products and reducing the time and cost associated with bringing new drugs to market.[24],[25],[26]

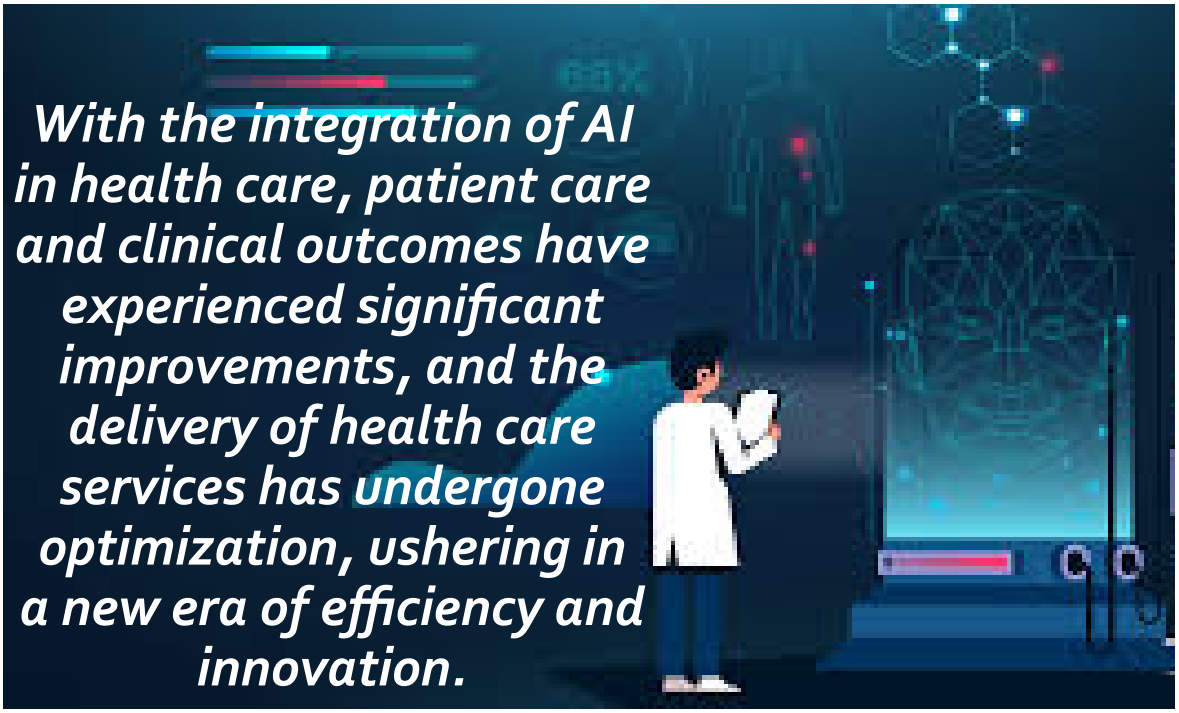
Transformative Role of AI in Medicine

The rapid advancement of machine learning models is expediting the incorporation of AI in medicine. To maximize its advantages and promote equitable access, it's essential to address challenges that come with full adaptation.[27] Health care data fragmentation and disparate storage poses challenges related to data quality, accessibility, interoperability as well as privacy.[28] Bias related to AI algorithm should also be considered as it could contribute to healthcare disparities.[29],[30] Ethical and safety considerations should also be studied with regulatory agencies.[31],[32] The WMC is leading the way in developing an AI in Medicine policy to navigate these challenges and ensure the responsible and ethical use of AI in medicine.

Stay informed:

- Online Courses and Resources: enroll in online courses, webinars, and educational platforms dedicated to AI in medicine. These courses cover topics such as machine learning, data analytics, and AI applications in healthcare. Platforms like Coursera and The American Board of Artificial Intelligence in Medicine (ABAIM) offer courses specifically designed for healthcare professionals interested in learning about AI.
- Professional Workshops and Conferences: Attending workshops, seminars, and conferences focused on AI in medicine provides doctors with opportunities to learn from experts in the field, explore cutting-edge research, and engage in discussions about the latest advancements and best practices. Many medical associations and professional organizations host conferences and events on AI and healthcare innovation.
    - *Changing healthcare one connection at a time* Gaylord Palms, Florida, May 29 - 31 2024
    - International Conference on Machine Learning (ICML) 2024
    - Mayo Clinic Platform Conference
    - Machine Learning for Healthcare 2024
    - Bio-IT World Conference & Expo 23rd Annual Expo
- Network and Participate: Collaborating with research university faculty offers valuable insights and perspectives on its applications in medicine. Participate in UW medicine interdisciplinary research, join AI-focused working groups or forums, and network with professionals from diverse backgrounds to gain a deeper understanding of AI technologies and their implications for healthcare. Participate in the Washington State Medical Association to develop a position and guidelines that define AI.

