UPDATE!

Washington Medical Commission Newsletter

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Message from the Chair

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

What Happens when my Malpractice Claim is Reported to the WMC?

John Maldon

When I was an employed risk management professional, I was aware of the Washington Medical Commission (WMC) medical malpractice reporting requirements. I knew WMC required a detailed report of the medical malpractice event together with supporting medical records as well as the dollar value of the settlement. What I did not know is what happened to the reports. What took so long for a response from WMC? Why were some cases investigated by WMC while other cases were closed without an investigation? What criteria was used to determine either to investigate or close a case? Whether WMC decided to investigate or not seemed a little inconsistent as some cases that I thought were candidates for investigation often were closed while some cases that were settled for economic reasons rather standard of care issues were investigated. The process seemed a bit mysterious and at that time was not subject to question.

Now that I am an enlightened WMC commissioner I understand the process and - more importantly - any respondent (physician or physician assistant) can call a WMC representative at any time and ask questions about the status of their case.

Uniform Disciplinary Act, RCW 18. 130.180, defines unprofessional conduct providing the basis for the medical complaint process against medical licensees in the state of Washington.

RCW 18.71.350 defines the requirements for reporting to WMC all medical malpractice settlement payments in excess of $20,000 for a physician's incompetency or negligence in the practice of medicine. The payor must report the settlement amount and description of the circumstances of the claim within sixty days of the date the settlement payment is made. Examples of payors include medical malpractice insurance companies, excess insurance companies, self-insured entities, and reciprocal risk retention groups. Any method of reporting a settlement is acceptable at the discretion of the payor. For example, a letter with optional supporting documents may be used to file a report. Insurers typically report settlement payment using the National Practitioner's Data Bank (NPDB) form since all settlements of any value are required to be reported to the NPDB.

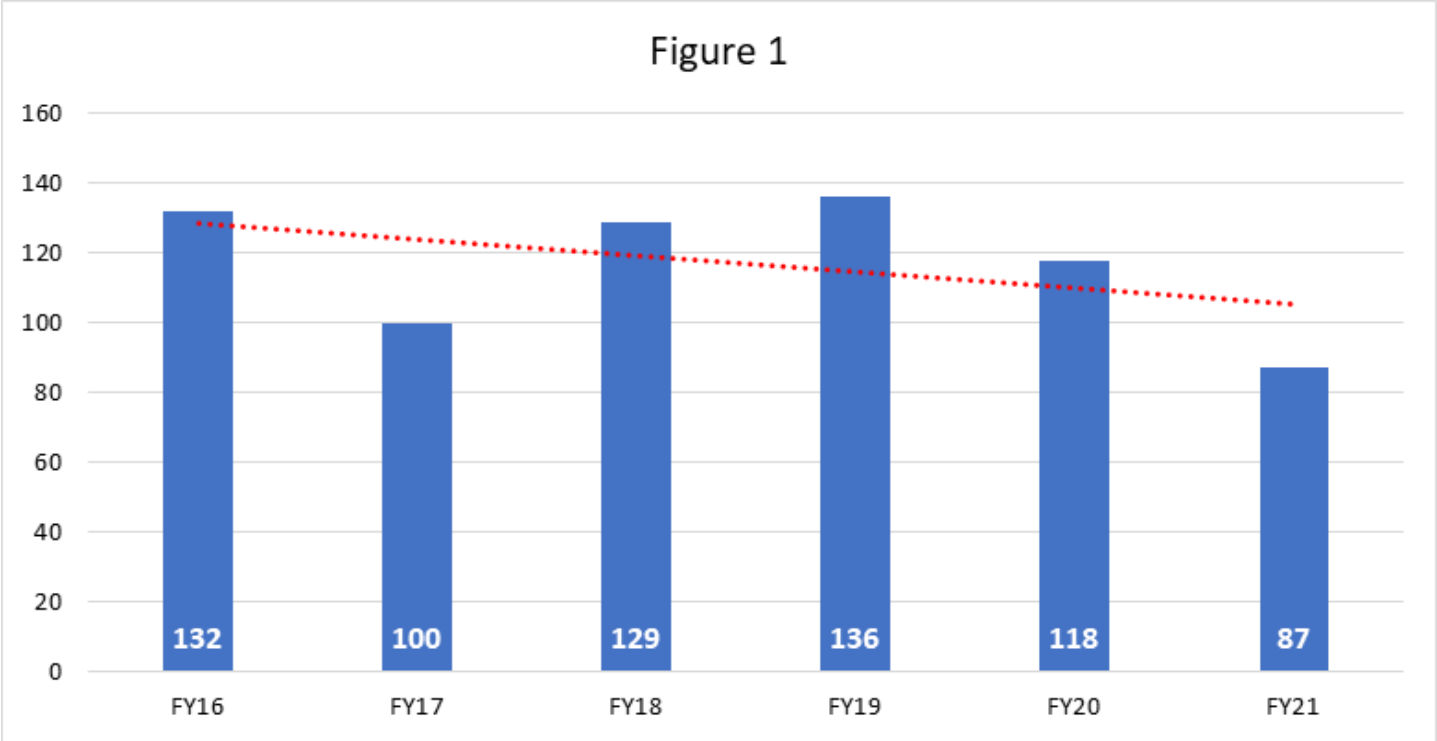
So, what is the process when WMC receives a medical malpractice settlement report? All physician and physician assistant complaints including malpractice settlement reports are reviewed each week by a Case Management Team (CMT). The CMT is composed of three medical providers and one public member. The decision to authorize an investigation or not depends on a variety of factors. The available medical facts of the case are the primary consideration in the decision to authorize an investigation or close a case. Unfortunately, the reports often do not contain enough information to make a decision to authorize or close a case. This usually leads to authorizing an investigation. Offsetting the decision to authorize an investigation, may include the length of time from the date of treatment to the date a claim or judgment is paid. It is not unusual for a malpractice claim to take five years or more to conclude making an investigation difficult to obtain relevant case documentation.

