



Message from the Chair

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

Season's greetings from the Medical Commission! While most businesses are preparing for the holiday season, the commission is focused on pushing through large initiatives relating to rule-making and participating with stakeholder groups working on statewide issues. I encourage you to read about our rule-making initiatives in the column by our Program Manager, Daidria Pittman.

I further encourage you to become involved by joining the rules listserv, emailing comment on proposed rule language, or attending a hearing to provide input personally. These rules, some mandated and some not, impact your practice in Washington. Get involved and make a difference. I am pleased to announce that Washington now has over 30,000 MD and PA licensees. A profile of our 30,000th licensee will appear in the spring 2015 newsletter.

Over the past year the Commission experienced increased interest from numerous parties in our work. This can take many forms and I emphasize that the Commission is open to working with all stakeholders to further this goal in a productive and respectful way. We have a robust and effective health care delivery system and it is up to all of us to make it better.

I experienced this point first hand last week on a medical mission trip to Haiti. Commissioner Tom Green, an orthopedic surgeon, has been making regular trips to the country for some time in this capacity. I joined him at his request this year and I am amazed at the daily experiences of the people in that country. Something as simple as cholera makes infant death a consistent and normal occurrence, all for lack of basic sanitation infrastructure.

Seeing this pushed me to ask what can we do in Washington? Most of you are aware of the push to reduce the deaths from prescription opioids that started in 2011. We now have time and experience to assess the response and overall it appears the trend is stopped but is shifting to heroin deaths. While this generates a larger discussion we must focus on how can we work to prevent this?

The Commission is collaborating with the Agency Medical Director's Group on updating the opioid guidelines. Further, we are working with the Department of Health and state law enforcement entities to get rescue naloxone in the hands of first responders along with proper training. The Commission will keep you updated on these efforts as they develop.

I wish you all good health and safety in your holiday celebrations and please take time to remember those serving overseas and away from family. Perhaps most important, please take time to nurture yourselves during these times of celebration and fellowship. Happy holidays!

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Mission

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

## Executive Director's Report

### Melanie de Leon, JD, MPA Executive Director

For several years, Washington state government has embraced Lean management principles and Governor Jay Inslee encouraged agencies, boards and commission to use Lean principles to:

- Create a culture that encourages respect, creativity and innovative problem solving;
- Continuously improve and eliminate waste from government processes;
- Align efforts across state agencies;
- Deliver results that matter to Washingtonians.

Lean thinking begins with eliminating all types of waste so that all work adds value and serves the customer's needs. Identifying value-added and non-value-added steps in every process is the beginning of the journey toward lean operations. We have begun our Lean journey to streamline our processes to save you time as well as provide better customer service for everyone.

During this Lean journey, we will be asking for stakeholder input to insure that any time our processes touch our stakeholders, they are quick and easy to use and understand, they make sense to the practitioner and they are informative to both practitioners and the public. We will also be engaging the help of patient safety organizations to review and revamp correspondence we send to citizens/patients.

My request is that you contact me at [melanie.deleon@doh.wa.gov](mailto:melanie.deleon@doh.wa.gov) if you have interacted with our licensing or other processes and have an idea for an area to improve or streamline. I will review comments/ideas to find opportunities for improvement.

Our goals are to become a more innovative and responsive organization, to slash as much "red tape" as possible from our processes and to make every experience with us as pleasant and productive as possible.

*"There is nothing so useless as doing efficiently that which should not be done at all."*

Peter F. Drucker

## Commission Rulemaking Efforts

### Daidria Pittman Program Manager

#### Physician Assistants

On October 16, 2014, the Commission filed a CR-102, Washington State Register (WSR) #14-21-109 proposing revisions to chapter 246-918 WAC—physician assistants (PAs).

The Commission is proposing revisions to this chapter pursuant to Substitute House Bill 1737 (2013) to update PA rules to incorporate national standards and best practices. The proposed rules are also intended to synchronize, where possible, with the osteopathic PA rules under the Board of Osteopathic Medicine and Surgery since many PA applicants for licensure now seek both an allopathic and osteopathic PA credential.

