UPDATE!

WASHINGTON
Medical Commission
Licensing. Accountability. Leadership.

VOL. 11 Winter 2021

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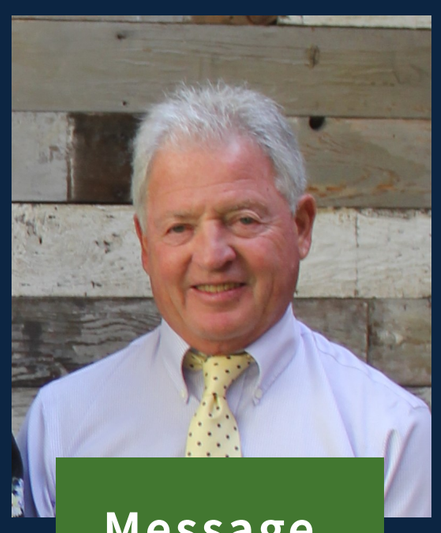

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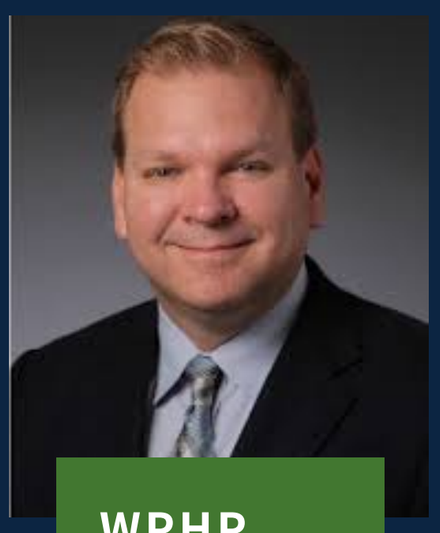

WPHP Report +

Making Meaning from Outrage

Message from the Chair

WASHINGTON Medical Commission
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Commissioner Qualifications and Code of Conduct

John Maldon

There have been examples of prospective Washington Medical Commissioners not realizing or not fully understanding what is involved in becoming a Commissioner on the WMC. An interested party should first learn the role and the general work of the WMC when considering submission of an application. No matter how well a prospective applicant is experienced in their career field, there is a steep learning curve when becoming a Commissioner on the WMC.

Individuals interested in becoming a Commissioner on the WMC should first do a self-assessment of the reasons why they are interested in becoming Commissioner, do a review of their qualifications as they relate to the role of a Medical Commissioner, assess the time commitment to be a Commissioner, be an effective communicator, be willing to work in a collaborative environment, demonstrate flexibility, educate their colleagues in areas of their expertise and be willing to be educated beyond current expertise.

Nothing in this article is meant to deter anyone away from becoming a Washington Medical Commissioner. The intent of this composition is meant to inform applicants of the role, responsibilities and conduct norms of being a Commissioner - to be certain an applicant has a continuing interest in being a Commissioner.

There are certain qualities identified by experts for a Board or Commission to be effective and I believe are expected by constituents and the public. The Board or Commission should be generally known for integrity, objectivity, accountability, honesty and leadership.

There also essential qualities of effective Board or Commission members. They are dedicated and committed, able to lead and influence others, be straight forward and impartial, knowledgeable, have a strong desire to learn, values and uses discretion and confidentiality, looks forward to serving on committees and workgroups and is always prepared in advance of meetings.

Effective Board and Commission members have a required mindset that understands they lead not manage, have a willingness to engage with colleagues, provide strategic support, understand meeting content and if not ask questions in order to be fully informed, work collaboratively as a team, challenge appropriately but get on board and support consensus decisions and never disparage the Board or Commission in public.

The WMC maintains a Commissioner Code of Conduct Policy that is periodically reviewed and updated by the Executive Committee. The policy contains many of the above criteria for effective Board or Commissioner members. The detail of the WMC's interpretation of the general principles of appropriate conduct is important to be repeated for clarity of specific expectations of members of the WMC The policy covers general characteristics, ethics and business meeting conduct.