CMT decision makers might also conclude that a respondent may have learned from the malpractice experience and improved their practice, which is the one of the goals of the WMC disciplinary process. On the other hand, a respondent's lengthy complaint history or no complaint history may contribute to the decision.

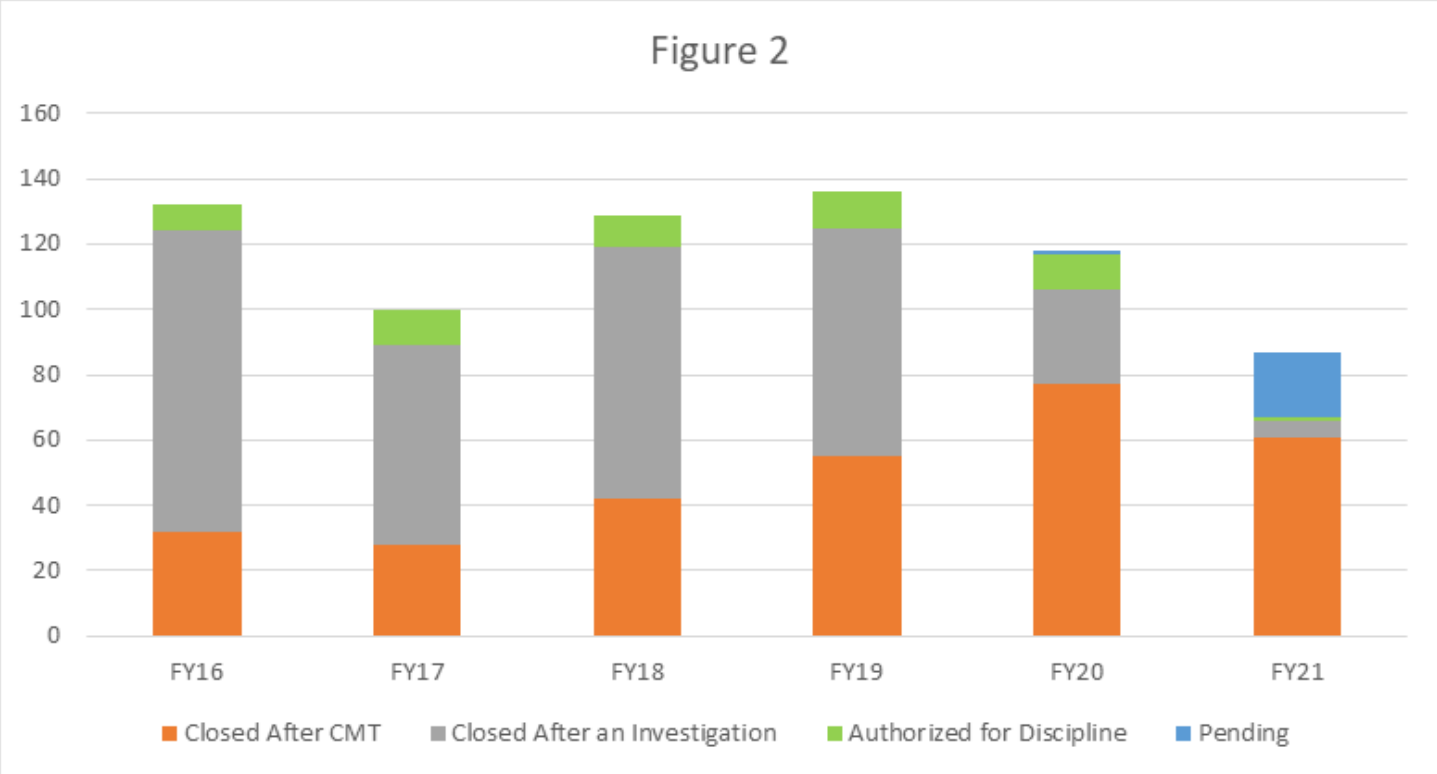
Lastly, although not usually a determining factor is the settlement amount. An unclear description of the treatment event and a large settlement might lead to an authorization of an investigation. While a small dollar settlement figure might lead to the conclusion that the standard of care was met, and the settlement is a reflection of a cost of defense settlement.

