Washington Medical Commission

# UPDATE!

Vol. 13 Winter 2023

## In This Issue...



## Also In This Issue...

# Message from the Chair

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

## Ensuring the Health of Washington's Physicians and Physician Assistants: Combatting Burnout

Karen Domino, MD, MPH

This edition of the Washington Medical Commission (WMC) Newsletter includes an important article from the Washington Physician Health Program (WPHP) about the tragic issue of physician suicide. As an academic physician, I have sadly learned that several of my former trainees committed suicide. As WPHP's Drs. Bundy and Sung describe, beyond depression, external factors may contribute to physician suicide. These factors include burnout, moral injury, malpractice claims, medical board complaints, and referrals to physician health programs, although causal relationships are not clear. From a larger viewpoint, burnout remains a significant cause of physician dissatisfaction with work-life balance and a cause of early retirement.

Physicians have a higher rate of dissatisfaction with work-life balance and burnout compared to the working population. Coping with patient illness and death is stressful. Physicians tend to be perfectionistic and blame themselves for poor patient outcomes. The corporatization of medical practice with top-down administration has resulted in lack of physician control over their practice and a proliferation of business-oriented performance metrics. Costly implementation of electronic health records created onerous charting requirements and reduced spending for extra health care staff to assist with high workloads. There is a misbalance between work demands and work resources.

The extraordinary physical and emotional stresses of COVID-19 increased burnout in all health care providers. Moral injury due to excessive work demands created the inability for physicians to adequately care for needy patients. This especially impacted those practicing emergency medicine, critical care, and family practice. COVID-19 also increased burnout in medical specialties providing elective care due to financial uncertainty from loss of income. In the post-COVID era, burnout results from short staffing paired with a higher public demand for healthcare in the face of early retirements.

Beyond the adverse impact of burnout on physician and physician assistant health, why else is the WMC so concerned about burnout? Burnout involves emotional exhaustion, depersonalization, and ineffectiveness at work. These factors impair communication with patients and lead to lower patient satisfaction and increased patient complaints to the medical board. More concerning is that burnout is associated with increased medical errors.
A recent systematic review of 170 published observational studies found that physician burnout was associated with a two times increase in adverse patient safety incidents (Hodkinson A, et al. British Medical Journal 2022; 378: e070442). Burnout also increased regret with choosing to become a physician and adversely affected career development of younger physicians.

Combatting burnout requires both workplace changes as well as increasing resiliency in providers. Early efforts to combat physician burnout focused solely upon personal wellness interventions such as mindfulness and exercise. Recently, with the new term, moral injury, there is increased recognition of the vital role of the workplace in easing burnout of health care providers. Organizational strategies to combat burnout involve reduction in provider workload and job demands, increasing provider control and flexibility, improving provider work-life integration, developing a sense of community in the workplace, improving workplace culture and values, and improving workplace efficiency and resources (Shanefelt TD, Noseworthy JH, Mayo Clinic Proc 2017; 82:128-146). In addition, systematic ways to improve medical student, physician, and physician assistant resilience also reduce burnout. I look forward to hearing more about ways to improve physician wellbeing from the WPHP in a future WMC newsletter!

***Physicians have a higher rate of dissatisfaction with work-life balance and burnout compared to the working population.***

# Executive Director Report

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

## Kyle Karinen, J.D., LL.M

This quarter I am going to touch on a growing trend in the healthcare licensing and regulation world: Interstate Licensing Compacts.

There is nothing inherently unusual about an interstate compact – it is simply an agreement between states to do or not do a certain thing. There are many instances of interstate compacts that, for example, govern regional transportation issues or access and use of natural resources. As a state enters into a compact, it cedes some of its individual sovereignty in return for the benefit of mutual cooperation with other states. On the licensing side of states' regulatory authority, one of the older compacts is the Driver License Compact. That compact allows states to freely exchange individuals' driver license information with each other in order to promote traffic safety.

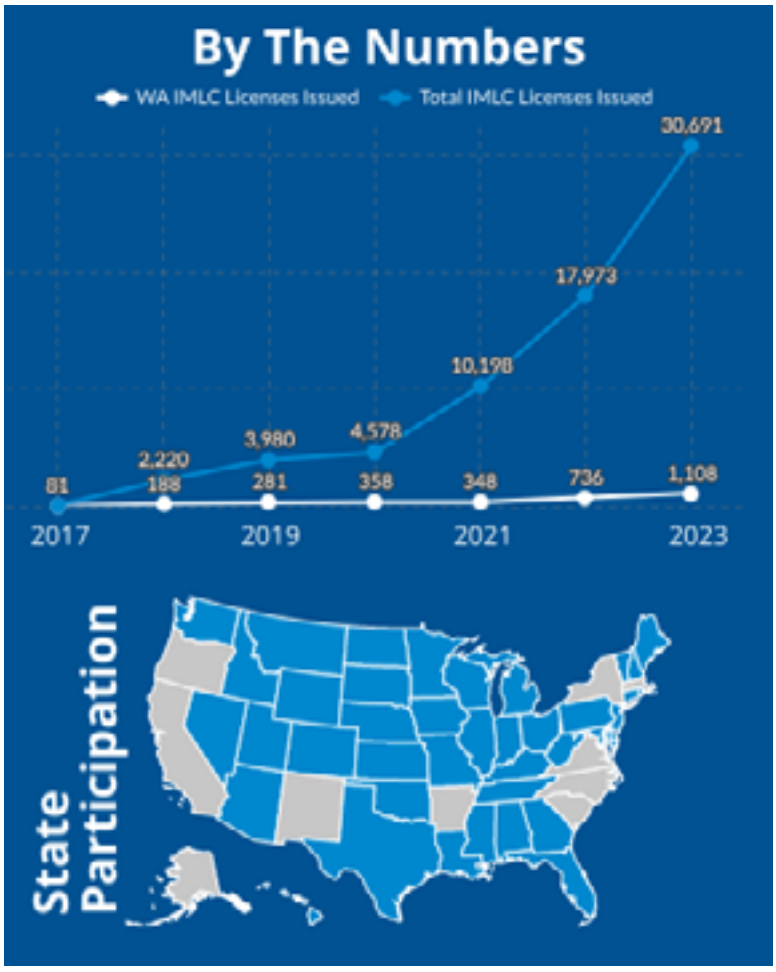
The concept of a medical licensing compact was begun in earnest in 2013. One of the primary goals, if not the primary goal, was to make licensure in multiple states easier for allopathic and osteopathic physicians. With the assistance of the Federation of State Medical Boards and assorted state medical boards, the first drafts of the proposed legislation circulated in Fall 2014. For the Medical Commission, entry into the Interstate Medical Licensure Compact (IMLC) came in the form of House Bill 1337 in 2017. That bill adopted the IMLC legislation for allopathic and osteopathic physicians and the WMC staff began a crash course in how the IMLC works as well as what was going to be expected of the WMC on an on-going basis. Our colleagues with the Board of Osteopathic Medicine and Surgery did the same. In December 2017, the WMC issued its first IMLC license.

