WASHINGTON
Medical
Commission
Licensing. Accountability. Leadership.

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Message from the Chair

Building Provider Relationships

Jimmy Chung, MD

Not long after starting my practice right out of residency, I received a letter from the Medical Board of California alerting me that they had received a complaint about my care from a patient's family. The patient had recently died of complications from pneumonia after an urgent bowel surgery. Although in my mind I had done everything I could do to help the patient, I was already quite distraught over her death, and receiving a letter from the Medical Board only added to my despair. Questions and doubt began to surface in my own head, and I began to lose confidence in my 10 years of training and the skills I had meticulously honed. I felt shame and confusion and kept this letter hidden without discussing it with any of my colleagues. I felt lonely and undeserving of the great privilege that was granted me to help heal others. In addition, I felt added guilt over feeling this bad myself when in reality, the patient and her family's loss was exponentially greater than mine.

Reading the letter over and over again, it slowly sank in that the letter simply requested an explanation of what had happened to the patient. I did my best to recount the events, avoiding any admission of guilt (that was what we were trained to do back then) and expressing my regret and sadness over the patient's death. I sent my response by certified mail the next morning. Since that day, I never heard from the Medical Board again.

Fast forward 22 years, and ironically, I find myself as chair of the organization where sending those letters to the physicians (MD) and physician assistants (PA) of Washington state is almost a daily routine. The Washington Medical Commission (WMC) receives dozens of complaints every week from various sources—patients, family, friends, mandatory reporters, other physicians and clinicians, other agencies, malpractice reports, other state boards, etc.

Many of these complaints result in a letter to the physician or physician assistant that describes the complaint and requires them to respond. The letters are innocuous enough, fairly standardized and not meant to sound accusatory or threatening. But the reality is that for the recipient, even the envelope with the WMC logo is enough to make their heart race and face become flush.

"There is no way we can eliminate the visceral reaction our letters can cause, and we recognize that most providers would rather not have to interact with us throughout their careers."

Message From the Chair

The mission of the WMC is "Promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rulemaking, and education." Some may presume that the word "discipline" implies "take away my license" or "pay a big fine" and "blacklist me forever." Indeed, some MDs and PAs may have experienced these as a result of a severe violation. However, what is not explicit in the mission statement is that ideally,
we strive to help physicians do what they do best and be successful in keeping Washingtonians healthy. Restricting or suspending physicians from practice is not a desired goal of the WMC if we can educate, rehabilitate, or assist them in other ways to keep working in their calling as a health professional.

In fiscal year 2022 (July 2021 – June 2022) the WMC received 1912 complaints, of which roughly 1/3 were investigated. Of these, only about 13% resulted in disciplinary action by the WMC. Almost all of these actions include requirements for continuing medical education and a report from the licensee, usually in the form of a paper that describes the clinical topic and how they have improved their practice. Despite the administrative hassles, many licensees have expressed appreciation for the WMC's help and guidance toward improving their patient care, knowledge base, and confidence.

Over the years, the WMC has slowly focused more on high reliability in prevention of errors in health care. This includes an emphasis on systems-based errors that cause individual actions to lead to harm and implementing just culture that studies all errors as process improvement opportunities without blame. We have created a new work group called HiRO (High Reliability Organization) committee which is charged with studying and recommending solutions to improve how we can help MDs and PAs with medical errors non-punitively. The WMC itself maintains high reliability practices in the way we process complaints.

There is no way we can eliminate the visceral reaction our letters can cause, and we recognize that most providers would rather not have to interact with us throughout their careers.

However, we continue to emphasize to the MDs and PAs that our goal is to be their partner, resource, and occasional guidepost to help them be the best they wish to be.

To all of our MDs and PAs, and to the public, I invite you to visit our website and learn about the WMC's achievements over the past few years and our performance in FY2022. Also check out our blog to hear from our commissioners and staff about other behind-the-scenes topics.

I also want to welcome the newest members of the WMC, Po-Shen Chang, MD, Congressional District 3, Mabel Bongmba, MD, Congressional District 9, Elisha Mvundura, MD, Physician at Large, Ed Lopez, PA-C, Physician Assistant, and Robert "Doug" Pullen, Public Member. Thank you all for your dedication and commitment to advancing the health care for our patients and communities.