Message From the Chair

The following graph depicts the number of malpractice reports received by WMC in the past five years and the number of reports received to date in 2021. The number of reported cases is fairly consistent on an annualized basis with a 5 year average of 123 reports per year.



Medical malpractice report outcomes are reflected in the next graph. Ninety percent of the reported malpractice cases are closed either before or after investigation. A relatively small number of reported cases result in discipline with just seven percent of the reported cases resulting in discipline.



In the event there are questions about the medical malpractice reporting process, please contact medical.commission@wmc.wa.gov.

The Investigative Process

Melanie de Leon, JD, MPA

Occasionally the WMC receives questions about how our investigative process works. Our first response is that it is entirely dictated by statute and rules as the WMC is authorized under RCW 18.130.050(2) to investigate all complaints or reports of unprofessional conduct. But it is important that we further explain our processes, so we can be as transparent as possible to our stakeholders.

Our investigation phase begins with a review of the complaint by our case manager to determine if the person who filed the complaint (the "complainant") is a "whistleblower" and would fall under the protection of RCW 43.70.075. If the complainant is the patient, employee of the institution where the healthcare was provided or a healthcare professional, their identity is confidential unless they waive that confidentiality. In certain situations, the WMC may not be able to investigate a case without releasing the identity of the complainant to the practitioner, so in those cases, we request the complainant waive their right to confidentiality. If they do, we proceed with the investigation; if they do not, we may close the complaint without taking any further action.

Upon receiving a whistleblower waiver, the complaint is assigned to an investigator and a reviewing commission member (RCM).

The RCM
Under RCW 18.130.050(11), the RCM is authorized to direct investigations. If possible, we try to match the specialty of the physician whom the complaint is against (we call this person the Respondent) with the specialty of the RCM. If the WMC does not have a matching specialty, we try to make the best match possible. We also can employ an expert in that specialty if needed.

The Investigator
The WMC has two types of investigators on staff: clinical and non-clinical. Clinical Healthcare Investigators must be currently licensed as a MD, DO, PA, ARNP or RN. They typically complete investigations regarding standard of care. Non-clinical Healthcare Investigators typically complete cases regarding sexual misconduct, fraud, actions taken in other states and other non-care centered complaints.

The assigned investigator reviews the complaint and sends out the initial notification letter of the complaint to the Respondent along with a redacted copy of the complaint if the allegations are not regarding sexual misconduct. The investigator is the Commission's point of contact for the Respondent throughout the duration of the investigation.

Investigators work with the RCM to plan the investigation and then complete that plan. **A typical investigation includes gathering documents, usually medical records regarding the allegations and interviewing the person who filed the complaint and other fact witnesses.** Our interviews are usually completed via phone, especially in the past 18 months.

After examining all the external sources, the investigator contacts the Respondent – in writing – with questions for the Respondent to answer. In most cases, the Respondent has an attorney who responds to that letter; however, we do work with non-represented doctors and physician assistants in the same manner. Under WAC 246-919-620, Respondents have 21 calendar days to respond to this letter and investigators may give one extension for good cause for up to 30 days. Also, under WAC 246-14-050, the basic time period for an investigation is 170 days.

Once the investigation is completed, the case file is provided to the RCM and assigned to a staff attorney for review. Then the complaint moves into the next phase of the process – case disposition. The next article provided by the WMC will review the case disposition process, as well as the final step in the disciplinary process – compliance. Stay tuned!

