



Message from the Chair

Richard D. Brantner, MD, FAAEM
Chair, Congressional District 10

Greetings at the start of this summer season from your Medical Commission. As an emergency department physician, I know summer brings in more injuries related to outdoor events. I am using this opportunity to urge everyone to enjoy the good weather and the outdoor activities, but please remember to be safe and take precautions. Nothing spoils a warm afternoon like a trip to the ED with a fracture.

I am pleased to report your Medical Commission had a strong showing at the April Administrators in Medicine (AIM) and Federation of State Medical Boards (FSMB) annual meetings in Denver, CO. This year AIM recognized our guidelines for Professionalism and Electronic Media use in non-clinical interactions with a Best of Boards Honorable Mention. You may remember that AIM awarded us the Best of Boards Award in 2012 for our education program related to the pain rules mandated by the legislature.

During our time in Denver, we witnessed our own Maj. Gen. (ret.) Leslie M. Burger, MD, receive the John H. Clark leadership award for a lifetime of excellence in medicine, licensing, and regulation. Additionally, Ellen Harder, PA-C, received the FSMB lifetime achievement award posthumously for her efforts in advancing the work of physician assistants in this state and nationally. Her son John graciously received the award on her behalf. Warm congratulations to Dr. Burger and Ms. Harder's family for the recognition of a lifetime in service to the medical profession. Without these two individuals, many lives and practices would not be as rich or received such meaningful guidance, wisdom, and humor. Thank you.

The annual meetings allow your Commission to address local issues at a national level, helping craft model policy

for the years ahead. One such event was the adoption of the FSMB telemedicine model policy, to which we contributed and support. It is certainly interesting to participate in a reference committee in the morning and read national news stories about the event by that same afternoon. While the subject of telemedicine received most of the attention, we covered much more ground during our four days in Denver.

Even as physicians we must look after our own health. In that effort I recently participated in my annual physical exam. Data entry into the electronic medical record (EMR) monopolized 40 of the 50 minutes allotted for that exam. Both my physician and I concluded that never in our wildest dreams during medical school did we think that data entry and typing skills would become the defining trait of modern medical practice.

I argue that it shouldn't be and it is a poor use of resources on an already strained system. While we can try stopgap solutions like medical assistants, scribes, or a resident,

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Mission

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

that does not address the fundamental issues and flaws with the current EMR.

The EMR should be a functional roadmap to meaningful patient care. Without this basic premise all we have is an onerous and expensive tool of questionable utility that reduces the practitioner with years of medical training to a clerk typist and the patient encounter to a billing justification. The problem compounds further if we consider that one of the initial “selling points” of EMR was its ability to transmit the patient records from any location to the Health Information Exchange, thereby creating a truly portable patient record that can be accessed by any authorized practitioner participating in the treatment of that patient. While we are probably years away from that future, I do not see a time where knowing particular previous billing codes will be relevant to the patient record during an emergent encounter or any other patient encounter for that matter. The quote “Render unto Caesar that which is Caesar’s” would seem to apply to the EMR. Let the billers, coders, and IT staff deal with their needs, but make the record useful for both the practitioners and the patients. In the end, the care of the patient is the only reason the record exists. This criterion alone should judge the utility of the EMR.

Switching gears to Continuing Medical Education (CME), I remind all practitioners that it is your responsibility to document your CME. Every one of us signs the attestation at renewal time and I hope we all document the proof of that attestation. This becomes especially important if a complaint is filed against your license. The Medical Commission receives roughly 1,500 complaints per year and in every one of those complaints we ask the practitioner to provide documentation of meeting their CME requirements for licensure. If you cannot produce documentation of CME then you face the possibility of the Commission finding you in violation of a number of statutes relating to licensure and unprofessional conduct. We all know the importance of continuing our education and meeting the requirements for licensure. Please remember to document that gained knowledge.

At the end of June the Commission will hold its last meeting of the fiscal year. At this meeting we will have several changes. The first is the possible end of terms for 1/3 of the Commissioners. While their terms don’t officially end until the Governor replaces them, these seven people have served Washington in this capacity for eight years and we thank them. We will also be holding elections for Commission leadership at this

meeting. No matter the outcome, I thank my fellow Commissioners for the opportunity to serve and for their trust and support during the past year. It is an honor to pause in this position of Commission Chair.