Refrences for this article are avalaible on page 25



Rulemaking Efforts

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Amelia Boyd
Program Manager

Health Equity Continuing Education for MDs and PAs
On October 20, 2023, the WMC adopted new sections of rule, WAC 246-918-195 (physician assistants) and WAC 246-919-445 (physicians) to meet the requirements of Engrossed Substitute Senate Bill 5229 (Chapter 276, Laws of 2021), codified as RCW 43.70.613, regarding health equity continuing education (CE). The CR-103, Rulemaking Order, was filed on November 29, 2023 as WSR #23-24-033. The rules were effective January 1, 2024.

Postgraduate Medical Training, WAC 246-919-330 via Standard Rulemaking
The Washington Medical Commission (WMC) officially filed a CR-101 with the Office of the Code Reviser on August 23, 2023. The WMC is considering amending WAC 246-919-330(4) to remove two requirements that have become a barrier to licensure. The WSR# is 23-18-005.

At their October 20, 2023, Business meeting, the Commissioners approved initiating the next step in the rulemaking process, CR-102 Proposed Rulemaking. The hearing for this rulemaking is tentatively scheduled for April 26, 2024. Please visit our Rules in Progress page for the current schedule and draft language.

Postgraduate Medical Training, WAC 246-919-330 via Emergency Rulemaking
The WMC has amended WAC 246-919-330(4) Postgraduate medical training via emergency rulemaking. The amendment eliminates the outdated requirement for consecutive years of training in no more than two programs. This emergency rule was filed on July 13, 2023, as WSR #23-15-056 and renewed on November 9, 2023, as WSR #23-23-071.

The immediate amendment of WAC 246-919-330 was necessary for the preservation of public health, safety, and general welfare. Continued demand for health care professionals, especially qualified physicians, makes it essential that qualified applicants are able to obtain licensure. This action will result in increasing the quantity of health care professionals able to respond to current and ongoing staffing demands.

Opioid Prescribing Rules
At their April 14, 2023, Business meeting the Commissioners voted to initiate rulemaking for both chapter 246-918 WAC (physician assistants) and chapter 246-919 WAC (allopathic physicians) to revise the opioid prescribing rules as follows:

1. Exempting patients with Sickle Cell Disease.
2. State in rule that not all chronic pain patients need to be tapered off opioids.
3. Clearer rules regarding biological specimen testing.

The WMC officially filed a CR-101 with the Office of the Code Reviser on August 16, 2023. The WMC is considering amending the following sections to modernize the language, add clarity, and bring the rules more in line with current practice:

- WAC 246-918-801 (physician assistants) Exclusions
- WAC 246-918-845 (physician assistants) Patient Evaluation and Patient Record—Subacute Pain
- WAC 246-918-855 (physician assistants) Patient Evaluation and Patient Record—Chronic Pain
- WAC 246-918-870 (physician assistants) Periodic Review—Chronic Pain
- WAC 246-918-900 (physician assistants) Tapering Considerations—Chronic Pain
- WAC 246-919-851 (physicians) Exclusions
- WAC 246-919-895 (physicians) Patient Evaluation and Patient Record—Subacute Pain
- WAC 246-919-905 (physicians) Patient Evaluation and Patient Record—Chronic Pain
- WAC 246-919-920 (physicians) Periodic Review—Chronic Pain
- WAC 246-919-950 (physicians) Tapering Considerations—Chronic Pain.

The WSR# is 23-17-094. At their October 20, 2023, Business meeting, the Commissioners approved initiating the next step in the rulemaking process, CR-102

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

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

Rulemaking Efforts

Proposed Rulemaking. The hearing for this rulemaking is tentatively scheduled for April 26, 2024. Please visit our Rules in Progress page for the current schedule and draft language.

2SHB 1009 Military Spouse Temporary Practice Permits
Second Substitute House Bill (2SHB) 1009 Concerning military spouse employment was passed during the 2023 legislative session. The WMC has a section in both the physician's chapter, WAC 246-919-397, and the physician assistant's chapter, WAC 246-918-076, which address how a military spouse can obtain a temporary practice permit. Both WACs are identical except for references to physician or physician assistant in their respective chapters. 2SHB 1009 provides additional information for issuing this temporary permit, a different definition of military spouse, and other items that are not included in the WACs. The WMC will consider amending these WACs to align with the bill more closely. The CR-101 for this rulemaking was filed on September 12, 2023, as WSR #23-19-029.

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

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.

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. The 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.

Upcoming Rulemakings
At their October 20, 2023, Business meeting, the Commissioners approved initiating rulemaking on the following:

- Use of nitrous oxide in office-based surgery settings
- Regarding SSB 5389 – define "qualified physician"

The CR-101, Preproposal Statement of Inquiry, for each of these rulemakings is in progress. Workshops will be held sometime this year. Please visit our Rules in Progress page for the current schedule.

