

# Update!

## Message from the Chair

As the fall season continues to change and we approach winter, the activities of the Commission shift as we prepare for the Legislative session. The special session began November 28, 2011 in response to the projected budget shortfall. Members of the Commission and administrative staff participate in weekly conference calls with the Department of Health to discuss proposed legislation that may affect your Commission. At the same time, members of the Commission are meeting with their legislators to update them on the activities and issues before the Commission.

Commission members may provide information or testimony on topics that are of concern or interest to us. Members of the Commission may not lobby the legislators. Often, this can be a fine line, but it has improved communication with legislators. It is an important Commission activity, and one in which we are actively engaged. Our job is to promote patient safety and enhance the integrity of the profession. We do this through licensing, discipline, rule making, and education.

The date for the implementation of the pain rules is rapidly approaching--January 2, 2012. Thus far, we have seen positive responses from the licensee population. Time will tell how much of an impact the rules will have on accidental opioid deaths and hospitalizations. Two things are certain; the Medical Commission is taking the lead in this effort and the rest of the country is watching our approach to this problem.

Commissioners continue to make presentations across the state upon [request](#). Physicians and physician assistants are strongly urged to complete

the four-hour continuing education package (CME/CE) available free of charge on the Medical Commission web site: <http://go.usa.gov/IEu>. To date, the opioid dosing guidelines have been downloaded almost 9,000 times and nearly 1,000 providers have successfully passed the CME, with 61 percent of those being MDs and PAs. Of those that have completed the CME, 66 percent rate the package as good or better.

The Commission continues to make strides towards paperless processes in all of our endeavors. We do this to take advantage of technological efficiencies and to be good stewards with the resources granted to us. This will be a big step towards improving services and timely closure for our cases.

The number of complaints received by the Commission continues to increase. We are on track to receive 1,567 complaints this fiscal year compared to 1,164 last year. Reasons for the increase in

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## Mission

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

complaints are not entirely clear, although some trends are becoming more apparent. The Commission established a communication link with the Washington State Hospital Association (WSHA) to report systems issues that arise during the investigation of a complaint. This is beneficial to hospitals, physicians, and patients, as best practices and care issues are addressed in a system setting before they become an active danger to the patient. This positive feedback loop is precisely the influence your Commission strives to achieve in its mission.

The Commission received a number of complaints filed against individual physicians for activities that did not take place in the practice of medicine, i.e. as an owner of an Adult Family Home. We strongly encourage physicians and physician assistants to provide clarity to the public when they are functioning in a role that is other than the direct provision of medical care. This can be a source of confusion on many levels.

The Commission is pleased with the response from the physician assistant providers to update practice plans as required. Thus far, the Commission has received a 70 percent increase in practice plans submitted and approved. I would like to take this opportunity to remind all of our physician assistant colleagues that any time there is a change in the details of a practice plan, it is required that you report this to the Commission.

As always, we encourage you to contact us via [email](#) if you have any question or would like information about the Commission. Thank you for all you do and have a joyful holiday season.

Happy Holidays,

Mimi Pattison, MD, FAAHPM, Chair  
Washington State Medical Commission

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**Learn about the rules for the management of chronic noncancer pain at the Medical Commission website: <http://go.usa.gov/IEu>**

## Message from the Executive Director

### Staff Profile: Chief Investigator James H. Smith

Mr. James Smith has been the Chief Investigator for the Medical Quality Assurance Commission since July, 1989. He is a graduate of Central Washington University with degrees in Law and Justice and Business Administration. He also holds an MBA in Organization and Management from Eastern Washington University. After eight years with the Ellensburg Police Department, Mr. Smith spent one year with the Department of Social and Health Services and then joined the Department of Licensing in 1982 as an investigator in the Spokane Office.

Mr. Smith investigated many of the Medical Disciplinary Board's complaints in eastern Washington between 1983 and 1989. In 1989 he was asked to become the Chief Investigator for the Medical Disciplinary Board and the Board of Medical Examiners in the newly created umbrella agency of the Department of Health. Mr. Smith moved to Olympia and has served as the Chief Investigator of Medical Investigations since July 1989.

Mr. Smith is responsible for the overall organization and management of Medical Investigations. The staff consists of nine professional investigators, which include four PA-Cs, four nurse investigators and two non-clinical investigators. Medical Investigations is responsible for over 1,100 investigations and compliance practice reviews each year.

Mr. Smith can be contacted at 360-236-2770 or by [email](mailto:Jim.Smith@doh.wa.gov) at [Jim.Smith@doh.wa.gov](mailto:Jim.Smith@doh.wa.gov).