At its heart, the IMLC offers a great benefit for physicians. Applicants apply to their home state for a letter that establishes their licensing qualifications. These qualifications involve medical education, specialty certification, and results of licensing examinations as well as a criminal background check. Applicants also must not be under investigation at the time of their application or have disciplinary history from their home state. These basic qualifications are then sent to the IMLC Commission and then transmitted to other states where the applying physician wants to be licensed. As a receiving state, when an IMLC request comes through, all of the regular information that an initial license applicant would need to submit is already provided in a tidy electronic package that greatly reduces the timeline to receive a license.

As of 2023, the majority of states in the country either participate in the IMLC or are in the process of implementing internal processes and procedures. Notably for Washington, the States of Oregon, California, and Alaska have not joined the IMLC and appear unlikely to do so in the near future.

As of the end of 2023, there were two bills that were pre-filed by legislators seeking to have Washington join the compact for licensing physician assistants (PA). The PA Compact is structured somewhat differently than the IMLC. Instead of the expedited licensure model that IMLC represents, the PA Compact adopted a legal structure more akin to what the Legislature adopted for physical therapists in 2017.

At the recent IMLC annual meeting, a fellow IMLC Commission member put it best: "IMLC is a technology operation." States still retain the authority to license and regulate as legislatures but for physicians many of the inefficiencies in the process of moving and/or practicing in different states have been knocked down. There is a growing consensus that licensing compacts for healthcare professionals are an essential part of healthcare in the United States.



# Dark Days of Winter or Christmas Time is Here

## Arlene Dorrough PA-C

As we come to the close of the year, we seem to find ourselves more and more busy, trying to get things done before the year is over, maintaining our cool in the face of increasing work demands as coverage is needed for so many who are gone for the holidays or simply home sick during cold and flu season.

During this busy time of the year, it is easy to lose yourself in the darkness of the season. Darkness? You ask, for most people, the holiday season is full of colorful lights, bright, gregarious music, and a barrage of well wishes, warm drinks and fun activities. But for some of us, those who have social anxieties, or are simply introverts, it is a time to turn inward, to avoid all of the noise and bustle of the season, we insulate ourselves from friends and family and social pressures and we often find ourselves disappointing those we love as we work to protect ourselves from the cacophony of 'The Holidays'. And this is followed inevitably by guilt that you are letting your friends and loved ones down if you do not participate in every activity, they wish you to.

How many social engagements you accept over the holidays is completely up to you, but I urge you to embrace your choices as the best ones for you, whether or not, you are disappointing others. The pressure to make people happy can create untenable situations for you as you are struggling to please others and neglecting your own needs in the process. It's just as okay to sip chai tea in the solitude of your home, as it is to sip cocoa in the back of a sleigh ride packed with family and friends.

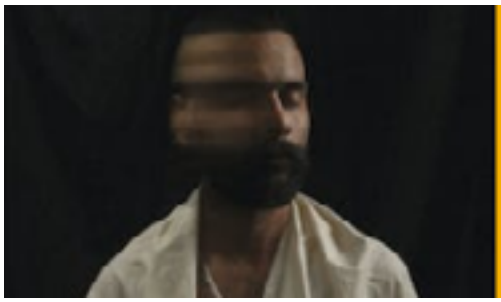
Whatever works for you is the key. If you find yourself at the bottom of your reserves after a busy workday, consider taking a rest over the weekend, instead of packing your days with must-do activities that will further stretch your reserves and leave you tired and overwrought come Monday morning when it's time to get back to your patients. I suggest choosing one weekly activity that does not cause you stress, and you can focus on being present for that activity and whomever you are doing it with. It will allow you time to appreciate the time together and enjoy yourself in a way that you will remember fondly, instead of a blur of activity that leaves you coming up for air and glad it's finally over.

I also suggest you scale things back. There is no need for you to host a party, scour your house, make every dish and be a scintillating host with games planned for everyone in the group. Choosing a select group of friends to come over and just put in a movie. (It doesn't even have to be a Christmas movie…Die Hard for instance). Enjoying the company of friends does not have to be a complicated affair, keep it simple so you have more time to enjoy yourself and soak up the camaraderie of your closest friends and family who have room for you and your feelings this holiday season.

It can be difficult to manage the packed clinic schedules and accommodate patients fitting in last minute healthcare needs before their insurance resets next month, but survival is imperative and sometimes that means simply saying "No". Setting boundaries in a respectful way is part of effective time management and good communication with your professional colleagues. It is much better to manage expectations up front, ahead of the busiest times, so effective planning can be done, and no one ends up holding the bag with more work than they can handle (especially if that person is you).