Finally, I encourage all Washington practitioners to consider opening their patient panels to accept more Tri-Care and veteran patients. As a former combat physician in the Army, this is an issue of great importance to me personally. With JBLM located just up the road from the Commission offices, this reminds us this is also public health issue. This past Memorial Day weekend Dr. Burger shared an email with the Commission, a portion of which I find relevant to share with you now:

“But since 9/11, over 6,000 of our sons and daughters and mothers and fathers and friends have given their lives in the service of their country. Over 50,000 have suffered visible injuries of that war, and thank goodness, overwhelmingly they have regained their health. For the 5,000 plus who have lost a limb or their vision or suffered terrible burns, there will always be a visible reminder of their sacrifice. It is estimated that perhaps 20% or more of those deployed have suffered post-traumatic stress or a traumatic brain injury.”

In my career as an Emergency Physician, the single most important and meaningful thing I have done is to care for young heroes that were seriously injured serving this great country. Extending ourselves just a little more to get them basic medical care does not seem an extravagant request. Please consider what you can do in your practice or your organization to extend this needed care to those who stand up and serve. Have a fantastic and safe summer.

Save the Date!

Commission Educational Conference

“Putting the Patient in Patient Safety”

Featuring national speakers and local experts presenting on public health, patient safety, health care disparities, professionalism, and innovations in health care delivery. Free and open to all.

October 1-2, 2014 in Tumwater, WA

<http://go.usa.gov/jZUT>

Executive Director's Report

Maryella E. Jansen Executive Director

In April of this year the Commissioners voted to adopt the 2014-2016 Strategic Plan (<http://go.usa.gov/8eD5>), signaling a shift towards increased stakeholder engagement and holding the organization to a higher standard. Much of this increase comes in the form of staff input to the Strategic Plan and the development of a comprehensive performance management system. The eventual goal is the development of true public health outcome measures that will accurately represent the organizational operations. The Commission started this process with the strategic planning effort launch in January of this year. It continues with an all staff training workshop in June.

Per HB 1518 (2013), the Commission is in negotiations with the Department of Health to revise the joint operating agreement between the two organizations. These agreements determine how the Commission obtains administrative services and support from the Department. Examples of this support come in the forms of accounting services, contracts, human resources, and technology services. We are encouraged with the progress and the openness of the Department to the concept of the Commission as a customer, including the idea that the Commission can request varied levels of support from the Department.

The Medical Commission continues the search for its next Executive Director. While we have met with and interviewed some outstanding candidates, the Commission faces some significant structural limitations in its recruitment package. Some of these issues are the same we face in recruiting professional staff. We hope to address these limitations through proper channels via the pathways of our joint operating agreement and the ever necessary creative solutions.

Did you know?

You can check the status of any license holder in the state of Washington? You can also view the legal documents if the license has disciplinary action.

Try it now: <http://go.usa.gov/VDT>

PA NEWS

Theresa M. Schimmels, PA-C Physician Assistant

The last meeting of the PA Rules Committee was on May 8, 2014, in Tumwater, WA. The Committee, members of the public, and representatives from the WA Academy of Physician Assistants continued to deliberate on some remaining aspects of the physician assistant rules. Rules are being revised and updated for both allopathic/Medical Commission and the Osteopathic Boards. Issues still being discussed by the Committee included:

- Updating language for PAs seeking to reactivate their license after a license has expired;
- Inclusion of retired active license information into PA rules;
- Clarifying language related to practice limitations of PAs as a result of a PA supervisor's practice being limited because of disciplinary actions per chapter 18.130 RCW;
- Utilization and supervision of PAs by supervising physicians (to include both sponsoring and alternate physicians) and prescription privileges;
- Updating of definitions;
- Maintenance of licensure issues;
- Clarifying the terms supervisor, sponsor, and alternate physician.

The meetings last about four hours and the dialogue and discussion is often lively. One of the issues tabled for now regards PAs owning a medical practice. There will not be rules added relating to this issue.

Once the Committee arrives at an agreement on draft language, the Committee will then recommend to the Osteopathic Board and the Medical Commission for consideration and approval, finally proceeding to the second phase of the rulemaking process—the proposal.