Changes in the Physician Assistant World

Theresa Schimmels, PA-C

The Physician Assistant world has been very busy in our state and nationally as well. Let me fill you in! The new PA rules regarding practice have been discussed here before. In summary:

- Name change from 'delegation agreement' to 'practice agreement'. The practice agreement will be retained at the site where the PA-physician (MD/DO) practice and filed with the WMC. There is no longer a requirement that a practice agreement be approved by the WMC.
- Doing away with having to have a separate remote site practice plan.
- Chapter 18.57A of the RCW regarding osteopathic physician assistants will go away. There will be just one set of laws and licensure governing physician assistants, found in chapter 18.71A RCW.

During the rules hearings, one of major areas of concern by anesthesiologists and nurse anesthetists was RCW language regarding the following:

> "(3) It must be noted in the practice agreement that a physician assistant delivering general anesthesia or intrathecal anesthesia has completed an accredited anesthesiologist assistant program and received certification as an anesthesiologist assistant."

Rules are meant to be an interpretation of the RCW or law. Interested parties as stated above and the WA Academy of PA's along with the WMC Commissioners on the rules panel crafted this language which was accepted by all:

> "(3) Pursuant to a practice agreement, a physician assistant may administer anesthesia, except the types of anesthesia described in subsection (4) of this section, without the personal presence of a supervising physician.
>
> (4) Administration of general anesthesia or intrathecal anesthesia may be performed by a physician assistant with adequate education and training under direct supervision of a supervising anesthesiologist. Adequate education and training for administration of general or intrathecal anesthesia is defined as:
>
> (a) completion of an accredited anesthesiologist assistant program, or
>
> (b) Performance of general or intrathecal anesthesia clinical duties pursuant to a valid practice agreement prior to the adoption date of this section."

Of note, the WMC is only aware of one PA practicing in anesthesiology, under direct supervision in our state.

Chapter 18.57A of the RCW regarding osteopathic physician assistants will go away. There will be just one set of laws and licensure governing physician assistants, found in chapter 18.71A RCW.

Physician Assistant News

The next news comes from the American Academy of PAs (AAPA). During the 2021 House of Delegates (HOD) assembly, the AAPA, by a vote of 198 yeas to 68 nays, passed a resolution to affirm Physician Associate as the official title of the PA profession. The AAPA Board of Directors must now work on implementing this change which includes public education and rebranding of the Physician Assistant name. Stated in a letter to AAPA members, "Title change implementation is a complex and intricately interwoven undertaking requiring a thoughtful and well-timed strategy involving a variety of stakeholders – not only other national PA organizations (PAEA, NCCPA, and ARC-PA), PA programs, and AAPA constituent organizations, but also state and federal governments, regulators, and employers." The AAPA has made a FAQ page you can find here with more answers to your questions: PA Title Change Investigation: FAQs - AAPA

Lastly, this will likely be my last newsletter article as my second - four year appointment/term- on the WMC is coming to an end. I want to thank you all for reading my articles over the past years. There are 31 applicants for my position, the most we've ever had in my memory and I've been involved here off and on for about 20 years. We'll be reviewing applications over the next few weeks to choose the next Physician Assistant Commissioner to take my place.

My service to the WMC has been an honor as I represented Physician Assistants in our state through rule making, legislation, discipline, and the many other facets that being a commissioner brings with it. I could not have done it without the support of my family and friends, my fellow PA's including current Commissioner Jim Anderson, PA-C, the supportive physician and public members of the WMC, and lastly the FANTASTIC staff we have available to help, support, lead, and follow us through these sometimes complicated processes.

The WMC has changed for the better over the past few years and I'm proud to have been part of it! Thank you!

A webinar was held on June 16th regarding the **Changes in Physician Assistant Practice in Washington**. You can watch the video here.

Supervision of Medical Assistants VIA Telemedicine

Starting April 14, 2021, providers may supervise their medical assistants during a telemedicine visit using interactive audio and video technology. The Legislature recently passed House Bill 1378, enabling this practice.

Before this law, a health care practitioner had to be present on site while a medical assistant was performing tasks associated with a telemedicine visit. Now, physical presence in the same facility is no longer required during a telemedicine visit, so long as the other requirements regarding delegation are met.

Email any questions to medical.assistants@doh.wa.gov.

Legislative Recap

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

This year was different for the Washington Medical Commission (WMC) and the world. As everything else affected by the COVID-19 pandemic, the legislative session in our state covered new territory via online meetings, hearings, testimony and votes. Despite this distanced format, legislators introduced 1,458 bills of which 334 passed.

In general, it was a good year for recognizing the importance of public health and the need to support and build out systems. The Department of Health (DOH) summed up the year this way, "Legislators agreed to make significant advances in public health this session, including major financial investments into Foundational Public Health Services and COVID-19 response. This was an unprecedented success!"