#### Suicide Prevention

The CR-101 for Suicide Prevention Continuing Education rulemaking was filed on October 6, 2014 (WSR #14-21-030). The next public workshop will be held at the Blackriver Training & Conference Center in Renton on Wednesday, January 7, 2015 where draft language will be presented for discussion.

#### Sexual Misconduct

The CR-101 to revise the Sexual Misconduct rules for allopathic physicians (WAC 246-919-630) was filed on October 30, 2014 (WSR #14-22-047). The first stakeholder workshop will be held at the Blackriver Training & Conference Center in Renton on Wednesday, January 7, 2015.

## Stay Informed!

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

<b>Newsletter:</b>	<a href="http://go.usa.gov/dGk">http://go.usa.gov/dGk</a>
<b>Minutes and Agendas:</b>	<a href="http://go.usa.gov/dGW">http://go.usa.gov/dGW</a>
<b>Rules:</b>	<a href="http://go.usa.gov/dGB">http://go.usa.gov/dGB</a>
<b>Legal Actions:</b>	<a href="http://go.usa.gov/dGK">http://go.usa.gov/dGK</a>

## Commission Case Reports

### Mimi Winslow, JD Public Member

The Uniform Disciplinary Act, RCW 18.130.180 provides the legislative definition of what is required, and prohibited, in medical practice in the state of Washington. The statute defines twenty five distinct categories of unprofessional conduct. Some of the conduct proscribed involves violations in regard to people with whom the physician has a supervisory relationship, with the statute imposing an affirmative obligation on the physician to ascertain licensing status. Specifically RCW 18.130.180(10) makes unprofessional conduct “*Aiding and abetting an unlicensed person to practice when a license is required.*” While typically this section is invoked when the physician knows that an assistant or colleague lacks the necessary license, the language of this section of the Uniform Disciplinary Act is not couched in a requirement of intent or recklessness. Thus, it is incumbent on the physician to have measures in place to assure that all employees whose jobs require a license, are in fact properly licensed. Two cases will serve to illustrate the obligation.

In the first case a pediatrician hired a person who had training but did not have the then-required Health Care Assistant credential, and assigned the employee to perform duties, including giving vaccinations, which required being credentialed as a Health Care Assistant. Subsequently the Health Care Assistant profession transitioned to Medical Assistant effective July 1, 2013. The physician had failed to educate herself about the changes in state credentialing requirements that were applicable to her practice, and the importance of appropriate licensure and credentialing to the quality of patient care. All procedures done by the employee were properly supervised by the physician. When she learned of the employee’s lack of licensure, the physician took the employee out of patient care until the licensing was completed properly. The physician subsequently established a system in her practice to assure that all staff are appropriately licensed or credentialed and that each person is practicing within the scope of practice. She ensures that all staff are aware of their obligation to obtain, maintain, and renew their licensure in a timely fashion, and provides the necessary oversight.

In the second case, an administrative oversight led to the absence of certification for two medical assistants, both of whom had been previously certified by the state, and who were performing duties within their training and competency. All other employees in the office were properly licensed. The physician revised his office protocols to include staff education, dual filing system with proper documentation, and calendaring to insure timely renewal.

The Commission strongly encourages its licensees to remain current on the licensing and credentialing requirements for all employees, and take regular steps to make sure that everything meets legal requirements. This will avoid running afoul of the requirements of the Uniform Disciplinary Act, and will help assure that all staff are skilled, competent, and promote excellent patient care.

#### 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>

#### 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>

# Medical Marijuana Authorization Practice Guideline

## William Gotthold, MD 1st Vice Chair, Congressional District 8

### Purpose

The legislature provided for the medical use of marijuana with Chapter 69.51A RCW. The intent was that practitioners caring for patients with certain specified terminal or debilitating conditions could, at their discretion, authorize marijuana for medical use for these conditions. Practitioners identified as able to provide these authorizations are MDs, DOs, NDs, and ARNPs. In the interests of public safety, the boards and commissions responsible for these practitioners propose a uniform guideline for practitioners who elect to use medical marijuana as part of their therapeutic approach. The full guideline is located on our website: <http://go.usa.gov/HWge>

### Conforming to the guideline

Patients who have terminal or debilitating conditions often have more than one practitioner involved in their care. If a practitioner participating in the care of one of these patients elects to authorize the use of medical marijuana, the medical record should reflect the standard of care expected of those practitioners, and should in addition reflect compliance with the RCW.