Finally, I would like to acknowledge John Maldon, immediate past chair of WMC. His steadfast leadership was critical to the continuity and resilience of the commission during the most challenging times of the pandemic as we faced constant changes while maintaining the highest quality of care and public safety. I cannot overstate the difficulties that the commission faced during these unprecedented times and the grace with which John led us through them.

If you have a suggestion for our quarterly newsletter, send us an email.

Executive Director Report

Abuse of a Patient

Melanie de Leon, JD, MPA

These statements were made by patients in their complaints against the physician:

> ***"…from the first I felt extremely uncomfortable with (the doctor's) peculiar attention to my physical details unrelated to my arm injury. One of the first statements by (the doctor) upon meeting me was that I was very beautiful for my age, and that it was fortunate that there was another person present because he wouldn't dare to be alone with me."***

> ***"During the examination of my body for moles (in which a male tech was in the room) (the doctor) did not ask me to remove my gown so they could check for moles on my chest and breasts. (The doctor) did not warn me either; did not ask my permission. Instead (the doctor) grabbed the collar of the gown around my neck and ripped it hard … out and down (aggressively) - exposing my breasts (in front of the male tech) – (the doctor) exposed much more than (the doctor) needed to or should have and left it that way for a period of time. I have never had a doctor do this before."***

You may think that while these statements are inappropriate, they would not rise to the level of unprofessional conduct – but that is incorrect. Washington state has a rule regarding "abuse of a patient," a situation that you probably think means something completely different than the actual rule language, so it is important for you to read and understand exactly what the rule says. The rule is:

WAC 246-919-640, Abuse.

(1) A physician commits unprofessional conduct if the physician abuses a patient. A physician abuses a patient when he or she:

- (a) *Makes statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose*;
- (b) *Removes a patient's clothing or gown without consent;*
- (c) Fails to treat an unconscious or deceased patient's body or property respectfully; or
- (d) *Engages in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.*

(2) A violation of any provision of this rule shall constitute grounds for disciplinary action.

Please note that to violate this rule, a practitioner need only make a statement regarding the patient's body, appearance, sexual history or orientation that has no medical or therapeutic purpose. The WMC receives complaints regarding statement made by practitioners to patients almost weekly, so it is a very common complaint and one that we take very seriously. Please think before you say something to a patient and if you are going to move their gown or their clothing, please let them know what you will be doing and why.

Please familiarize yourself with this rule to make sure that you understand the ramifications of your statements as well as your actions.

Abuse of a Patient... A Clinical Perspective

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Diana Currie, MD
WMC Physician at Large

If you're like me you weren't taught anything about the laws that govern licensees in the health professions when you were in school. The goal of this article is to educate you about an important part of the law so you don't end up learning about it "the hard way."

The Uniform Disciplinary Act for the Regulation of Health Professions (UDA for short) is found in chapter 18.130 of the Revised Code of Washington (RCW). When the WMC investigates complaints from the public, we evaluate if there was 'Unprofessional Conduct' according to UDA subsection RCW 18.130.180. Listed under Unprofessional Conduct are 28 variations that constitute a violation of the UDA. Some are obvious such as: don't commit fraud, don't hire an unlicensed person in your practice, don't misrepresent yourself or your credentials, don't come to work intoxicated or with a serious infectious disease. Some are a little arcane, such as (19) "the offering undertaking or agreeing to cure or treat a disease by a secret method". One of these, (24) "Abuse of a client or patient or sexual contact with a client or patient", is unfortunately a source of many of the complaints we receive here at the WMC.

The Washington Administrative Code (WAC) for Physicians and Physician Assistants is the interpretation of the RCW. It is the means by which the RCW is understood and implemented on a practical level. The category of **abuse** (WAC 246-919-640) is an interesting one and the name, in my opinion, is a bit misleading. Personally, I think of it as behavior that could be misconstrued or experienced as inappropriate or offensive by a patient.

Many common activities that we routinely perform could be a potential violation depending upon how a patient interprets the situation. During an exam, for example, taking a patient's clothing or gown off or just moving it to one side to expose a body area *without adequate explanation and consent* is a potential violation of paragraph (b). Asking personal questions about the patient's sexuality, sex life or gender without clearly explaining why the information is relevant to the chief complaint or medical condition being evaluated is a violation of (a). Making casual comments, using casual or slang language, could be construed as disrespectful by a patient, and cause them to feel embarrassed or demeaned which could be a violation of paragraph (d). Making comments about a patient's hair, body, clothing or appearance, even as a way to establish rapport, could be misconstrued by a patient and taken the wrong way (a).