Commission members will:

- Demonstrate decorum, honesty, integrity, professionalism and ethical behavior in all aspects of their duties and in their relations with fellow Commission members, staff, service providers and other constituents;
- Abide by all policies and decisions of the Commission;
- Refer to policies and decisions of the Commission in a respectful manner with external parties;
- Participate in case reviews and other activities as required to include conference calls, formal hearings and special committees on a regular basis.

"The Commission should be generally known for integrity, objectivity, accountability, honesty and leadership."

Message From the Chair

Ethics: In addition to the requirements under RCW 42. 52, Ethics in Public Service, Commissioners will;

- Make fair and objective decisions;
- Strictly maintain confidentiality;
- Avoid improper ex parte contacts;
- Recuse themselves and proactively disclose when there is a real or potential conflict of interest, or an appearance of such conflict;
- Protect the integrity of those who appear before the Commission;
- Support the decisions of the Commission in public.

Meeting Conduct: When participating in a Commission meeting, Commissioners will;

- Actively prepare for each meeting by thoroughly reviewing all meeting materials in advance;
- Attend and participate in all scheduled meetings unless excused. If a Commissioner misses more than two meetings in a row or more than two in a year, discussion with the Chair will be undertaken to evaluate the ability of the Commissioner to serve as a full-time member;
- Complete written case reviews on the Assessment Form in a timely manner and be prepared to present cases at scheduled meetings.

Physicians, Physician Associates and public members who are aligned with above criteria are encouraged to apply to be Commissioners. The WMC web site is an excellent source of information for those interested in learning more about the Commission.

Electronic Prescribing and PMP-EHR Integration Mandate

Electronic Prescribing Waiver Attestation Form

Washington State law mandates all health care practitioners communicate prescriptions and prescription refills for Schedule II-V controlled substances to the pharmacy electronically.

The law also allows the department to grant practitioners a waiver from complying with the mandate under certain circumstances. Any practitioner meeting one of the below qualifications for a waiver may receive one. Waivers will be granted upon submission of **an attestation form**.

Attestations last for one year and may be renewed two (2) times for a total of three (3) waivers, except in the case of other exceptional circumstance waivers. Other exceptional circumstance waivers may be submitted an unlimited number of times.

Please note: Waivers are valid for one calendar year. Beginning in December each year you may submit a waiver for the following year. Waivers submitted part way through the year are valid for that calendar year and will not be prorated. **Submit your attestation form.**

More Information and waiver attestation forms for the e-prescribing mandate and PMP-EHR integration mandate can be found here.

EHR/PMP Integration Waiver Attestation Form

Washington State law requires all facilities, entities, offices, or provider groups with ten(10) or more prescribers using a federally certified electronic health records (EHR) system to demonstrate that EHR system is able to fully integrate data to and from the prescription monitoring program using a mechanism approved by the Department of Health.

The department may issue a waiver of this requirement to any facility, entity, office, or provider group that meets one of the qualifications for a waiver. Waivers will be granted upon submission of an **attestation form**.

Attestations last for one year and may be renewed two (2) times for a total of three (3) waivers, except in the case of other exceptional circumstance waivers. Other exceptional circumstance waivers may be submitted an unlimited number of times.

Please note: Waivers are valid for one calendar year. Beginning in December each year you may submit a waiver for the following year. Waivers submitted part way through the year are valid for that calendar year and will not be prorated. **Submit your attestation form.**

Please contact the PMP Program if you have any questions or if you need assistance.

Executive Director Report

WASHINGTON Medical Commission
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Compliance – The Last Act in our Behind the Curtain Series

Melanie de Leon, JD, MPA

The last step in the disciplinary process is compliance, which begins after the Commission determines that a provider has violated the Uniform Disciplinary Act, RCW 18.130.180. Once the case has been resolved through a stipulation to informal disposition (STID) or a Statement of Charges (SOC), the case is transferred from the Commission's Legal Unit to the Compliance Unit.