So whether you are lighting a menorah, a kinara or a yule log, take time for yourself, to rest, to re-charge and to fully enjoy the best and brightest of the year before another year rolls around with its own fresh new challenges and rewards.

Happy Holidays everyone, and have a healthy, happy and prosperous New Year!



*It can be difficult to manage the packed clinic schedules and accommodate patients fitting in last minute healthcare needs before their insurance resets next month, but survival is imperative and sometimes that means simply saying "No".*

# Rulemaking Efforts

WASHINGTON Medical Commission
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## Amelia Boyd
### Program Manager

**Health Equity Continuing Education for MDs and PAs**

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

The WMC officially filed a CR-102 with the Office of the Code Reviser on August 23, 2023. The WMC is proposing new sections of rule to establish health equity continuing education (CE) requirements to implement Engrossed Substitute Senate Bill (ESSB) 5229 (chapter 276, Laws of 2021). The WSR# is 23-18-007. In response to the filing, the WMC held an open public rules hearing on Friday, October 20, 2023. The proposed language was approved.

The CR-102 Proposed Rulemaking filed document can be viewed here. The CR-103, Rulemaking Order, is in progress.

**Postgraduate Medical Training, WAC 246-919-330 via Standard Rulemaking**

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

At their October 20, 2023, Business meeting, the Commissioners approved initiating the next step in the rulemaking process, CR-102 Proposed Rulemaking. The hearing for this rulemaking will be held in 2024.

**Postgraduate Medical Training, WAC 246-919-330 via Emergency Rulemaking**

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

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

**Opioid Prescribing Rules**

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

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

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

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

# Rulemaking

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

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

The WSR# is 23-17-094.

At their October 20, 2023, Business meeting, the Commissioners approved initiating the next step in the rulemaking process, CR-102 Proposed Rulemaking. The hearing for this rulemaking will be held in 2024.

### 2SHB 1009 Military Spouse Temporary Practice Permits

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

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

### Collaborative Drug Therapy Agreements

The CR-101 for creating rules related to Collaborative Drug Therapy Agreements was filed with the Office of the Code Reviser on July 22, 2020 as WSR #20-16-008.

One aspect of the practice of medicine is working with pharmacists to deliver drug therapy to patients. This coordination can take many forms, but the WMC's concern involves treating patients under a collaborative drug therapy agreement (CDTA). These arrangements occur pursuant to a written agreement entered into by an individual physician or physician assistant and an individual pharmacist.

The Pharmacy Quality Assurance Commission has adopted a rule that governs CDTAs from the pharmacy perspective, however there are no statutes or rules that govern a physician's responsibilities under a CDTA. A rule is needed to define the roles and responsibilities of the physician or physician assistant who enters into a CDTA, any defined limit to the number of pharmacists who may have a CDTA with any one physician or physician assistant, and how the physician or physician assistant and pharmacist can best collaborate under these agreements.

Regulating the use of CDTAs would place the WMC in an active patient safety role. Rulemaking would provide clarity around this issue to help avoid potential discipline and increase patient safety. New sections being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

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

### More Information

Please visit our rulemaking site and for continued updates on rule development, interested parties are encouraged to join the WMC's rules GovDelivery. WMC rulemaking comments or questions may be emailed to medical.rules@wmc.wa.gov.

# What is the Washington Physicians Health Program Doing About Physician Suicide?

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

**Jeffrey Sung, MD**
**Board of Directors, Washington Physicians Health Program**

As Washington's trusted resource for restoring the health of medical professionals, the Washington Physician Health Program (WPHP) considers physician suicide awareness and prevention an important priority – one in which we are leading efforts at state and national levels. Through our education and outreach mission, WPHP strives to provide accurate information about physician suicide as well as resources to support physicians and physician assistants (PAs) with health conditions that are associated with suicide.

Recent estimates suggest that approximately 120 physicians in the United States die by suicide each year.[1] Whether physicians in the U.S. experience elevated rates of suicide compared to the general population, however, remains unanswered. That said, studies consistently find a higher risk for female physicians vs. female non-physicians.[2]

Many medical practice variables have been suggested as potential contributors to physician suicide: burnout, moral injury, unhealthy medical education and training environments, toxic practice settings, malpractice claims, medical board complaints, and referrals to physician health programs. While these factors may relate to distress and dissatisfaction among physicians or PAs, causal links to suicide remain unclear. A review of 498 physician suicide decedents found that intimate partner problems and physical health problems were the most common circumstances associated with the deaths. About half of the physician suicides involved a firearm. Job problems were more common among physicians than non-physicians, but were found to be a contributing circumstance in less than 20% of the physician suicides.[2] While job-related stressors are prevalent in medical practice, the vast majority of physicians with these stressors will not die by suicide, and most physicians who died by suicide do not appear to have job problems. As such, examining practice stressors may inform prevention efforts, but they are poor predictors of physician suicide on an individual, case-by-case basis.

Suicide prediction, in general, is fraught. Multiple studies have shown that clinical judgement is no better than chance at predicting suicide. Current or recent psychiatric hospitalization dramatically elevates suicide risk. Yet, the positive predictive value of prior psychiatric hospitalization for future suicide – 2.5% for men and 1.5% for women – is too low to predict suicide even among these high-risk individuals. As such, universal and selective prevention strategies that seek to improve overall health and provide early intervention for distress are likely to have more impact on physician suicide than prevention efforts that rely on probabilistic suicide prediction models.[3]

Regardless of prevalence or predictability, suicide remains a tragic outcome. People in suicidal despair suffer deep emotional anguish, and suicide loss survivors often experience painful and complicated grief with persisting questions of "Why?" and "What if…?". From this perspective, even one suicide is too many. It is therefore critical to use accurate and balanced information when discussing suicide among physicians. Sensationalistic, overly simplistic reports about the "alarming epidemic" of physician suicide, relating to specific stressors or the collective problem, can misdirect resources toward ineffective advocacy and prevention efforts, add distress to surviving loved ones, cost people their jobs and careers, damage reputations, traumatize organizational cultures, discourage gifted individuals from taking leadership roles, undermine the public trust in our profession, and may increase suicide risk among vulnerable populations by discouraging help-seeking and promoting suicide contagion.