We realize this may feel unfairly restrictive, but it behooves us all to remember that we work with a wide variety of people from many different backgrounds and cultures and what we think of as a benign comment could be misinterpreted by a patient who comes from a different background than our own. It is always safest to remain very professional, use only professional language, and keep non-medical comments general and as broadly socially acceptable as possible. The general advice about steering clear of all talk of religion, sex or politics applies here as well. We receive many complaints from patients that allege the provider was inappropriate, disrespectful, rude, dismissive, arrogant and when we investigate it turns out there was a communication issue. The provider meant to be funny, but the patient was offended. The provider paid a complement, but the patient did not understand it as such. The provider said something about politics or religion and the patient felt threatened.

A frequent scenario we find when we investigate allegations about a disruptive or rude provider is the provider is trying to explain something, maybe interrupts the patient, or doesn't give weight to a certain symptom, (often because the symptom doesn't shed light on the diagnosis) and the patient feels unheard or that their concerns are brushed off as unimportant which leads the patient to feel threatened, humiliated, or angry. Our advice: try to explain your reasoning, explain what you are doing, why a concern of theirs isn't a concern for you,

"Many common activities that we routinely perform could be a potential violation depending upon how a patient interprets the situation"

Abuse of a Patient...A Clinical Perspective

and check the patient understands. If you don't know why they have a certain symptom, sympathize and tell the patient you don't know, offer follow up or a referral for a second opinion. Patients want to be taken seriously and sometimes in our hectic world we forget there is a worried human who thinks the hangnail is a cancer. Chuckling and brushing it off may lead to a call from the WMC that could be avoided with a little sympathy, brief explanation, and reassurance.

While most behavior that constitutes **sexual misconduct** is likely very apparent, it is worth pointing out some less obvious aspects of this law. Not only is it not OK to have sex with a patient, it is also not OK to have sex with a ***key third party*** which is explained 1b in the sexual misconduct WAC. Paragraph 1(g) states ***that not allowing a patient the privacy to dress or undress*** can constitute sexual misconduct. Paragraph (7) **states it is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.** Finally, for those of us who do pelvic exams all day, paragraph (6) reassures us the WAC does *not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.*

As a parting reminder to help us all stay out of trouble, the WMC has developed policies, rules, guidelines and interpretative statements to guide practitioners. These contain recommendations, opinions, and also explain the WMC's current approaches to particular issues. There is a guideline on sexual misconduct, discrimination in healthcare, informed consent and many others.

Abuse: WAC 246-919-640 (Physicians) and WAC 246-918-420 (Physician Assistants) are essentially identical.

Sexual misconduct: WAC 246-919-630 (physicians) and WAC 246-918-410 (physician associates) are essentially identical.

WA Regulation of Health Professionals and Abortions FAQ

- Will abortions remain legal in Washington state?
- How do state regulators determine discipline and licensure if Roe v. Wade is overturned?
- Who may perform an abortion in Washington state?
- May a pharmacist dispense hormonal, non-hormonal, or emergency contraceptives in Washington State?

The Full FAQ is Available on the WMC Website

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Wait Till Your Father Gets Home

Ed Lopez PA-C

I recently heard a statement from a Physician "*We are deathly afraid of the Washington Medical Commission,*" which made me take notice and ask why?

While thinking about that statement my thoughts faded off briefly to my childhood memories, as I harkened back to a time when I got into some trouble and my Mom would say, "*Wait till your father gets home!*". So for the rest of that day, I would worry about how Dad would punish me and remembered how sick to my stomach and nervous I would get just anticipating my punishment because I had realized that what I had done or how I had behaved clearly was wrong and now I had to face the consequences of my actions.