Best Regards,

Maryella Jansen  
Executive Director

## Commissioner Spotlight: *Welcome to New Members*

The Washington State Medical Commission was recently joined by three appointed members, replacing outgoing members whose terms have expired. Please join us in welcoming these new and distinguished members to the Commission. We hope the people of Washington will benefit from their experience.

### Jack Cvitanovic (Public Member-Tacoma, term expires June 2015)

Jack Cvitanovic graduated from Seattle University in 1963, and attended Gonzaga University in 1964 for graduate studies. Married in 1965, he has three children with eight grandchildren that range in age from 12 to 23.

In 1965, Mr. Cvitanovic went to work for the Boeing Company in Industrial Relations & Industrial Engineering, leaving in 1970 to work in hospital administration. He started working in the EMS field in 1973, developing a community college based paramedic program. He followed this by assisting the Tacoma Fire Department in implementing their comprehensive EMS system.

In 1975, he consulted with the state of Washington on developing and implementing a statewide Regional EMS system. This resulted in Mr. Cvitanovic becoming a state employee in 1976 and managing the program. In 1990, he became the EMS Licensing and Certification Manager, and continued in this capacity until 2005, when he retired.

### Peter Marsh, MD (Physician at Large-Lakewood, term expires June 2015)

Dr. Peter Marsh began his term with the Commission in June 2011. He attended his undergraduate training at Indiana University and received his medical degree from Jefferson Medical College. Board certified in infectious diseases and internal medicine, Dr. Marsh did his internship at Albert Einstein Hospital and his residency at Thomas Jefferson University Hospital, both located in Philadelphia. He completed his postgraduate

training with a fellowship at New England Medical Center in Boston.

With a research interest in new antimicrobial agents, Dr. Marsh works with Northwest Medical Specialties in Tacoma. He served as past president of the Washington State Medical Association, Pierce County Medical Society, North Pacific Society of Internal Medicine, a Fellow of the American College of Physicians, and on the board of directors for Physicians Insurance. When not working, Dr. Marsh enjoys golf, gardening, and bird watching.

### Mimi Winslow, JD (Public Member-Seattle, term expires June 2015)

Mimi Winslow is a public member of the Commission. She graduated with a B.A. from Stanford University and a J.D. from the Stanford University School of Law. A former law professor in Des Moines, Iowa, she has a broad history of public involvement including the Iowa Commission on the Status of Women, Friends of the Seattle Public Library, and institutional review boards. She and her husband live in Seattle. They are the parents of adult children.

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## Handling Holiday Stress:

### *Tips for Patients, Physicians and Physician Assistants*

#### Robert H. Small, MD (Pro Tem Member-Psychiatry)

#### Theresa J. Elders, LCSW (Public Member)

The days between Thanksgiving and New Year's Day, and especially those at the close of December, present a dichotomy. Generally, we perceive and portray the holiday season as a time of joyous get-togethers, reconnections with family and friends, giving and receiving, and cheerful over-indulgence. On the other hand, unfulfilled expectations can lead to what we now know as holiday stress.

The media has popularized the concept of holiday stress for years. As the season proceeds, articles appear on how to avoid or cope with it. These articles

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cite statistics to demonstrate that holiday stress is real and can be serious. They refer to increased rates of hospital admissions, mortality from certain medical conditions, automobile accidents, domestic violence, and suicide.

Surprisingly, relatively little on this topic has appeared in the professional medical and healthcare literature. Therefore, physicians and physician assistants lack evidence-based or expert consensus advice to consult when considering how to help patients suffering from holiday stress. Physicians and physician assistants have to rely on information in the media, their own experience, and intuition.

When patients say, or admit when asked, that they are stressed by the holidays, some of these tips may prove useful, depending on what a patient may be stressed about:

- Be aware of any particular stimuli that trigger stress. Try to limit exposure to triggers, or take a friend or trusted family member along when you suspect you might be exposed to one.
- Keep expectations realistic to keep the holiday season manageable. Everything does not have to be the biggest, the best, or perfect. This can apply to gift buying, entertaining, attending get-togethers, and other holiday activities.
- Prioritize activities. Be realistic about how much time you can allow for various holiday activities, and eliminate low priority items. Respectfully say “no” when you are feeling overloaded.
- If financial stress is an issue, buy gifts for only the closest relatives and friends, keep them inexpensive, and seek out free community holiday activities.
- Avoid overindulging in food or alcohol, which can increase stress.
- Spend time with family or friends who are supportive and caring. Don’t feel obligated to split time between dozens of different people.
- Plan some “down time” for doing something enjoyable.
- Consider using any spare time to volunteer to help others.