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. WMC rulemaking comments or questions may be emailed to medical.rules@wmc.wa.gov.

Rules Hearing Notice

The WMC will hold two Rules Hearings on Friday, April 26, 2024:

1. Regarding general provisions for opioid prescribing and tapering rules for allopathic physicians and physician assistants. Begins at 9:15 am. The CR-102, Proposed Rulemaking, filed as WSR #24-07-106, includes the proposed language.
2. Regarding postgraduate training for physicians, WAC 246-919-330. Begins at 9:45 am. The CR-102, Proposed Rulemaking, filed as WSR #24-07-107, includes the proposed language.

The comment period for both rules will expire on April 19, 2024. If you would like to provide comments, you may do so here.

These hearings will be held in conjunction with the WMC's Business meeting, which will begin after the last hearing is adjourned or 10:15 am, whichever is later. These meetings will be held virtually via Teams.

April 26, 2024 Meeting Registration

Physical meeting location:
111 Israel Rd SE
TC2 Room 153
Tumwater, WA 98501

WPHP Report

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Questions and Answers

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

Since 1986 the Washington Physicians Health Program (WPHP) has served as the legally authorized professional support program in Washington for licensed physicians and physician assistants. We are a small, independent, physician-led, non-profit organization that is contracted with the Department of Health to provide assessment, treatment referral, post-treatment health support and advocacy for professionals with health conditions that may impair their ability to safely practice. This is largely possible through laws in Washington that allow WPHP to work with professionals confidentially and without notification or involvement of the Medical Commission (WMC). We endeavor to assist our colleagues, who are often suffering silently, obtain help before a career and/or life altering event occurs. A referral to WPHP is a courageous act of compassion for a colleague whose life and career may be at risk.

Q: What is impairment?
A: Impairment is defined as the inability to practice with reasonable skill and safety to patients as the result of a physical or mental health condition. Impairment is a functional classification related to illness, but the presence of illness does not mean an individual is impaired. Clinical competence is often confused with impairment. Impairment, by definition, results from an underlying illness. In the absence of impairing illness, performance problems related to competence are outside of the scope of WPHP's mission and expertise.

Q: How common is impairment?
A: No one knows the true prevalence of physician impairment. Estimates suggest 1-2% of health care providers may be impaired annually. Impairing conditions such as substance, mood and anxiety disorders appear to occur at least as frequently in physicians if not more frequently. However, physicians are less likely to seek help for such problems on their own due to fear, shame, stigma, and denial.

Q. Does WPHP only address substance use disorders?
A: No. In fact, about 60% of WPHP referrals today are for non-substance related concerns such as mental health issues, burnout and distress, medical conditions, and concerns related to aging and cognition. WPHP can help with any health condition that can cause impairment and, in general, WPHP's enabling statutes are not different for substance vs. non-substance related conditions. However, WPHP does take an individualized approach to each participant based on guidelines established by the Federation of State Physician Health Programs. As such, recommendations for evaluation, treatment, and monitoring will differ according to the condition(s) being addressed.

Q. What "rules" dictate the relationship between the WMC and WPHP?
A: Washington state law (RCWs), administrative rules (WACs), and the contract between WPHP and the Department of Health govern the relationship between WPHP and WMC. The laws and rules provide for the existence of a confidential physician health program and set out the definitions and requirements of the program. RCW chapters 18-71 (Physicians) and 18-130 (especially 18-130-175) are the most relevant statutes.

Q: If I am worried that a colleague is impaired, whom should I call?
A: If your colleague is an MD or a PA, you can fulfill your obligation by notifying the Washington WMC or the Washington Physicians Health Program (WPHP) at 1-800-552-7236 or making a referral through our website at www.wphp.org.

Q: Do I really have to call someone if I am worried about a colleague who may be impaired?
A: Per Washington Administrative Code (WAC 246-16-220 and 246-16-235), if you hold a clinical license through DOH and you have knowledge "that another license holder may not be able to practice his or her profession with reasonable skill and safety due to a mental or physical condition," you are legally and ethically obligated to make a report for the safety of your colleague and the patients they treat. You do not have to be certain that a colleague is impaired (such certainty is rare), knowledge that a colleague may be impaired triggers a reporting requirement. It is WPHP's role to determine whether and to what extent a health professional may be impaired.

Q: What happens if I make a report with WMC?
A: WMC will be obligated to review the case and may open an investigation. This may result in disciplinary sanctions, including public disclosure of facts relevant to the case. There is also a high likelihood that WMC will have empathic concern for the well-being of your colleague and strongly encourage your colleague to self-refer to WPHP for immediate clinical help.