### Evaluate the patient

Prior to authorizing medical marijuana, the practitioner should obtain and document a complete medical history, including any history of substance abuse or mental illness, and a pertinent physical examination of the patient.

To comply with the RCW, the history must include identification of a listed terminal or debilitating condition, and, except for those listed under (6) (a) in the law, a conclusion that the more standard therapies are not sufficient.

(6) «Terminal or debilitating medical condition» means:

(a) Cancer, human immunodeficiency virus (HIV), multiple sclerosis, epilepsy or other seizure disorder, or spasticity disorders; or

(b) Intractable pain, limited for the purpose of this

chapter to mean pain unrelieved by standard medical treatments and medications; or

(c) Glaucoma, either acute or chronic, limited for the purpose of this chapter to mean increased intraocular pressure unrelieved by standard treatments and medications; or

(d) Crohn's disease with debilitating symptoms unrelieved by standard treatments or medications; or

(e) Hepatitis C with debilitating nausea or intractable pain unrelieved by standard treatments or medications; or

(f) Diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when these symptoms are unrelieved by standard treatments or medications; or

(g) Any other medical condition duly approved by the Washington state Medical Quality Assurance Commission in consultation with the board of osteopathic medicine and surgery as directed in this chapter.

In accordance with paragraph (g), in 2010 the Medical Quality Assurance Commission added chronic renal failure requiring hemodialysis to the list of terminal or debilitating conditions. Use of medical marijuana in this clinical setting has two special conditions the practitioner must consider and document.

1. The health care provider must ensure informed consent of risks associated with marijuana use based on the patient's condition, including but not limited to, any potential adverse effect of marijuana use on the patient's eligibility for renal transplant.

2. Marijuana use by a chronic renal failure patient in connection with side effects of hemodialysis, including use of the smoked form of marijuana, must be consistent with requirements and restrictions at the dialysis facility where dialysis is received.

As with the conditions in (6) (a), there is no requirement to show that standard treatment is insufficient.

### Develop a care plan

The record should include a treatment plan, which may include various standard therapies along with the use of medical marijuana, and a plan for follow-up evaluation by a practitioner involved in the care of the patient.

As with any other therapeutic regimen, one that includes marijuana should be reevaluated on a periodic basis to see if changes are needed. The care plan should include documentation that the risks and benefits of the various modalities, including marijuana, have been discussed with and understood by the patient. Patients under the age of 18 years, or patients without decision making capacity, must have a parent or appropriate legal surrogate agree to any care plan that includes marijuana.

## Maintain a record

Medical records should be maintained in accordance to usual rules and guidelines. They should be available to other practitioners involved in the care of the patient, and also to the patient.

## Education

Marijuana is a complex herb with many components. Appropriate CME of at least 3 hours is recommended for any practitioner who intends to authorize medical marijuana. CME should include the various effects of the psychoactive and non-psychoactive components, the risks and potential side effects.

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## PA News

### Theresa Schimmels, PA-C Physician Assistant Member

At the MQAC we care about “promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rule making, and education”. We care that you are providing safe, effective care.

Everywhere you go there is discussion of best practices, quality measures, and on and on. You may be getting input from your employer or the insurance companies you work with regarding your quality indicators. Your evaluations from your employer or even your pay may be directly impacted by your quality numbers. In most cases these numbers are generated at some big computer far away from your clinic or hospital and are frequently associated to patient input, given in the form of surveys. So what can you do to increase your quality in health care?

