



Message from the Chair

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

Greetings to the medical doctors and physician assistants licensed with the Washington State Medical Commission. I am honored to serve as Chair of your Commission. As I begin my term, I would like to thank Dr. Mimi Pattison, Immediate Past Chair, for her leadership, guidance, and friendship during her tenure as Chair. I would also like to thank Brig. Gen. Leslie Burger, MD, former chair and my former commanding officer, for his friendship, guidance and mentorship. During the last several years, the Commission, under the leadership of Dr. Pattison and Dr. Burger has made significant contributions to the people of the state of Washington, to the Department of Health, and to the national standards and conversations surrounding medical regulation. The numerous achievements include:

- The writing and implementation of the Pain Rules (<http://go.usa.gov/DjRe>);
- The implementation of educational efforts and CME associated with the pain rules;
- The 2012 Best of Boards award from Administrators in Medicine for the Pain Rules education package;
- The 2013 Administrators in Medicine excellence awards for our Executive Director, Maryella Jansen, and Chief Investigator, James Smith;
- The successful conclusion to the legislatively-mandated Pilot Project that resulted in the increased authority of the Medical Commission over staffing, budget, and operations.

Recounting successes previous to the tenure of Dr. Pattison are the completion of the Office-Based Surgery Rules through the efforts of past Chairs Dr. Hampton Irwin and Dr. Samuel Selinger along with Commissioner Dr. Bruce Cullen. Dr. Selinger received the John H. Clark Leadership Award from the Federation of State Medical Boards at the 2011 annual meeting in Seattle. In fact, securing the legislative authorization to conduct the Pilot Project in 2008 can be considered a Commission success.

So what do the changes in the Commission status as a result of the Pilot mean to you as a licensee or to patients in Washington State? It means that the Commission has permanent control over its dedicated staff. If the Commission does not like the way business is accomplished, we can change it through the efforts of the Executive Director who reports to the Chair. It means the Commission determines what projects are important and how we will fund those efforts. It means the Commission has proven it is more than capable of performing at the highest levels of efficiency in the areas of licensing and discipline. It means we are free to focus on policy and

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Save the Date!

Educational Conference

October 2-3, 2013 in Tumwater.

Learn more online: <http://go.usa.gov/jZUT>

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Mission

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

education efforts, which we believe can have a larger impact than traditional discipline on health care delivery and patient safety. It means that you as a medical doctor or physician assistant or a member of the public in Washington can attend a public Commission meeting or reach out to the Commissioner in your Congressional District to provide feedback that can have a direct impact on the efforts or operations of the Commission. Put another way, it means your Commission representatives possess appropriate, direct control to effect positive change in medical regulation, health care delivery, and patient safety.

I face several challenges in my upcoming term. The first is turnover of Commission membership and senior staff because of term limits and well-earned retirements. This year we are replacing four Commission members, our Executive Director, our Chief Investigator, and our Credentialing Manager. Next year, we must replace seven members of the Commission. The amount of institutional memory lost to the Commission in these changes is difficult to quantify. As such, I made it clear at our August meeting that we must complete key projects before the departure of these senior Commissioners and key critical staff members. The Commission will be conducting a national search in our effort to recruit the most talented individuals available to replace our Executive Director and Chief Investigator.

Licensure issues are some of the highest priority issues we face at the Commission. It is a constant struggle to balance the needs of the health care workforce with updating education and training requirements. To that end we are pursuing HB 1409 in the 2014 legislative session, which modernizes physician licensure standards (<http://go.usa.gov/GZt>) and transfers some requirements from statute to rule. Complicating these issues are telehealth and the market forces driving licensure trends like interstate compacts, technological development, reciprocity, military licensure, and national licensure. The Commission is actively monitoring those discussions through participation in national organizations and concurrently working on policies to address the electronic health practice issues of telehealth.

On the other side of the issue is professionalism in use of electronic media. We have all read at least one news article about social media gone wrong when used by a clinician. The Commission recognizes this is an area that is not typically addressed by social media guidelines and we have assigned a work group to produce a guideline for practitioners. This guideline is in the vetting process but the basic premise is that is in non-clinical settings

professionalism does not change. Actions considered inappropriate for physicians and physician assistants in person are inappropriate using electronic media.