The WMC tracked 25 bills this session that impact the practice of medicine. The WMC connected weekly with our legislative sub-committee (consisting of commissioners, the WMC chair and the Executive Director) about these bills and others the DOH tracked. The sub-committee then weighed-in with their thoughts via a weekly DOH call.

The WMC had several items of interest impacting our work. Three bills stand out from the rest:

- House Bill 1129, concerning the licensure of International Medical Graduates (IMG) passed. This bill authorizes the WMC to issue limited licenses to IMGs and persons accepted for certain public and private institutions. This license lasts for two years and is renewable one time for a total of four years. As WMC is staff for the IMG Implementation Workgroup, we have heard a lot optimism around this bill. The bill gives us the capacity to provide new opportunities for IMGs, helps address gaps in culturally competent care and creates a path for IMGs to have clinical experience prior to applying for a residency.

- Senate Bill 5423, which clarifies the exemptions in our statute (RCW 18.71.030), also passed. This bill, supported by the WMC, allows peer-to-peer consultation across state lines regarding the diagnosis or treatment of patients. We have often received inquiries in the past asking if an out-of-state physician can consult within Washington State and we have used our telemedicine policy to provide affirmative guidance. This bill gives WMC clear statutory authority to say, "Yes, doctors can consult with another physician on care even if that person is not licensed in Washington." SB 5423 mirrors laws in 30 other states. This is a win for physicians in our state and the public.

- Senate Bill 5229 adopts new standards for continuing medical education (CME). The bill requires that by January 1, 2024, DOH in consultation with WMC and other boards and commissions, adopt rules for CME programs to address bias, racism, poverty and other elements that manifest as health inequities. These CME are not additional and can count towards the 200 hours per cycle already required.

The legislature added an audit of the WMC licensing and disciplinary processes to the budget. This law requires us to contract with the state auditor's office to analyze licensing times and compare our disciplinary processes with other states. As was the case with other boards and commissions, the COVID-19 pandemic highlighted elements of our processes in need of improvement. The WMC has taken steps to do that and we will see that reflected in the audit outcome. While it is not something we were planning on, we believe this audit will actually demonstrate the great work the WMC does - especially compared to other states.

Several other bills that are of interest to the medical profession, although not directly impactful to the WMC, passed this session. Those bills include topics like opioid overdose reversal medication prescriptions, protecting pregnancy and miscarriage-related patient care, the supervision of medical assistants, and audio-only telemedicine billing. For more insight into the 2021 Legislative Session, and discussion about these bills, please visit our YouTube channel.

Next session, legislators plan to be working back at the Capitol, although there is talk that many procedures put into place during the pandemic may continue. It will be a "short session" of only 60-days and the second half of the biennium cycle so a supplemental budget to fix gaps will be considered. Until then, keep your eyes out for our upcoming articles that are a deeper dive into new legislation that may affect you!

WPHP Report: Q&A

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Physician Impairment and the Washington Physicians Health Program: Questions and Answers

Chris Bundy, MD, MPH

Executive Medical Director, Washington Physicians Health Program

Since 1986 the Washington Physicians Health Program (WPHP) has served as the legally 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.

What "rules" dictate the relationship between the WMC and WPHP?

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 available to take your call 24 hours per day, 365 days per year.

Q: What happens if I make a report with WMC?

A: WMC will be obligated to review the case and may open an investigation of your colleague. This may result in disciplinary sanctions for your colleague, 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 and facing the risk of investigation and disciplinary action.

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 avoid a disciplinary process serves as a powerful motivator for physicians to commit to thorough evaluation and treatment if needed.

Q. Are physicians and PA's 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 clients do best when internal motivators are engaged, rather than externally leveraged through a possible WMC referral.

What happens if I make a report to WPHP instead of WMC?

Q: In the absence of patient harm, why is the law set up to allow reporting of suspected impairment to WPHP as a substitute for reporting to the Department and WMC?

A: To support patient safety, the law is set up to encourage early identification, assessment and treatment of providers who are thought to be impaired. Allowing physicians to self-report to WPHP or to be reported by their employer or colleagues to WPHP rather than to

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 prolongs the unacceptable exposure of patients to the risk of unsafe care from the potentially impaired provider. Failing to act also needlessly jeopardizes the career of a colleague that can be easily saved through therapeutic treatment for their illness. 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.

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 has to 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 have to 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 this is one of those rare cases in which a call to WMC or DOH is mandatory, we will explicitly clarify this for you.