In December 2010, the Australian Commission on Safety and Quality in Healthcare came up with a discussion paper entitled “*Patient-centred care: improving quality and safety through partnerships with patients and*

*consumers.*” Here are some of the keys, as paraphrased from this document:

Safe, high-quality health care is always:

- Patient focused, providing care that is easy for patients to get when they need it;
- Providing care that is respectful of and responsive to individual preferences/choices, needs, and values;
- Forming partnerships between patients, family, caregivers, and healthcare providers.

What it means to the patient:

- I can access high quality care when I need it;
- I can obtain and understand health information, so that I can make decisions about my own care and participate in ensuring my safety;
- My health care is well organized. The doctors, nurses and managers all work together. I feel safe and well cared for in a system that works partnership with me
- I know my healthcare rights;
- If I am harmed during health care, it is dealt with fairly. I will get an apology and a full explanation of what happened.

(source: [http://www.safetyandquality.gov.au/wp-content/uploads/2012/03/PCC\\_Paper\\_August.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2012/03/PCC_Paper_August.pdf), page 89)

How do we honor our patients by providing these things with all the time constraints we have today including the distraction of EMR and electronic devices, phone calls and other interruptions, difficult patients, and our own personal lives?

I don't have all the answers for you and I don't believe anyone does. I believe our job as healthcare providers is to increase health literacy, involve patients so that they can make decisions about their care, provide care that is culturally safe with equality in treatment, enhance continuity of care, minimize risks at all levels (not just our own), and make care safe by reducing harm in our delivery of care for each and every patient. If we continue to strive to provide care that is safe and effective then we continue to work at being optimal providers in a system that is imperfect yet every changing, just like you and me.

## The WPHP Report

By Charles Meredith, MD  
Medical Director

### Practitioner Impairment Part Two:

#### Q: What happens if I make a report with MQAC?

A: The MQAC will be obligated to open up an investigation of your colleague for “unprofessional conduct” for practicing medicine while potentially impaired due to an untreated or undertreated illness. For unavoidable reasons, this has a high likelihood of resulting in disciplinary sanctions for your colleague. (This is due in part to the limited array of tools available to the MQAC in protecting the public from substandard medical care). There is also a high likelihood that the MQAC will have empathic concern for the well-being of your colleague and strongly encourage your colleague to self-refer to WPHP for immediate clinical help.

#### Q: What happens if I make a report to WPHP instead of MQAC?

A: You have fulfilled your legal obligation to make a report. WPHP now has an obligation to assess your colleague as soon as possible to “rule-out” that they are impaired, or to get them adequately treated if WPHP “rules-in” impairment. For patient safety reasons, your colleague will have a reasonable, but limited, time frame in which to respond and comply with WPHP’s clinical evaluation. They may very well have to take extended medical leave if truly impaired, and complete sufficient treatment before they can return to work with active WPHP monitoring in place. If they are non-compliant with this process, WPHP has the legal obligation to make a report to the MQAC as appropriate.

By making your report to WPHP, you have fulfilled your legal and ethical reporting requirement. WPHP assumes any reporting requirements to MQAC should your colleague not comply. You have given your colleague a chance to receive confidential help without being identified to the MQAC and facing the risk of disciplinary action for trying to practice while impaired by illness.

#### Q: Once I’ve made a report to WPHP, under what circumstances does WPHP report my colleague to the MQAC?

A: If WPHP is significantly concerned that your colleague is impaired and your colleague will not follow redirection to take medical leave from work and complete necessary evaluation and/or treatment, WPHP will notify the MQAC of your colleague’s non-compliance and the risks this behavior poses to public safety. In this rare scenario, there is a high likelihood this will result in significant and swift disciplinary action from the MQAC. The risk of this contingency serves as an effective motivator for providers who are impaired but are otherwise ambivalent about committing to the level of help they really need for their untreated illness.

#### Q: How frequently does the WPHP report my colleague to MQAC?

A: These events are very rare. At this time, 90% of the physicians being actively monitored by WPHP are unknown to the MQAC. Of the 10% who the MQAC is aware are in our program, the majority of these physicians were actually referred to WPHP by the MQAC in the course of an investigation or sanction process that led to disciplinary action for illness-related behavioral transgressions. In other words, when concerns of impairment first came to light in these cases, no one called WPHP and eventually someone made a call to MQAC instead.

