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Washington Medical Commission

Update!

In This Issue...

Message from the Chair

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

The Importance of Reflection

Karen Domino, MD, MPH

Greetings to all Physicians (MDs) and Physician Assistants (PAs) practicing in Washington State! It is an enormous honor to be Chair of the Washington Medical Commission (WMC)! In my first "Message from the Chair," I will recognize three individuals at the WMC and then introduce myself.

Jimmy Chung, MD, immediate past chair of the WMC, has been instrumental in introducing the focus of high reliability in health care, through the High Reliability Organization (HiRO) work group. High reliability principles emphasize the importance of systems in medical errors and focus on a "just culture". This culture treats medical errors as process improvement opportunities without blame. The WMC has been working hard to implement these principles in their review of medical error complaints. The WMC investigators now include principles of communication and resolution processes in investigation of medical error complaints. The WMC also maintains high reliability practices in the processing of patient complaints.

Melanie de Leon, JD, MPA, Executive Director of the WMC retired this month after nine (9) years leading the WMC. Ms. de Leon did an outstanding job bringing the WMC to the forefront of state medical boards in the US. She instituted a new process for handling sexual abuse cases by establishing Sexual Misconduct Assessment and Review Teams (SMART). She also dramatically reduced turnaround time for new medical licenses in WA State, something that has benefited all medical practices over the past few years.

Kyle S. Karinen, JD, former Supervising Staff Attorney at the WMC, is the new Executive Director. As well as being a superb attorney, he has outstanding communication and personal skills and is committed to continually improving the WMC. He is open to meeting with MDs and PAs, as he did recently with the Pain Telemedicine group.

As far as my background: I am a professor of Anesthesiology and Pain Medicine and an adjunct professor of Neurologic Surgery at the University of Washington (UW). I attended medical school at the University of Michigan where I grew up. I did my anesthesia residency and fellowship at the University of Pennsylvania. My first academic position was at the University of Pittsburgh. After my husband finished medical school there, we moved across the US where I joined the faculty at the UW and worked clinically at Harborview Medical Center. For the past 20 years, my research focus has involved quality improvement and patient safety in perioperative care and pain medicine. I have practiced at the University of Washington Medical Center-Montlake for the past decade.

My experiences caring for underserved and trauma patients at Harborview motivated me to work on an MPH degree at the UW during my pre-and post-call time. Harborview also inspired me to apply for the Robert Wood Johnson Health Policy Fellowship program in Washington DC. Fortunately, I got into the program and spent a year and half in DC. I worked as a legislative assistant in the Health Subcommittee of the House Ways & Means Committee, which focuses on federal funding of health care (Medicare, Medicaid, Affordable Care Act). Additionally, I received broad exposure to other aspects of federal health policy and met with MDs, PAs, and other health professionals from Michigan and WA State during their advocacy meetings with legislative staff. When I returned to Seattle, my policy exposure made me interested in working on health policy in WA State and submitted my WMC application. I am the previous Chair of the WMC Policy Committee.

Message from the Chair

When I worked in Congress, I frequently visited the reflecting pools near the US Capitol. These ponds remind our nation's Senators, Congressmen, and legislative aids to reflect about the impact of their policies on the public. Reflection is important for all involved in government, including members of the WMC.

The mission of the WMC is to "promote patient safety and enhance the integrity of the profession through licensing, discipline, rulemaking, and education." Our goal is to help MDs and PAs provide excellent care to keep people in WA state healthy. Over the last few years, there have been enormous changes in the philosophy, policies, and diversity of the WMC. Reflection on the role of the WMC, the profound stresses of COVID-19 on health care workers, and the role of systems issues in medical errors have resulted in significant changes to the WMC. In addition to modifications in investigation of medical error complaints described above, the WMC instituted a process to address an inappropriate referral of a complaint for investigation through a practitioner support program. This program sends educational information to the practitioner to help them improve their practice and avoids the need for a WMC investigation.

The WMC also is cognizant of the emotional toll of COVID-19 and post-COVID eras for MDs and PAs. The stresses of providing care during the first year of COVID-19 and the post-COVID production push with inadequate numbers of practitioners has resulted in huge rates of burnout. While emergency medicine physicians have the highest rates of burnout as they worked on the front lines during COVID-19, the American Medical Association has reported that over 50% of all physicians in most specialties are suffering from burnout. Burnout results in poor communication with patients and health care team members, more medical errors, and retirements. Thus, improving MD and PA health is also an important mission of the WMC.

This is an important era in the health care profession and for the WMC. I am excited to embark on this journey with you.

Executive Director Report

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

Greetings to all. After nine years of service as the Commission's Executive Director – and many more in state service and the military – Melanie de Leon stepped down. In July, I accepted the Commission's offer to succeed her. I say "succeed" because replacing Melanie is not in the cards. For those who knew and worked with her, she was a tireless advocate on so many fronts that I could devote multiple newsletters to listing them. On the policy side, she led the Commission through a major revision of opioid-prescribing rules, multiple revisions to the Commission's licensing rules, and significant changes in the way the Commission investigates allegations of sexual misconduct. On the operational side, Melanie oversaw the re-structuring of the Commission's staff that has resulted in unprecedented efficiency in licensing processing as well as converting the Commission to entirely digital processes. Finally, Melanie led the Commission through the pandemic and the nearly overnight move to remote work. Underlying all of these achievements was a commitment to patient safety that served as a touchstone for all of us who were fortunate enough to work under her leadership. She will be missed.