I encourage all interested parties to come to the meeting or email the Commission for more information. We are making great strides and I am very pleased with the direction we are headed. Together, we are making WA a better place for PAs to practice medicine!

For more information, please contact Julie Kitten, Operations Manager for the Medical Commission, at julie.kitten@doh.wa.gov, or Brett Cain, Program Manager for the Osteopathic Board, at brett.cain@doh.wa.gov. You can stay up to date by joining the Medical Commission rules listserv: <http://go.usa.gov/DJRY>.

Commission Case Reports

Bruce Cullen, MD Physician at Large

End of Life Care

A 76-year-old female was admitted to the hospital with widely metastatic colon cancer. It was the intent of her oncologist that she be readied for additional palliative chemotherapy. She weighed 70 lbs., her hematocrit was 18%, she could not feed herself or take fluids, she was unable to turn herself in bed, and she was in pain. The patient was transfused and maintained on IV fluids. The hospitalist asked the patient about her end of life wishes and determined that she wanted “everything possible” to be done to prolong life. Yet, she was offended by the discussion and said that all future decisions should be made by her daughter. The patient’s daughter was only available by phone, but agreed with her mother’s request as relayed by the hospitalist. The hospitalist’s progress note stated “talked to the family about EOL issues.” A note in the patient’s chart by the hospital chaplain stated the patient knew she was dying and expressed a desire “to go home.” The patient was ultimately discharged to a skilled nursing facility still receiving IV fluids. She died 3 days later.

The patient’s daughter filed a complaint with the Commission expressing anger about inappropriate care and not being informed that her mother was dying. “I had no time to prepare for her death and say good-bye.” She insisted no one spoke frankly to her about the gravity of her mother’s condition or the possibility of hospice care.

After Commission investigation and review of this complaint, there were several points of concern. The patient’s response to the initial discussion of her code status with the hospitalist was likely brief and did not thoughtfully explore the patient’s fears or goals for future care. The documentation of the talk in the physician’s note was curt, at best. It could be alleged that the treating physician met the standard of care. The patient did not

exhibit agonal breathing when she was discharged, her anemia was appropriately treated, and the focus was on getting her stronger for additional treatment. Yet, the Commission opined that more should have been done. The “whole” patient was not addressed. Was the expense of her hospitalization and transfusion justified? Was the emotional trauma to the patient of hospitalization justified? Why did the patient not tell the physician she knew she was dying? Why did the physician not seek counsel from the chaplain? Why was the true state of the patient, and her prognosis, not fully relayed to the patient’s daughter?

Perhaps as a consequence of the aging population and/or the stresses on physicians associated with present day medicine, the Commission is receiving an increasing number of complaints against physicians for alleged poor end of life care. Most of the issues revolve around inadequate communication between the physician and patient, and the physician and family members. If a person with a serious progressive illness is under a physician’s care, the patient and family must be counselled about the patient’s real prognosis, and about options for future care. Such discussion should include the option for allowing natural death, with care focused on comfort and symptom management, as opposed to continuing aggressive measures with little chance of success.

Physicians at every point of contact with a patient have the opportunity to influence the ultimate narrative about the illness and death. They have a professional responsibility to make empathetic appropriate medical recommendations. The patient and family or surrogates make the ultimate treatment decisions but it must be an informed decision, not merely choices from a menu of treatments that can be done. If physicians do not have the skills, or the desire, to undertake such discussions with patients and family about end of life care, they are obligated to consult someone who can provide that care.

Lastly, it is incumbent on the physician to document these end of life discussions, in detail, in the patient’s chart. Understandably, these are emotionally laden subjects for all involved. And, grieving relatives of deceased patients may forget that these discussions took place.

The Commission is more likely to close a complaint against a physician if appropriate measures were taken with the “whole” patient, and his/her family, prior to the patient’s death and there is good documentation to substantiate it.

Did you know?

The Commission publishes case studies based on complaints we receive. We send these to the Washington State Hospital Association and publish them on our website to share best practices.

Try it now: <http://go.usa.gov/dG8>

Maintenance of Licensure

William Gotthold, MD Congressional District 8

In 2010, the Federation of State Medical Boards (FSMB) adopted a framework for Maintenance of Licensure (MOL) that called for license renewal to be contingent on evidence of participation in a program of life-long learning and continuous professional development.