#### Q: What happens if I don’t call anyone and make a report?

A: When impairment is suspected, not making a report prolongs the unacceptable exposure of patients to the risk of unsafe care from the potentially impaired provider. Failing to act also needlessly jeopardizes the career of a colleague that can be easily saved through therapeutic treatment for their illness. By doing so, you may open yourself up to the risk of legal action from the Department of Health.

#### Q: What if the “impaired” physician in question is my patient?

A: You may still have an obligation to make a referral to WPHP or MQAC, although your concern has to reach a higher threshold before you would be legally obligated to make that report. Per WAC 246-16-235, you do not have to make a report until your physician-patient “poses a

clear and present danger to patients or clients.” You have to weigh this obligation versus your legal obligations under HIPAA if your patient is not willing to consent to you disclosing their identity in a report to WPHP.

**Q: Are there any possible “impairment” situations in which I cannot fulfill my legal reporting obligation by calling WPHP instead of the MQAC?**

A: Yes, there are two. Any behaviors falling under the definition of sexual misconduct (WAC 246-16-100) cannot be reported to WPHP and stay confidential. These incidents must be directly reported to the Department of Health. Any situation in which there is concern for impairment and there is known patient harm stemming from the suspected impairment, a direct report to the Department of Health is required. In these situations, a report to WPHP is “not a substitute for reporting to the Department.”

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

A: In order to maximize patient safety, the law is set up to encourage early identification, assessment and treatment of providers who are thought to be impaired. Allowing physicians to self-report to WPHP or to be reported by their employer or colleagues to WPHP rather than to the MQAC serves this purpose. It encourages use of WPHP as a therapeutic alternative to discipline for providers who need help and can be rehabilitated. Having a chance to avoid the threat of discipline serves as a powerful motivator for such physicians to commit to intensive treatment and an intensive recovery program.

**Q: If I need to make a report, is there any disadvantage to me or to my colleague if I call the MQAC instead of WPHP?**

A: No. If we feel you are not fulfilling your obligation by calling us and this is one of those rare cases in which a call to MQAC or DOH is mandatory, we will explicitly clarify this for you.

### **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>

## **WPHP Skills Course**

### **SKILLS TO PREVENT BURNOUT**

Burnout has become endemic to the practice of medicine, and is a leading cause of premature retirement and decreased satisfaction with the profession. The medical literature has consistently shown that the most effective approach for treating or preventing the development of burnout in physicians is something called Mindfulness-Based Stress Reduction (MBSR).

Developed by Dr. Jon Kabat-Zinn, MBSR incorporates Eastern-based mindfulness practices and other interventions to target burnout and other behavioral health conditions. Multiple studies have shown that MBSR training and practice decreases burnout, increases productivity, increase quality of life and increases job satisfaction among physicians and other health care providers. MBSR has been shown to improve performance and resilience among various high performing professional groups, including the US Marine Corps and the Seattle Seahawks.

Since this is the most evidence-based intervention for protecting yourself from burnout and prolonging your career, the Washington Physicians Health Program is offering two 5 session MBSR training workshops in Seattle this winter. We have a series on Wednesday nights, starting January 14th and a second series on Thursday nights, starting January 15th.

The cost is \$150, which is less than half of what this workshop would cost you through the community. This workshop is open only to physicians, physician assistants and their significant others. If you're willing to do something for your long term health, consider taking this class along with your physician peers who can relate to the stresses you're feeling in the workplace.

If you're interested, contact Jason Green at WPHP at (206) 583 0127 today. If either schedule does not work for you, check back later in the year as we anticipate holding several offerings throughout 2015.