This unit is comprised of two Compliance Officers and a Physician Medical Consultant. Their role is to work with the respondent practitioner to insure they understand the requirements of the WMC sanctions, help the practitioner find any required education or training, review any papers required by the WMC and mentor them through the compliance process.

When a case is moved into the compliance phase, the Compliance team schedules a phone call with every practitioner (and their attorney, if applicable) to explain what the practitioner's next steps should be, how to pay any fines, where to go to get any required evaluations and answer any questions. The Compliance Unit becomes the main point of contact with the practitioner throughout this phase and keeps in contact with the practitioner every step of the way.

Except in a very few cases, the WMC requires practitioners to appear in front of a Commission panel at least once to discuss their case, what they learned after taking any required education or training and what they would do differently in the future, if applicable. Typically, a practitioner is in the compliance phase for three years depending on what the WMC deems appropriate. Once a practitioner has completed the requirements set forth in the WMC sanctions and met any required timelines, the practitioner may request that the WMC terminate the STID or order and close the case.

WMC Adopts New Telemedicine Policy to Help those in Need

The pandemic continues to teach us how important telemedicine is. Now more than ever telemedicine technology is needed to reach patients in underserved areas. With this in mind, the Washington Medical Commission (WMC) adopted a new 2021 Telemedicine Policy.

The WMC has been forward thinking about the use of telemedicine across borders for many years. The WMC first guideline was adopted in 2014 and additions regarding continuity of care were adopted in 2018. This new policy supersedes even those.

Many people contact the WMC looking for clarity on telemedicine in Washington. Our policy answers several of those questions. Such as:

- What are the WA licensure requirements for using telemedicine?
- What are the best practices when using telemedicine?
- What about mobile apps or artificial intelligence? How does the WMC address those?

One of the most frequent questions we get asked about our policy is how it relates to the law and what are the licensure exemptions? Washington state recently passed a telemedicine law that legalizes practitioner-to-practitioner consultations across state borders. WMC policy has always been in alignment with this recent statute change and encourages other regulators to adopt similar positions.

WMC policy takes it a step further to encourage WA citizens to get a second opinion or a consultation with a specialist out of state, such as a cancer center. This second opinion provider can give input on treatment directly with the patient. Learn about this exemption and more, in the 2021 Telemedicine Policy.

The WMC holds business and policy committee meetings approximately every six weeks in which we address important issues impacting public health and the medical profession. These meetings are open to the public. If you would like to weigh-in on decisions like the telemedicine policy, you may do so at a policy committee meeting. The public may provide comments not only to the policy committee members but to other interested parties in attendance. If you would like all-inclusive notifications for these meetings, including dates, locations or links to register for virtual sessions, please subscribe to the Meetings Listserv.

Meet the New WMC PA Member

Arlene Dorrough PA-C, MCHS/MPH, BCHS

Hi, my name is Arlene Dorrough. I am a new member to WMC. I am a lifetime Washingtonian, in fact my sister and I were the first twins born at the University of Washington Hospital's new OB Wing in nineteen--- (that date is redacted).

I started my medical career in the Air Force as a medic. I learned medicine at Shepard Air Force base in Texas and gained proficiency at the David Grant Medical Center hospital at Travis Air Force Base in San Francisco. My education rotated me through most of the hospital treatment centers from the Morgue to the Birthing center, with the majority of time spent in the ER, where I was required to get EMT certified. I experienced my first mass casualty situation with the '89 earthquake. I worked with the Reservists, National Guard and Emergency Medical Services to recover survivors from the Nemitz freeway collapse and with the Red Cross providing disaster relief.