This was to be more focused than the current requirements in most states for some hours of CME. In the past two years an FSMB task force, including many different stakeholders, has developed a set of recommendations that states can consider when they create their MOL requirements.

There are two parts to the model. One is to stay up to date in your area of practice, which is CME in its various forms. The other is to measure your performance in your actual practice to look for possible areas of improvement, obtain education or guidance on how to improve, apply that knowledge, and then measure again to verify improvement. Staying up to date with CME is not a new idea. The new concept is to measure actual practice performance, focus the CME where needed, apply this new knowledge to the practice, and then re-measure.

For many practitioners the measurement component is already part of various mandated reporting on quality parameters. Physician groups, hospitals, insurers and Medicare all do some form of quality measurement. Most of these are aimed at process (did you measure the A1c), but more recently some are attempting to measure actual outcomes (what percent of your patients have an A1c at an acceptable level). Active participation in these types of programs should satisfy the measurement requirement. For other practitioners not involved in these formal programs, there are many CME programs that that have initial measurement and subsequent re-measurement as part of the CME process. More of these will surely be developed as more states move to the MOL model for license renewal.

For physicians certified by a member board of the American Board of Medical Specialties, active participation in the Maintenance of Certification program of their board will suffice for the requirements of MOL.

More information about the history of the MOL concept, and resources for CME programs, can be found on the FSMB website at www.fsmb.org/mol.html

The Medical Quality Assurance Commission plans to develop MOL policies and rules by 2016, and will work with physician and physician assistant organizations, medical groups, hospitals and other stakeholders to craft MOL requirements that as much as possible build on the quality improvement systems already in place.

Stay Informed!

The Medical Commission maintains four email listserves to deliver relevant information to your inbox. Sign up today and keep up to date!

Newsletter:	http://go.usa.gov/dGk
Minutes and Agendas:	http://go.usa.gov/dGW
Rules:	http://go.usa.gov/dGB
Legal Actions:	http://go.usa.gov/dGK

Volunteers Needed

Free clinic on October 23-26

Seattle/King County Clinic with Remote Area Medical will take place October 23-26 at Key Arena. Equipment and supplies, parking, and meals are provided. If fully staffed by volunteers, the event expects to provide free services to 1,000 patients per day. All services are free to patients. The event needs both medical professionals and non-medical support volunteers.

To Volunteer

First, please go to www.ramvolunteers.org to complete your primary registration. Afterward, please go to www.surveymonkey.com/s/SupplementalVolunteerRegistration to provide some additional information that will be helpful to Seattle/King County Clinic organizers. Both online processes are relatively brief.

The WPHP Report

By Charles Meredith, MD
Medical Director

Medical Marijuana

Since California became the first state to pass a voter initiative legalizing the medical use of marijuana in 1996, twenty additional states and the District of Columbia have also done so, either by voter initiative or legislative mandate. By passing ballot initiative I-692 in 1998, Washington State became one of the first states to legalize the medical use of marijuana. RCW 69.51A allows medical doctors and physician assistants to recommend marijuana for cachexia, cancer, HIV/AIDS, epilepsy, glaucoma, multiple sclerosis and intractable pain when these conditions are not relieved by standard medications or treatments. In 2008, the legislature expanded the list to include Crohn's disease and hepatitis C, again when these conditions are not relieved by standard medications or treatments. Ironically, the American Gastroenterological Association states that regular cannabis use has been shown to accelerate fibrotic changes in chronic hepatitis C and thus is not recommended.

Washington State is unique in that there is no patient registry, making it difficult to ascertain the frequency of prescribing or recommending the use of medical marijuana by providers (or utilization by patients). Washington is thought to allow patients to possess more marijuana than most other states where it is legal to do so for medical purposes, permitting them a "60 day supply" which has been defined as up to 24 ounces of cannabis, and/or 15 growing plants.