What is on the horizon for the Washington Medical Commission?
In the immediate future, the Commission is involved in a number of issues that affect physicians, physician assistants, and members of the public. It's difficult to narrow down what may be interesting or noteworthy, but there are three (3) issues worth at least a short mention here.

Rule-making
The Commission is currently engaged in active rule-making around the opioid prescribing rules. The primary focus for this rule-making effort will be on three recommendations: 1) exempting sickle cell disease from the opioid prescribing rules; 2) clarifying the rules regarding the possibility that tapering some chronic pain patients may not be clinically-indicated; and 3) clarifying the rules around biological specimen testing. The first virtual workshop for this rule-making was held on Monday, September 18. The recording can be viewed here.

The Commission has moved its policy and business meetings to a quarterly schedule. Those meetings will be conducted virtually to maximize the opportunity for interested parties to observe and participate. The goal of these latter changes is to continue to maximize the efficiency of these meetings while also maintaining accessibility.

I I am an attorney by training. After several years of private practice, I came to the Department of Health in 2011 and then the WMC in 2017. Although that training and experience certainly informs my approach to the issues the Commission faces in the future, I also draw on a lifetime of other experience – my grandmother and mother were both nurses and my oldest sister is a nurse. Prior to law school, I worked in hotels, commercial fisheries, carpentry, and construction. In short, I come to the Executive Director post with an approach that has been informed by a multitude of experiences and not just those formed in law school or practicing law.

2022 Audit
In 2021, the Legislature passed a bill requiring the Commission to contract with the State Auditor's Office to undergo a performance audit with regard to: 1) the amount of time it takes to license an applicant; and 2) a comparative analysis of the Commission's disciplinary processes to those in other states. That process finished in May 2023 and the final audit report contained nine recommendations. Some of the recommendations require legislative changes to allow the Commission and a few others are dependent on the arrival of the new licensing and regulation database, i.e. the Healthcare Enforcement and Licensing Management System (HELMS).

Executive Director Report

A handful of the others are being piloted through changes the Commission has made to its internal processes. The full audit report, which includes the Commission's responses to the recommendations, is available through the Office of Washington State Auditor's website.

Operations
On the operational side, the Commission has made several changes in the past year. First, as many of the public health measures around the SARS-CoV-2 pandemic have largely receded, the Commission has taken the opportunity to significantly reduce its physical office space. The vast majority of the Commission's staff continue to work remotely, and the plan is to continue that practice. Additionally, the Commission has moved its policy and business meetings to a quarterly schedule. Those meetings will be conducted virtually to maximize the opportunity for interested parties to observe and participate. The goal of these latter changes is to continue to maximize the efficiency of these meetings while also maintaining accessibility. A full list of upcoming public meetings can be found on our website.

There are a handful of other initiatives the Commission is considering that I will describe in upcoming newsletter articles. In the meantime, please don't hesitate to reach out to me if I can be of assistance. My direct phone line is (360) 236-4810 and my email address is kyle.karinen@wmc.wa.gov.

By The Numbers

Notifiable Conditions Rule Revisions

The State Board of Health adopted revisions to the Notifiable Conditions chapter of Washington Administrative Code (WAC) which became effective January 1, 2023. For a complete list of notifiable conditions and the requirements, see WAC 246-101. For more information, see the Department of Health's page: Notifiable Conditions. The updated posters for HealthCare Providers and Facilities and Clinical Laboratories can be found on the Reporting Notifiable Conditions page and are linked below:

- Notifiable Conditions and the Healthcare Providers and Facilities (PDF)
- Notifiable Conditions and the Clinical Laboratory (PDF)

Additionally, the COVID-19 provisional reporting letter was recently updated and can be found in the Provisional Reporting Notifications section of the Notifiable Conditions page. The direct link to the letter: COVID-19 Provisional Reporting Letter

More information about the Notifiable Conditions rulemaking can be found on the Board's rulemaking webpage. Please direct any questions to notifiableconditions@sboh.wa.gov.

Physician Assistant News

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Communication Is Connection

Ed Lopez, PA-C

For as long as I can remember my now 94-year-old Latino mother would say, "*Mi hijo, hablando es como la jente se entienden."* Which translated is to say, "*Speaking/ communicating is how people understand themselves".* And as I have gotten older, I have realized more and more how important and vital those few words were and are today.

There seems to be one topic that is the most frequently brought up by most complainants and fits into one single subject.... Communication

I now have been a commissioner for over a year and have within that year reviewed conservatively an estimated 200 complaints involving Physicians, Physician Assistants, Nurses, Hospitals, Clinics, poor scheduling, lack of empathy, not enough pain meds, insults, verbal abuse, lack of clinic parking, rudeness and among those complaints some very serious and some not so serious. But within all of those reviewed complaints there seems to be one topic that is the most frequently brought up by most complainants and fits into one single subject.... *Communication,* It's either lack of or poor communication. In fact, anecdotally I can say that at least one third of complaints I have reviewed had a communication origin. Now that is what you call "statistically significant" and cannot nor should be ignored! In fact according to Dave Martinez, VP of Enterprise & OEM Accounts in his article of April 8, 2019 in LinkedIn Online titled, *The 3 Most Common Patient Complaints and How To Fix Them*, he asserts, "*Insufficient communication is a constant source of complaint."*

So bear with me a moment as I get rudimentary here. What is communication? The Oxford Dictionary defines it as "*the imparting or exchanging of information or news."* Others describe the essential elements of communication as having the 5 C's which are: clarity, correctness, completeness, being concise, and compassion. Yes... we all know what it is, but how or why do we fall so short in successfully achieving this most essential of all human interactions? Well.... I am not planning to bore or insult you with a treatise on the how's and why's of poor communication as this is extremely complex.