I then settled back in Washington state. My military EMT certificate was not accepted outside of the service and I couldn't afford to repeat the classes, so I became a Certified Nurse Assistant, then a Medical Assistant. Several years after that, I was deployed with my Reserve unit, to Waddington Royal Air Force Base in England for Desert Storm. My unit set up a Medical Staging Facility out of a hangar on the Air Force base. We triaged military members who were flown out of the arena of conflict and stabilized them at a makeshift hospital we had converted from a nursing home. Those who got better we sent back to the arena of conflict, those with more serious injuries were sent home. We were sent home after 89 days abroad and I had big plans to go into nursing, but it was very expensive and I did not qualify for the GI bill, further, most of the medical school guidance counselors were actively steering me away from professional medicine, as they felt I was not a good fit for a career as anything more than a medical assistant. One counselor even congratulated me for getting that far, but said, it was her experience that professional medicine was too rigorous for me to expect to succeed in, especially as I was the first member of my family to attend college. She considered herself doing me a kindness to tell me the truth. So of course, I HAD to try.

Around that time, I met a young PA who had just graduated and was buying herself her first new car. At the time, my husband was a Saturn dealer. I was waiting for him to be finished so I could take him home. This young woman and I struck up a conversation that changed my life. The more information she gave me about Physician Assistants, the more it seemed to fit who I was and how I wanted to practice medicine. I got her phone number and started my path toward becoming a PA in Washington state. She and I are friends to this day, and I can't even say that about my now ex-husband, or as I sometimes call him, my was-band.

"Most of the medical school guidance counselors were actively steering me away from professional medicine, as they felt I was not a good fit for a career as anything more than a medical assistant."

I love my job and have had a richly rewarding career. That chance meeting has lead me to the opportunities I most cherish; meeting new people, becoming a seasoned professional, and now, being able to impact medicine in a positive way by assuring providers get support and the opportunity to recover when the worse of the worst happens to them. Thank you for the opportunity to serve on the WMC with such a knowledgeable group of professionals.

Growing up in the Northwest I have experienced the shifting tides of medical treatment and care over the years. In that time, I have seen nurses stretched to their limits, as they hired and dismissed in droves, as well as the advent of the Electronic Medical Records System. I have seen medical healthcare organizations utilize capitalist ideals, to deliver 'conveyer belt' medical care. I am so glad that we have moved beyond counting 'widgets' and decreasing 'Muda'. It seems we have come full circle and after last year, we are discovering the importance of interpersonal relationships in medicine and in medical culture in general.

As a PA, I am excited to be involved in the front lines of medical care and I am pleased that so many other medical professionals have a better idea of what a PA is and what we do. That being said, we still have a long way to go, and I am happy to continue the work. I am so proud of my PA colleagues and what we have been able to accomplish as our profession has evolved. The advent of Covid and so many other factors, have threatened medical providers' ability to practice medicine in a safe and timely manner, but we have been able to turn that lemon into lemonade in the utilization of more PAs, to step in and meet the increasing patient care needs that doctors were breaking their backs and risking their lives to manage.

There is much to do and I'm lacing up my shoes and setting my sights for the horizon. Full speed ahead!

The Impact of Racism on Health

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Mahlet Zeru
Equity and Social Justice Manager

An increasing collection of evidence has documented America's long history of racism and its detrimental impact on people of color. The consequences of racism are broad and deeply ingrained in our society, affecting where people live, learn, work, pray, and play, as well as causing inequities in access to social and economic benefits. These unequal distributions of resources lead to disparate health outcomes. When compared to their White counterparts, racial and ethnic minority groups in the United States have greater rates of mortality and morbidity across a wide variety of health issues[1], including maternal mortality[2], hypertension[3], obesity[4], and heart disease[5].

Definitions
Allostatic load: the wear-and-tear on the body and brain that results from chronic dysregulation (overactivity or inactivity) of mediators of allostasis[6].

Allostasis: the active process of responding to a challenge to the body by triggering chemical mediators of adaptation (HPA, autonomic, metabolic, immune) that operate in a nonlinear network. Allostasis is essential for maintaining homeostasis in the face of challenges or demands imposed by changes in the environment and an individual's behavioral state that are registered by the brain[7].