Q: What happens if I make a report to WPHP instead of WMC?
A: A referral to WPHP fulfills your reporting requirement while also taking advantage of the WPHP confidential, therapeutic alternative to discipline. This means that WPHP can assist your colleague without WMC's knowledge or involvement. WPHP has an obligation to assess your colleague as soon as possible to rule out impairment or refer for further evaluation and treatment if impairment cannot be ruled out. For patient safety reasons, your colleague

will have a reasonable, but limited, timeframe in which to respond and engage with WPHP's evaluation process. They may be directed to take medical leave if impaired or at substantial risk for impairment and complete sufficient treatment before they can return to work pursuant to a WPHP health support agreement. If they are unwilling or unable to take advantage of this process, WPHP has the legal obligation to make a report to the WMC.

Q: In the absence of patient harm, why is the law set up to allow reporting of suspected impairment to WPHP as a substitute for reporting to the Department and WMC?
A: To support patient safety, the law is set up to encourage early identification, assessment, and treatment of providers who are thought to be impaired. Allowing physicians to self-refer to WPHP or to be referred by their employer or colleagues to WPHP rather than to WMC serves this purpose. It encourages use of WPHP as a therapeutic alternative to discipline for providers who need help and can be rehabilitated. Having the opportunity to confidentially avoid a disciplinary process serves as a powerful motivator for physicians to commit to thorough evaluation and treatment, if needed.

Q. Are physicians and PAs required to report their involvement with WPHP to their employer?
A: It depends. Individuals who come to WPHP without their employer's knowledge have no obligation to report their health condition or participation in WPHP to their employer. However, a need for medical leave or a recommendation for a health support agreement will necessitate some communication with the employer. With the participant's consent, WPHP will act as an intermediary with the employer to advocate for the participant's needs while minimizing the protected health information that is disclosed. Practically speaking, referral by an employer is more common than self-referral. In those cases, participant authorized communication with the employer can help put concerns to rest and promote continuation or return to work.

Q: Once I've made a report to WPHP, under what circumstances does WPHP report my colleague to the WMC?
A: If WPHP is significantly concerned that your colleague is suffering from an impairing health condition and they do not follow WPHP recommendations for evaluation, treatment, or a health support agreement, we are obligated to notify WMC. We are also required to notify the WMC in any circumstance where program non-compliance poses a reasonable likelihood of patient harm. We work very hard to help our participants avoid such circumstances. We feel that participants do best when internal motivators are engaged, rather than externally leveraged through a possible WMC referral.

Q: How frequently does the WPHP report individuals to WMC?
A: These events are rare. Currently, around 85% of the physicians in WPHP health support agreements are unknown to WMC. Over half that are known to WMC were referred by WMC to WPHP when an investigation revealed a potentially impairing health condition. Usually these are cases in which no one called WPHP when concerns of impairment came to light and eventually someone called WMC instead. Historically, WPHP reporting obligation has been triggered for less than 5% of participants annually.

Q: What happens if I do not call and make a report?
A: When impairment is suspected, not making a report risks unsafe care. Failing to act also needlessly jeopardizes the career of a colleague where adverse professional consequences can be avoided or minimized through therapeutic intervention. Finally, if it is shown that you knew there was a concern for impairment and failed to act, you may be exposed to legal risk from the DOH or a civil liability action. Both the Washington State Medical Association and the American Medical Association recognize that physicians have an ethical obligation to report impaired and potentially impaired colleagues.

Q: What if a potentially impaired physician or PA is my patient?
A: You may still have an obligation to make a referral to WPHP or WMC, although your concern must reach a higher threshold. Per WAC 246-16-235, you do not have to make a report until your physician-patient poses "a clear and present danger to patients or clients." You must weigh this obligation versus your legal obligations under HIPAA if your patient is not willing to consent to you disclosing their identity in a report to WPHP. You may always contact WPHP anonymously for guidance on whether to report a physician or PA patient.

Q: Are there situations in which I cannot fulfill my legal reporting obligation by calling WPHP instead of the WMC?
A: Yes, there are two. (1) Any behaviors falling under the definition of sexual misconduct (WAC 246-16-100) cannot be reported to WPHP and stay confidential. These incidents must be directly reported to the DOH. (2) Any situation in which there is concern for impairment and there is known patient harm stemming from the suspected impairment, a direct report to the DOH is required. WPHP will advise accordingly should such circumstances come to light during the referral process.

Q: If I need to make a report, is there any disadvantage to me or to my colleague if I call the WPHP rather than WMC?
A: No. If we feel you are not fulfilling your obligation by calling us and it is one of those rare cases in which a call to WMC or DOH is mandatory, we will explicitly clarify this for you.

To learn more about WPHP or make a referral please call us at 800-552-7236 or visit our website at www.wphp.org.