## Legal Actions

### August 1, 2014 - October 31, 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
<b>Formal Actions</b>				
Atteberry, Dave S. (MD60125296) Yakima County	<b>Agreed Order</b>	8/21/14	Respondent performed back surgery at the wrong level and charted a separate wrong level on his operative notes.	Respondent will: document consults with the radiologist prior to any surgery; contract with an approved independent reviewer; \$5,000 fine; practice monitoring for two years.
Barone, Christopher M. (MD60251013) Portland, OR	<b>Agreed Order</b>	8/21/14	Respondent misrepresented facts in his Oregon and Washington license applications; failed to timely attend to patients, and falsified chart entries.	Indefinite probation; conditional restriction from practice in WA; Practice in Oregon under supervision of a mentor; \$1,000 fine; medical documentation and medical ethics courses.
Farzad, Said (MD00044681) Pierce County	<b>Hearing Order</b>	8/13/14	Respondent cannot practice medicine with reasonable skill and safety due to a mental condition.	License suspended. Respondent shall submit to a neuropsychological examination and cooperate with WPHP.
Fox, Samuel R. (MD00005293) Snohomish County	<b>Agreed Order</b>	8/21/14	Respondent over-prescribed Phentermine for weight loss on a long term basis and failed to appropriately monitor patients.	Restrictions on Phentermine prescribing; recordkeeping requirements; \$2,500 fine; practice reviews and compliance monitoring for three years.
Harrie, Robert R. (MD60284253) Bradford, PA	<b>Final Order</b>	09/30/14	Respondent violated the Oregon Medical Practice Act, and is under a disciplinary order with that board.	Prior notification before practicing medicine in Washington; \$1,000 fine; quarterly reports If practicing in Washington.
Reedy, R. Graham (MD00014991) King County	<b>Agreed Order</b>	8/21/14	Respondent failed to comply with the Commission's January 2010 order stating requirements for conducting patient exams.	Permanent restriction to telemedicine; \$5000 fine; restricted from issuing prescriptions, physically touching patients or students, instructing on heart and lung examinations.
Shively, Donovan P. (MD60167422) Fairfield, CA	<b>Agreed Order</b>	09/30/14	Respondent failed to meet the standard of care by incorrectly interpreting fetal heart rates and delaying delivery.	Surrender of License.

Informal Actions				
Aytch, Mark A. (PA10004075) King County	<b>Informal Disposition</b>	8/21/14	<b>Alleged:</b> Respondent forged his supervising physician's signature to meet patient needs.	\$1,000 costs; ethics course.
Evans, Heather L. (MD60027234) King County	<b>Informal Disposition</b>	10/03/14	<b>Alleged:</b> Respondent performed a hernia repair surgery at the wrong site which required an additional surgery for the patient.	\$1000 costs; written analysis of factors contributing to the wrong-site surgery; written prevention procedures; peer group presentation.
Hughes, Christopher R. (PA60267583) King County	<b>Informal Disposition</b>	9/30/14	<b>Alleged:</b> Respondent pre-signed blank prescription forms. One was used without authorization by a physician assistant to refill a prescription.	\$500 costs; paper and peer group presentation on prescribing practices relating to the issues of this case.
Hott, Erin M. (MD60208279) King County	<b>Informal Disposition</b>	10/3/14	<b>Alleged:</b> Issuing prescriptions for family without documentation in violation of standard of care and of pain management rules.	Course on boundaries/ethics; presentation to peer group; WPHP evaluation; \$1000 costs; practice review and oversight for one year.
Ideker, Randall W. (PA10000364) Snohomish County	<b>Informal Disposition</b>	8/21/14	<b>Alleged:</b> Respondent violated monitoring agreement with WPHP.	Surrender of license.
Kim, Cholwoo A. (MD00037136) Pierce County	<b>Informal Disposition</b>	9/30/14	<b>Alleged:</b> Respondent planned a simple mastectomy on elderly patient but instead performed a segmental mastectomy, missed the breast lesion, and caused the patient to have two additional surgeries.	Paper on the management of malignant ductal carcinoma in-situ (DCIS) in elderly patients; \$1,000 costs; peer group presentation regarding the management of DCIS in elderly patients.
Litwin, Josh P. (MD00043743) Berkeley, CA	<b>Informal Disposition</b>	9/30/14	<b>Alleged:</b> Respondent under discipline with the California Medical Board. Practice and lifestyle restrictions, including abstention from alcohol and controlled substances.	Comply with California Stipulation.
Majors, James T. (MD00042946) Pierce County	<b>Informal Disposition</b>	8/21/14	<b>Alleged:</b> Respondent failed to perform a D&C as planned. Patient then had to have hysterectomy to rule out cancer.	Written protocol and paper on pre-operative precautions; \$500 costs; compliance appearances and monitoring for two years.