How does racism impact health?
Researchers have coined the terms "allostatic load[8]" and "weathering[9]" to define and describe the ways in which systemic and individual racism can make people physically vulnerable to illness and premature death. Allostatic load refers to the damage caused by chronic stress, which overtakes the body's regulatory mechanisms—including the immune, endocrine, and circulatory systems, as well as those that regulate blood sugar and mood. A review of representative sample of general population and clinical studies on consequences of allostatic load on both physical and mental health across a variety of settings found a positive association between allostatic load and poor health outcomes[10]. The chronic activation of stress response in Blacks has led to higher allostatic load and weathering than whites and these racial differences were not explained by poverty[11].

Maternal Mortality
Allostatic load contributes to adverse outcomes during pregnancy[12]. Non-Hispanic Blacks have higher rates of mortality and morbidity than any other ethnic group at every education and income level[13]. In populations with equal access to healthcare, such as members of the US military, racial disparities in pregnancy outcomes are reduced but not eliminated. Non-Hispanic Black women receiving military medical care are still at increased risk for low birth weight, preterm birth, and placental abruption, implicating the role of additional factors in poor maternal-fetal outcomes among women of color[14]. A study conducted at a large US military installation clinic found black women to have twice the risk of preterm delivery than whites[15]. The risk of preterm delivery was also observed in black women of all military ranks[16]. Black women with graduate degrees have higher rates of severe maternal morbidity than non-Hispanic White women who never graduated from high school[17]. For black Americans, social determinants of health factors including income, education, socio-economic status are not protective as they are for white Americans[18].

Peripheral Arterial Disease
Allostatic load has also been linked to increased risk for cardiovascular diseases, particularly peripheral arterial disease (PAD)[19] . Nelson et al. analyzed data from the 1999-2002 National Health and Nutrition Examination Survey for individuals 40 years of age and higher with a measured ankle brachial index greater than 0.9. The authors performed bivariate and multivariate analyses to describe the association of race/ethnicity with PAD, controlling for sociodemographic factors, clinical risk factors and allostatic load. The national representative sample indicated African Americans to have highest rates of PAD even when conventional risk factors such as hypertension and hyperlipidemia were controlled. African Americans with PAD had higher allostatic load scores when compared with other ethnicities.[20]

The two studies above highlight the detrimental cumulative physiological effects of stress over the life course. There are actions practitioners can take to mitigate the consequences of racism on our health.

The WMC can address racial equity in the following ways:

- Raise awareness of racial inequities via the adoption of an Anti-Discrimination Policy (In Progress).
- Redacting complaints submitted to the WMC complaint department. This eliminates implicit and explicit bias during the complaint review process (Process Completed).
- Institute equity lenses in all administrative processes, policies and procedures (Ongoing).
- Advocate for legislation and regulatory policies that address inequities.

The Impact of Racism on Health

Workplace:

- Mentor people of color interested in pursuing medicine.
- Encourage diversity and promote inclusive workplace.
- Advocate disaggregation of quality control practice data.
- Encourage your facility to share equity and performance outcomes data to identify areas in need of improvement.
- Institutionalize community outreach programs that promote healthy behaviors and connect patients with wrap-around social services in at-risk communities.

Individual:

- Support causes that promote social integration and improve quality of life.
  - Northwest Justice Project: provides legal help to all low-income individuals.
  - Equal Justice Initiative: provides legal representation and assistance to formerly incarcerated people.
- Advocate for social safety net policies (federalize Medicare/Medicaid, paid maternity/paternity leave) that improve quality of life.
- Volunteer at WA state free and Charitable Clinics serving underinsured populations.

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Rulemaking Efforts

WASHINGTON Medical Commission
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Amelia Boyd
Program Manager

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.

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.