However, what I would like to say is that it doesn't take a PhD, MD, PA or any other degree to properly communicate with someone. It is an essential human process of interaction that we do every day with every encounter that we have wherever we may find ourselves. Whether it's picking up our laundry at the cleaners, grocery shopping at Walmart or speaking with our spouse or our children, what is essential is the how and what we say that can arouse another's anger, suspicion or resentment or exhibit kindness, compassion and love! This includes whether we are the initiator or the receiver. Which begs the question, as PA's and Physicians, to who may be more in need of our compassion, kindness and love than those that we care for when they come to us often times broken and hurting mentally, physically and spiritually.

And look, I'm not so naïve as to think that this is an easy task! I have been in clinical practice in the hospital, the out-patient clinic, the jail, in the O.R, the penitentiary, at death row, at a locked involuntary psychiatric unit and a variety of other places for the last 40 years and have been threatened, humiliated by racial and ethnic slurs, thrown out of rooms as well as hugged and kissed. I have learned more about the human condition and realized that my work is NOT about me but about those I care for at that moment - who are in my charge. I am constantly reminded that I must maintain my physical, spiritual and mental health if I am to be the best version of myself to those I care for.

I do not have to remind any of us that America is in the midst of an existential social crisis where racial, ethnic, cultural, political and gender hatred, insensitivity and intolerance has become tolerated, encouraged and even celebrated. As the "healers" in our society we are looked upon to be part of the solution to this social crisis and NOT part of it. We must do our best to be the "repairers of the breach" that we are experiencing in our society.

Physician Assistant News

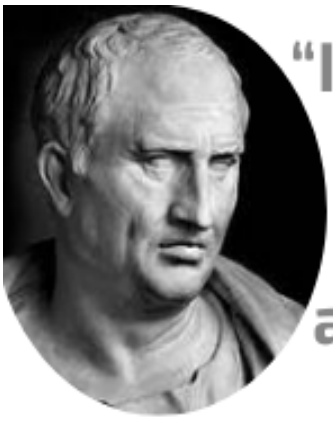
Remember, what we do is of the most honorable of any profession.

Most, if not all of us, entered our profession to be of help to others in need. Remember the excitement we felt when we saw that first sick patient alone, figured out the diagnosis ourselves, wrote the treatment plan for the patient and saw them again later to see how well they did and how happy they were with our treatment and advice. We were thrilled because we helped someone, and they got better because of what we did AND what we SAID! Americans are not going to stop complaining but I am hopeful that they stop complaining about us. I entreat you to not forget why you do what you do! We need you to be the "healer" that you chose to be.

I leave you now with thoughts to ponder as you continue on your personal and professional journey.

"Wherever the art of Medicine is loved, there is also a love of Humanity."

— Hippocrates



"In nothing do men more nearly approach the gods than in giving health to men."

—Cicero (106 B.C. - 43 B.C.

HCA Starts with One Campaign

The WMC is excited to share information about the Washington State Health Care Authority's (HCA) *Starts with One* campaign which is designed to inform and educate young adults, their parents, and older adults about the dangers of prescription opioid misuse and the importance of safe storage, responsible use, and disposal. HCA is currently working to increase awareness of the ways in which hospitals and hospital-based prescribers can help educate patients and prevent opioid misuse before it starts.

As health care providers, we can help influence the choices our patients make. By having honest conversations and discussing locking up opioid medications in the home or disposing of unused or expired prescriptions at a safe medication return kiosk — we can help them make choices that protect the health of their loved ones and prevent opioid misuse in our communities.

We urge you to take a look at the resources available on the campaign website **here.** Materials such as posters, informational rack cards and more are available upon request through the form on the site. If you have a specific need or request or would like more information about the campaign, you are welcome to email Katie Lewis (katiel@wearedh.com) who is managing this effort.

Rulemaking Efforts

WASHINGTON Medical Commission
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Amelia Boyd
Program Manager

Health Equity Continuing Education for MDs and PAs
The WMC officially filed a CR-101 with the Office of the Code Reviser on February 10, 2023 as WSR# is 23-05-054. The WMC is considering adopting a new section in chapter 246-918 WAC (physician assistants) and 246-919 WAC (physicians) to meet the requirements of Engrossed Substitute Senate Bill 5229 (Chapter 276, Laws of 2021) regarding health equity continuing education (CE). The Department of Health created model rules, WAC 246-12-800 through 246-12-830, to comply with the bill codified in RCW 43.70.613. The WMC will consider these model rules as part of this rulemaking. The WMC will also consider whether additional CE hours and course topics should be included.

The Washington Medical Commission (WMC) officially filed a CR-102 with the Office of the Code Reviser on August 23, 2023. The WMC is proposing new sections of rule to establish health equity continuing education (CE) requirements to implement Engrossed Substitute Senate Bill (ESSB) 5229 (chapter 276, Laws of 2021). The WSR# is 23-18-007.

In response to the filing, the WMC will conduct an open public rules hearing on Friday, October 20, 2023, beginning at 8:30 am. This hearing will be held virtually via Teams. Please register for this Rules Hearing here. After registering, you will receive a confirmation email containing information about joining the webinar. This hearing will be open to the public and the WMC encourages your participation. The hearing will be held in conjunction with WMC's Business meeting, which will begin as soon as the hearing is adjourned or by 9 am, whichever is later.

The CR-102 Proposed Rulemaking filed document can be viewed here.
Physical location for rules hearing:
Department of Health,
111 Israel Rd SE, Room 145
Tumwater, WA 98501

Postgraduate Medical Training, WAC 246-919-330
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.