The implementation of a registry in Colorado makes tracking the number of medical marijuana patients and prescribing physicians more practical in that state. In 2009, US Attorney General Eric Holder clarified that the federal government would not prosecute individuals using, possessing, or distributing marijuana via state medical marijuana laws. Subsequently the number of valid Medical Marijuana Registry identification cards issued in Colorado increased by more than a factor seven between 2009 and 2011, from less than 20,000 to more than 140,000. Many believe the same pattern has occurred in Washington. In Colorado, 94% of these cards were issued for "intractable pain," where two thirds of patients are male and the average age is 41. Observers have noted that there has either been a sudden epidemic in intractable chronic pain unresponsive to standard treatments –

a condition for which often no objective diagnostic testing exists - or the law may have been exploited by individuals seeking marijuana for other reasons. While RCW 69.51A does not legalize medical dispensaries in Washington, state policy leaves the decision up to individual municipalities and their respective policies may vary. Whereas Kent recently outlawed dispensaries, Seattle is known to be fairly permissive of dispensaries and there has been an explosion in number and concentration since Eric Holder's statements in 2009. A resident of Seattle, I pass by significantly more medical marijuana dispensaries on my commute home from work than gas stations.

Cannabinoid 1 receptors are distributed widely throughout the central nervous system, but particularly in brain areas regulating coordination, short term memory, high level cognition and sedation. Use of "four or more joints per week" has been consistently shown to lead to lower cognitive performance in experimental paradigms, with cumulative negative effects correlated with increasingly chronic use. Experienced pilots who have smoked one "joint" showed impaired performance in multiple arenas of functioning in a flight simulator 24 hours later, with little to no awareness of their impairment in occupational performance. While the correlation between THC (the chemical in marijuana that is believed to be responsible for intoxication and addiction) serum levels and the experience of intoxication is poor, data indicate that cognitive functions start to become impaired at levels as low as 3ng/ml, leading some states to propose a cut off level of <5ng/ml as safe for driving. Of note, emesis is generally not relieved by medical marijuana at serum levels below 10ng/ml.

Safe use of medical marijuana is further complicated by the increased potency of cannabis today compared to that which was widely available in prior decades. The level of THC in marijuana is seven times higher today than it was 30 years ago when the National Organization to Reform Marijuana Laws (NORML) began the drive toward medicalization of marijuana. Ironically, cannabidiol (the chemical in marijuana believed to be responsible for medicinal benefit) has sharply declined. Other concerns include the lack of a safe and reliable dosing system for inhaled marijuana products, and a lack of adequate dose-finding or safety studies. Without basic safety and efficacy data, the American Society of Addiction Medicine has issued a policy paper explicitly rejecting marijuana as medicine. It simply has not met the standards required of all other medications in the United States. And while the policy paper endorses the need for further study of medicinal marijuana products, it rejects the notion that

smoked cannabis will ever meet standard definitions of medicine in the United States.

The experience of the Washington Physicians Health Program with physicians being treated with medical marijuana is very limited so far. Despite the recent legalization of recreational marijuana use by Initiative 502, case law in the state of Washington indicates that any employer can enact a policy forbidding its employees to use marijuana recreationally or medically, allowing for termination of employees who violate this policy. However, we are unaware of any hospital or group clinic in Washington that has explicit language forbidding the recreational use of cannabis or medical use of marijuana, with the subsequent risk of loss of privileges or employment. WPHP has been asked to evaluate several physicians using marijuana for medical purposes and in these situations neurocognitive testing has typically demonstrated that the physician in question is obviously cognitively impaired and unsafe to practice medicine.

Physician health programs in several states do have formal policies that the use of medical marijuana is too dangerous to be permitted in any practicing physician, primarily given concerns around the high risk for cognitive impairment at serum levels needed to have effective benefits for emesis and other medical indications. At this time, the Washington Physicians Health Program does not have a formal blanket policy statement. However, given what we do know about this substance, we would strongly discourage any individual physician from attempting to practice medicine while utilizing cannabis for medical or recreational purposes.

Did you know?

You can complete your demographic census for renewal online!

The Commission has been asked to develop demographic data, and we will be asked for the results by State and Federal policy makers, and other interested parties, as they make decisions about the future structure of the medical workforce. We have roughly a 60 percent response rate to our census. Please take a few minutes to fill out the demographic questionnaire so the decisions made about your future work environment can be based on accurate data.