Rulemaking Efforts

Senate Bill (SB) 6551 – International Medical Graduates

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

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

The next step in the rulemaking process, the Proposal or CR-102, was approved at the WMC's November 19, 2021 Business meeting and is in the process of being drafted. A hearing related to this rulemaking will be held in the first half of 2022.

Chapter 246-918 WAC – Physician Assistants and SHB 2378

The WMC has updated chapter 246-918 WAC regarding physician assistants (PA) to more closely align with current industry standards, modernize regulations to align with current national industry standards and best practices, and provide clearer rule language for licensed PAs. The rule also incorporates the requirements of Substitute House Bill (SHB) 2378 (chapter 80, Laws of 2020) and amends the rules to be in alignment with the bill. This bill combines the osteopathic PA licensing under the 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 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 an employment level process. Employers are required to keep agreements on file. The bill requires the WMC to collect and file the agreements. Amendments also change nomenclature from "delegation" to "practice" agreement and from "supervising physician" to "participating physician" agreement. These rules were effective November 27, 2021. The rulemaking order, which includes the updated rule language, is available here.

More Information

For 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.

2022 Recruitment Notice

The Washington Medical Commission (Commission) is currently accepting applications to fill upcoming vacancies. The Commission helps make sure physicians and physician assistants are competent and provide quality medical care.

We are looking for people willing to study the issues and make decisions in the best interest of the public. Our member selection reflects the diversity of the profession and provides representation throughout the state. On July 1, 2022 the Commission will have openings for:

- One physician representing Congressional District 3
- One physician representing Congressional District 5
- One physician representing Congressional District 9
- One Physician-at-Large
- One Physician Assistant
- Three Public Members

To determine what congressional district you live in, please visit this website and enter your zip code in the upper right part of the page.

The Commission consists of 21 members appointed by the governor. It meets about eight times a year, usually on Thursday and Friday every six weeks. There is an expectation to review multiple disciplinary cases between meetings, and additional meetings or hearings are often necessary. Additional information regarding commission membership and a link to the governor's application can be found on our website.

Please take the time to review the valuable information on commission membership available at the above website. Applications, along with a current resume, must be received by **March 25, 2022.**

If you have any questions about serving on the Commission, please contact Amelia Boyd, Program Manager, by email or call (360) 918-6336.