Workshops for this rulemaking will be scheduled soon and the details for the workshops can be found on the Rules & Regulations in Progress page of our website.

Amended: 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 rule was filed on July 13, 2023, as WSR #23-15-056.

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.

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

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. Workshops for this rulemaking will be scheduled soon and the details for the workshops can be found on the Rules & Regulations in Progress page of our website.

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. 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.

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.

The Washington Physician Health Program CARES for Physicians and PAs

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

The following is a fictional account created for the purposes of illustrating how the Washington Physicians Health Program (WPHP) works with health care providers. In this example "Cary" is a composite of multiple cases and no identification with actual persons (living or deceased) is intended or should be inferred.

Cary is a 42-year-old physician with increasing stress and difficulty at work over the past couple of years. It all seemed to start when he and his partners sold their practice to a large regional healthcare organization. Almost overnight, it felt like what was once an intimate and supportive practice environment had turned into a tsunami of productivity demands and prior authorization requests, more time in the electronic health record, and less time with patients.

The longer hours at work worsened an already strained marriage, leading to divorce and a bitter child custody battle. Cary thought he might be getting depressed but could not find the time to talk with anyone about it. Then the pandemic hit - worsening Cary's isolation and compounding the financial fallout of the divorce. Restful sleep was becoming increasingly elusive without the help of a nightcap or some Ambien - sometimes both.

Cary was having trouble concentrating at work, chronically behind on his charting, and sometimes late or hurried at work after oversleeping. Colleagues started to notice, quietly worried about Cary, even speaking amongst themselves at times, reluctant to talk with him directly. They knew the rough sketch of what he had been through in the past couple of years and wanted to give him some space. They did not want to pry and did not need to know the gory details. Plus, Cary could be surly with nurses and medical assistants over minor issues. Nobody was eager to ruffle his feathers. However, as time passed, it became increasingly difficult (and awkward) to ignore the situation. There were growing concerns of Cary's ability to practice safely. Something needed to be done, and fortunately, Cary's physician supervisor knew what to do.

The Washington Physicians Health Program (WPHP) has served physicians in Washington for over 30 years. Despite this fact, many have neither heard of WPHP nor understand how it works. Even among those who have some awareness of WPHP, misconceptions abound. Understanding how your physician health program supports you and your peers can help you to effectively utilize this resource should the need arise.

WPHP is a physician-led, non-profit organization whose mission is to facilitate the rehabilitation of healthcare professionals who have physical or mental conditions that could compromise patient safety and to monitor their recovery. Our work is based on a simple and highly effective model: confidential help, not discipline, best promotes a healthy and safe healthcare workforce. WPHP works and our program participants, their families, patients, and communities benefit from our efforts.

WPHP is not part of the Washington Medical Commission (WMC). However, we have a contract with the Department of Health (DOH) which, combined with enabling legislation, allows concerns of impairment to be reported to us in lieu of a report to the WMC. Impairment, by definition, is the inability to practice with reasonable skill and safety to patients due to a health condition. All licensed healthcare professionals are required by law to report healthcare workers who might be impaired to their appropriate regulatory entity. That said, if the concern involves licensees served by WPHP, including physicians and PAs, you are legally permitted to call us instead of the medical commission so long as the illness has not resulted in harm to a patient. WPHP can help with any potentially impairing health condition including psychiatric, substance, non-psychiatric medical conditions, cognitive concerns, burnout, and interpersonal issues.

85-90% of those participating in WPHP today do so without any knowledge or involvement of their licensing board. Some are self-referred to the program, having heard the stories of lives and careers changed for the better, and others have been referred by employers, credentialing entities, or concerned others such as colleagues or family members. Those who are known to their regulator are usually cases in which no one called WPHP when concerns of impairment began to surface and, eventually, someone filed a complaint with DOH instead. Rarely, WPHP must notify the regulator that a professional may not be safe to practice. We work hard to avoid this outcome whenever possible, but we also know that the privilege of the confidential opportunity we offer is conditioned upon balancing the professional's needs with public safety.

WPHP Report

Cary's WPHP journey began with a call from his supervisor to WPHP. The supervisor was not sure if he was ready to make a referral, but he remembered a presentation from WPHP where he learned that WPHP is available anytime for consultation, even anonymously. During the call, WPHP outlined some of the reasons the physician might wish to proceed with a referral:

Confidentiality: Privacy is protected
Advocacy: Reassurance of safe practice is needed
Report: Discharge the responsibility to report a concern
Ease: Reduce stress and worry for yourself and others
Support: Access world-class care for a health professional in distress

At the end of the call, the supervisor decided to discuss the matter with the chief medical officer and then together they would talk with Cary and let WPHP know how things went. Two days later, Cary called us. He was not happy to have been referred to WPHP but agreed to the referral in lieu of being placed on administrative leave.

During his initial call to WPHP, Cary was given the opportunity to discuss the situation from his perspective, learn more about the program, and what the process would look like if he chose to move forward. He learned that information he discussed with WPHP would not be shared with his employer, the medical commission, or anyone else without his consent. With these reassurances, he gave an overview of his difficulties in the prior few years and admitted that it might be helpful to talk in some more detail.