Try it now: <http://go.usa.gov/2pkm>

The October Educational Conference

Micah Matthews, MPA Performance & Outreach Manager

Every October the Medical Commission holds a two-day educational conference with a focus on patient safety issues. The goal of the conference is to further the education aspect of the strategic mission and statutory authority of the Commission. In the past, the Commission received presentations from leaders in the medical industry and patient safety organizations. Some examples are Gary Kaplan, MD, from Virginia Mason, leaders from the National Quality Forum and the National Committee for Quality Assurance, and local experts from University of Washington, Wenatchee Valley Medical Center, the Polyclinic and others. This year will be no exception. We are pleased to announce that the Commission has confirmed the following presenters for the October Conference:

- Augustus White, MD, PhD, from Beth Israel and Harvard Medical School, will present on cultural competence and its impact on health care disparities;
- William Sage, MD, JD, from University of Texas Law, will present on new approaches to addressing medical errors, systems issues, and involving the patient from the earliest possible moment;
- John Wiesman, Dr.PH, MPH, Washington State Secretary of Health, will present on issues relating to health care delivery and the future of public health;
- Byron Joyner, MD, MPA, from Seattle Children's and UW School of Medicine, will present on professionalism and how we can improve the concept in the world of the medical practitioner;
- Molly Voris, MPH, from the Washington Health Benefit Exchange, will present on the Exchange and its future;
- Randy Simmons, Deputy Director of the Liquor Control Board, will update attendees on issues relating to the retail marijuana market and possible impacts to the medical marijuana industry.

More speaker announcements will be coming as they are confirmed. The event will take place at the same location as in previous two years, the Capital Event Center/ESD 113 at 6005 Tyee Road in Tumwater, WA. The Commission will email certificates of attendance for those who wish to claim Category 2 CME. The event is free, does not require registration, and open to all who have an interest in the health care delivery system, patient safety, medical practice and regulation issues. We hope to see you in October!

Legal Actions

February 1, 2013 - April 30, 2014

Below are summaries of interim suspensions and final actions taken by the Commission last quarter. 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. (*Due to a temporary technical issue we will not be linking to the order documents as we have done in the past. We regret the inconvenience.-Ed.*) All legal actions are updated quarterly and can be found with definitions on the Commission website: <http://go.usa.gov/DKQP>

Practitioner	Action	Date	Cause of Action	Commission Action
Formal Actions				
Duggal, Narinder M., MD (MD00036603)	Agreed Order	2/13/14	Respondent provided substandard care to four patients and had sexual contact with one patient.	Surrender of license.
Goldflies, Myles E., MD (MD00046009)	Agreed Order	4/3/14	Respondent relinquished his license to practice medicine in South Carolina; had his license in Illinois placed on probation. Respondent violated the standard of care by failing to provide adequate preoperative screening of patients and admits he left a medical facility between double surgical procedures.	Probation; will perform surgery only on patients who have had a pre-operative evaluation by his preceptor; submit a report describing appropriate evaluation of a patient for plastic surgery; fine of \$1,000; submit to practice reviews.
Jangala, Chester E., MD (MD00023662)	Agreed Order	2/13/14	Respondent accepted a \$100,000 loan from a patient.	Reprimand; boundaries course.
Morris, Laura K., MD (MD00026856)	Agreed Order	2/13/14	Florida placed Respondent's license on probation and restricts Respondent from owning, operating or practicing in a pain management clinic.	Probation; permanent restriction from treating and managing chronic non-cancer pain; complete courses.
Informal Actions				
Adao, Cirilo P., PA (PA10001585)	Informal Disposition	2/13/14	Alleged: Inadequate documentation, including failing to document the rationale for prescribing multiple drugs for a psychiatric patient, and failing to document a plan for appropriate follow-up.	Agreement not to prescribe new psychoactive medication for any patient without first conducting an in-person evaluation; course work; paper on clinical issues; presentation to other providers in his clinical practice; \$1000 costs; practice reviews.
Alexander, Steven J., MD (MD00017680)	Informal Disposition	2/13/14	Alleged: Respondent spoke to a patient in a joking demeaning manner that offended the patient.	Ethics course; \$1000 costs; compliance appearances.