Physicians and physician assistants who are busy and may be even more overloaded with stressed patients during the holiday season, may not have as much time as they would prefer to listen to, and talk with their patients. It could be helpful to have a few resources on holiday stress to give to patients. The Internet is an excellent source of information and advice, with a number of web sites on holiday stress. A few of the good sites for holiday stress are those of Cleveland Clinic, Mayo Clinic, WebMD, PsychCentral, Psychology Today, the American Psychological Association, and the National Mental Health Association. The simplest way to find any of them is to Google them by name, and then, once in their sites, type holiday stress into their search boxes to get to that specific topic.

Some patients may need more than just advice or resources. They may need professional help in order to cope with and manage their stress. Consider referring such patients to a psychiatrist or mental health clinician.

Physicians and physician assistants should consider whether a patient may be experiencing or exhibiting depressive symptoms, or holiday blues. Holiday blues will present in the same fashion as depressive symptoms or depressive disorders. Interventions or treatment is the same as when managing patients with depressive disorders, including referral to a psychiatrist or mental health clinician when necessary.

Lastly, physicians and physician assistants should monitor their own stress levels. They are just as susceptible to holiday stress, and even holiday blues, as their patients are, and for the same reasons. They may, in fact, be more susceptible if feeling overburdened by large numbers of patients with holiday stress. The tips and web sites we referred to in this article can be just as useful to physicians and physician assistants as they can be to patients. Healthcare providers can be negligent in taking care of themselves, and should be especially vigilant about not neglecting themselves during the holiday season.

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### **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 had action against it.*

*Try it now: <http://go.usa.gov/822>*

## Legislator Profile: Sen. Karen Keiser

Sen. Keiser has been a Washington State Senator since 2001 and has earned a reputation as a tireless advocate for improving the nation's outdated, inefficient and fragmented health care system. Before coming to the senate, she served in the state House of Representatives from 1996 to 2001.

Karen is chair of the Senate Health & Long-Term Care Committee, where she works tirelessly to improve the state's health care delivery system. She also sits on the Senate Financial Institutions, Housing & Insurance, Labor, Commerce, & Consumer Protection, Rules, and Ways & Means Committees.

The former journalist and communications director holds a Bachelor's degree in political science and a Master's in journalism from the University of California.

Karen has earned numerous awards for her legislative and civic achievements including:

- 2009 Progressive States Network State Leader Award
- 2009 Children's Alliance Champions for Children Award
- 2008 Lifelong Aids Alliance Legislator of the Year
- 2007 Center for Policy Alternatives State Legislator of the Year
- 2007 Washington Health Care Legislator of the Year
- 2007 Washington Community Health Centers Health Care Champion

In her spare time Karen enjoys gardening, spending time with her family and friends, international travel and attending community service events.

### Bills impacting healthcare in Washington State

- [SB 5005](#) Immunization Exemptions
- [SB 5120](#) Regulating insurance rates
- [SB 5149](#) Collecting current and past information for cancer registry program

- [SB 5346](#) Administrative simplification for payers and providers of health care
- [SB 5360](#) Establishing a community health care collaborative grant program
- [SB 5371](#) Health insurance coverage for persons under 19
- [SB 5394](#) Concerning primary care health homes and chronic care management
- [SB 5445](#) Establishing a health benefit exchange
- [SB 5501](#) Concerning the secure exchange of health information
- [SB 5930](#) Implementing recommendations of Blue Ribbon Commission on health care quality and access
- [SB 5958](#) Creating innovative primary health care delivery
- [SB 6019](#) Employee wellness programs
- [SB 6248](#) Regarding the use of bisphenol A
- [SB 6333](#) Establishing citizens' commission on health care

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## Commission Case Reports: Use of Incorrect Suture

[Bruce Cullen, MD](#)  
(Physician at Large)

This is the first of what will become a regular feature in the newsletter. The Commission wishes to alert physicians (MDs) and physician assistants (PAs) about some of the medical errors committed that have been observed during the course of reviewing complaints against MDs and PAs. It is the goal of the Commission that by alerting MDs and PAs to these errors, they will become better informed and institute measures to ensure they do not commit a similar error.

In this instance, the operating surgeon requested his "usual" suture to close the patient's incision. The scrub nurse handed him his "usual" suture device. Neither the surgeon nor the nurse carefully

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examined the suture device. The vendor of the device had recently begun placing both resorbable and non-resorbable sutures in a similar looking device. The wrong suture was used on the patient. The patient developed a serious abscess postoperatively and had to have a second procedure to remove the incorrect suture. The surgeon and his insurance company settled a malpractice claim for several thousand dollars. A complaint was filed with the Commission regarding the surgeon's error.