Cary scheduled an initial assessment which included toxicology testing, a cognitive screen, and clinical interview. The clinical team then met to discuss his case and formulate a plan. Cary was recommended to complete a comprehensive diagnostic evaluation at a WPHP-approved facility qualified in the evaluation of safety-sensitive healthcare workers. Initially, Cary was reluctant and angry about the referral for additional evaluation. He thought he was being railroaded by WPHP and questioned our expertise and motives. He had read some stories online about doctors who were mistreated by PHPs and wondered whether there was any truth to them. WPHP answered all of Cary's questions, reviewed program outcome and satisfaction data with him, and encouraged him to take time to discuss his options with his key supports, his employer, and even an attorney if needed. Ultimately, Cary was able to begin trusting WPHP and decided to proceed with the evaluation.

Cary was diagnosed with untreated recurrent major depression dating back to early college and a mild alcohol and sedative/hypnotic use disorder. He was surprised because the evaluation process was much more valuable than he expected - Cary felt like he was beginning to connect the dots and gain a better appreciation for the causes of his unhappiness. He discovered he was suffering from professional burnout, which was contributing to his depression and maladaptive use of substances. He was referred to a mental health counselor, psychiatrist, and primary care physician and enrolled in a one-year behavioral health monitoring agreement that included toxicology monitoring for abstinence from drugs and alcohol. WPHP obtained quarterly treatment updates from his health care providers and, in turn, WPHP provided quarterly verification of safety to practice to his employer without the need to disclose any private health information.

After a year of monitoring, toxicology testing was discontinued. However, Cary asked to continue in the other program elements for another 6 months because he was benefiting from the coaching, support, and accountability that he was receiving. He told his case manager, "This past year has been better than I could have ever imagined. I thought I would miss the alcohol or have trouble stopping Ambien, but I've learned healthier coping methods and my depression is way better. I was resentful at having to come here at first, but now I am grateful for how much things have improved. I'm getting along better with my ex, and I'm more present for my kids. I want to keep the momentum going."

Cary continued in his therapy and began dating a woman in the running group he joined. He cut back his hours at work and, ironically, his work RVU productivity and income improved as his burnout lessened. At program discharge, Cary's worksite monitor (the supervisor who referred him to WPHP) remarked that, not only had Cary's performance concerns improved, but he was a model physician in the group and seemed to enjoy his practice more. He said, "Cary actually thanked me for sending him to WPHP!"

It might be tempting to imagine that the foregoing narrative is an overly optimistic portrait intended to shamelessly promote WPHP. However, it is outcomes like Cary's that get me out of bed in the morning. Cary's story, while fictitious, exemplifies the rule rather than the exception. However, you do not need to take my word for it. Visit our website and review the outcomes in our annual report. Read our participant success stories and watch an inspiring video. Know that where there is despair, we offer hope.

WPHP Report

I am grateful that physicians and PAs continue to choose and support WPHP. You have helped make us a national leader among physician health programs, an accomplishment that benefits all we serve. Beyond our direct service to program participants, know that we are also working tirelessly to advocate on behalf of the professions that underwrite our work, that we are always in your corner and ready to help. With concerns about physician burnout, mental health, and suicide at an all-time high, our mission and partnership with you could not be more critical.

Need help or have further questions? WPHP **CARES** for you and is ready to help!

Call 800-552-7236 or visit www.wphp.org

COVID-19 Disaster Cascade Recovery Updates

October 18, 2023 12:00 – 1:00 PM PST

Register Here

In this webinar, Dr. Mauseth will identify current trends in behavioral health, recommend specific evidence-based resilience and coping strategies for at-risk populations, and increase awareness and facility about cross-cultural communication and behavioral health issues.

Educational Objectives

Upon completion of this educational activity, participants should be able to:

1. Identify current trends in behavioral health.
2. Recommend specific evidence-based resilience and coping strategies for populations at risk.
3. Create awareness and facility about cross-cultural communication about behavioral health issues.

The webinar will be recorded and continuing education is available for physicians and PAs.

Continuing Medical Education

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Federation of State Medical Boards, the Washington Medical Commission, and the Washington State Department of Health. The Federation of State Medical Boards is accredited by the ACCME to provide continuing medical education for physicians. The Federation of State Medical Boards designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Age-based Discrimination in Healthcare

WASHINGTON Medical Commission
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Mahlet Zeru, MPH
Equity and Social Justice Manager

Older adults are disproportionally impacted by health disparities due to the complex and inter-related social, economic, and overall well-being that work together to limit equitable access to quality medical care. Age discrimination in healthcare is the unfair or biased treatment of individuals based on their age within the healthcare system. This discrimination can take many forms to significantly impact the quality of care and overall health outcome for older individuals.[1]

Societal stereotypes that characterize older adults as frail, burdensome, senile, and dependent are shared by providers and observed in clinical setting.[2 3] Providers implicit bias has an impact on patient-provider interactions leading to under diagnoses/treatment. A literature review of pain prevalence studies among nursing home residents collected from 1990-2009 illustrated the insufficient use of analgesics for treating residents with pain.[4]

Additionally, providers assumptions about the process of aging leading to treatable conditions to be dismissed as age-related problem rather than atypical symptom of illness. A complete assessment is especially important for emergency care as a third of older patients present with atypical presentation.[5] The absence of fever with a disease known to cause fever was the most common atypical presentation.[6]

Age based discrimination is also observed in breast cancer surgical options by medical students. A 2001[7] and 2006 study published in Tennessee Medicine indicated medical students still demonstrate age bias against older women in their recommendations of breast conservation and breast reconstruction.[8]

Older patients may not receive appropriate diagnostic testing or treatment options due to age-related biases. A 2021 review presented in the educational book for American Society of Clinical Oncology found that across multiple cancer types, cancer treatment outcomes among older age groups to be inferior then those among younger patients.[9] Older patients cancer treatment arises "complicated by the need to adapt treatment to baseline health, fitness, and frailty, all of which vary widely within this age group."[10]

Age discrimination can also lead to poor communication between the provider and older patients. Under estimation of patients' cognitive ability may lead to providers not taking time to explain treatment options.