Rulemaking Efforts

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Amelia Boyd
Program Manager

Clinical Support Program

The CR-101 for WAC 246-919-XXX Physicians and WAC 246-918-XXX Physician Assistants was filed with the Office of the Code Reviser on February 22, 2018 as WSR #18-06-007.

The WMC is considering creating two new rule sections, and revising related rule sections as appropriate, to establish a clinical support program (program), its criteria and procedures for allopathic physicians and physician assistants. The intent of the program is to assist practitioners with practice deficiencies related to consistent standards of practice and establish continuing competency mechanisms that will protect patients proactively through a plan of education, training and/or supervision. The WMC may resolve practice deficiencies through the program at any point in a practitioner's period of licensure.

The program would allow for quick identification of issues requiring clinical support, through practitioner or employer inquiry, referral, and including complaints that may not rise to the level of a license sanction or revocation. These issues could be resolved with voluntary participation from the allopathic physician or physician assistant in the program. The WMC is considering education, training, supervision, or a combination of the three as part of the program. Issues appropriate for clinical support would likely include but are not limited to practice deficiencies such as a failure to properly conduct a patient assessment or document treatment. This also allows an allopathic physician or physician assistant a structured process to quickly improve his or her clinical skills.

Finally, participation in this program places the WMC in an active patient safety role.

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

Telemedicine

The CR-101 for Telemedicine was filed with the Office of the Code Reviser on September 17, 2019 as WSR #19-19-072.

The WMC will consider rulemaking to address the practice of physicians and physician assistants engaging in telemedicine with Washington patients. Possible subjects the WMC may address are: What, if any requirements for licensure; recordkeeping requirements; establishing a patient-practitioner relationship; prescribing issues; and standard of care. Regulating the use of telemedicine would place the WMC in an active patient safety role.

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

Exclusions – Opioid Prescribing

The CR-101 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 March 25, 2020.

As part of the WMC's rule making 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 long-term acute care (LTAC) 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.

Since the rules related to ESHB 1427 became effective January 1, 2019, the WMC has continued to receive comments related to LTAC and nursing home patients. To address this issue, the WMC filed an interpretive statement: "Exempting Patients in Nursing Homes and Long-Term Acute Care Hospital from the Opioid Prescribing Rules." While the interpretive statement

has helped to curb the comments and concerns from prescribers, the WMC feels this important exemption should be in rule. Furthermore, this could allow us [to] rescind the interpretive statement.

The WMC has also received a comment regarding patients in Residential Habilitation Centers (RHC) that they are also similarly situated to LTAC and nursing home patients. As such, the WMC may also consider exempting patients in RHCs.

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

Stem Cell Therapy

The CR-101 for creating rules related to Stem Cell Therapy was filed with the Office of the Code Reviser on April 21, 2020 as WSR #20-09-132.

The WMC has received complaints from licensees, stakeholders, and the public about the use of stem cells. The complaints have been regarding the advertising related to stem cell therapy, practitioners using non-FDA approved stem cell therapy, as well as concerns stem cell therapy not being within a practitioner's scope of practice. Regulating the use of stem cell therapy would place the WMC in an active patient safety role. Rulemaking would provide clarity around this emerging medical technology and procedure 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.

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.

Senate Bill (SB) 6551 – International Medical Graduates

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

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

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

Rulemaking Efforts

Chapter 246-918 WAC – Physician Assistants and SHB 2378

The CR-101 for revising physician assistant (PA) rules pursuant to Substitute House Bill (SHB) 2378 (Chapter 80, Laws of 2020) and updating PA rules to incorporate current, national standards and best practices was filed with the Office of the Code Reviser on November 19, 2020 as WSR #20-24-015.

The WMC is considering updating the PA chapter to more closely align with current industry standards, modernize regulations to align with current national industry standards and best practices, and provide clearer rules language for licensed PAs.

Included in this rulemaking proposal is incorporating the requirements of SHB 2378 Concerning physician assistants. The WMC is considering adding new sections in accordance with SHB 2378. This bill combines the PA licensing under the Washington Medical WMC effective July 1, 2021 and eliminates the profession of Osteopathic Physician Assistant. The bill instructs the WMC to consult with the Board of Osteopathic Medicine and Surgery (BOMS) when investigating allegations of unprofessional conduct by a licensee under the supervision of an osteopathic physician. The bill also reduces administrative and regulatory burdens on PA practice by moving practice agreements from an agency-level approval process to employment level process. Employers are required to keep agreements on file. The bill requires the WMC to collect and file the agreements. Changes nomenclature from "delegation" to "practice" agreement and from "supervising physician" to "participating physician" agreement.