Discussions that attribute physician suicide to specific actions, events, organizations, institutions, circumstances, or conditions in the healthcare ecosystem can be interpreted as understandable efforts to grapple with meaning-making after tragic events. Complex problems in systems of healthcare delivery unquestionably contribute to burnout and distress among health care professionals. At the same time, we caution against narratives that justify the inevitability of suicide – i.e., that a "perfect storm" of events can or will lead to suicide. Instead, we maintain that dignity, hope and agency are possible regardless of circumstances. A compassionate approach should neither trivialize

nor demonize high-intensity stressors, including those related to medical practice. As recommended by people with lived experience of suicidality, we suggest an approach that focuses on a message of hope that affirms the existence of life-directed pathways: that suicide is not the inevitable consequence of any individual or set of circumstances, no matter how difficult.

As physicians and physician assistants, we have a professional responsibility to critically appraise health information and communicate accurately to the public and to ourselves. We must educate ourselves about mis- and disinformation so that we may guard against unintentionally propagating it and recognize that suicide and physician suicide are complex, nuanced phenomenon. We must be watchful for confirmation bias, recognizing how seductive it is to favor information, regardless of its accuracy, that confirms our pre-existing beliefs and values, including the understandable frustrations many of us share regarding the modern practice environment. The American Foundation for Suicide Prevention provides safe reporting guidelines for the media that can help health professionals recognize and avoid harmful communication about suicide.

WPHP has a long-standing commitment to addressing suicide among physicians. At the individual level, for program participants, WPHP's suicide risk assessment and management protocols are a model among physician health programs. While suicide risk assessment has limited utility in predicting suicide, it can help identify appropriate targets of therapeutic intervention. This represents a shift in focus from "risk assessment" to "needs assessment."[4] Every referral call to WPHP is screened for concerns of suicide and all intake assessments include the empirically validated Columbia Suicide Severity Rating Scale Screen Version. Positive screens undergo comprehensive suicide risk assessment by licensed mental health professionals and are staffed with one of our program psychiatrists. Program participants are asked about thoughts of hopelessness and suicide during any encounter where a clinically relevant increase in distress is observed. Acute distress or exacerbation of illness triggers communication with the participant's care team, identification of unmet needs, and linkages to additional resources and support as indicated.

Although not required by our DOH contract, WPHP provides 10-year suicide data to both the DOH and the Washington State Medical Association, underscoring our commitment to transparency and partnership on this important issue. WPHP is the only physician health program in the country that obtains external peer review, conducted by nationally recognized experts in physician suicide, for all program suicides. In the past 12 years, five program participants died from suicide and, while WPHP met the standard of care in each of these tragic cases, these reviews always help us improve our work.

Key findings of external reviews are provided to the WPHP Board of Directors which includes nationally recognized psychiatrists and other physician and non-physician experts who lend valuable insight to our internal and external prevention efforts.

At the local and state level, WPHP conducts educational presentations about physician suicide to Washington's medical community, including students and trainees, and recently collaborated with the Department of Health (DOH) to develop suicide training for veterinarians. In addition, we recently participated in a Washington Medical Commission webinar, Coffee with the Commission: Personal Data Questions, to report on regulatory reforms that demonstrate our shared commitment to removing barriers to seeking help for mental health conditions. WPHP is also involved in national educational events that promote physician suicide awareness and resources for physicians in distress. For example, we recently presented at the American Conference on Physician Health and participated in a national webinar on suicide prevention, Physician Suicide Prevention Listening to the Voices of Experience, sponsored by the Federation of State Physician Health Programs and the American Foundation for Suicide Prevention. Both presentations are available to the public at the links provided.

You can find more resources for suicide prevention and crisis intervention, request a speaking engagement on physician suicide, and learn more about physician health and well-being on our website. In addition, you may wish to sign up for our newsletter, where you can stay up to date on the issues in physician health and wellness of interest to you.

At the national level, WPHP is working in close partnership with the Federation of State Physician Health Programs, American Medical Association, Federation of State Medical Boards, American Foundation for Suicide Prevention, Accreditation Council for Graduate Medical Education, and the Lorna Breen Heroes Foundation on physician suicide prevention and advocacy efforts including educational sessions and webinars, communications strategies, licensure and credentialing application reform, financial support, and decreasing barriers to mental health care access across the physician and PA career spectrum. Collectively, we are aligned in the belief that these efforts will decrease stigma, increase help acceptance, and promote life - now and in the years to come.

We are sometimes asked whether a referral to WPHP might precipitate a physician or PA suicide. While we cannot know the constellation of factors that may contribute to a suicide at the point of referral, we do understand that it can be a precarious time. WPHP has the experience, expertise, and outcomes that demonstrate our ability to effectively address the health conditions that relate closely to suicide risk. We believe,

on balance, that a referral to WPHP decreases rather than increases suicide risk. Because numbers are too low to empirically validate this belief, we turn to the direct, lived experience of our program participants. 25% of program graduates report that WPHP saved their life. Experience suggests one of the most important ways we can protect our participants from suicide is by quickly establishing a collaborative connection based on mutual trust and support. In so doing, we provide a beacon of hope to help physicians and PAs navigate through despair. Over the years, countless physicians and PAs have shared with us how WPHP brought them back from the brink of suicide. These heartfelt reports deepen the meaning, purpose, and importance of our mission. You can find examples of these personal stories on our website.