Older patients may also not be involved in decision making or be provided with sufficient information to make informed decisions about their care.

Addressing age discrimination in healthcare is essential to ensure equitable medical care to patients of all ages. It is important to raise awareness of the care disparity experienced by older patients and provide training on cultural competence and bias recognition to minimize age-related biases. Additionally, advocating for the rights of older patients and promoting policies that protect against age discrimination can contribute to fair and equal access to healthcare for all age groups.

Resources

Health Equity Continuing Education Providers can select courses from the list complied by DOH to learn more about implicit bias and satisfy the ESSB 5229 requirements of health equity continuing education training. (Training must be taken at least once every four years).

Geriatric Medicine CME For providers who care for elderly patients.

Endnotes for this article can be found on page 14

Age-based Discrimination in Healthcare Endnotes

1. National Institutes of Health: Goal F: Understand health disparities related to aging and develop strategies to improve the health status of older adults in diverse populations (2023) https://www.nia.nih.gov/about/aging-strategic-directions-research/goal-health-disparities-adults
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3. Stubbe D. E. (2021). Check Your Ageism at the Door: Implicit Bias in the Care of Older Patients. Focus (American Psychiatric Publishing), 19(3), 322–324. https://doi.org/10.1176/appi.focus.20210010
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9. Dharmarajan, K. V., Presley, C. J., & Wyld, L. (2021). Care Disparities Across the Health Care Continuum for Older Patients: Lessons From Multidisciplinary Perspectives. American Society of Clinical Oncology educational book. American Society of Clinical Oncology. Annual Meeting, 41, 1–10. https://doi.org/10.1200/EDBK_319841
10. Dharmarajan, K. V., Presley, C. J., & Wyld, L. (2021). Care Disparities Across the Health Care Continuum for Older Adults: Lessons From Multidisciplinary Perspectives. American Society of Clinical Oncology educational book. American Society of Clinical Oncology. Annual Meeting, 41, 1–10. https://doi.org/10.1200/EDBK_319841

Health Equity Continuing Education Training Website

The Department of Health has developed a website for healthcare providers regarding the new health equity continuing education (CE) requirements. Engrossed Substitute Senate Bill 5229 (Chapter 276, Laws of 2021) requires healthcare providers to take two hours of health equity CE every four years. You can access the website at
Health Equity Continuing Education | Washington State Department of Health

On the webpage you will find:

- Background information
- Course requirements
- Free trainings
- Paid trainings
- Educational opportunities

The WMC is in the process of creating rules to address this requirement. You can find the draft rules here. For more information, please contact us at medical.rules@wmc.wa.gov.