Medical errors, unfortunately, are all too common and, to some extent, unavoidable. However, the goal of those who are involved in patient care should be to prevent, or at least to minimize, these errors. There are many methods to avoid errors such as the development of checklists, repetitive verification of drug orders, and pre-surgical "time-outs". In this particular case, the error could have been avoided if:

- The vendor had notified the hospital of the change in packaging
- If the operating room staff had been notified of the change
- If the surgeon had specifically looked at the device to insure that it was what he wanted before using it, instead of assuming it was "the usual"

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## **Administrative Actions: July 1, 2011-December 1, 2011**

Below are summaries of interim suspensions and final actions taken by the Commission last quarter. We did not list Statements of Charges, Notices of Decision on Application, Modifications to Orders and Termination Orders. You can find all orders on the Commission's website: <http://go.usa.gov/822>

### **Adamson, Richard T., MD (MD00019594) (Seattle, King County, Washington)**

Findings of Fact, Conclusions of Law and Final Order of Default (Failure to Respond). Respondent committed acts of moral turpitude, failed to meet the standard of care, improperly disclosed confidential health care information, and engaged in sexual misconduct. After failing to respond to a Statement of Charges, the Commission revoked Respondent's license to practice medicine in the state of Washington. July 26, 2011.

### **Bardsley, Nigel, MD (MD00023309) (Everett, Snohomish County, Washington)**

Stipulation to Informal Disposition. Respondent allegedly was under investigation by the United Kingdom General Medical Council. Respondent does not admit to unprofessional conduct. Respondent agreed to surrender his license to practice medicine in the state of Washington. August 10, 2011.

### **Bordner, Michael D., MD (MD00024881) (Omak, Okanogan County, Washington)**

Stipulation to Informal Disposition. Respondent allegedly diagnosed a patient with rectal fecal impaction and failed to inform a patient of a radiologist's recommendations for further evaluation of an abnormality that turned out to be ovarian cancer. Respondent does not admit to unprofessional conduct. Respondent agreed to a probationary period during which he will develop a protocol for notifying patients of the results of imaging tests and the recommendations of the specialist performing the imaging tests, complete a CME course on tumors, and submit to chart audits. August 10, 2011.

### **Chulman, Michael A., MD (MD00012337) (Monrovia, California)**

Stipulation to Informal Disposition. Respondent had his California license placed on probation. Respondent does not admit to unprofessional conduct. Respondent agreed to a probationary period during which he will provide documentation of his compliance with the California order and appear before the Commission before practicing in the state of Washington. August 24, 2011.

### **Featherkile, Stephen M., PA (PA10003559) (Deer Park, Spokane County, Washington)**

Stipulated Findings of Fact, Conclusions of Law and Agreed Order. Respondent was convicted in federal court of causing a materially false representation to be made for use in determining the right to payment under a federal health care program, a misdemeanor. Respondent agreed that his license would remain suspended and that he could petition for reinstatement of his license in one year provided he fulfill certain requirements. If the license were reinstated, Respondent would be subject to a term of probation during which he would be restricted from working in a remote site, cause his preceptor to submit quarterly reports to the Commission, and submit to practice reviews. September 29, 2011.

### **Garfein, George S., MD (MD00012618) (Yakima, Yakima County, Washington)**

Stipulation to Informal Disposition. Respondent allegedly failed to

adequately manage a patient with chronic non-cancer pain, including inappropriate narcotic pain prescriptions, and inadequate treatment and recordkeeping. Respondent does not admit to unprofessional conduct. Respondent agreed to stop prescribing, dispensing, or administering any controlled substances to patients with chronic non-cancer pain and a probationary period during which he will cooperate with annual practice reviews to confirm his compliance with the practice restriction. September 29, 2011.

**Greer, Michael E., MD (MD00019765) (Seattle, King County, Washington)**

Stipulated Findings of Fact, Conclusions of Law and Agreed Order. Respondent failed to comply with a Commission order. Respondent agreed to surrender his license to practice medicine in the state of Washington. July 21, 2011.

**Hamilton, Karen J., MD (MD00034688) (Bellevue, King County, Washington)**

Findings of Fact, Conclusions of Law and Final Order of Default (Failure to Respond). Respondent failed to respond to an investigation. After failing to respond to a Statement of Charges, the Commission suspended Respondent's license to practice medicine in the state of Washington. August 24, 2011.