At their May 14, 2021 meeting, the WMC approved initiating the CR-102, Proposal, rulemaking process. A hearing is tentatively scheduled for August 25, 2021.

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.

Upcoming Events

Medical Commission Policy Meeting
July 8th 4:00 PM PST
Virtual Meeting

Medical Commission Business Meeting
July 9th 8:00 AM PST
Virtual Meeting

Medical Commission Policy Meeting
August 19th 4:00 PM PST
Virtual Meeting

Medical Commission Business Meeting
August 20th 8:00 AM PST
Virtual Meeting

Health Equity Advisory Committee
September 15th 9:30 AM PST

Event details can be found on our calendar.

2021 Conference Announcement

We have made the decision to not hold an in-person conference this year. We are looking for you feedback on what virtual activities you would like to see the WMC offer. Please provide any suggestions or feedback to medical.speakers@wmc.wa.gov

Legal Actions

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

February 1, 2021 – April 30, 2021

Below are summaries of interim and final actions taken by the Washington Medical Commission (WMC) that were reported to the Federation of State Medical Boards between February 1, 2021 and April 30, 2021. Statements of Charges, Notices of Decision on Application (with exceptions), Modifications to Orders (with exceptions), 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 WMC website.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Summary Actions				
Krebs, Richard MD60647377 Out of State	Ex Parte Order of Summary Action - Suspension	02/18/21	Alleged surrender of Respondent's license while under investigation by the Oregon Medical Board.	Suspension – pending completion of proceedings.
Oliver, Cara MD00048841 king	Ex Parte Order of Summary Action - Suspension	04/08/21	Alleged inability to practice with reasonable skill and safety due to a health condition.	Suspension – pending completion of proceedings.
Interim and Formal Actions				
Bietz, Duane MD00009786 Out of State	Final Order - Default	02/03/21	Respondent's license to practice medicine revoked by the Oregon Medical Board.	Indefinite suspension.
Jutla, Rajinder MD00047987 King	Final Order	04/27/21	Respondent's license to practice medicine revoked by the Oregon Medical Board.	Indefinite suspension pending approval of a practice monitor; pain management, ethics, and recordkeeping coursework; monitor reports, practice reviews, personal appearances, and termination no sooner than two years after reinstatement.
Kolodziej, Bruno MD00041671 Out of State	Final Order - Default	02/08/21	Respondent's license to practice medicine revoked by the Virginia Board of Medicine.	Indefinite suspension.
Rose, Mark MD00023797 Out of State	Final Order - Default	04/08/21	Respondent surrendered his license to practice medicine to the Oregon Medical Board.	Indefinite suspension.
Sterling, Ronald MD00038889 King	Agreed Order	03/04/21	Sexual misconduct, failure to comply with a Commission order, and misrepresentation or fraud.	Voluntary surrender.

Trevino, Rodolpho MD00048467 Out of State	Final Order - Default	02/05/21	Negligent prescribing of controlled substances and legend drugs, mismanagement of pediatric patients with behavioral issues, and misrepresentation or fraud.	Indefinite suspension.
Informal Actions				
Anderson, Jodee MD00049081 Clark	Informal Disposition	03/04/21	Alleged practice restriction by the Oregon Medical Board.	Voluntary surrender.
Bauer, William MD00035422 Kitsap	Informal Disposition	02/17/21	Alleged negligent management of clinical issues for several patients and inadequate recordkeeping.	Screening, diagnosing, and clinical coursework; written research papers, practice reviews, personal appearances, $1,000 cost recovery, and termination no sooner than fifteen months.
Beers, Joshua MD60241235 Spokane	Informal Disposition	03/04/21	Alleged negligent and delayed diagnosis.	Pediatric patient coursework, written research papers, personal appearances, $1,000 cost recovery, and termination no sooner than three years.
Brown, Michael MD00028042 King	Informal Disposition	03/04/21	Alleged negligent prescribing of controlled substances, inadequate recordkeeping, and violation of a Commission order.	Voluntary surrender.
Crane, Samuel MD60217759 Spokane	Informal Disposition	03/04/21	Alleged misdemeanor conduct casting disrepute onto the profession.	Personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Dezenberg, Carl MD00044683 Out of State	Informal Disposition	03/04/21	Alleged negligent patient communications.	Physician-patient communications coursework, review of Commission guidelines on professional communications, personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Drouillard, Dennis MD00020525 Pierce	Informal Disposition	04/08/21	Alleged delayed diagnosis of giant cell arteritis.	Written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than two years.
Graybill, Jordan MD60544409 Clark	Informal Disposition	03/04/21	Alleged failure to provide monitoring devices for employees exposed to radiation.	Ethics and radiation safety coursework, written paper, quarterly self-reports, personal appearances, $2,000 cost recovery, and termination no sooner than one year.
Harris, Laurel MD00029429 Pierce	Informal Disposition	04/08/21	Alleged delayed diagnosis of giant cell arteritis.	Written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than two years.