The Commission is actively researching pathways towards achieving greater efficiency in our organizational operations. Our current primary focus is transitioning to a paperless system. Our estimated costs for printing and mailing of case file materials are around \$90,000 per year and we suspect these estimates to be on the low end of the spectrum. Many of these processes are unavoidable due to the legal requirements of our work, but that does not mean we should not make efforts to refine and reduce the costs involved. Technology and medicine have evolved. The Commission must evolve as well. The Commission is mindful of its budget and we are good stewards of your fees. Through the efficiencies gained in refining our operations and our fiscal responsibility, we do not anticipate the need for any licensure fee changes in the foreseeable future.

Finally, the Commission is exploring new tools to address complaints that don't merit formal or informal discipline. Too often, the Commission receives a complaint that would be better addressed through education of the physician or physician assistant, or direct (in person, face to face) interaction between members of the Commission and the respondent. A resolution using these methods allows the Commission to protect patients by educating the provider and keeping them in the workforce. To meet this need, the Commission is actively studying collaboration with the Disclosure and Resolution Program at the University of Washington School of Medicine. This program attempts to resolve medical errors through root cause analysis, directly involving the patient, and shared learning across systems.

The time has come to update our strategic plan (<http://go.usa.gov/DjNJ>), renegotiate our joint operating agreement, and modernize our physician assistant practice rules (<http://go.usa.gov/DjRY>). I encourage you to attend Commission meetings (<http://go.usa.gov/GZd>), participate in rules hearings, join our rules listserv (<http://go.usa.gov/dGB>) and provide us with feedback. This is your Commission and it impacts your profession and practice. Those who show up make decisions and I encourage you to do so. A perfect opportunity is the Annual Educational Conference on October 2-3 in Tumwater. We have secured two days of fantastic local and national speakers covering topics from integrative medicine to opioid issues to professional boundaries to the Affordable Care Act. There is no cost to attend and you can claim Category 2 CME. Visit our Annual Conference web page (<http://go.usa.gov/jZUT>) for further details.

The Commission is keenly aware of the impact of its decisions when taking action against a practitioner in the state of Washington. Commissioners are charged by the Governor to protect the citizens of Washington. We, as a Commission, feel that we are in the best position to reprimand and/or restrict a practitioner's license and recommend educational and remedial remedies. We are also aware of the unintended consequences imposed on practitioners by hospitals, insurers, and certifying boards.

In the future, we will be making every effort to balance the required uniform disciplinary guidelines with a concern for the unintended consequence to the medical licensee along with the importance of protecting patients in the state of Washington.

Thank you for reading and I will keep you informed regarding these developments.

Commission Educational Conference

While the Commission expends the majority of its time and resources on licensing and discipline functions, every year the Commission makes education the focus of one extended meeting. On October 2-3, the Medical Commission will hold its educational conference in Tumwater at the Capitol Event Center (ESD 113) <http://go.usa.gov/jZUT>. The conference, free and open to the public, is a two-day event featuring local and national speakers from the public, private, and non-profit sectors of health care delivery, quality improvement and medical regulation. The theme of the 2013 conference is "*The Evolution of Medicine - Improving Patient Safety*." Some confirmed presenters are:

- **Scott Fishman, MD.** Author of *Responsible Opioid Prescribing: A Clinician's Guide*, clinical professor, and Chief of Pain Medicine at University of California, Davis;
- **Glen Gabbard, MD.** Clinical Professor with the Gabbard Center;
- **Michael Tronolone, MD, MMM.** Chief Medical Officer, the Polyclinic;
- **Ann Greiner.** Vice President of External Affairs, National Quality Forum;
- **Robert Crittenden, MD.** Executive Policy Advisor to the Governor;
- **Heather Tick, MD.** Clinical Professor, UW School of Medicine and expert on integrative medicine and pain management;
- **Charles Meredith, MD.** Medical Director, WPHP;