**Jain, Kiren S., MD (MD00039747) (Fremont, California)**

Stipulation to Informal Disposition. Respondent allegedly read films of an injured patient, failed to initially identify the presence of a T5 burst fracture, and then failed to communicate this condition to emergency room personnel. Respondent does not admit to unprofessional conduct. Respondent agreed to a probationary period during which she will develop a written protocol to ensure physician-to-physician communication of urgent and critical findings, or to write a paper describing what she has learned from her review of the American College of Radiology Practice Guideline for Communication of Diagnostic Imaging Findings, complete a CME course on trauma CTs, write a paper on trauma CTs, and submit semi-annual declarations of compliance. September 29, 2011.

**Kohler, Erik P., MD (MD00028438) (Eagle River, Alaska)**

Stipulation to Informal Disposition. Respondent allegedly performed spinal surgery at the wrong level. Respondent does not admit to unprofessional conduct. Respondent agreed to a probationary period during which he will develop protocols designed to prevent wrong-level or wrong-site surgery at each hospital or facility at which he operates, write a paper on wrong-level or wrong-site surgery, report surgical never events to the Commission, and submit to practice reviews. July 21, 2011.

**Lidor, Yaron J., MD (MD00048575) (Denver, Colorado)**

Stipulated Findings of Fact, Conclusions of Law and Agreed Order. Respondent engaged in boundary violations and provided substandard care to a patient. Respondent agreed not to renew or reactivate his expired license to practice medicine in the state of Washington. September 29, 2011.

**Nixon, John E., MD (MD00005160) (Anacortes, Skagit County, Washington)**

Stipulation to Informal Disposition. Respondent allegedly has a condition that prevents him from practicing medicine. Respondent surrendered his license to practice medicine in the state of Washington. September 29, 2011.

**Rains, Anthony J., MD (MD00021268) (Renton, King County, Washington)**

Stipulated Findings of Fact, Conclusions of Law and Agreed Order. Respondent failed to consider alternative causes of a patient's abdominal pain, failed to provide intravenous hydration, and failed to transfer the patient from the jail to a hospital emergency department. Respondent agreed to a probationary period during which he is restricted diagnosing or treating patients, provide his supervisor with a copy of the order, and submit to practice reviews. August 24, 2011.

**Roys, David S., MD (MD00010221) (Seattle, King County, Washington)**

Stipulated Findings of Fact, Conclusions of Law and Agreed Order. Respondent, a psychiatrist, failed to coordinate the care of a suicidal patient with the patient's therapist and failed to establish a crisis plan with the patient. Respondent agreed to a probationary period during which he will complete CME on outpatient management of the acutely suicidal psychiatric patient, and submit to practice reviews. August 24, 2011.

**Sandler, Richard A., MD (MD00011707) (Edmonds, Snohomish County, Washington)**

Stipulation to Informal Disposition. Respondent allegedly performed prolotherapy injections into a patient without insuring cleanliness of the injection site and using a single needle for six injections. Respondent also allegedly falsely dictated that he cleansed the injection sites with betadine, but later pointed this out on his own initiative. Respondent does not admit to unprofessional conduct. Respondent agreed to a probationary period during which he will submit to practice audits. July 21, 2011.

**Sobrin, Marco A., MD (MD00039788) (Newcastle, King County, Washington)**

Stipulated Findings of Fact, Conclusions of Law and Agreed Order. Respondent provided substandard care to a patient before, during and after a liposuction procedure. Respondent agreed to a 30-day suspension of his license to end on November 15, 2011, followed by a probationary period during which he will develop a protocol for the facility at which he works to ensure that patients have a ride post-procedure and will have a caregiver for 24 hours after the procedure; complete CME on local anesthetic toxicity, risks and complications of office-based surgery, complications of tumescent anesthesia and liposuction, and documentation; maintain complete medical records of his patients; personally prepare the tumescent solution containing lidocaine, for every liposuction procedure he performs; submit to practice reviews; comply with the Commission's rules on office-based surgery; complete an ethics course; and appear before the Commission annually. September 29, 2011.

**Stewart, William C. II, MD (MD00013269) (Kenmore, King County, Washington)**

Stipulation to Informal Disposition. Respondent allegedly discontinued Plavix and aspirin for a patient in a nursing home after heart stent placements without consulting with the patient's cardiologist or the patient. Respondent does not admit to unprofessional conduct. Respondent agreed to a probationary period during which he will complete a CME course on coronary stenting and anti-coagulation, write a paper on the CME course, and submit to practice audits. September 29, 2011.