Harris, Victoria MD00028715 Spokane	Informal Disposition	04/08/21	Alleged inability to practice with reasonable skill and safety due to a health condition.	Voluntary surrender.
Healey, David MD60565218 Out of State	Informal Disposition	04/08/21	Alleged medical condition that requires ongoing monitoring in order to maintain safe-to-practice status.	Compliance with out-of-state health monitoring program, Commission and in-state health monitoring program approval before returning to practice in WA, $1,000 cost recovery, and termination no sooner than discharge by health monitoring programs.
Jones, Danica PA10003346 Whatcom	Informal Disposition	03/04/21	Alleged failure to diagnose and treat an Achilles tendon laceration.	Clinical coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.
Luedke, Paula PA60337595 Clark	Informal Disposition	04/08/21	Alleged failure to obtain valid informed patient consent to procedure and negligent wound care.	Voluntary surrender.
Manawadu, Bingumal MD00018892 Benton	Informal Disposition	03/05/21	Alleged negligent pain management and clinical care.	Probation, chronic pain management and recordkeeping coursework, review of pain management rules, utilization of PMP, practice reviews, personal appearances, $3,000 cost recovery, and termination no sooner than two years.
McAllister, Debra MD00034905 Pierce	Informal Disposition	04/08/21	Alleged inability to practice with reasonable skill and safety due to a health condition and retirement from practice.	Voluntary surrender.
Mullen, James MD00034905 Pierce	Informal Disposition	02/20/20	Alleged failure to cooperate with a Commission investigation.	Voluntary surrender.
O'Neill, Jay PA10004128 Skagit	Informal Disposition	03/04/21	Alleged negligent failure to diagnose and treat a patient's cardiac condition.	Clinical skills assessment and completion of all recommendations, written research paper, personal reports, personal appearances, $1,000 cost recovery, and termination no sooner than two years.
Roman Cabezas, Alberto MD60716172 King	Informal Disposition	03/04/21	Alleged sexual misconduct and inadequate recordkeeping.	Voluntary surrender.
Sartin, Aaron MD603949919 Stevens	Informal Disposition	03/04/21	Alleged negligent failure to diagnoses and treat a patient's testicular torsion.	Acute testicular pain coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.

Shlafer, Stephen MD00028401 Snohomish	Informal Disposition	04/08/21	Alleged negligent documentation of a patient examination.	Recordkeeping coursework, written research paper, practice reviews, personal appearances, $1,000 cost recovery, and termination no sooner than two years.
Stoneking, Kim MD00048025 Cowlitz	Informal Disposition	03/04/21	Alleged diversion and abuse of controlled substances.	Evaluation by a health monitoring program and completion of all recommendations, ethics and medication management coursework, written research paper, utilization of PMP, quarterly personal reports, personal appearances, $2,000 cost recovery, and termination no sooner than two years and endorsement by the health monitoring program..
Swackhammer, Randy MD60890058 Out of State	Informal Disposition	03/04/21	Alleged health care fraud felony conviction.	Voluntary surrender.
Thomas, Andrew MD60799264 Kittitas	Informal Disposition	03/04/21	Alleged negligent laceration repair.	Laceration repair coursework, written research paper, proctored simulator training, preceptor, personal reports, personal appearances, $2,000 cost recovery, and termination no sooner than two years
Yoong, Vee PA10003812 Out of State	Informal Disposition	03/04/21	Alleged failure to diagnose and treat an Achilles tendon laceration.	Clinical coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than one year.

Stipulated Findings of Fact, Conclusions of Law, and Agreed Order: A settlement resolving a Statement of Charges, and containing an agreement by the licensee to comply with certain terms and conditions to protect the public.

Stipulated Findings of Fact, Conclusions of Law, and Final Order: An order issued after a formal hearing before the Commission imposing certain terms and conditions to protect the public.

Stipulation to Informal Disposition (STID): A settlement resolving a Statement of Allegations., and containing an agreement by the licensee to comply with certain terms and conditions to address the Commission's concerns.

Ex Parte Order of Summary Action: An order summarily restricting or suspending a licensee's practice of medicine. The licensee has an opportunity to defend against the allegations supporting the summary action.

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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.

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News and Announcements

Rules and Regulations In Progress

Frequently Asked Questions (FAQ)

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