Executive Director's Report

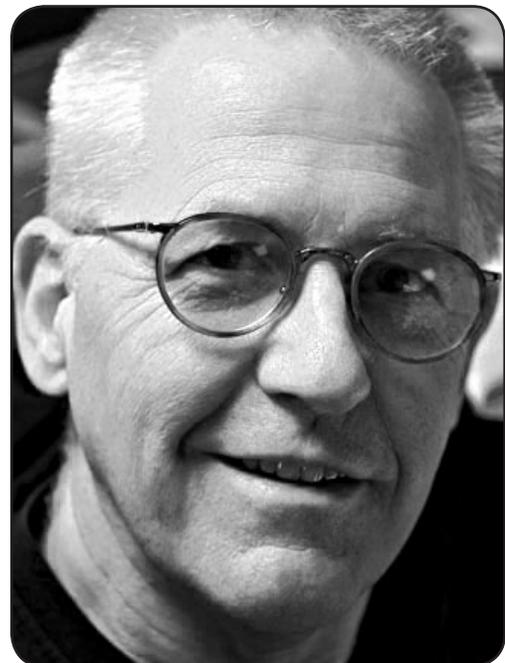
Maryella E. Jansen Executive Director

In Memory of Wayne R. Carlson, PA-C

The Medical Quality Assurance Commission has lost one of our family. On August 5, 2013, Investigator Wayne Carlson passed away after a courageous battle with cancer.

In October of 2005, Wayne joined the Commission as a Health Care Investigator after a successful career as an ophthalmologic physician assistant – certified. Wayne was also a proud US Army veteran. Wayne's medical knowledge, particularly in the specialty of ophthalmology, his outstanding investigative skills and his commitment to the public protection had a significant impact on the success of Medical Investigation during the five-year Pilot Project.

Wayne was a positive spirit in our office. He was kind and respectful to staff and to the people he dealt with while conducting investigations. Wayne was a talented photographer and many of us are fortunate to have his photography in our cubicles and homes. We will always fondly remember and miss Wayne. It was our honor to have him in our lives.



Commissioner Spotlight

2013 Elected Leadership

On June 29, 2013, the Medical Commission elected a new slate of executive officers. Dr. Richard Brantner is now Chair of the Commission. Dr. William Gotthold is first Vice Chair and Dr. Michelle Terry is second Vice Chair. Dr. Mimi Pattison is Immediate Past Chair.

Richard D. Brantner, MD, FAAEM Congressional District 10

Dr. Richard Brantner is the newly elected Chair of the Medical Commission. A former Army Lieutenant Colonel, he earned a BA as a Physician Assistant from George Washington University before completing his MD degree at the University of Colorado. He completed his residency at Madigan Army Medical Center. He is Board Certified in emergency medicine and works as an emergency physician at Providence St. Peter Hospital in Olympia. Dr. Brantner has been with the Medical Commission since 2007, and became first Vice Chair in 2011. During his tenure, Dr. Brantner played a vital role in developing the Pain Management Rules and the Guideline for the Transmission of Critical Medical Information (TCMI). He is married, has three adult children, and one grandchild.

William Gotthold, MD, FAAEM Congressional District 8

Dr. William Gotthold earned his MD degree from Tulane Medical School in 1969, and began a career in emergency medicine. He joined the Medical Corps where he directed the Emergency Department at Fort Ord. After leaving the Corps with the rank of Major, he became the Emergency Department Director at Mercy Hospital in Redding, California. He also worked as Medical Director for the Northern California EMS system. Since he came to Washington in 1978, Dr. Gotthold has served as medical Chief of Staff and on ethics committees at both Central Washington Hospital and at Wenatchee Valley Medical Center. At Wenatchee, he held the position of Associate Medical Director and Medical Informatics Officer. He was also president of the Washington Chapter of ACEP, and of the Chelan-Douglas County Medical Society. Before he joined the Commission, Dr. Gotthold served as an oral examiner and on the Board of Directors at the American Board of Emergency Medicine. He is married with two adult sons.

Michelle Terry, MD, FAAP Physician at Large

Dr. Michelle Terry is the newly elected 2nd Vice-Chair for the Medical Commission. A native of Texas, she earned her MD degree from Baylor College of Medicine. She moved to Seattle and completed her residency in pediatrics at Seattle Children's. She continues to work at Children's, seeing patients and teaching medical students. Dr. Terry also works for the Department of Social and Health Services (DSHS) as a medical consultant. As a member of the Fostering Well Being Care Coordination Unit, she provides the family and child social workers with information to help manage the health care needs of children in State or Tribal placement and care authority. She served for eight years as a board member for Child Care Resources, and writes the "Ask Dr. Terry" blog for the Children's Trust Foundation. She is married with three children.