Legal Actions

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

August 1, 2021 -October 31, 2021

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				
Lovin, Jeffrey D. MD33709 Out of state	Order of Summary Suspension	08/03/2021	Alleged revocation of license to practice medicine in California	Indefinite suspension
Miller, Scott C. PA60427988 Clark County	Order of Summary Suspension	10/12/2021	Respondent allegedly publicly touted the use of ivermectin to treat COVID-19, treated one patient with ivermectin without adequate examination and without regard for possible interaction with other medications, was abusive and disruptive with hospital providers caring for COVID-19 patients, publicly threatened physicians and hospitals who would not administer ivermectin, and omitted information from his application for a PA license in Washington.	Indefinite suspension
Formal Actions				
Antoci, Valentin MD60307626 Yakima County	Final Order	10/21/2021	Respondent provided negligent surgical care to five patients.	Indefinite suspension. Respondent may petition for reinstatement after undergoing a clinical competency assessment. If Respondent is reinstated, conditions may be imposed on Respondent's practice.
Atteberry, Dave MD60125296 Yakima County	Agreed Order	08/20/2021	Respondent provided negligent care during spinal surgery to a patient.	Clinical competency assessment, personal appearances, $1000 fine, and termination no sooner than three years.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Brecht, Kristine MD44369 King County	Agreed Order	08/04/2021	Respondent provided negligent care to several patients, did not adequately supervise a PA, and did not document adequately.	Probation with restrictions and conditions including: restricted from performing procedures that require sedation, and if this restriction is lifted, there will be a permanent requirement to have an anesthesiologist or CRNA is present; restricted from prescribing Schedule II-IV controlled substances; restricted from supervising PAs, and from delegating management of pain and primary care to mid-level providers; required to implement an EMR system; coursework on record keeping and on pain management; develop a protocol for licensing of staff; a $25,000 fine; and personal appearances. A petition to modify must include a clinical competency assessment.
Lu, Kang MD60257984 Out of state	Final Order	08/03/2021	Revocation of medical license in Massachusetts	Indefinite suspension
Oliver, Cara MD00048841 King County	Final Order on Default	09/8/2021	Inability to practice with reasonable skill and safety due to a health condition or conditions.	Indefinite Suspension
Osten, Thomas J. MD11131 Spokane	Final Order	07/31/2021	Respondent engaged in abusive behavior toward 3 patients.	Probation; coursework on boundaries, ethics, communication, gender and sexual orientation; practice reviews; personal appearances, and a $6000 fine.
Smith, Larry H. MD6067174 Out of state	Final Order on Default	10/05/2021	Suspension of medical license in Louisiana.	Indefinite suspension
Wiebe, Jonathan P. MD60672857 Out of state	Final Order on Default	09/30/2021	Respondent did not respond to requests from the WMC investigator.	Indefinite suspension
Informal Actions				
Bremner-Dexter, Sandra J. MD33557 Spokane County	Informal Disposition	09/30/2021	Respondent allegedly mailed signed prescriptions to a clinic for distribution to Respondent's patients.	Paper on the potential adverse consequences of mailing signed prescriptions, and personal appearances.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Harris, Anthony E. MD44952 Pierce County	Informal Disposition	08/19/2021	Alleged negligence in performing spinal surgery	Coursework on complex anterior cervical spine surgery; research paper; participate in ten anterior C7-T1 surgeries, five assisting and five precepted by a WMC approved surgeon; practice reviews by CPEP; and personal appearances.
Hendler, Jared M. MD16589 Kitsap County	Informal Disposition	09/30/2021	Respondent allegedly sent a medical clearance form to a university athletic department along with a vaccination record provided by the patient's father that Respondent knew was not accurate.	Coursework and paper on vaccination as part of public health, letter to athletic department regarding the patient's vaccination status, personal appearances.
Lawson, Ian B. MD35040 Pierce County	Informal Disposition	08/19/2021	Respondent allegedly had sexual relationships with patients over 20 years ago.	Maintain compliance with WPHP contract, comply with treatment recommendations, ethics course, scholarly paper, and personal appearances. May request termination in three years.
Lee, Maximilian F. MD60222397 King County	Informal Disposition	08/20/2021	Respondent allegedly accessed the electronic medical record system for patients before establishing a physician-patient relationship.	Coursework in professional boundaries and record keeping, paper, personal appearances.
Marshall, Robert J. MD30900 Benton County	Informal Disposition	08/19/2021	Respondent allegedly permitted unlicensed staff to perform duties that required a license.	Office protocol ensuring that all staff is properly credentialed prior to providing services, and personal appearances.
Shinstrom, David C. MD17180 San Juan County	Informal Disposition	07/08/2021	Respondent allegedly inadequately documented treatment of a patient with stimulant medication.	Restricted from prescribing stimulant medications, and can petition to terminate in 2 years.
Siggard, Kipley J. MD60548172 Island County	Informal Disposition	09/30/2021	Respondent allegedly berated other providers and staff.	Voluntary surrender of license to practice medicine in Washington.
True, David D. MD31104 King County	Informal Disposition	08/20/2021	Respondent allegedly prescribed pain medications to a patient despite evidence the medications were causing the patient harm.	Coursework on treatment of patients with substance use disorders, scholarly paper, and personal appearances.

Stipulated Findings of Fact, Conclusions of Law and 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.
Stipulated Findings of Fact, Conclusions of Law and Final Order: an order issued after a formal hearing before the Commission.
Stipulation to Informal Disposition (STID): a document stating allegations have been made, and containing an agreement by the licensee to be subject to sanctions, including terms and conditions to resolve the concerns raised by the allegations.
Ex Parte Order of Summary Suspension: an order summarily suspending a licensee's license to practice. The licensee will have an opportunity to defend against the allegations supporting the summary action.