**Wannarachue, Nikom, MD (MD00012028) (Kennewick, Benton County, Washington)**

Stipulation to Informal Disposition. Respondent allegedly failed to confirm the correct dosage of Dilantin that a young patient was prescribed after visiting an emergency room. Respondent does not admit to unprofessional conduct. Respondent agreed to a probationary period during which he will complete a CME course on managing pediatric medication dosages, write a paper on the importance of performing independent verification of pediatric prescription dosages. August 24, 2011.

## **Interpretive Statement on the Management of Chronic Noncancer Pain**

### **Description of the Issues**

The Medical Commission (Commission) is aware of some questions and concerns regarding the rules related to the management of chronic noncancer pain (WAC 246-919-850 through 863, and WAC 246-918-800 through 813). These questions and concerns include:

1. Does the presence of "shall" within the rules create inflexible legal mandates, or do the rules in their totality allow for sound clinical judgment that may vary from the rules in some circumstances
2. Will the Commission apply the rules to a practitioner who, in managing an injury or condition, is secondarily treating pain for longer than the usual course?
3. In WAC 246-919-862(2) and WAC 246-918-812(2) the rules provide an exemption from the consultation requirement when a practitioner (and the sponsoring physician for a physician assistant) has completed 12 hours of continuing education on chronic pain management in the last two years, but when does this two year period begin and end?
4. Does the rule define the entire standard of care for the management of chronic noncancer pain?
5. Is the 120 mg. (MED) "consultation threshold" a maximum dose under the rules?
6. Is the 120 mg. (MED) "consultation threshold" the minimum dosage at which a consultation should be obtained under the rules?

### **The Commission's Position**

Before answering these questions it is important to express and respond to the Commission's concern that misunderstanding of, or over-reaction to, the rules may cause some physicians and physician assistants to refuse, discharge, or fail to treat pain patients. The Commission recognizes that patients in Washington need access to appropriate and effective pain management and does not want to negatively affect the access to care. It is the Commission's goal that the pain management rules provide clarity to an area of previous uncertainty, resulting in better management of chronic noncancer pain. It is the Commission's goal to eliminate some of the misunderstanding and ease some of the concerns through this interpretive statement.

### **Background Information**

The pain management rules satisfy the requirements of Engrossed Substitute House Bill (ESHB) 2876 (Chapter 209, Laws of 2010) which directs the Medical Quality Assurance Commission to repeal existing pain management rules and adopt new rules for the management of chronic noncancer pain. The adopted rules include the mandatory elements for dosing criteria, guidance on specialty consultations, guidance on tracking

clinical progress, and guidance on tracking opioid use. The adopted rules also describe practitioner and situational exemptions to the consultation requirement.

In addition the Commission also chose to further clarify its position on chronic pain management by adopting a comprehensive set of rules based upon the “Model Policy for the Use of Controlled Substances for the Treatment of Pain” created by the Federation of State Medical Boards.

## **Response and Analysis**

### **1. Does the presence of “shall” within the rules create inflexible legal mandates, or do the rules in their totality allow for sound clinical judgment that may vary from the rules in some circumstances?**

The rules are not inflexible and recognize the importance of sound clinical judgment.

It is important for those concerned about the use of the word “shall” within the rules to consider the Intent Section of the rules. This opening provision describes the purpose of the rules and sets the tone for interpretation and application of the entire rule by the Commission. The intent provision explicitly states that the rules are not inflexible and repeatedly recognizes the importance of clinical judgment.

The Intent Section of the pain rules, found at WAC 246-919-850 and 246-918-800, makes it clear that while the word “shall” does identify generally necessary elements of care, a practitioner “*may take a course of action different from that specified in the rules*” (emphasis added) when, “in the reasonable judgment of the practitioner” the differing action is indicated by: (a) the patient’s condition; (b) limited available resources; or (c) advances in knowledge or technology. This specific statement in the intent section reinforces the Commission’s position that the rules “are not inflexible rules or rigid practice requirements.” The purpose of the rules is to assist practitioners in providing appropriate medical care for patients.

The word “shall” appears in the rules as a mechanism to communicate what the Commission considers as necessary elements as opposed to recommended or elective elements of pain care. There is no other clear manner to communicate this distinction. However, as made clear by the intent provision, the rules recognize that “[t]he ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the practitioner.”

Much of what is contained in the pain management rules is a reiteration of some of the elements already required by the standard of care though previously unarticulated in a manner easily accessible to physicians and physician assistants. As stated in the intent provision, this rule has been developed to clarify the Commission’s position in order to alleviate physician uncertainty and to encourage better management of chronic noncancer pain.