Legislator Profile

Senator Linda Evans-Parlette

Linda Evans-Parlette has represented legislative district 12 in the Senate since 2000 and has served as Republican Party Caucus Chair since 2006. Prior to her election to the Senate, Linda served four years in the House of Representatives. She graduated from Washington State University with a BS in Pharmacy with honors. Linda is both a registered pharmacist and a member of the Washington State Pharmacy Association. She currently sits on the Ways and Means Committee, the Rules Committee, Natural Resources Committee, and Senate Health Care Committee. She resides with her husband, with whom she has five adult children. They have three granddaughters.

Representative Joe Schmick

Joe Schmick has represented legislative district nine since 2007. A second generation farmer, Joe has an extensive background in agriculture. He graduated from Eastern Washington University with a degree in accounting and from the Washington Agriculture and Forestry Education Foundation. During his career Joe became a small business owner and has worked as a Little League coach. He currently serves on the House Health Care & Wellness Committee where he is the Ranking Minority Member. Additionally, he sits on the Appropriations Subcommittee on Health & Human Services, the Agriculture & Natural Resources, Appropriations, and the Rules committees. He resides in Colfax with his wife, Kim.

Commission Case Reports

Bruce Cullen, MD Physician at Large

Boundary Violations

Physicians must always remember that a mandatory aspect of professional behavior is to be cognizant and respectful of social and sexual boundaries with patients and employees. Boundaries define the limits of appropriate behavior by a professional toward his or her clients. Inadvertent or intentional crossing of these boundaries by a physician can have devastating effects on the patient, or the employee, and the physician.

A 45 year-old male internist was a competent and respected member of a small group practice in a rural area. The physician, who was married and had children, became attracted to a female patient with a history of psychiatric illness, they began to date, and eventually he was spending nights at her residence. After a few weeks, the patient experienced extreme anxiety, realized the inappropriateness of the physician's behavior, and filed a complaint with the Medical Commission. Despite what may have had the outward appearance of a mere "consensual" affair between these two individuals, the consequences of the physician's unprofessional behavior were immense:

- The patient required intense psychotherapy;
- The physician's marriage was nearly destroyed;
- The Medical Commission filed charges, placed the physician's license on probation (enabling him to continue to practice), and demanded that he undergo a psychosexual evaluation, take a course in ethics, inform all of his patients that he was under a Medical Commission order, have a chaperone present whenever seeing female patients, and pay a large fine;
- The physician's colleagues terminated him from the group practice and the physician was unable to find employment elsewhere. He lost his hospital admitting privileges. He set up a solo office practice;
- Health insurance carriers removed the physician from their list of preferred providers and would no longer pay him for his services;
- Due to a severe reduction in his income, and large legal bills, the physician came close to filing bankruptcy and quitting the practice of medicine. He was able to survive by supplementing his income by accepting non-medical part-time employment.

Professional boundary violations arise when a physician's personal interests displace his or her fiduciary duty to promote a patient's good health and welfare. Even if a physician and the patient are unmarried, and the patient welcomes the attention, it is unethical for a physician to pursue a romantic relationship while the patient is still under his or her care. This is because the physician is in a position of power relative to the patient and the patient may be unable, or unwilling, to limit the physician's advances. If the physician's advances are resisted there is an implied threat that the physician may disclose the patient's illnesses or disabilities to others, withhold appropriate medical care, or otherwise harm the patient. A romantic relationship between physician and patient can also significantly affect the physician's objectivity, in much the same manner as when a physician treats a close member of his or her family.

In order to determine whether behavior with a patient is ethical, or not, the physician should address the following questions:

- Is this activity a normal, expected part of the practice of medicine?
- Will engaging in this activity compromise my relationship with the patient, or with other patients, my colleagues, or the public?
- Could participation in this activity cause others to question my professional objectivity?
- Would I want my patients, my colleagues, or the public to know I engage in this activity?

If the answer is "no" to any of these questions, the proposed activity is likely to be unethical. The physician should either not undertake the activity, or seek guidance from a trusted, objective peer before embarking on the activity. The above physician did not take these precautions and as a consequence, caused great harm to his patient, to his family, and to himself.

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>

The WPHP Report

By Charles Meredith, MD
Medical Director

A Primer on Physician Burnout

"I'm so burned out. I've got to get off this unit," said the social worker.