Legal Actions

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

May 1, 2023 -July 31, 2023

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				
Bothamley, William C., MD MD00033514 Klickitat County	Order of Summary Suspension	7/26/23	Alleged health condition prevents licensee from practicing with reasonable skill and safety.	Indefinite suspension of license.
McQuivey, David P., PA PA10003472 Out of state	Order of Summary Restriction	5/16/23	Alleged inappropriate prescribing of testosterone.	Restricted from prescribing or managing hormones.
Formal Actions				
Agustsson, Thordur S., MD MD60403910 Mason County	Final Order-Waiver of Hearing	6/1/23	Inappropriate prescribing of medication and failure to maintain medical records.	Indefinite suspension of license and reprimand.
Bosma, Angela L., PA PA60660199 Yakima County	Agreed Order	7/13/23	Providing opioid medication to a co-worker; inappropriate prescribing of controlled substances to patients.	Restricted from prescribing controlled substances; course on ethics and boundaries; CME on proper prescribing; paper; register with and regularly query PMP; personal appearances; fine. May petition for termination in 3 years.
Brecht, Kristine S., MD MD00044369 King County	Final Order	7/18/23	Failure to comply with Commission Order by performing procedures requiring sedation.	Suspension of license for five years; Acumen assessment; restricted from practicing in a solo setting; mini-residency; personal appearances; fine.
Filgas, Frances MD MD61002719 Out of state	Final Order on Default	5/4/23	Medical Board of California placed Licensee's license on probation.	Indefinite suspension of license.
Greenwood, Nick C. MD MD60178937 Out of state	Final Order on Default	5/25/23	Surrender of license to practice medicine in Utah.	Indefinite suspension of license.
Hyson, Morton MD MD60619965 Out of state	Final Order on Default	5/5/23	Surrender of license to practice medicine in Oregon.	Indefinite suspension of license.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Formal Actions				
Jutla, Rajinder MD00047987 Out of state	Final Order	7/11/23	A health condition prevents licensee from practicing with reasonable skill and safety.	Revocation of license.
Kimura, Irene MD MD00032455 Grant County	Final Order	7/18/23	Incompetent and negligent care to three patients; violation of opioid rules; failure to cooperate with an investigation; borrowing money from a patient and prescribing medication in exchange in lieu of making interest payments.	Revocation of license.
Russell, Trent J. PA PA60578902 Clark County	Final Order on Default	5/25/23	A health condition prevents licensee from practicing with reasonable skill and safety.	Indefinite suspension of license.
Stone, Joseph J. MD MD60621765 Out of state	Final Order-Wavier of Hearing	6/1/23	Surrender of license to practice medicine in California.	Indefinite suspension of license.
Wingfield, Guito C., MD MD00048810 Lewis County	Final Order	7/19/23	Prescribing medication without a sufficient rationale, without providing adequate informed consent, without discussing alternative treatments.	Restricted from prescribing ivermectin for non-FDA-approved indications; restricted from prescribing medication or providing case care to patients without first establishing a physician-patient relationship by seeing the patient in-person or via real-time video, taking the patient's history, and examining the patient; required to inform patients that monoclonal antibodies and vaccines are effective; must review CDC website and UpToDate website for current guidelines on treating COVID-19; ethics course; record-keeping course; paper; personal appearances; practice monitor; fine.
Informal Actions				
Balog, Carl C., MD MD60650960 Out of state	STID	7/13/23	Oregon Medical Board restricted license.	Compliance with Oregon order; personal appearances; costs. May petition to terminate when Oregon terminates its order.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions				
Baukol, Andrew W., PA PA61141315 Out of state	STID	5/25/23	License in Wyoming placed on probation.	Compliance with Wyoming order; notify WMC before practicing in Washington; personal appearances; costs. May petition for termination after Wyoming order is terminated.
Bjarke, Chris B., MD MD00031382 King County	STID	5/25/23	Criminal conviction.	Voluntary surrender of license.
Goodman, Gittle G., MD MD00039703 Whatcom County	STID	7/13/23	Alleged inappropriate prescribing of opioids, anti-depressant medication, and benzodiazepines to patients, and failure to refer patients with an MED over 120 to a patient specialist.	CME in chronic pain management; paper; peer group presentation; personal appearances; costs. May petition to terminate in two years.
Hares, Abdul K., MD MD60910626 Out of state	STID	7/13/23	Alleged failure to cooperate with investigation and prescribing controlled substances to patients. During this time licensee told Commission he was too ill to cooperate with the investigation.	Restricted from prescribing opioid or benzodiazepine medications; provide records and information requested during initial investigation; course in prescribing opioid medication for chronic pain; course in ethics; office protocol for use of EMR; compliance audits; personal appearances; costs. May petition to terminate in 3 years.
Kaizer, Deiter M., PA PA10005325 Out of state	STID	5/25/23	Alleged inappropriate behavior and communication with a patient.	Ethics and boundaries course; multi-disciplinary evaluation; paper; personal appearances; costs. May petition to terminate in 2 years.
Koteen, Glenn M., MD MD00047979 Out of state	STID	5/25/23	Surrendered license in Oregon.	Voluntary surrender of license.
Lee, Katherine B., MD MD00032284 Out of state	STID	5/25/23	Surrendered license in California. License in Florida restricted.	Voluntary surrender of license.
Liu, Helios, MD MD60451715 King County	STID	5/25/23	Alleged failure to recognize severe illness in patient in emergency department, failure to document a differential diagnosis and to consider sepsis or diabetic ketoacidosis.	CME in management of diabetic ketoacidosis and sepsis; CME in clinical documentation; paper; personal appearances; costs. May petition to terminate in 3 years.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions				
Meraglia, Tami S., MD MD00047481 King County	STID	7/13/23	Entered into Consent Decree with Attorney General's Office prohibiting licensee from using adipose-derived mesenchymal stromal cell treatments to treat a number of conditions, from using cord cell treatments or exosome treatments for any condition unless scientific evidence shows effectiveness, and from treating COVID-19 for any condition unless reliable scientific evidence shows effectiveness.	Restricted from treating patients or hiring others to treat patients with adipose-derived mesenchymal stromal cell treatments, cord cell treatments, and exosome treatments for any disease or condition; ethics course; CME in human subject research and IRBs; paper; personal appearances; costs. May petition to terminated in 2 years.
Nguyen, Thanh T. PA PA60651580 King County	STID	7/13/23	Alleged failure to adequately supervise a medical assistant who gave an injection in the wrong area to a patient resulting in hospitalization and failed to document the patient's negative reaction to the injection.	CME in record keeping and ethics; paper; personal appearances; costs. May petition to terminate in one year.
Ooi, James P.G., MD MD00033746 Out of state	STID	5/25/23	Surrendered license in California.	Voluntary surrender of license.
Potthoff, Troy L., MD ILMC.MD.60837263 Out of state	STID	5/25/23	Alleged ordering of battery of genetic tests for patients via telehealth and not providing an explanation for the tests and the medical records to the Commission.	CME in telehealth best practices; paper; personal appearances; costs. May petition to terminate in one year.
Schiff, Stanley R. MD MD00025574 King County	STID	5/26/23	Alleged prescribing to a person without establishing a physician-patient relationship and without keeping records.	CME in ethics; paper; personal appearances; costs. May petition to terminated in one year.
Sidhu, Pamil P., MD MD60090629 Spokane County	STID	5/25/23	Alleged prescribing an off-label medication to a patient without seeing or examining the patient or providing informed consent.	Restricted from prescribing ivermectin for non-FDA approved indications; CME in prevention, treatment, and management of COVID-19; paper; compliance audit; personal appearances; costs. May petition to terminate in one year.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions				
Trail, Jeffery A., MD MD00026145 Spokane County	STID	5/25/23	Alleged prescribing of high doses of opioid and benzodiazepine medication without adequately document medical decision-making or justification, without ordering urine drug screens, and without checking the prescription monitoring program.	CME in safe prescribing of opioid medications for chronic noncancer pain; paper; register with and regularly query the prescription monitoring program; personal appearances; costs. May petition to terminated in 1.5 years.
Zolcik, Wojciech MD M60212421 Out of state	STID	7/13/23	Alleged conviction for driving under the influence in Colorado.	WPHP assessment and compliance with recommendations, if any; personal appearances; costs. May petition to terminate after WPHP endorses as safe to practice.