### **2. Will the Commission apply the rules to a practitioner who, in managing an injury or condition, is secondarily treating pain for longer than the usual course?**

It is not the intent of the Commission to be either rigid or over-inclusive in its application of the rules. The definition of “chronic noncancer pain” found at WAC 246-919-852(3) and WAC 246-918-802(3) leaves some flexibility in determining when and to whom the rules apply.

The rules apply to the use of opioids in the treatment of patients for chronic noncancer pain. WAC 246-919-850 and WAC 246-919-800 (first paragraph). The definition of chronic noncancer pain” is significant in determining if the rules apply in a specific situation. The definition of chronic noncancer pain, WAC 246-919-852(3) and WAC 246-918-802(3), provides some flexibility in that it references pain that persists beyond the “*usual course*” of an acute disease, injury, or pathologic process, and continues for “*months or years.*” (Emphasis added.)

The Commission intends to use a reasonable approach in determining how to enforce the rules. The Commission may determine the following sample situations are exempt circumstances:

A. A practitioner treating a patient for an acute injury or condition that improves, but is a source of pain that continues for a few months beyond the usual course for that injury or condition, if the following are true: (a) the treatment being provided is specific in scope and duration; (b) the treatment for pain is secondary to treating the condition or injury, meaning that pain management is not the primary focus of treatment; and (c) the opioid medication used to treat the pain is prescribed at a low, stable, non-escalating dose.

B. A specialist, for example an orthopedic surgeon, treating a patient’s pain using a low, stable, non-escalating dose of opioid medication as part of a conservative management or rehabilitation approach when the

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approach and time period are within the standard of care for the practitioner's specialty or sub-specialty.

The interpretation that the rules may not apply to these situations is supported by the following: (1) there may be circumstances that extend the "usual course" of pain following an acute injury or condition; (2) the number of months of resulting pain is not specified in the rules, and the Commission intends to use a reasonable standard in applying these rules; and (3) the substance of the requirements under the rules regarding evaluation, treatment plans, informed consent, treatment agreements, and periodic review, do not squarely apply to situations where the treatment of pain is secondary to treatment of an injury or condition, or is part of a specialty's conservative management or rehabilitation approach, given the conditions described above.

3. The Consultation Exemptions Section of the rules, WAC 246-919-862(2) and 246-918-812(2), provides an exemption from the consultation requirement when a practitioner (and the sponsoring physician for a physician assistant) has completed 12 hours of continuing education on chronic pain management in the last two years, but when does this two year period begin and end?

The two year CME exemption is measured by the date a practitioner provides chronic pain care to a patient who meets or exceeds the 120 mg. (MED). For example, a practitioner providing chronic pain management to a patient who meets or exceeds 120 mg. (MED) on January 2, 2012, when the rules become effective, must have successfully completed all 12 hours of Category I continuing medical education on chronic pain management, since January 2, 2010 to qualify for an exemption. If four of the hours were completed in October 2009, for example, the sample practitioner would be four hours short of qualifying for the exemption.

However, if the patient is at or above 120 mg. (MED) on January 2, 2012, there may also be situational exemptions that apply. In WAC 246-919-861 ("Consultation--Exemptions for exigent and special circumstances"), the rules provide an exemption to the consultation requirement when the treating practitioner has otherwise followed the requirements of the rules, and: (a) the patient is following a tapering schedule; (b) the patient requires treatment for acute pain that requires a temporary escalation in dose; (c) the practitioner documents that they were unsuccessful in obtaining a consultation after reasonable attempts, and documents the circumstances justifying the dosage at or above 120 mg. (MED); or (d)

the patient is on a non-escalating dose and the patient's pain and function are stable.

4. Does the rule define the entire standard of care for the management of chronic noncancer pain?

No. The contents of the rules do address some important elements of the standard of care for chronic pain management, but they do not define the entire standard of care. The rules are not exhaustive. The standard of care (current practice guidelines articulated by expert review) will continue to control circumstances and issues not addressed by the rule.

5. Is the 120 mg. (MED) "consultation threshold" a maximum dose under the rules?

No. The 120 mg. (MED) threshold is a triggering dose, intended to alert the practitioner to the fact that prescribing at this dose or higher significantly increases morbidity and mortality, and requiring a consultation with a pain specialist unless the physician or circumstances are exempted under the rules. The articulation of this dose in the rules is consistent with the legislature's requirement in ESHB 2876 to adopt rules that contain a dosage amount that must not be exceeded without pain specialist consultation.

Some have referred to the 120 mg. (MED) threshold (or "triggering") dose as a "maximum dose." The rules do not provide a maximum dose. They simply require, absent an exemption, that the practitioner obtain a pain specialist consultation before continuing on to prescribe opioids at a level that is associated with significant increases in opioid-related overdoses and deaths.