What does she mean? Burnout is a term we commonly employ in medicine, but does it mean anything more than having a bad day? And is it serious? It must be, as this exceptional social worker had tears in her eyes when she publicly shared her statement in a morning staff meeting.

Burnout is defined as a triad of depersonalization, emotional exhaustion and low personal accomplishment. My social work colleague was suffering from all three, and she knew it was decreasing her effectiveness at work. We were working in a large, rapid-paced inpatient psychiatric unit with high case volumes, and she felt powerless to impact the homelessness and other external factors that often precipitated our patients' cycle of frequent re-hospitalization. Over time this led to a chronic sense of *low personal accomplishment*.

Day after day of hearing patient stories of traumatization left her *emotionally exhausted*, so that when she went home she had nothing left to give her family and felt "checked out." To protect herself against further emotional injury, or feeling further "burned out," she began to experience *depersonalization*. Rather than seeing each patient as an individual with a unique story like herself, she began to see them as objects in a queue that she was to move towards discharge as rapidly as possible. Subsequently she had moved away from her natural empathy for our patients. Her patients could sense this and were less likely to engage with her and to trust the treatment plans she designed.

Unfortunately for us, burnout is endemic to the practice of medicine, a gratifying but emotionally exhausting profession. Many researchers feel it has increased in prevalence over the last decade, primarily with economic and logistical changes in medicine resulting in increased patient loads, decreased appointment times, decreased autonomy, increased demand for higher number of clinic visits per day, and decreased control over our external working environments.

A recent survey of the membership of the American Medical Association identified the prevalence of burnout

in practicing physicians in the US to be 44%. Not surprisingly, the prevalence of burnout in specialties with high volume, rapid-paced care (i.e. emergency medicine) or extended work hours (i.e. general surgery) was significantly higher. Research has consistently shown that hours worked, number of patient visits/day, and call frequency are all positively correlated with prevalence of burnout. For reasons we do not yet understand, burnout is more common among younger providers than senior physicians.

If burnout continues long term, some believe it can precipitate more serious diseases. Burnout is associated with an increased likelihood of meeting diagnostic criteria for major depressive disorder or alcohol use disorders such as alcohol abuse or dependence. It has been associated with increased likelihood of an episode of significant suicidal ideation in both attending level physicians and fourth-year medical students.

Finally, the presence of continued burnout has been shown to increase the likelihood of making a significant medical error in the near future. Furthermore, when we lose our ability to tap into our natural empathy, patients are less likely to follow our behavioral recommendations. Our patient satisfaction scores decrease, as do our patients' general health outcomes and their compliance with their healthcare directives. And unfortunately, over the long term, burnout increases the likelihood that a provider will leave the field due to their chronic disillusionment. Sadly for her colleagues, my social work friend elected to move to a career much different than mental healthcare delivery.

Research into strategies to target burnout is growing. While many of us have or will experience burnout at some point, the good news is that it is often a transient state. There are several things an individual can do to combat burnout, all of which revolve around maintaining a healthy work/life balance. Utilizing vacation time is important, as is having the courage to exercise what control you can over work hours and call frequency. Reflective writing on meaningful clinical experiences and sharing these experiences with colleagues have been shown to be helpful. In addition, multiple researchers have shown that learning and implementing the practice of mindfulness meditation can combat and prevent the development of burnout. In fact, a number of medical schools are altering their medical student curriculum to incorporate content on wellness and training their students in Mindfulness-Based Stress Reduction. UW Medicine offers a free six-week course in MSBR to its faculty and their families, and we hope to see other large

healthcare organizations throughout the state do the same for their medical staff.

When burnout lingers, we lose the joy that comes from the practice of medicine. If the above interventions don't work, a brief course of supportive psychotherapy may be very helpful. Many individuals will confidentially call the Washington Physicians Health Program seeking a local therapist who is experienced in working with physicians and understands the pressures we face. Give us a call and we can find help for you in your local community.