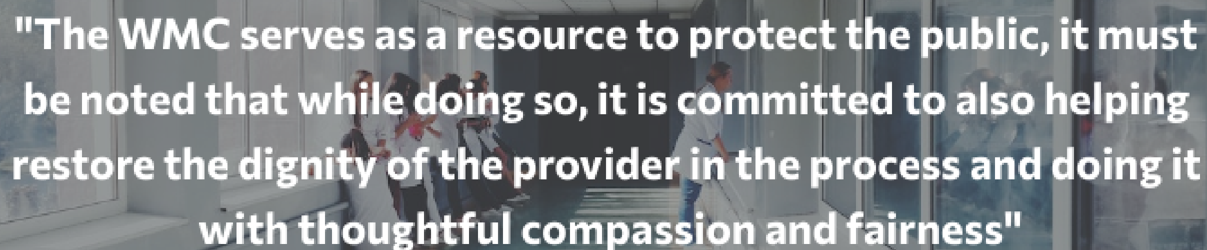
So, as I think about the Washington Medical Commission (WMC) and it's role and why some Medical Providers might feel that they may be "deathly afraid of the Washington Medical Commission", I couldn't help but think perhaps if that person had a history of "getting into trouble" then they indeed may feel "deathly afraid". But not of the WMC, but of facing the consequences of their wrongdoing, which is decided by statute and rules and not by the whims of any one person or a commission bent on revenge who might impose a "punishment for getting into trouble."

We as Physician Assistant providers must remember that we have been imbued with a sacred trust to "first do no harm" and to behave as professionals beyond reproach despite the situation. And while I and all of our commissioners realize that "to err is human", to intentionally act or behave in a way while posing as our patient's "healers", counselors and advocates, not in accordance with appropriate professional or moral standards, is not acceptable and the WMC is called upon by state statute to respond.

In the words of the WMC itself, *"It is the purpose and responsibility of the Washington Medical Commission to protect the public by ensuring quality healthcare is provided by physicians and physician assistants. The WMC establishes, monitors, and enforces qualifications for licensure, consistent standards of practice, and continuing competency. The WMC currently regulates about 34,000 licenses, more than 3,000 of which are PAs. Rules, policies, and procedures developed by the WMC promote the delivery of quality healthcare to the people in Washington"*

And while most medical providers have little or no direct contact with the WMC in our state, it is because most live and practice beyond reproach. Nonetheless the WMC may be called upon at times to properly evaluate, investigate and help adjudicate accusations, claims or notifications of something or someone gone wrong in the delivery of care by our healthcare providers in order to help protect the citizens of Washington. But while the WMC serves as a resource to protect the public, it must be noted that while doing so, it is committed to also helping restore the dignity of the provider in the process and doing it with thoughtful compassion and fairness.

In conclusion, I would like to reach out to all of my colleagues to assure them that as Washington Medical Commissioners, we are all committed to fairness and equity in everything that we do. Not only on behalf of the citizens of Washington, but also on behalf of our Physicians & PA's who have committed themselves to work tirelessly, in often very difficult professional or personal circumstances. Particularly during these last 2 years, while continuing to do the right thing while delivering some of the best healthcare in the nation.



WPHP Report: Questions and Answers

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

Since 1986 the Washington Physicians Health Program (WPHP) has served as the legally qualified 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 monitoring 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 licensing authority. 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, over half of WPHP referrals 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: Do I really have to call someone if I am worried about a colleague who may be impaired?

A: Per Washington Administrative Code (WAC's 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 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 "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 "impaired professional" 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 calling one of two agencies. You can call the Washington Medical Commission (WMC), or you can make a report to the Washington Physicians Health Program (WPHP) at 1-800-552-7236. Someone at WPHP is always available to take your call, 24 hours per day.

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 confidential, therapeutic alternative to discipline that WPHP offers. 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 comply with WPHP's evaluation process. They may be directed to take extended medical leave if impaired or at substantial risk for impairment and complete sufficient treatment before they can return to work under WPHP monitoring. If they are non-compliant with this process, WPHP has the legal obligation to make a report to the WMC as appropriate.

You have given your colleague a chance to receive confidential help without being identified to WMC or facing the risk of investigation and disciplinary action.

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-report to WPHP or to be reported 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 monitoring 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 monitoring we are obligated to notify WMC. We are also obligated 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. At this time, nearly 90% of the physicians being actively monitored by WPHP 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 Department of Health or a malpractice suit. 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. 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 Department of Health. 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 Department of Health is required. In these situations, a report to WPHP is not a substitute for reporting to the Department of Health. 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.

Updates to CME Requirements

Micah Matthews, MPA

Deputy Executive and Legislative Director

In response to the pandemic onset in 2020, the WMC and other stakeholders worked with the Governor's office to develop a set of proclamations to assist the health care system in response to the novel Coronavirus. Two years on, 12 of these proclamations are in the process of being rescinded. There are numerous impacts, but specific to physicians and physician assistants, the most significant are CME attestation requirements and the renewed requirements of practice agreements. The proclamations will be rescinded on October 27, 2022. The WMC is sending out multiple communications through its media channels and this newsletter to inform practitioners of the changes. Further information may be found on our website: Inslee announces pending rescission of Proclamation 20-32: Waivers ending, and CME requirements being reinstated.