Legal Actions

WASHINGTON Medical Commission
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November 1, 2023 – January 31, 2024

Below are summaries of interim suspensions and final actions taken by the Medical Commission. Statements of Charges, Notices of Decision on Application, Modifications to Orders and Termination Orders are not listed. We encourage you to read the legal document for a description of the issues and findings. All legal actions can be found with definitions on the Medical Commission website.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Summary Actions				
Crandall, Sarah L., MD MD.MD.60951421 Out of state	Order of Summary Restriction	1/19/24	Alleged performance of elective breast surgery procedures on poor surgical candidates with inadequate planning.	Restricted from performing any type of breast surgery.
Olsson, Roger B., MD MD.MD.00015303 Snohomish County	Order of Summary Suspension	11/5/23	Alleged failure to comply with a Commission Order.	Indefinite suspension of license.
Parakh, Rugvedita S., MD MD.MD.60917578 King County	Order of Summary Suspension	11/13/23	Suspension of license in Indiana	Indefinite suspension of license.
Formal Actions				
Bauer, William M., MD MD.MD.00035422 Kitsap County	Agreed Order	11/2/23	Substandard clinical documentation; inadequate physical examinations; cutting and pasting of records; failure to diagnose ascites leading to emergency treatment of seriously ill patient.	Clinical competency assessment. May petition to terminate after completing all terms of the order.
Cole, Ryan N., MD MD.MD.00048229 Out of state	Final Order	1/4/24	Acts of dishonesty; making false and misleading statements about COVID-19; and negligent care to four patients.	Restricted from engaging in primary care medicine; practice limited to pathology; may petition to remove restrictions after completing reentry course in family medicine; CME in COVID-19, pulmonary and respiratory diseases, record keeping, and telehealth; ethics course; paper; fine; personal appearances.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Formal Actions (Continued)				
McQuivey, David P., PA PA.PA.10003472 Out of state	Agreed Order	11/16/23	Failure to meet standard of care in prescribing testosterone for male hypogonadism.	Restricted from prescribing testosterone medications without oversight and approval of supervising physician; obtain Commission-approved supervising physician who is board-certified endocrinologist, urologist, or equivalent; clinical competency assessment; CME in prescribing testosterone, treating hypogonadism, informed consent, and record keeping; paper; compliance audits; personal appearances; fine. May petition to terminate in 4 years.
Rice, James W., MD MD.MD.00015479 King County	Agreed Order	11/16/23	Negligent care of cardiac patient and negligent care prescribing of opioids to a second patient.	Restricted from prescribing, administering, ordering schedule II-IV controlled substances; clinical skills assessment; CME on out-patient cardiac management; paper; compliance audits; personal appearances; fine. May petition to terminate in 3 years.
Riyaz, Farhaad R., MD IMLC.MD.61103258 Out of state	Agreed Order	11/7/23	Suspension of license in Virginia; and subsequent disciplinary action in Massachusetts, Michigan, and Colorado.	Indefinite suspension of license; CME in ethics; personal appearances; fine. May petition to terminate after completion of all terms.
Saadi, James A., MD MD.MD.00022398 Out of state	Final Order	11/7/23	Revocation of license in Missouri.	Indefinite suspension of license; fine.
Saify, Emil A., MD MD.MD.00045364 Out of state	Default Order	12/14/23	Revocation of license in California.	Indefinite suspension of license.
Thompson, Robert G., MD MD.MD.00012796 King County	Final Order	1/22/24	Provided substandard treatment in numerous respects to chronic pain patient; and prescribed buprenorphine to patients without naloxone, prescribed opioids with other sedatives, co-prescribed stimulants and sedatives, co-prescribe stimulants and suboxone.	Indefinite suspension of license. May petition for reinstatement after completing a competency assessment and paying fine.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Formal Actions (Continued)				
Thorn, Thomas A., MD MD.MD.00039020 Ferry County	Default Order	1/24/24	Failing to cooperate with investigation.	Indefinite suspension.
Welling, Eric C., MD MD.MD.61275435 Out of state	Default Order	1/3/24	Suspension of license in Wyoming.	Indefinite suspension.
Wright, Jonathan V., MD MD.MD.00011394 King County	Agreed Order	11/29/23	Inappropriate care of a patient, including negligent management of a hypothyroidism; inappropriate diagnosis of vitamin B12 deficiency; recommending the patient go to a compounding pharmacy to purchase vitamins and supplements; inappropriate pain management therapies; recommending no evidence-based medical therapies; permitting medical assistant to recommend supplement adjustments and treatment recommendations.	CME in thyroid medication management' ethics course; two scholarly papers; personal appearances; and a fine. May petition to terminate in one year.