Legal Actions

May 1, 2013 – August 30, 2013

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 linked opinion for a description of the issues and findings. All legal actions are updated quarterly and can be found on the Commission website: <http://go.usa.gov/DKQP>

Legal Actions continued on page 8

Practitioner	Type of Action	Date	Cause of Action	Commission Action
Formal Actions				
Marlow, Lea Ann, MD (MD60202294) Indiana	Default Order	March 21, 2013	The Medical Licensing Board of Indiana suspended Respondent's license. The Commonwealth of Kentucky Board of Medical Licensure suspended Respondent's license.	Indefinite suspension.
Mixon, Jerry N., MD (MD00023643) Kirkland, King County	Agreed Order	June 27, 2013	Respondent inappropriately provided a long-term regimen of human growth hormone supplementation (HGH) to patients.	Five-year probation; Restricted from advertising or prescribing or administering HGH; Ethics course; \$10,000 fine; Practice reviews; Appear before Commission annually.
Shah, Mian M., MD (MD60010649) California	Agreed Order	June 27, 2013	The North Carolina Medical Board denied Respondent's application for a license to practice medicine because Respondent failed to report that he was on probation in the last year of his residency, was placed on provisional disciplinary probation in another residency, and there was a discrepancy with one of his references.	Indefinite probation; Psychological evaluation; Ethics course; \$2500 fine; Appear before Commission before practicing in Washington.
Wright, Jonathan V. MD (MD00011394) Renton, King County	Final Order	May 15, 2013	Respondent aided or abetted the unlicensed practice of medicine and failed to cooperate with the Commission's investigation.	Suspension for 90 days, probation for 30 months; Provide a written office policy on the importance of licensure; Fine of \$7500; Appear before Commission on annual basis.
Informal Actions				
Chan, Roger S., MD (MD60002105) Olympia, Thurston County	Stipulation to Informal Disposition	May 16, 2013	Alleged: The Arizona Medical Board issued an order placing Respondent's license on probation and requiring Respondent to hire a monitoring company to monitor his practice.	Probation for one year; \$1000 cost recovery; Hire a preceptor to monitor Respondent's practice.
Dickson, Richard L. MD (MD00016829) Forks, Clallam County	Stipulation to Informal Disposition	May 16, 2013	Alleged: Respondent failed to comply with the Commission's rules on managing chronic pain by prescribing high dose opioids without including necessary information in the records, not conducting appropriate risk assessment or responding to risk factors and signs of medication misuse and diversion.	Probation two years; Complete continuing medical education in opioid prescribing for chronic pain; Comply with pain management rules; Register with the WA Prescription Monitoring Program; \$1000 cost recovery; Practice reviews.

Dill, Robert S., PA-C (PA10003663) Colorado	Stipulation to Informal Disposition	May 16, 2013	Alleged: Respondent and the Colorado Medical Board entered into an order placing Respondent's license on probation after Respondent self-referred to the Colorado Physician's Health Program for alcohol abuse.	Indefinite probation; Compliance with Colorado Physician's Health Program; Enter into memorandum of agreement with Washington Physician's Health Program.
Garman, Sean W., MD (MD00035833) Spokane, Spokane County	Stipulation to Informal Disposition	May 16, 2013	Alleged: Respondent failed to order a chest x-ray on a patient who complained of shortness of breath during several visits. The patient was later found to have chronic lung disease suggestive of severe sarcoidosis.	Complete continuing medical education in diagnosis of chest complaints, including pulmonary sarcoidosis; Paper on diagnosis and treatment of pulmonary sarcoidosis; \$1000 cost recovery; Practice reviews.
Gibbs, Warren MD (MD00020846) Seattle, King County	Stipulation to Informal Disposition	June 27, 2013	Alleged: Respondent failed to provide appropriate care for a patient complaining of dizziness and right-sided weakness, signs of a stroke or TIA. Respondent failed to obtain CT imaging, EKG testing, or lab tests and carotid duplex testing. Respondent failed to consider a perfusion scan or MRI or referral to an emergency department.	Two-year probation; CME in stroke and TIA evaluation; Paper on evaluation of stroke or TIA symptoms; Peer group presentation; \$1000 cost recovery; Appear before Commission annually.
Lee, Anthony H., MD (MD00017269) Oregon	Stipulation to Informal Disposition	May 16, 2013	Alleged: The Oregon Medical Board and Respondent entered into an order in which Respondent agreed to retire from the practice of medicine.	Surrender of license.
Nikolaisen, Robert E., PA-C (PA10004934) Hawaii	Stipulation to Informal Disposition	June 27, 2013	Alleged: Respondent signed pre-written prescriptions for a co-worker, a PA-C, for Adderall. Respondent did not conduct an H & P, keep a medical record, or consult the supervising physician of the PA-C.	Agree not to renew expired license; \$1000 cost recovery.
Ochiai, Tomoyuki, MD (MD00038611) Burlington, Skagit County	Stipulation to Informal Disposition	May 16, 2013	Alleged: Respondent performed a wedge resection that revealed squamous cell cancer and proceeded to perform a left upper lobectomy, during which he found that a staple that was placed to ligate a pulmonary vein had inadvertently transected the left mainstem bronchus. Respondent was unable to complete the surgery. Respondent was diagnosed with a medical condition that contributed to his performance of this surgery. The condition is being managed with medication.	Monitoring for five years; Cease the practice of thoracic surgery; Remain in compliance with WPHP; Remain under care of psychiatrist.
Randecker, Harold H., MD (MD00014276) Lake Stevens, Snohomish County	Stipulation to Informal Disposition	June 27, 2013	Alleged: Respondent was convicted of the crime of making a false statement under oath relating to a bankruptcy proceeding. Respondent has not practiced clinical medicine since 2006.	Surrender of license.
Waters, Harris J., MD (MD60167480) Oregon	Stipulation to Informal Disposition	May 16, 2013	Alleged: The Oregon Medical Board issued an order restricting Respondent from placing guided lines without the use of ultrasound and without affirmatively charting the confirmed placement of such guided lines.	Indefinite probation; Compliance with Oregon Order; Restricted from placement of guided line without the use of ultrasound to guide and confirm the placement of the line into a patient; must affirmatively verify the placement of a guided line in the chart within 24 hours of the procedure. Released from STID on June 19, 2013