McGill, Charles L. (MD00038212) Lewis County	<b>Informal Disposition</b>		<b>Alleged:</b> Failure to meet the standard of care and violation of pain management rules. Misrepresented CME hours completed.	Restriction on prescribing controlled substances; completion of continuing medical education deficiency with a minimum of 12 credit hours on chronic pain management; paper on Commission's pain management rules; \$1,000 costs; practice reviews and monitoring for three years.
Simons, Louise A. (MD00044441) Chelan County	<b>Informal Disposition</b>	9/30/14	<b>Alleged:</b> Continuing to prescribe methotrexate to an elderly patient without doing follow up lab work, causing pancytopenia.	\$1000 costs; paper on appropriate methotrexate treatment of psoriasis in geriatric patients.
Wellman, Gary N. (PA10001347) Snohomish County	<b>Informal Disposition</b>	8/21/14	<b>Alleged:</b> Practice outside the scope of a PA, violation of practice plan, inadequate documentation of treatment rationales, including the prescribing multiple drugs for psychiatric patients.	Probation; course work; paper on when poly-pharmacy is or is not indicated with benzodiazepines and stimulants and the risks of prescribing stimulant medications for patients with PTSD; paper on medical record keeping; paper on scope of practice of PAs; \$1000 costs; practice reviews; compliance appearances for two years.
Yang, I. Yen (MD00013145) Benton County	<b>Informal Disposition</b>	8/21/14	<b>Alleged:</b> Inappropriate breast exam which constituted a boundary violation.	\$1000 costs; ethics course.

**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.

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## Medical Commission Vital Statistics

- 21 members: 13 MDs, 2 PAs, 6 public members;
- 39 staff, \$14.8M biennial budget;
- 30,004 licensed physicians and physician assistants;
- 99.9% of complaints processed on time in 2014;
- 90.9% of investigations completed on time in 2014;
- 89.6% of legal cases completed on time in 2014;
- 99% of orders complied with Sanction Rules.

### Actions in Fiscal 2014

- Issued 2,290 new licenses;
- Received 1,488 complaints/reports;
- Investigated 909 complaints/reports;
- Issued 70 disciplinary orders;
- Summarily suspended or restricted 11 licenses;
- Actively monitoring 181 practitioners;
- 48 practitioners completed compliance programs.

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## Policy Corner

At the most recent business meetings the Commission approved/updated the following:

- Adopted: MD2014-07 Medical Marijuana authorization guidelines;
- Reaffirmed: MD2013-08 Retention of medical records.

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](mailto: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 2015

Date	Activity	Location
January 8-9	Regular Meeting WPHP Report	Puget Sound Educational Service District (PSESD), Blackriver Training & Conference Center 800 Oakesdale Ave SW Renton, WA 98057-5221
February 12-13	Regular Meeting	Department of Health (DOH) 310 Israel Rd SE, 152/153 Tumwater, WA 98501
March 26-27	Regular Meeting	PSESD
May 14-15	Regular Meeting	DOH
June 25-26	Regular Meeting	Davenport Hotel 10 S. Post Street Spokane, WA 99201
August 20-21	Regular Meeting	TBD Vancouver, WA
Sept. 30-Oct. 2	Educational Conference	TBD
November 5-6	Regular Meeting	PSESD

*All Medical Commission meetings are open to the public*

## Other Meetings

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](mailto: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](mailto: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](mailto:medical.commission@doh.wa.gov)
- Demographics:** [medical.demographics@doh.wa.gov](mailto:medical.demographics@doh.wa.gov)
- Website:** [www.doh.wa.gov/medical](http://www.doh.wa.gov/medical)
- Public Disclosure:** [PDRC@doh.wa.gov](mailto: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>

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