Informal Actions				
Bitton, Blake K., PA PA.PA.60697705 Franklin County	STID	11/16/23	Alleged inappropriate prescribing of testosterone, hCG, HGH, phentermine, and other medications with inadequate assessment and inadequate record keeping.	Restricted from prescribing testosterone and androgen-related medications; restricted from providing hormone replacement therapy to patients; supervising physician must be approved by Commission; CME in record keeping; ethics course; literature review and paper; clinical monitoring program; supervising physician reports; personal appearances; costs. May petition to terminate in 18 months.
Bothamley, William C., MD.MD.00033514 Yakima County	STID	11/16/23	Alleged inability to practice with reasonable skill and safety due to a health condition.	Voluntary surrender of license.
Browning, Ashley, PA PA.PA.61243211 Island County	STID	1/11/24	Inability to practice with reasonable skill and safety due to a health condition.	WPHP assessment; personal appearances. May petition to terminate when WPHP determines monitoring no longer necessary.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions (Continued)				
Case, Irina N., MD MD.MD.00049468 Kitsap County	STID	1/11/24	Alleged inappropriate discharge of patient from hospital of patient with significant cognitive deficits.	CME in recognition and proper documentation of patient cognitive progression; paper; personal appearances; costs. May petition to terminate in one year.
Ceccacci, Brandon J., PA PA.PA.61124689 Clark County	STID	1/11/24	Alleged inappropriate prescribing of testosterone.	Restriction from prescribing testosterone and similar hormone replacement therapy medications to patients without the oversight and approval of a Commission-approved supervising physician; CME in prescribing testosterone, treating hypogonadism, informed consent, and recordkeeping; paper; personal appearances; costs. May petition to terminate in 4 years.
Edwards, John S., PA PA.PA.61066250 Grant County	STID	1/11/24	Alleged inappropriate question regarding patient's tongue piercing.	Boundaries and ethics course; paper; personal appearances; personal reports; costs; may petition to terminate in one year.
Foland, Jaime A., MD MD.MD.60927468 Pierce County	STID	11/16/23	Alleged prescribing of controlled substances to a family member without keeping records.	CME in proper prescribing; ethics course; record keeping course; review WMC policy; paper; maintain appropriate boundaries; personal appearances; costs. May petition to terminate in 3 years.
Fowler, Stephen D., MD MD.MD.60147300 King County	STID	11/16/23	Alleged prescribing of glyburide to diabetic patient in ER without checking to see why PCP had discontinued prescribing glyburide and discharging patient without lab work indicated for patient with high blood glucose level.	CME in evaluation and management of hyperglycemia in patient with type 2 diabetes; CME in communication; paper; personal appearances; costs. May petition to terminate in one year.
Herndon, Christopher MD MD.MD.60788000 King County	STID	11/29/23	Alleged use of own sperm when providing fertility care to patient.	Voluntary surrender of license.
Marsh, Robert E., MD MD.MD.00039426 Out of state	STID	1/11/24	Alleged negligent laparoscopic hernia repair.	Agreement not to apply for renewal, reactivation of expired license without prior approval of Commission. Prior to requesting approval, must undergo evaluation by WPHP, complete re-entry program, pay costs. May petition to terminate upon completion of terms and with endorsement of WPHP.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions (Continued)				
Proano, Pablo MD MD.MD.00020243 King County	STID	11/16/23	Alleged prescribing of controlled substances to two patients without doing drug screens despite signs of abuse and prescribing controlled substances to two family members.	CME in prescribing controlled substances; boundaries and ethics course; maintain appropriate boundaries; paper; register with PMP; develop protocol for substance abuse monitoring; compliance audits; personal appearances; costs. May petition to terminate in 2 years.
Ravasia, Debra J., MD MD.MD.00045314 Out of state	STID	11/16/23	Alleged misrepresentations in bankruptcy proceeding.	Voluntary surrender of license.
Shaffer, Jaclyn E., MD MD.MD.60529772 Out of state	STID	1/11/24	Alleged in appropriate discharge of patient with retained placenta home from emergency department.	CME in management of first, second, and third trimester miscarriages; personal appearances; costs. May petition to terminate in 2 years.
Shoemaker, Jerad R., MD MD.MD.60303749 Clark County	STID	11/16/23	Alleged discriminatory comments made to patients and staff.	CME in implicit bias and communication; review Commission policy on discrimination; paper; personal appearances; costs. May petition to terminate in 2 years.
Tavakoli, Mehran, MD MD.MD.00046113 Clark County	STID	1/11/24	Alleged criminal conviction of a class C felony.	Fitness to practice evaluation; CME in ethics; paper; personal appearances; costs. May petition to terminate in 4 years.