We consider it a continuing privilege to serve the physicians and PAs of Washington and to be recognized nationally for our expertise and advocacy in addressing physician suicide. If you or someone you know is thinking about suicide, needs help, or has questions, do not hesitate to call us at 800-552-7236 or reach us via our website contact form at www.wphp.org.

1. Gold KJ, Schwenk TL, Sen A. Physician Suicide in the United States:Updated Estimates from the National Violent Death Reporting System. *Psychol Health Med. Aug 2022;27(7):1563-1575. doi:10.1080/13548506.2021.1903053*

*2. Ye GY, Davidson JE, Kim K, Zisook S. Physician death by suicide in the United States: 2012-2016. J Psychiatr Res. Feb 2021;134:158-165. doi:10.1016/j.jpsychires.2020.12.064*

*3. Large MM. The role of prediction in suicide prevention. Dialogues Clin Neurosci. Sep 2018;20(3):197-205. doi:10.31887/DCNS.2018.20.3/mlarge*

*4. Kapur N. Management of self-harm in adults: which way now? Br J Psychiatry. Dec 2005;187:497-9. doi:10.1192/bjp.187.6.497*

# Medical Cannabis Update

The Medical Cannabis Program has been getting questions about whether authorization forms and recognition cards that contain the term "marijuana" are still valid. The short answer is yes. In 2022, a bill passed that replaced the term "marijuana" with "cannabis" in Washington State Law. As a part of this change, the DOH updated the patient authorization form and recognition cards to reflect the term "cannabis".

Key Information

- Recognition cards and authorization forms printed on tamper-resistant paper with the term "marijuana" are still valid.
- Healthcare providers should use the new authorization form when printing authorizations in-clinic.
- Vendors that provide forms to healthcare professionals should switch to the new authorization form as soon as practicable.
- Current recognition cards do not need to be replaced. At the next renewal cycle, patients will be issued an updated card with the term "cannabis."
- No other changes have occurred on the card or in the database.
- The term "marijuana" may still appear in the database or program resources as we go through this transition.

Related Regulations:

- Second Substitute House Bill 1210 (passed in 2022) replaces the term "marijuana" with "cannabis" in Washington state law.
- Expedited rulemaking in November of 2022 updated the term cannabis in Chapters 246-71 through 246-72 WAC.

Contact Information
Phone: 360-236-4819 (option 1)
Email: medicalcannabis@doh.wa.gov

Need database support?
Phone: 360-236-4819 (option 1) or 1-877-303-3869
Email: medicalcannabis@doh.wa.gov or support@cloudpwr.com
Website: www.doh.wa.gov/MedicalCannabis

For additional training references and information, please visit the Medical Cannabis Retail Store Setup website.

# WMC Public Meetings

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| WMC Meeting Type | Date & Time | Location | More Information |
|---|---|---|---|
| Personal Appearances | January 11, 2024<br>10:00 - 12:00 pm | Virtual | More Information |
| Rules Workshop<br>Military Spouse Temporary Practice Permits (2SHB 1009) | January 16, 2024<br>3:00 - 5:00 pm | Virtual Meeting and In-Person<br>111 Israel Rd SE DOH<br>Town Center 2<br>Rm 166<br>Tumwater, WA 98501 | More Information and Registration |
| CME Webinar<br>Optimizing Care for People Experiencing Homelessness | January 18, 2024<br>12:00 - 1:00 pm | Virtual | More Information and Registration |
| Business Meetings | January 19, 2024<br>9:00 - 11:00 am | Virtual | More Information and Registration |
| Coffee with the Commission<br>Communication and Resolution Program Certification | February 7, 2024<br>11:00 - 12:00pm | Virtual | More Information and Registration |
| Personal Appearances | March 7, 2024<br>10:00 - 12:00 pm | In-Person, Location TBD WA | More Information |
| Policy: Interested Parties | March 21, 2024<br>10:00 - 11:00am | Virtual | More Information and Registration |
| Additional Events can be found on our Meetings Page and Events Calendar | | | |

## Rules Adopted: Health Equity Continuing Education for Physician Assistants and Allopathic Physicians

The WMC has adopted WAC 246-918-195 (new) (physician assistants) and WAC 246-919-445 (new) (allopathic physicians) to implement Engrossed Substitute Senate Bill (ESSB) 5229 (chapter 276, Laws of 2021). This adoption implements the health equity model rules, WAC 246-12-800 through 246-12-830, for physician assistants and allopathic physicians to comply with RCW 43.70.613. The CR-103P was filed on November 29, 2023, as WSR #23-24-033. These rules will be in effect on January 1, 2024. The CR-103P includes the adopted language for WAC 246-918-195 and WAC 246-919-445.

RCW 43.70.613(3)(b) directs the rulemaking authority for each health profession licensed under Title 18 RCW that is subject to continuing education (CE) to adopt rules requiring a licensee to complete health equity CE training at least once every four years. The statute also directed the Department of Health (department) to create model rules establishing the minimum standards for health equity CE programs. The department filed model rules for health equity CE minimum standards on November 23, 2022, under WSR 22-23-167. Any rules developed by the commission must meet or exceed the minimum standards in the model rules in WAC 246-12-800 through 246-12-830.

The adopted rule adds two hours of health equity education, as required in the model rules, to be completed as part of the current continuing competency requirements every four years. The adopted rule does not change the total CE hours but requires two hours in health equity CE every four years which is absorbed into the existing number of CE hours required. The health equity CE requirement is counted under existing, unspecified CE requirements for the profession.

# Communication and Resolution Program Certification

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## The Value of Collaboration to Improve Patient Safety after Adverse Events

Felicidad Smith, MPH
CRP Manager, Foundation for Health Care Quality

Despite the best efforts of healthcare professionals, systemic faults leave a chance that a medical error may occur. Adverse events where a patient is unintentionally harmed during their care can be dangerous, leading to injury or even death. Medical errors are preventable and may require systems change to reduce the risk of harm to future patients.