WPHP Report
Making Meaning from Outrage

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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

A few weeks ago, I was leading a wellness workshop for physicians. In one of the exercises, I asked participants to reflect on a time in their career when the alignment between their actions and their values had been most challenged. Stories from COVID-19 frontliners, caring for unvaccinated patients at the height of the Delta surge, overshadowed any other discussion. These physicians painfully described, with candor and vulnerability, the causes and consequences of actions which left them demoralized and often disappointed in themselves.

Fear, anger, frustration, and moral distress experienced by healthcare workers throughout the pandemic have been intensified during Delta. The preventability of suffering and death, the absurdity of it all, the overwhelm and exhaustion, the disregard and hostility toward science and public health, all contribute to our collective outrage.

This outrage, a normal psychological response to unacceptable circumstances, is a place we may be forced to visit but we should not live there. As Pulitzer Prize winning author, Sherry Fink, MD, PhD, reminded us in her keynote at the WSMA Annual meeting this year, doctors have survived genocides by making meaning from their outrage. Staying in outrage cannot move us forward, we must redirect that energy to a higher purpose.

Over the last several months we have begun to see outrage galvanizing workforce reform efforts. This past summer, the Health Resources and Services Administration announced over $100 million in grants to support health care workforce mental health, resilience, and wellness. At the same time, the Lorna Breen Health Care Provider Protection Act was passed in the U.S Senate and is now making its way through the House. It is expected to provide another $140 million in grants to support education and programs aimed at addressing the drivers of burnout and dissatisfaction in the profession.

In recent testimony on the Lorna Breen Act before the U.S. House Committee on Energy and Commerce, Representative Kim Schrier, a Washington physician, recognized and applauded the Washington Medical Commission and Washington Physicians Health Program (WPHP) as models for institutionalized wellness. She noted that Washington is a place that encourages physicians to get help and does not punish them for having done so.

In November, the WMC adopted yet another round of improvements to the licensing application that replace health related questions with an advisory. Accordingly, applicants are advised of their responsibility to contact WPHP if they have an impairing or potentially impairing health condition. And, while the application still asks about current substance use, applicants can answer "no" to the question if they are known to WPHP. These improvements are not only regulatory best practices nationally, but they represent a sincere effort to encourage physicians and PAs to seek help when needed.

One of the silver linings of the pandemic is that physicians have learned that it is okay to open discuss not being okay. Vulnerability, the power of shared experience, and our collective outrage have coalesced into a local and national dialogue that is finally moving the needle on efforts to address fundamental flaws in the healthcare ecosystem that are critical threats to the sustainability of our workforce. This silver lining is critical, considering that some of our most challenging days may still be ahead.

In his Meditations, Marcus Aurelius, wrote, "Impediment to action advances action. The obstacle on the path becomes the way." The COVID-19 pandemic has provided countless examples of resilience and adaptation, that were responses to obstacles on the path. As we turn the calendar on a new year, we can confront challenges knowing that they are necessary for our advancement. We should not be discouraged by what we have faced or by what we must still overcome. An abiding faith in our ability to succeed in the face of adversity, to make meaning from our outrage and become stronger for it, can help ease the woes that sometimes accompany us on the happy road of destiny.

WMC Meetings and Events
Full Schedule

WMC Policy Meeting	January 13, 2022 4:00pm
WMC Business Meeting	January 14, 2022 8:00am
WMC Policy Meeting	March 3, 2022 4:00 pm
WMC Business Meeting	March 4, 2022 8:00am

Members

WASHINGTON Medical Commission
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Links To Our Website

Pain Management Resources

Update your Physical And Email Address

News and Announcements

Rules and Regulations In Progress

Frequently Asked Questions (FAQ)

Contact Us

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.