Order of Summary Suspension: An order suspending a license prior to a hearing based on a determination that the licensee's continued practice represents a danger to the public.

Order of Summary Restriction: An order restricting an aspect of a licensee's practice prior to a hearing based on a determination that the licensee's continued practice with an unrestricted license represents a danger to the public.

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.

Final Order: an order issued after a formal hearing before the Commission.

Final Order on Default: an order issued after the licensee fails to respond to a statement of charges.

Final Order-Waiver of Hearing: an order issued after the licensee waives the right to a hearing on a statement of charges by the licensee to comply with certain terms and conditions to protect the public.

Stipulation to Informal Disposition (STID): a document detailing allegations, but with no findings or admissions, and containing an agreement by the licensee to comply with certain terms and conditions to protect the public.

WMC Compliance Paper

WASHINGTON Medical Commission
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The Inappropriateness of Providing Marijuana to a Minor and the Unprofessional Act of Accessing Electronic Health Information of a Non-patient.

The WMC often requires licensees to write an educational paper as part of their compliance requirements. The WMC Reviewing Commission Member and the Update! Editorial board found the lessons presented in this paper to be exceptional and of value to the larger provider population. This is in no way an endorsement of the practices from this specific provider and should not be seen as such in future events.

On multiple occasions between 2019 and 2020, I allegedly provided cannabidiol (CBD and delta-9-tetrahydrocannabinol (THC) edible gummies and candies to a minor family member who was not my patient. The edibles I allegedly provided to the minor family member contained an approximate CBD to THC ratio of 1:1. I allegedly accessed the minor family member's electronic health record in a facility where the minor received care. The minor family member was not my patient, and this access was not for treatment, payment, or operations purposes. This paper aims to explore and demonstrate a thorough understanding of the inappropriate and unprofessional nature of my actions, identify the potential impact my actions may have on the minor family member, and identify the changes I have made to my practice to heighten my awareness, hold myself to a higher ethical standard in a personal as well as professional manner to ensure these actions never occur again. I will also reflect on the knowledge gained from my experience in the PROBE program.

Providing CBD/THC edible gummies to a minor family member and inappropriately accessing their electronic health record, crossed several ethical boundaries, placed a minor family member in harm's way, and risked potential negative physical, psychologic, and social effects for them. Widespread legalization and normalization of marijuana use in many states, has led to increased accessibility and The American Academy of Pediatrics showed "states that decriminalized medical marijuana have shown an increase in emergency department (ED) visits and regional poison center (RPC) cases for unintentional pediatric marijuana exposures." In a JAMA Pediatric article evaluating minor exposure: "allowing access to high-potency marijuana products can be deemed negligent, similar to allowing access to potentially harmful pharmaceuticals, household products, or ethanol." In giving a CBD/THC gummy to my minor family member, I crossed several ethical boundaries. In the PROBE program, I learned to evaluate ethical situations utilizing three general frameworks.

From a virtue ethics standpoint, providing a schedule I drug to a minor is not only illegal, but it also goes against the virtues associated with being an responsible and ethical healthcare provider. Honesty, integrity, and professionalism are expected of me as a Physician Assistant, and my actions placed a minor in harm's way. Additionally, accessing their electronic medical record without proper consent or authorization goes against the virtue of integrity as it was an act of dishonesty, breached professional guidelines, and compromised patient privacy. The ripple effect reverberated well beyond the initial harm. From a Consequentialism perspective, providing a CBD/THC edible to a minor can have serious physical health effects for them. According to the American Academy of Pediatrics article, "exposure to marijuana can disrupt brain development, leading to impaired cognition, memory deficits, and decreased educational aptitude and attainment." Regular use during adolescence increases the risk of respiratory issues, cardiovascular problems such as tachycardia and hypertension with an overall increased risk of cardiac events. The cognitive and psychological effects of marijuana have been linked to a decreased IQ, poor attention and memory, as well as executive function.

Furthermore, CBD/THC in adolescent age groups had an increased risk of anxiety, depression, and psychosis, which can have a profound negative impact on a minor's overall well-being and can persist into adulthood, not to mention the added negative impact on academic performance and social relationships. Studies have shown that minors who use CBD/THC regularly are more likely to experience poor academic performance, absenteeism, decreased engagement in extra-curricular activities and increased risky behaviors. My actions involving inappropriate unauthorized access to the minor family member's health record resulted in a breach of privacy, emotional distress, loss of trust, and exposed them to potential discrimination and financial harm.

I HAVE SINCE TAKEN THE TIME FOR SELF-REFLECTION AND INTROSPECTION, AS WELL AS RE- EVALUATION OF MY OWN INDIVIDUAL MORALS AND TRAITS, AND HOW THEY HAVE BECOME MISALIGNED WITH THE VIRTUES OF BEING AN ETHICALLY SOUND PHYSICIAN ASSISTANT.

The Inappropriateness of Providing Marijuana to a Minor and the Unprofessional Act of Accessing Electronic Health Information of a Non-patient.