Andronic, Cristian, MD (MD00043374)	Informal Disposition	2/13/14	Alleged: Delaware suspended Respondent's license to practice in that state. During this time Respondent called in prescriptions for family members to a Washington pharmacy and asked the pharmacy to transfer the prescriptions to a pharmacy in Delaware for dispensing.	Probation; ethics course, opioid prescribing and record keeping courses; write paper detailing the risks inherent in treating family members; \$1000 costs; register with the Washington Prescription Monitoring Program.
Clark, Joan G., MD (MD00022064)	Informal Disposition	4/3/14	Alleged: Respondent failed to comply with a STID.	Surrender of license.
Fiala, Suzanne J., MD (MD00031697)	Informal Disposition	4/3/14	Alleged: Respondent violated professional boundaries by entering into a business and personal relationship with a patient and engaging in harassing conduct with the patient.	Course work; \$1000 costs; psychotherapy monitoring.
Hanson, Mark T., MD (MD00013982)	Informal Disposition	4/3/14	Alleged: Respondent regularly prepared prescriptions for controlled substances, ordered lab tests and made referrals for a family member. A colleague who denied being the patient's regular physician signed the prescriptions. Neither Respondent nor the colleague provided any documentation of patient encounters or follow-up with the patient.	Agreement to not provide prescriptions or medical care to family members except in emergent circumstances; \$1,000 costs; write a report after reviewing policies on prescribing and treating family members.
Modarelli, Robert O., MD (MD00014207)	Informal Disposition	4/3/14	Alleged: Respondent mistakenly removed the patient's left testicle and then removed the remaining testicle. Respondent consulted patient's mother, who had been significantly involved in the patient's care, but did not involve the patient in the decision to remove the remaining testicle.	Practice limited to office-based practice with no general anesthesia; written protocol to prevent wrong-site surgery; ethics course; \$1000 costs; practice reviews.
Nisco, Steven J., MD (MD00037581)	Informal Disposition	2/13/14	Alleged: In removing the left lung of a patient with significant radiation damage to her anatomy, Respondent failed to sufficiently wait after clamping and inadvertently divided the main pulmonary artery rather than the intended left main pulmonary artery.	\$1,000 costs; submit written protocol and paper to the Commission.

Orvald, Thomas O., MD (MD00016180)	Informal Disposition	4/3/14	Alleged: Respondent authorized a patient to use medical cannabis for asthma, a non-qualified condition.	Restriction from authorizing the use of medical cannabis for asthma with conditions; \$750 costs; practice reviews.
Power, Charles W., MD (MD00026418)	Informal Disposition	4/3/14	Alleged: Respondent did not comply with the pain management rules by failing to appropriately monitor the efficacy of opioid therapy, and failing to appropriately respond to indications that a patient was violating their contract and exhibiting signs of misuse, abuse or diversion.	Write paper regarding the assessment of the efficacy of opioids in improving functional status; presentation to a peer group; prescribing course; \$1,000 costs; practice reviews.
Salib, Hani I., MD (MD00026798)	Informal Disposition	4/3/14	Alleged: The Medical Board of California suspended Respondent's license for 30 days and placed his license on probation with terms and conditions.	Indefinite probation; prohibited from supervising physician assistants.
Sands, Andy J., MD (MD00019593)	Informal Disposition	2/13/14	Alleged: Respondent abruptly closed his office without advance notice to his patients and some medical records were destroyed after Respondent suffered from a health condition that left him unable to practice temporarily.	Practice in an office-based group setting, hospital-based setting or clinical setting where he does not need to perform all administrative functions; comply with WPHP agreement; practice reviews; personal reports; appear before Commission.
Story, Errett T., MD (MD00044091)	Informal Disposition	2/13/14	Alleged: Respondent failed to meet the standard of care by not personally attending to a patient sooner during the course of post-operative complications.	Probation; write paper; presentation to staff regarding communication of critical information during post-operative care; \$1000 costs; compliance appearances.
Williams, Jeffery A., MD (MD00045071)	Informal Disposition	4/3/14	Alleged: Respondent failed to inform a patient that treatment with gentamicin can have toxic side effects and failed to sufficiently monitor gentamicin levels.	\$1,000 costs; submit paper to the Commission on the use of gentamicin as a broad spectrum antibiotic.

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 take some type of remedial action 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.