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.

Expert Reviewers Needed

The Medical Commission is seeking physicians to review records to determine whether care was within accepted and prevailing standards in the state of Washington. This service is critical to the Commission's ability to assess complaints in a timely manner. This may include providing expert testimony in an administrative proceeding before a panel of Commission members.

Specific specialties needed are:

- Pain Management;
- Internal Medicine;
- Interventional Radiology;
- Obstetrics-Gynecology.

Experience testifying in court or hearings is preferred but not required. If you are interested, please contact Michael Farrell at: michael.farrell@doh.wa.gov or 509-329-2186.

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>

Commission Performance Report

Micah T. Matthews, MPA Performance and Outreach Manager

For quite some time, this publication has provided readers with updates on the operational performance of the Commission with specific focus on the recently concluded and successful Pilot Project to increase efficiency and performance. While the data collection period for the Pilot ended on June 30, 2012, the efforts to improve performance and gain operational efficiencies did not. With the conclusion of our first post-Pilot fiscal year, it is my pleasure to share with you the performance of your Medical Commission. Briefly stated, the performance improvements of the Pilot Project (<http://go.usa.gov/Djpm>) are not an aberration and have continued.

The Commission operates on a fiscal year running from July 1-June 30, with the time divided into four three-month quarters. The Commission has both performance and tracking measures. The Commission negotiated these performance measures with the Department of Health (DOH) and during the Pilot Project the Commission performance was compared with the Secretary administered professions, professions administered by the Health Systems Quality Assurance Division, and the performance of the Nursing Commission.

Tracking measures are those developed by the Medical Commission for internal monitoring of "performance health" and generally measure global production. With the conclusion of the Pilot Project, the legislature mandated the Medical Commission to renegotiate its Joint Operating Agreement with DOH and the time has come to update the Commission strategic plan. Both of these efforts will result in development of new or updated performance and tracking measures. The Commission will update its stakeholders as these issues progress.

The Commission operates an internal performance management system, which focuses on set times of reporting and accountability of key staff for the performance of their individual units. Internal reporting occurs on a monthly basis with two time-based check points during the month to allow for data error correction and addressing performance issues.

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Licensing

The Medical Commission establishes the standards for medical licensure and practice in Washington. 29,397 MDs and PAs held a valid Washington license on July 1, 2013. In fiscal 2013 the Commission issued 2,429 MD and PA licenses, which is an increase of 208 from fiscal 2012. This metric measures the amount of time it takes to issue a license once the Commission receives all required documents from the applicant. The Medical Commission issued 100 percent of its licenses within timelines in fiscal 2013.