With respect to CME, there will be a grace period of 12 months for those practitioners whose CME is due after October 27. For those whose due date fell during the period the proclamation was active, if you do not believe you will meet your CME requirements prior to your next due date, please reach out to Medical.Licensing@wmc.wa.gov to request a waiver or extension so that we may update your account.

Scammers Continue to Impersonate State Regulators: What You Need to Know

An ongoing fraud ring has been preying on healthcare practitioners for the last year. The fraudulent behavior includes: using the Washington Medical Commission (WMC) phone number, email and web URL; Impersonating Drug Enforcement Administration (DEA) agents; and posing as Department of Health (DOH) officials. All to make providers believe they are in danger of discipline or loss of license.

The scam involves using personal information to exploit you for money or information to execute scams on others.

Recent near victims of this scam were:

- Sent official looking documents on fake letterhead from the WMC and U.S. Department of Justice. The letters included forged signatures of WMC officials and fictitious investigative staff.
- Contacted via telephone to discuss the provider's "over-prescribing of opioids".
- Told they were under official investigation for drug related charges and that their license had been suspended.
- Told not to check the WMC website because that would be an admission of guilt.
- Recipients of emails from a wmc.wa.gov address.

Legitimate regulatory agencies will not:

- Ask you for money.
- Ask you to respond to any action in less than twenty days.
- Advise against speaking with a lawyer.
- Ask you to confirm personal details, passwords, or social security numbers.

Protect yourself by adhering to the following recommendations:

1. Never click on links or download attachments from suspicious senders.
2. Do not fall prey to a manufactured urgency. A vital component of this fraud is the urgency of request or demand. A legitimate regulatory agency will inform you of your rights and you have a legally protected timeframe to respond.
3. If you suspect that you are being contacted by a fraudulent regulator, you can verify the request with the WMC by calling: (360) 236-2750.
4. Restrict your online personal information. Scammers leverage information from social media accounts and other public forums.

If you have verified that you are being targeted, file a complaint with the State Attorney General and contact your local police department right away.

Legal Actions

WASHINGTON Medical Commission
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May 1, 2022 -July 31, 2022