Over the years, momentum has been building for the adoption of a "Just Culture" in healthcare. In the Institute of Medicine's groundbreaking report, To Err is Human, the report found that the most effective way to reduce errors and enhance safety in high-risk industries is to not blame individuals. Instead, a cultural shift that promotes transparency, creates a safe environment for reporting errors, identifies the root causes, and takes action to prevent future errors can take patient safety measures to new heights.

The fear of harsh disciplinary actions can prevent healthcare workers from reporting errors made by themselves or their colleagues. However, Just Culture recognizes that medical errors often involve competent providers working in flawed systems. Just Culture replaces hostility with a team-oriented process that encourages open error reporting, responding to mistakes with enhanced training and supervision, and a drive to learn from medical errors. Communication and Resolution Programs (CRPs) provide a framework for organizations to activate Just Culture principles and contribute to state-wide learning from adverse events.

> ***"The use of CRP is a significantly different approach to handling medical error than the traditional procedure of secrecy, denial, and defensiveness.***

**Communication and Resolution Programs**

CRPs promote a patient-centered response to adverse events. When a patient is harmed by medical care, the patient should be informed of exactly what happened, the steps that will be taken to address the event and ensure that it will not happen again. The use of CRP is a significantly different approach to handling medical error than the traditional procedure of secrecy, denial, and defensiveness.

After an adverse event, the primary things patients want are an honest explanation of what happened and a compassionate apology. Reflecting Just Culture, CRPs are characterized by transparent and prompt communication; apologizing; meeting the needs of involved patients, families, and providers; a rapid investigation of what led to the adverse event; proactive resolution; collaboration across all involved stakeholders; and system-level changes to prevent the error from happening again. In this process, CRPs save space for these important conversations to occur in order for patients to maintain a positive relationship with their provider and for organizations to improve their quality of care.

**The Foundation for Health Care Quality, the Commission, and CRP Certification**

The Foundation for Health Care Quality (FHCQ) is a nonprofit organization that administers quality improvement programs, including CRP Certification. With CRP Certification, FHCQ has gathered a neutral, non-judgmental panel of patients, patient advocates, physicians, surgeons, risk managers, attorneys, and other healthcare stakeholders to create the CRP Review Panel. This panel will review submitted adverse events to "certify" if the organization's response was aligned with the essential CRP principles. Organizations can apply for CRP Certification once the CRP event is complete. At the end of the CRP Certification process, applicants will receive feedback from the review panel summarized in a report with a determination of certified, not certified, or certified with contingency.

## Communication and Resolution Program Certification

It is important to note that CRPs do not tolerate recklessness or intentional disregard of safe practices. If evidence suggests that the provider(s) involved participated in unprofessional or unethical behavior, the event is not eligible for CRP or CRP Certification.

One benefit of undergoing the CRP Certification process is FHCQ's partnership with the Washington Medical Commission. If a complaint regarding the CRP event is filed with the Commission and the event has been certified by the CRP Review Panel, the CRP Certification report can be submitted to the Commission and will be combined with their investigation. If the Commission determines that the CRP process has thoroughly enhanced patient safety, the Commission may close the case as satisfactorily resolved.

Within the CRP Certification umbrella is CRP Validation. CRP Validation is a process that happens before CRP Certification and presents organizations with the opportunity to receive real-time feedback of their CRP response. CRP can be complex and challenging. For this reason, the review panel will be available to provide support, troubleshoot challenges, answer questions, and create additional opportunities for organizations to contribute to shared learning.

Learning from medical errors is crucial to improving patient safety. To facilitate and enhance learning, the Commission and FHCQ are committed to collaborating and developing a state-wide system to disseminate lessons learned from medical error cases to the healthcare community. To advance this work, it is encouraged for all institutions, clinics, and practices in Washington to join in the effort to encourage open communication, reduce medical error and improve patient safety through CRP. To learn more about CRP, CRP Certification, and how to apply, visit our website.

**To learn more about this topic - Join us for a webinar "The Value of Collaboration to Improve Patient Safety after Adverse Events" February 7, 2024 11:00 AM PST**

# Culturally and Linguistically Appropriate Care

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


On September 23, 2023, the U.S. Department of Health and Human Services (HHS) announced $8 an million investment to train primary care medical students, physician assistant students, and medical residents to provide culturally and linguistically appropriate care for individuals with limited English proficiency (LEP) and individuals with physical or intellectual and developmental disabilities.[1] The allocation is intended to provide equitable access to healthcare for these historically underserved communities.

A 2022 study cited in the HHS press release highlighted the barriers people with disabilities face when accessing health services. Out of the 714 physicians surveyed (primary and sub-subspecialty) only 41% of respondents reported that they were "very confident" about their ability to provide the same quality of care to people with disabilities as those without, and 57% strongly agreed that they welcomed people with disabilities into their practices.[2] 22.6% (standard error = 2.2) attempted to regularly weigh people with disabilities[3]; and only 40% always or usually used accessible exam tables or chairs. The study also revealed notable gaps in knowledge about requirements of the ADA: 36% reported knowing "little or nothing" about their legal responsibilities under the ADA, and nearly 70% reported that they were at risk for ADA-related lawsuits.[4] The survey results suggest that physicians' attitudes and behaviors relating to care for people with disabilities is substantially lacking and in need of further training.

Similar to individuals with disability, individuals with limited English proficiency (LEP) are disproportionately impacted by inequitable access to healthcare leading to healthcare disparities. LEPs are defined as individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English. These individuals are entitled to language assistance when seeking services, benefits, or encounters.[5] Around 25.7 million or 8% of people ages five or older living in the United States are estimated to have limited English proficiency[6]. Individuals with limited English proficiency experience increased medical errors[7], adverse events[8], longer hospital stays[9] and are at a higher risk of a return visit for emergency admission[10] which indicates reduced quality of healthcare.