HIPAA was created to ensure an individual's trust in the healthcare system to keep their personal healthcare information confidential. When this privacy is compromised, a loss of trust and confidence in the relationship between the patient and healthcare provider can occur. My actions were especially egregious for a minor, as adolescents have a difficult time sharing information with their doctor to begin with. The emotional distress of my actions likely caused the minor to have feelings of being exposed, embarrassment and shame. As a victim of a breach of privacy, leaked health information could possibly expose the minor to future employment discrimination based on medical history and conditions, or even financial exploitation such as identity theft and medical insurance fraud.

From a principles based ethical framework and perspective regarding my actions, I will refer to the American Academy of Physician Assistants Guidelines for Ethical Conduct for the PA Profession. The Statement of Values of the PA profession maintains that a PA should uphold the tenets of autonomy, beneficence, non-maleficence, and justice. My actions violated the principle of beneficence and non-maleficence, as it is my charge to act in the best interests of patients and to do no harm. At one point, I contested this was a personal family matter and an issue not related to healthcare, but I see now and understand that my primary value as a PA is "the responsibility to the health, safety, welfare and dignity to all human beings." I violated the principle of non- maleficence by providing a minor family member with a CBP/THC edible because, as a PA, I must avoid causing harm. Moreover, I violated the principle of patient autonomy by accessing their electronic medical record. According to the statement of values: "PAs hold in confidence the patient specific information shared in the course of practicing medicine. According to the Department of Health and Human Services regarding HIPAA violations, inappropriately accessing mental health information is especially egregious and I have since taken the time for self-reflection and introspection, as well as re- evaluation of my own individual morals and traits, and how they have become misaligned with the virtues of being an ethically sound Physician Assistant.

As I reflect on my actions, I realize and acknowledge where I went wrong. Over the past few years, I have also witnessed the ripple effect my actions had upon myself, my family member's health and well-being, eroded trust in the provider-patient relationship, my supervising physician, department, employer, and both hospital systems in which I work. I understand why my accountability is a must to preserve that ever-so- fragile "social contract" between healthcare and society. Because of that trust, I, as a professional, have to hold myself to a better standard and conduct myself in and out of my white coat in a manner consistent with the Guidelines for Ethical Conduct. My actions and decisions were made during a very tumultuous time in my life as they occurred several years ago in the setting of a very contentious divorce. In 14 years as a practicing Physician Assistant, I have never had a complaint from a patient, a patient's family, co-worker, or colleague. While I had worked hard to not allow the events in my personal life to affect my life's work in the white coat, I went against my own personal values, and I abused the privileges inherent in that role, against all four main bioethical principles. I have since made changes to my personal and professional life after completing the PROBE Program. The program taught me how to have a heightened awareness for, and approach potential ethical dilemmas from not only a personal virtue standpoint, but to apply a principle-based interrogation of the action and consider the consequences of such actions to all of the potential stakeholders. So much comes with the white coat a PA wears and I have renewed my solemn vow to first do no harm, provide healing and objective advice with moral integrity, transparency, and self-accountability. In addition to the heightened awareness, I will employ ethical "time-outs" to give myself pause should a dilemma present itself. In addition to the PROBE program, I have taken an additional HIPAA awareness course to strengthen my commitment to holding patient information in confidence. As far as providing CBD/THC or marijuana products to a minor, well, it's illegal and it is no longer a part of my life or anything I do. Because of my actions, my relationship with my family member has suffered. From the Washington State Department of Health, I utilized their website to learn about the power of influence adults have in their children's lives and how to take opportunities to set clear and specific boundaries.

In summary, Providing CBD/THC edible gummies to a minor family member and inappropriately accessing their electronic health record, crossed several ethical boundaries, placed a minor family member in harm's way, and risked potential negative physical, psychologic and social effects for them. I realize and acknowledge where I went wrong and understand why my accountability is a must to preserve that ever-so- fragile "social contract" between healthcare and society. I have grown from being held accountable and have gratitude for the experience as it has caused me to peel away the layers of what caused me to make such decisions, realize the impact of my actions on the various stakeholders in my life and my career, as well as the field of medicine, and have made the necessary changes to bring my personal and professional life into alignment so events like these never happen again.

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WMC Public Meetings

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

April - 2024

01 - HELMS - What does this mean for your license (Recording Available)

26 - Business Meeting

May - 2024

02 - Personal Appearances

24 - Personal Appearances

27 - WMC Offices Closed

June - 2024

06 - Policy: Interested Parties

13 - Personal Appearances

19 - WMC Offices Closed

27 - Policy Committee

July - 2024

04 - WMC Offices Closed

11 - Personal Appearances

19 - Business Meeting

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WMC Mission

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.

Endnotes

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