6. Is the 120 mg. (MED) "consultation threshold" the minimum dosage at which a consultation should be obtained under the rules?

No. A physician or physician assistant should obtain a consultation when warranted. In WAC 246-919-860(2) and WAC 246-918-810(2) the threshold for mandatory consultation is set at 120 mg. (MED) for adult patients. However, WAC 246-919-860(1) and WAC 246-918-810(1) reference, more generally, additional evaluation that may be needed to meet treatment objectives. This provision makes specific reference to evaluation of patients under 18 who are at risk, and patients with co-morbid psychiatric disorders. However, other circumstances may call for a consultation with a pain management specialist for patients who have not met the threshold dose.

## Medical Commission Vital Statistics

- The Commission is currently participating in a 5-year pilot project to measure performance and efficiency.
- 21 members: 13 MDs, 2 PAs, 6 public members.
- 39 staff, \$11M biannual budget.
- The Commission currently licenses 28,797 physicians and physician assistants.
- 90% of investigations completed on time in 2010.
- Reduced investigative aged-case backlog by 75%.
- Reduced legal aged-case backlog by 50%.
- Followed legislatively-mandated disciplinary sanction rules in 99% of disciplinary orders.

## Actions in Fiscal 2011

- Issued 2540 new licenses
- Received 1164 complaints/reports
- Investigated 731 complaints/reports
- Issued 84 disciplinary orders
- Summarily suspended or restricted 13 licenses
- Actively monitoring 171 practitioners

## Policy Corner

At the November 18, 2011 Business Meeting the Commission approved the following policies:

- MD2011-09: Elective Educational Rotations, 9-30-11 (reaffirmed as written)
- MD2011-08: Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery, 9-30-11 (newly adopted)
- MD2011-05: Transmission of Time Critical Medical Information (TCMI) "Passing the Baton" Guidelines, 9-30-11 (newly adopted)
- MD2011-01-IS: Management of Chronic Noncancer Pain Interpretive Statement, 9-30-11 (newly adopted)
- MD96-07: Guidelines for Management of Pain, 11-18-11 (repealed)

To view the most current policies and guidelines for the Commission, please visit our website:

<http://go.usa.gov/828>

**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 will be updated quarterly on the Commission website and may be found at the following web address:**  
<http://go.usa.gov/82X>

## Washington State Medical Commission Meetings 2011-2012

Date	Activity	Location
January 12 -13, 2012	Regular Meeting and WPHP Report	Puget Sound Educational Service District (PSESD) Blackriver Training & Conference Center 800 Oakesdale Ave SW Renton, WA 98057
February 23-24, 2012	Regular Meeting	Department of Health (DOH) – Point Plaza East 310 Israel Rd Rms 152/153 Tumwater, WA 98501
April 5-6, 2012	Regular Meeting	PSESD
May 17-18, 2012	Regular Meeting	DOH
June 28-29, 2012	Regular Meeting	PSESED
August 22-24, 2012	Workshop	DOH
October 4-5, 2012	Regular Meeting	PSESD
November 15-16, 2012	Regular Meeting	DOH
January 10-11, 2013	Regular Meeting and WPHP Report	PSESD

## Other Meetings

Federation of State Medical Boards	Annual Meeting April 26-28, 2012	Fort Worth, TX
Washington State Medical Assoc.	Annual Meeting Sept. 15-16, 2012	Tacoma, WA

*All Medical Commission meetings are open to the public*



Washington State Medical Commission  
PO Box 47866  
Olympia, WA 98504-7866

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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)**

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<b>Applications:</b>	<b>MD A-L</b>	360-236-2765
	<b>MD M-Z</b>	360-236-2767
	<b>PA</b>	360-236-2771
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<b>Continuing Education:</b>		360-236-2766
<b>Complaints:</b>		360-236-2762
<b>Complaint Form:</b>		<a href="http://go.usa.gov/824">http://go.usa.gov/824</a>
<b>Discipline:</b>		360-236-2764
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<b>Website:</b>		<a href="http://go.usa.gov/82B">http://go.usa.gov/82B</a>
<b>Public Disclosure:</b>		<a href="mailto:PDRC@doh.wa.gov">PDRC@doh.wa.gov</a>
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Rules:		<a href="http://go.usa.gov/82b">http://go.usa.gov/82b</a>
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Newsletter:		<a href="http://go.usa.gov/82Z">http://go.usa.gov/82Z</a>

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### Washington State Medical Commission Newsletter–Winter 2011

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