The Biden-Harris Administration is taking steps nationally to tackle structural and policy inequalities. Physicians practicing in WA can be agents of change and address the needs of patients with physical and/or intellectual disabilities and limited English proficiency by implementing strategies that strive to reduce physical and language barriers.

Increase the accessibility of your medical practice by implementing the following strategies:

- Select care locations that have universal designs (ramps, elevators, and wide doors ways) to accommodate individuals with physical disabilities as well as people throughout the lifespan.
- Replacing furniture and equipment with adjustable and accessible diagnostic equipment can help to ensure your practice is inclusive of all individuals. Explore Standards for Accessible Diagnostic Medical Equipment for the proposed rule by the Architectural and Transportation Barriers Compliance Board.
- Familiarize yourself with assistive listening devices (ALDs) for patients with speech and other impairments. The National Institute on Deafness and Other Communication Disorders has detailed information.
- Utilize professional interpreters either in person or remotely to facilitate effective communication with patients with limited English proficiency. In WA state, the Health Care Authority (HCA) uses Universal Language Services to coordinate spoken language in-person, over-the-phone interpreting (OPI), and video remote interpreting (VRI) requests. For providers who have patients utilizing Washington Apple Health (Medicaid), Sign Language Interpreter Request Form can be used to secure interpretation. Community Plan of Washington Medicare Advantage and most other insurance providers reimburse for language services.
- Ensure that written materials such as consent forms and patient education materials are available in multiple languages.
- Partake in educational opportunities that centralize cultural competence of communities around WA. Select opportunities that are presented from the perspectives of people with physical disabilities and those that have limited English proficiency. WA Department of Health (DOH) has resources for healthcare professionals who are new to the cultural competency training journey. DOH recommends several foundational training courses free of charge.

- Engage with community organizations and support groups that focus on the needs of individuals with physical disabilities and linguistic diversity to strengthen your overall understanding of the barriers faced by the community.
- Provide health information in accessible formats such as braille, large print, or audio for patients with visual or reading impairments. Washington State School for the Blind has several services for braille production and technology assistance.
- Strive for individualized care that centers on collaboration between healthcare providers, language support services and rehabilitation specialists to comprehensive care for patients with physical disabilities and language barriers.
- Implement quality improvement or patient feedback mechanisms to understand the accessibility of your practice and evaluate the effectiveness of accommodations to continuously work on improvement.

Figure 1: 37 languages spoken by LEP in WA – utilizing 2016 Office of Financial Services Data[11] Languages are spoken by at least 5% of the state population or 1,000 people.

| | | | |
|---|---|---|---|
| 1. Spanish | 11. Chinese (simplified) | 21. Romanian | 31. German |
| 2. Vietnamese | 12. Chinese (traditional) | 22. Tigrinya | 32. Pilipino/Filipino |
| 3. Russian | 13. Marshallese | 23. Farsi | 33. Burmese |
| 4. Ukrainian | 14. Samoan | 24. Tamil | 34. Thai |
| 5. Tagalog | 15. Hindi | 25. French | 35. Oromo |
| 6. Somali | 16. Amharic | 26. Nepali | 36. Karen |
| 7. Korean | 17. Japanese | 27. Hmong | 37. Portuguese |
| 8. Arabic | 18. Telugu | 28. Chuukese | |
| 9. Punjabi | 19. Urdu | 29. Mixteco | |
| 10. Cambodian | 20. Lao | 30. Swahili | |

Figure 2: Most commonly spoken languages in WA among Medicare beneficiaries with Limited English Proficiency[12]

| Language | Percentage | Number |
|---|---|---|
| Spanish | 25.78 | 17,758 |
| Vietnamese | 12.04 | 8,292 |
| Korean | 9.05 | 6,232 |
| Tagalog | 7.25 | 4,992 |
| Chinese | 6.75 | 4,653 |
| Russian | 6.35 | 4,372 |
| Japanese | 5.69 | 3,917 |
| Cantonese | 3.83 | 2,638 |
| Panjabi | 2.31 | 1,591 |
| Ukrainian | 2.19 | 1,509 |
| **Total** | **81.24** | **55,954** |

Providers are required to facilitate spoken and sign language access according to Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA).

Healthcare providers need to take a comprehensive and inclusive approach to meet the needs of patients with physical disabilities and limited English proficiency. Considering these factors in practice can help create a more accessible healthcare environment that caters to the diverse needs of all patients. Implementing best practice strategies that take patient-centered approach improves communication, understanding, and overall health outcomes for most vulnerable populations.

Endnotes

1 U.S. Department of Health and Human Services (HHS) September 23, 2023 Press Release https://www.hhs.gov/about/news/2023/01/25/hhs-invests-8-million-improve-health-care-access-training-new-physicians-care-individuals-disabilities-individuals-limited-english-proficiency.html

2 Lagu, T., Haywood, C., Reimold, K., DeJong, C., Walker Sterling, R., & Iezzoni, L. I. (2022). 'I Am Not The Doctor For You': Physicians' Attitudes About Caring For People With Disabilities. Health affairs (Project Hope), 41(10), 1387–1395. https://doi.org/10.1377/hlthaff.2022.00475

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10 Gallagher, R. A., Porter, S., Monuteaux, M. C., & Stack, A. M. (2013). Unscheduled return visits to the emergency department: the impact of language. Pediatric emergency care, 29(5), 579–583. https://doi.org/10.1097/PEC.0b013e31828e62f4

11 Department of Health Language Access Plan https://doh.wa.gov/sites/default/files/2022-04/37_Most_Spoken_Languages_in_WA_State.pdf

12 Centers for Medicare & Medicaid Services (CMS) Understanding Communication and Language Needs of Medicare Beneficiaries https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf

# Legal Actions

WASHINGTON Medical Commission
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## August 1, 2023 – October 31, 2023

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

| Practitioner<br>Credential and County | Order Type | Date | Cause of Action | WMC Action |
|---|---|---|---|---|
| **Summary Actions** | | | | |
| Welling, Eric C., MD | Order of Summary Suspension | 8/3/23 | Suspension of license in Wyoming. | Indefinite suspension of license. |
| **Formal Actions** | | | | |
| Antonatos, Miguel R.<br>IMLC.MD.61023368<br>Out of state | Agreed Order | 8/24/23 | Prescribing ivermectin based on an internet questionnaire. | Agreed that prior to prescribing medication or providing care to patients in Washington, will first establish a physician-patient relationship by seeing patient in person or via real-time video; agrees not to prescribe ivermectin for non-FDA-approved indications; CME in record keeping; compliance audits; personal appearances; fine. May petition to terminate in 5 years. |
| Fenstermacher, Erin, L.<br>MD60435875<br>Out of state | Default Order | 8/22/23 | Revocation of license in New Mexico. | Indefinite suspension. |
| Garman, Edward T.<br>MD00034686<br>Spokane County | Default Order | 9/20/23 | Inability to practice with reasonable skill and safety due to a health condition. | Indefinite suspension. |
| Go, Rosana L.<br>MD00043083<br>Skagit County | Default Order | 8/10/23 | Inability to practice with reasonable skill and safety due to a health condition. | Indefinite suspension. |
| Malan, Jedidiah J.<br>MD60225585<br>Out of state | Default Order | 8/4/23 | Suspension of license in Alaska. | Indefinite suspension. |
| Miller, Scott C.<br>PA60427988<br>Clark County | Default Order | 10/25/23 | Failure to provide medical records to the parent of a patient; failure to cooperate with an investigation. | Revocation of license. |

| Practitioner<br>Credential and County | Order Type | Date | Cause of Action | WMC Action |
|---|---|---|---|---|
| **Formal Actions** | | | | |
| Okonkwo, Adaobi<br>MD60583906<br>Out of state | Agreed Order | 10/5/23 | Failure to cooperate with an investigation. | Restricted from practicing obstetrics without a preceptor or proctor present; must work with a preceptor for 12 months; then complete 12 deliveries observed by a proctor; CME in electronic fetal monitoring; CME in record keeping; advanced life support in obstetrics course; personal appearances; fine. May petition to terminate after completing requirements. |
| Oliver, Richard T., Jr.<br>PA60271207<br>Walla Walla County | Default Order | 10/23/23 | Negligent care provided to eight patients. | Indefinite suspension. |
| Pascale, Michael J.<br>MD00031098<br>King County | Agreed Order | 10/5/23 | Failure to comply with Commission Order. | Voluntary surrender of license. |
| Wilkinson, Richard, S.<br>MD00016229<br>Yakima County | Final Order | 8/12/23 | Provided substandard care to patients infected with COVID-19, and misrepresented information about COVID-19 and the efficacy and safety of vaccines to the public. | Restricted from prescribing ivermectin for non-FDA-approved indications; restricted from prescribing to patients without first establishing a physician-patient relationship by seeing patients in-person or via real-time video, taking a history, conducting an exam, obtaining informed consent, and documenting in medical record; completion of clinical competency assessment; CME; compliance audits; personal appearances; and a fine. |
| **Informal Actions** | | | | |
| Flinders, Craig G.<br>MD00038361<br>Asotin County | STID | 10/5/23 | Alleged inappropriate prescribing of ivermectin for COVID-19. | Restriction from prescribing ivermectin or azithromycin for non-FDA-approved indications; CME in prevention, treatment, and management of COVID-19 infection; CME in record keeping; paper; compliance audits; personal appearances; costs. May petition for termination in 2 years. |
| Gundle, Michael J.<br>MD00024861<br>King County | STID | 10/5/23 | Alleged prescribing for family member | Surrender of license. |
| Havin, Derrick R.<br>MD00046334<br>Spokane County | STID | 10/5/23 | Alleged inadequate informed consent and discussion of alternative treatments prior to gynecological surgery, and removal of health organs without patient consent. | CME in informed consent and shared decision-making, patient-centered care, pre-operative evaluation of surgical patients, and surgically induced and early menopause; topic review of informed consent and shared decision-making in obstetrics and gynecology; paper; personal appearances; costs. May petition to terminate in 3 years. |

| Practitioner<br>Credential and County | Order Type | Date | Cause of Action | WMC Action |
|---|---|---|---|---|
| **Informal Actions** | | | | |
| Husein, Omar F.<br>MD60000994<br>Spokane County | STID | 8/24/23 | Alleged prescribing medication and picking up medication in family member's name; inappropriate access of the medical record of 2 family members; criminal conviction for violation of order and fourth degree assault, both gross misdemeanors. | Psychotherapy; CME in record keeping, ethical prescribing and HIPAA; ethics course; paper; personal appearances; costs. May petition to terminate in 4 years. |
| Simons, Louise A.<br>MD00044441<br>Chelan County | STID | 8/24/23 | Alleged failure to perform adequate workup to identify possible sepsis in patient who met systemic inflammatory response syndrome criteria. | CME in implicit bias; review of literature on cognitive error, and on sepsis diagnosis and management; paper; personal appearance; costs. May petition to terminate in 3 years. |
| Stiles, Zachary D.<br>PA60896690<br>Spokane County | STID | 8/24/23 | Alleged inappropriate prescribing of intra-nasal ketamine. | CME in prescribing and monitoring ketamine for patients with depression; paper; personal appearances; costs. May petition to terminate after completing requirements. |

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

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

**Agreed Order:** a settlement resolving a statement of charges. This order is an agreement by a licensee to comply with certain terms and conditions to protect the public.

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

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

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

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

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## 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.