Discipline

A chart of the Commission disciplinary process can be found on our website: <http://go.usa.gov/DWYB>.

Complaint Intake and Assessment

The Commission received 1,493 complaints against Washington licensed medical practitioners in fiscal 2013, an increase of 93 over fiscal 2012. Upon receipt of a complaint, the Commission staff enters the complaint into the computer system, obtain a whistleblower waiver from the complainant, and distribute the complaint to the Commissioners for assessment and decision to close or investigate the complaint. The Commission's goal is to complete these steps within 21 days. In fiscal 2013, the Commission processed 99.9 percent of complaints within timelines, which is the same performance as fiscal 2012. In both fiscal 2012 and 2013, the Commission processed one complaint over timelines.

Investigations

The Commission has timeline of 170 days to investigate a complaint. In fiscal 2013, the Commission staff investigated 911 complaints and completed 91.5 percent of those investigations on time. 2.9 percent of open investigations were over timelines in quarter four, for an average of 3.5 percent of open investigations over timelines for fiscal 2013.

Legal Actions

At the conclusion of an investigation, staff sends the file to the Reviewing Commission Member receives the case file for review and presentation to a panel for action or closure. The Commission has 140 days to close the case serve a Statement of Charges or offer a Stipulation to Informal Disposition. In fiscal 2013, the Commission legal unit processed 920 of these cases and completed 94.7

percent within timelines. 27 percent of open cases were over timelines in quarter four, for an average of 23.7 percent of open cases over timelines for fiscal year 2013.

Case Resolution Timelines

In fiscal 2013, the Commission resolved 94.4 percent of all cases within 360 days, 81.9 percent of those within 180 days.

Commission Orders

The Commission issued 86 formal and informal orders of discipline and summarily suspended or restricted 15 licenses. 100 percent of these orders complied with the Sanction Rules, which ensures uniform discipline standards are applied. The Commission actively monitors the practice of 181 licensees and 44 licensees successfully completed their compliance programs in fiscal 2013.

Other Categories

Human Resources and Budget

The Commission measures the productiveness of its staff attorneys and investigators, along with the timely submission of performance evaluations. The Commission closely monitors its revenue, allotment, and expenditures on a monthly basis. In all HR and budget measures, the Commission submitted a positive performance.

Conclusion

Overall, fiscal year 2013 is one of impressive performance submitted by the Medical Commission. This performance is further proof that the Commission, in its new statutory permanence of additional authority over personnel and budget, is able to maintain and improve its operational efficiencies. The next steps for the Medical Commission are a renegotiation of its Joint Operating Agreement, updating of its Strategic Plan, and refinement of its performance management system. With careful application, this will lead to proper organizational analysis and a Medical Commission that is efficient, effective, and engaged.

Did you know?

You can complete your demographic census for renewal online!

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Medical Commission Vital Statistics

- The Commission successfully completed a Pilot Project to measure performance and efficiency;
- 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 August 23, 2013 business meeting the Commission approved/updated no new 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/dGO>

Medical Commission Meetings 2013

Date	Activity	Location
October 2-4	Educational Conference	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
November 14-15	Regular Meeting	Puget Sound Educational Service District (PSESD) Blackriver Training & Conference Center 800 Oakesdale Ave SW Renton, WA 98057

All Medical Commission meetings are open to the public

Other Meetings

Washington State Medical Association	Annual Meeting Sept. 28-29, 2013	Spokane, WA
Citizens Advocacy Center (CAC)	Annual Meeting Oct. 29-30, 2013	Seattle, WA
Administrators in Medicine (AIM)	Annual Meeting April 23, 2014	Denver, CO
Federation of State Medical Boards	Annual Meeting April 24-26, 2014	Denver, CO



Washington State Department of Health
 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:		360-236-2770
Fax:		360-236-2795
Email:		medical.commission@doh.wa.gov
Demographics:		medical.demographics@doh.wa.gov
Website:		http://go.usa.gov/dGj
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
- 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
- Ellen J. Harder, PA-C
- Frank M. Hensley
- Bruce G. Hopkins, MD
- Warren B. Howe, MD
- Mark L. Johnson, MD
- Peter K. Marsh, MD
- Mimi E. Pattison, MD
- Linda A. Ruiz, JD
- Mimi Winslow, JD

Washington State Medical Commission Newsletter–Fall 2013
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