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				
Klos, Martin M., MD MD60271665 Out of state	Order of Summary Suspension	5/24/22	Surrender of Oregon license	Summary suspension of license.
Formal Actions				
Edgerly, Richard D., MD MD00034059 Yakima County	Agreed Order	7/15/22	Prescribing ivermectin to patient with contraindication.	Restricted from prescribing ivermectin for non-FDA-approved indications; restricted from prescribing without first establishing physician-patient relationship; CME on prevention, treatment and management of COVID-19 infections; written paper; compliance audits; personal appearances; $5000 fine; may petition for termination in one year.
Enoh, Victor S., MD MD00042579 Out of state	Final Order	6/21/22	Alleged unprofessional and dishonest behavior.	Denial of application for license.
Roesler, Paul J., MD MD60316930 Out of state	Final Order (Waiver of Hearing)	5/27/22	Surrender of license in Florida.	Reinstatement of suspended license. License expired.
Skelly, Katherine G., PA-C PA60983012 King County	Final Order (Waiver of Hearing)	6/30/22	Health condition that may interfere with ability to practice with reasonable skill and safety.	Indefinite suspension.
Sutton, Joseph, PA-C PA60604531 Spokane County	Final Order (Waiver of Hearing)	7/7/22	Sexual misconduct	Revocation.
Tsen, Andrew, MD MD00043090 Out of state	Final Order	6/30/22	Oregon Medical Board restricted license.	Comply with Oregon order; personal appearances; $5000 fine.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Yoho, Robert A., MD MD00038131 Out of state	Final Order of Default	6/2/22	Surrender of license in California.	Indefinite suspension.
Informal Actions				
Adao, Cirilo, PA PA10001585 Pierce County	Stipulation to Informal Disposition	7/14/22	Alleged making of crude remark to patient.	Undergo multi-disciplinary evaluation; CME in boundaries and ethics; paper; personal appearances; costs; may petition for termination in 3 years.
Balogun, Anifat O., MD MD00039276 King County	Stipulation to Informal Disposition	5/26/22	Alleged aiding or abetting unlicensed practice.	Ethics course; written paper; personal appearances; costs; may petition for termination in one year.
Carter, Randi G. PA-C PA10003174 Spokane County	Stipulation to Informal Disposition	7/14/22	Alleged failure to send excised tissue to pathology that turned out to be cancerous.	CME on diagnosis and treatment of skin cancers; paper; peer group presentation; personal appearances; costs; may petition for termination in one year.
Flaugher, Carol E., PA-C PA10002620 Walla Walla County	Stipulation to Informal Disposition	5/26/22	Alleged going to work in impaired condition but did not see patients.	Comply with WPHP contract; personal appearances; costs; may petition to terminate in three years.
Goody, Brian, PA-C PA.60316095 Grays Harbor County	Stipulation to Informal Disposition	7/14/22	Alleged unauthorized access to co-worker's electronic medical record and going to co-worker's home.	CME on boundaries and ethics; CME on confidentiality and ethics; personal appearances; costs; may petition for termination in 3 years.
Jain, Manas, MD MD60244399 Kitsap County	Stipulation to Informal Disposition	5/26/22	Alleged failure to immediately refer patient to oncologist following diagnosis of prostate cancer.	CME on intraductal carcinoma of prostate; written paper; personal appearances; costs; may petition to terminate in two years.
Jordan, Timothy W., MD MD00046301 Spokane County	Stipulation to Informal Disposition	5/26/22	Alleged unprofessional communication with pediatric patients.	Consultation with professional coach to improve behavior and communication skills; personal appearances; costs; may petition to terminate in two years.
Kinane, Thomas J., MD MD00019971 Out of state	Stipulation to Informal Disposition	7/14/22	Alleged failure to cooperate with investigation.	Surrender of license.
McClelland, Jesse MD60133293 King County	Stipulation to Informal Disposition	7/14/22	Alleged providing of psychiatric care to a patient with whom he had a business relationship, and not properly documenting informed consent; and poor documentation of treatment of a second patient.	CME in medical documentation; paper; develop a template for medical records; personal appearances; costs; may petition for termination after completing requirements.

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 amendment exempts 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 commission is also exempting patients in RHCs and RTFs.

In response to the filing, the WMC conducted an open public rule hearing on May 27, 2022. At the hearing, the Commissioners adopted revised draft language. The revised draft language can be found in the hearing packet by clicking here. The next step in the rules process is the CR-103, or Rulemaking Order. The CR-103 is in progress. The revised language will be in effect 31 days after the filing of the CR-103. The hearing can be viewed here.

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 they 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.

Rulemaking Efforts

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.

In response to the filing, the WMC conducted an open public rule hearing on August 26, 2022. At the hearing, the Commissioners adopted revised draft language. For a copy of the revised language, please send your request to medical.rules@wmc.wa.gov. The next step in the rules process is the CR-103, or Rulemaking Order. The CR-103 is in progress. The revised language will be in effect 31 days after the filing of the CR-103. The hearing can be viewed here: August 26, 2022, Business Meeting & Rules Hearing (IMG License) it begins at 29:27 and ends at 1:03:40.

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.

Reminder: Suicide Prevention CME Requirement

As providers may know, September is National Suicide Prevention Awareness Month. To help educate physicians and physician assistants on suicide prevention and awareness, the Washington Medical Commission (WMC) provides the following reminder regarding continuing medical education (CME) and self-care to address suicide prevention.

In 2014, RCW 43.70.442 was amended to extend mandatory suicide prevention education requirements to include other health professionals beyond behavioral health and social work. Washington physicians and physician assistants became statutorily required to "complete a one-time training in suicide assessment, treatment, and management that is approved by the relevant disciplining authority".

The WMC is taking the opportunity presented by National Suicide Prevention Awareness Month to remind all licensees about the CME requirement and to be mindful of their own mental health when considering suicide prevention. The WMC promotes self-care as an essential part of medical practice, both for providers and for the patients they treat.

The WMC is sharing an example of a course that fulfills the suicide prevention CME requirement. The course is being offered by the University of Washington Psychiatry and Behavioral Sciences, entitled All Patients Safe. This online asynchronous course is currently available for free to Washington providers who provide care to Washington patients (with a $25 fee to obtain CME credit).

The WMC encourages providers to review the statutory requirement regarding suicide prevention CME, to ensure compliance with that requirement, and to promote self-care in an effort to help save lives.

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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.