Medical Commission Vital Statistics

- 21 members: 13 MDs, 2 PAs, 6 public members;
- 39 staff, \$14.7M biannual budget;
- 29,397 licensed physicians and physician assistants;
- 99.9% of complaints processed on time in 2013;
- 91.5% of investigations completed on time in 2013;
- 94.7% of legal cases completed on time in 2013;
- 100% of disciplinary orders complied with Sanction Rules.

Actions in Fiscal 2013

- Issued 2,429 new licenses;
- Received 1,493 complaints/reports;
- Investigated 911 complaints/reports;
- Issued 86 disciplinary orders;
- Summarily suspended or restricted 15 licenses;
- Actively monitoring 181 practitioners;
- 44 practitioners completed compliance programs.

Policy Corner

At the most recent business meetings the Commission did not approve/update any policies.

To view the most current policies and guidelines for the Commission, please visit our website: <http://go.usa.gov/dG8>

Do you have ideas or suggestions for future Commission newsletters? Is there something specific that you think we should address or include?

Please submit suggestions to:
micah.matthews@doh.wa.gov

Recent Licensee Congratulations

The Washington State Medical Commission wishes to congratulate and welcome all of the recent licensees to the state.

A list of recent licensees is updated quarterly on the Commission website and may be found on our website: <http://go.usa.gov/dG0>

Medical Commission Meetings 2014

Date	Activity	Location
June 26-27	Regular Meeting	Puget Sound Educational Service District (PSESD), Blackriver Training & Conference Center 800 Oakesdale Ave SW Renton, WA 98057-5221
August 21-22	Regular Meeting	Department of Health 310 Israel Rd SE, 152/153 Tumwater, WA 98501
October 1-3	Educational Conference	Capital Event Center ESD 113 6005 Tyee Road SW Tumwater, WA 98512
November 6-7	Regular Meeting	PSESD Renton, WA

All Medical Commission meetings are open to the public

Other Meetings

Washington State Medical Assoc.	Annual Meeting Sept. 20-21, 2014	Seatac, WA
Administrators in Medicine (AIM)	Annual Meeting April 22, 2015	Ft. Worth, TX
Federation of State Medical Boards	Annual Meeting April 23-25, 2015	Ft. Worth, TX



Medical Quality Assurance Commission
 PO Box 47866
 Olympia, WA 98504-7866

The law requires each practitioner to maintain a current name and address with the department. Please submit address changes and appropriate documentation for name changes to:
medical.commission@doh.wa.gov

Medical Commission Contact Information

Applications:	A-L	360-236-2765
	M-Z	360-236-2767
Renewals:		360-236-2768
Complaints:		360-236-2762
		medical.complaints@doh.wa.gov
Complaint Form:		http://go.usa.gov/dGT
Legal Actions:		http://go.usa.gov/DKQP
Compliance:		360-236-2781
Investigations:		360-236-2759
Fax:		360-236-2795
Email:		medical.commission@doh.wa.gov
Demographics:		medical.demographics@doh.wa.gov
Website:		www.doh.wa.gov/medical
Public Disclosure:		PDRC@doh.wa.gov
Provider Credential Search:		http://go.usa.gov/VDT
Listserv Sign-up Links:		
Minutes and Agendas:		http://go.usa.gov/dGW
Rules:		http://go.usa.gov/dGB
Legal Actions:		http://go.usa.gov/dGK
Newsletter:		http://go.usa.gov/dGk

Medical Commission Members

- Richard D. Brantner, MD– Chair
- William E. Gotthold, MD– 1st Vice Chair
- Michelle Terry, MD– 2nd Vice Chair
- William M. Brueggemann, Jr., MD
- Leslie M. Burger, MD
- Athalia Clower, PA-C
- Michael T. Concannon, JD
- Bruce F. Cullen, MD
- Jack V. Cvitanovic
- Theresa J. Elders, LCSW
- Thomas M. Green, MD
- Frank M. Hensley
- Bruce G. Hopkins, MD
- Warren B. Howe, MD
- Mark L. Johnson, MD
- Charlotte W. Lewis, MD
- Peter K. Marsh, MD
- Mimi E. Pattison, MD
- Linda A. Ruiz, JD
- Theresa M. Schimmels, PA-C
- Mimi Winslow, JD

Washington State Medical Commission Newsletter–Summer 2014

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