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.

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Update! Editorial Board

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Commissioner Richard Wohns, M.D., JD, MBA recently returned from Nepal where he was honored with an award for his work and support for academic neurosurgery. Dr. Wohns Has been teaching neurosurgery in Nepal for 10 years and is the founder of the nonprofit organization – Nepal Spine Foundation – which supports the educational activities for neurosurgeons at the Tribhuvan University Teaching Hospital in Kathmandu. More information about the program and its successes can be found here.

Congratulations Dr. Wohns!

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.

WMC Public Meetings

WASHINGTON Medical Commission
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WMC Meeting Type	Date & Time	Location	More Information
Policy Committee	October 13 10 am – 11 am	Department of Health 111 Israel Rd SE Town Center 2 Room 160 Tumwater, WA 98501 , Virtual Option Available	Events Calendar
CME Webinar COVID-19 Disaster Cascade Recovery Updates	October 18, 2023 12:00 – 1:00 pm	Virtual	Webinar Page
Rules Hearing ESSB 5229 - Health Equity CE	Ocotber 20 8:30 am	Department of Health 111 Israel Rd SE Town Center 2 Room 160 Tumwater, WA 98501 , Virtual Option Available	Meeting Notice
Business Meeting	October 20 9 am – 11 am	Department of Health 111 Israel Rd SE Town Center 2 Room 160 Tumwater, WA 98501 , Virtual Option Available	Events Calendar
Personal Appearances	November 16 2 pm – 5 pm	Capitol Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater, WA	Events Calendar
Policy: Interested Parties	December 8 10 am – 11 am	Virtual	Events Calendar
Policy Committee	January 4, 2024 - 10:00 - 11:00 am	Virtual	Registration
Personal Appearances	January 11, 2024 - 2:00 - 5:00 pm	Virtual	TBA
Webinar Optimizing Care for People Experiencing Homelessness	January 18, 2024 12:00 - 1:00 pm	Virtual	More Information and Registration
Business Meetings	January 19, 2024 - 9:00 - 11:00am	Virtual	Registration
Additional Events can be found on our Meetings Page and Events Calendar			

Important Changes for the Women, Infants, and Children (WIC) Program

WASHINGTON Medical Commission
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While WIC will offer in-person appointments, we know that most participants will choose to receive WIC services remotely. This means that WIC staff will need to obtain measurements and hemoglobin values from other health service providers. If you or your staff take growth measurements, or test hemoglobin or blood lead levels, we encourage you to provide this information to your patients so they can share it with WIC staff. This form is available to share this information.

We also encourage you to reach out to the WIC clinics in your community to see how you can work together to streamline services for your patients who participate in WIC. The ParentHelp123 Resource finder locates WIC clinics in your area.

Being on WIC doesn't impact immigration status. Encourage all your patients to see if they are eligible for WIC.

Resources

- WIC Nutrition Program | Washington State Department of Health
- About WIC | Washington State Department of Health

1. **WIC will offer in-person as well as remote appointments starting September 1, 2023.**

   The Washington State WIC program is transitioning from federal waivers under The Families First Coronavirus Response Act. WIC staff must now:

   - Offer in-person as well as remote appointments.
   - Obtain weight, height/recumbent length and hemoglobin values if not performed during the WIC appointment.

2. **WIC has updated the WIC Medicaid Nutrition Form to request Medicaid coverage for formula not provided by WIC.**

   We hope the updates ease the process for your patients to get nutritional products that WIC doesn't provide. Please review the links below.

   - **Process to Request Formula from Medicaid Form (wa.gov).**
   - **Medical Nutrition WIC Information Form (wa.gov).**

3. **WIC now refers children to their health care provider if they haven't had a blood lead test.**

Contact
Washington State Department of Health
Jean O'Leary, MPH, RDN WIC Nutrition Coordinator, Office of Nutrition Services
Phone: 360-463-6536 Email: jean.o'leary@doh.wa.gov

Address Confidentiality Program
Office of the Secretary of State
ESHB 1469

Effective April 27, 2023

Protected Health Care workers now eligible for ACP

Individuals providing reproductive health care services or gender-affirming treatment are now eligible for the Washington Address Confidentiality Program (ACP). This includes providers, their employees, and their affiliates.

What is the Address Confidentiality Program?

The Address Confidentiality Program (ACP) provides survivors of domestic violence, sexual assault, stalking, trafficking, and eligible criminal justice and elections officials with a substitute address to use when creating public records with state and local agencies. ACP participants can also protect two normally public records – voter registration and marriage licenses.

The ACP acts as the legal agent for participants to receive and forward mail and service of process.

ACP services are intended as one tool in an individual's broader safety plan.

How to enroll in ACP:

An individual can meet with a certified ACP advocate in their own community or contact the ACP for more information at 1-800-822-1065. To find an advocate go to www.sos.wa.gov/acp, click on the Apply tab, then How to Apply.

Enrolling works best if an individual has recently moved or is about to move and has not created public records with their new address.

How does the ACP work?

Participants are issued an authorization card from ACP that lists the substitute address assigned to the participant. When the participant presents their ACP issued authorization card, state and local agencies are legally required to accept the substitute address as the participant's home, work or school address when creating a new public record, with few exceptions (RCW 40.24.050).

Mail for participants is received at the substitute address by ACP staff and forwarded to the participant's address on file.

For more information on the ACP visit www.sos.wa.gov/acp.