

Medical Quality Assurance Commission

Update!

www.doh.wa.gov/medical

Vol. 6, Spring 2016

Message from the Chair

Michelle Terry, MD
Chair, Physician at Large

Many of our physician and physician assistant colleagues excel in the practice of medicine because they are able to translate their scientific knowledge of pathology and physiology into the application of evidenced-based therapies. This knowledge helps patients recuperate from illness and make healthful choices. However in many circumstances, the patient's medical diagnosis may not be the patient's biggest problem. Food insecurity, unreliable transportation, inadequate housing, language barriers, and untreated mental illness are all potential stressors which can negatively influence a patient's adherence to standard medical treatment regimens.

In order to provide appropriate and effective treatment for patients, physicians and physician assistants also have to become advocates, both individually and collectively. Our professions are uniquely situated to translate patient information and community trends into data that can help inform patient health, public policy, and legislation. Because our professions' place in society is closely tied to a moral sense of responsibility, our related skill sets are anchored in both the science of health and the social determinants of health.

In our state's current legislative session, the Washington Chapter of the American Academy of Pediatrics has promoted several priorities to contribute to the health of children and families. Examples include: measures to increase the availability of pediatric primary and specialty care for all children, assure the access to behavioral health for children, and decrease vaccine preventable illnesses. Likewise the Washington State Medical Association supports critical programs to benefit patients which include: increased Medicaid reimbursement, improved access to mental health services for adults, and funding for graduate medical education. In addition, the Medical Quality Assurance Commission advocates for physician licensure modernization and the adoption of an interstate compact, in order to help secure patient access to medical care by providing a means for increased physician capacity.

Medicine is a profession which endorses the values of altruism, accountability, duty to patients, and excellence. Advocacy, often in partnership with both professional and community organizations, is essential to facilitate communication with national, state, and local regulatory agencies in order to ensure health care focuses on the whole person, so that medical care may positively influence patient wellbeing. There are many primary and specialty advocacy organizations relevant to medical practice, and I encourage all physicians and physician assistants to become involved and "speak up" for patients. Through collaboration locally and regionally, better medical and health care coordination can influence better health outcomes, for our patients, in our communities.

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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: Looking At Legislation Melanie de Leon, JD, MPA Executive Director

It's that time of year again and we are busy monitoring the 2016 legislative session by reviewing and analyzing bills that have the potential to impact the practice of medicine. The regular session started on January 11, 2016 and ends March 10, 2016. The last day to consider bills passed by the opposite house was March 4. Although this session only lasts 59 days, 2174 bills have been introduced (1155 in the House; 1019 in the Senate). Of the total number of bills introduced, 493 passed out of their house of origin to go through the process in the opposite house, a 22.6 percent passage rate, lower than the 30 percent last session.

The Medical Commission introduced two bills: **HB 2452** to adopt the Interstate Medical Licensure Compact and **HB 2832** regarding limited licenses. The Compact bill passed out of the House and was heard in the Senate Committee on Health Care on February 22, 2016. The limited licenses bill did not pass out of the House; instead last year's version, HB 1874, passed out of the House and was referred to the Senate Committee on Health Care on February 16.

During this session, a variety of health care bills were passed on to the opposite house that might interest you:

HB 2793: Provides for suicide awareness and prevention education to make homes safer by establishing a "Safe Homes Task Force" to develop suicide awareness, prevention education messages, training, and implement advocacy efforts to pair suicide prevention training with distribution of devices for safe storage of lethal means (firearms for example). It also creates a Safe Homes Project to certify firearms dealers and firearms ranges that meet specified requirements as Safe Homes Partners and requires licensed pharmacists to complete a one-time training on suicide assessment, treatment, and management.

SB 6421: Under this act, prescribing health care practitioners could prescribe EpiPens to restaurants, recreation camps, youth sports leagues, amusement parks, colleges, universities, and sports arenas. These entities may acquire and stock a supply of EpiPens if they are stored in an area that is accessible in an emergency, in accordance with manufacturer instructions and Department of Health requirements. Employees of an entity or organization must complete a training program before they are able to administer an EpiPen.

SB 6445: Clarifies the role of physician assistants in the delivery of mental health services. It clarifies that physician assistants are qualified to provide services, of which they are competent to perform based on their education, training, experience and that are consistent with the delegation agreement approved by the Medical Commission. Physician assistants may not practice beyond the scope of their supervising physician's own scope of expertise and practice.

HB 2350: Specifies that a medical assistant's ability to "administer" medication means both the retrieval and application of medication.

Stay Informed!

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

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

Request a speaker from the Medical Commission

The Medical Commission actively conducts educational presentations around the state to educate the public and the licensees of Washington.

The Commission provides presentations to clinics, hospitals, training programs, medical societies, and other interested groups.

If you would like a speaker from the Medical Commission at your event or webinar, contact us!

Washington State Medical
Commission Speaker's Bureau
Medical.Speakers@doh.wa.gov
Fax: 360-236-2795



Commission Clarifies Laser Supervision Requirement

Mike Farrell

Policy Development Manager

Are you a medical director for a med spa? Do you supervise someone who uses a laser or other device to remove hair, remove tattoos or treat the skin? If so, you need to be familiar with the legal requirements of such a practice.

In 2007, the Commission adopted a rule (Washington Administrative Code (WAC) 246-919-605) that covers any FDA-designated prescription device that uses laser, noncoherent light, intense pulse light, radiofrequency, or plasma (LLRP devices) to topically penetrate the skin. A physician may delegate the use of an LLRP device to “a properly trained and licensed professional whose licensure and scope of practice allow the use of an LLRP device.” This includes RNs, LPNs, and master estheticians.

The Commission has become aware that some physicians serve as medical directors of clinics or med spas where LLRP devices are used, but spend significant amounts of time at a separate medical practice in another facility. The Commission wants to make it clear that this arrangement is not permitted by the rule.

The rule requires the physician to be on site for the initial treatment, except if called away for an emergency. The rule provides that for existing patients with an established treatment plan, the patient can receive treatment during “temporary absences” of the physician provided there is a back-up physician reachable by phone and able to see the patient within 60 minutes.

The Commission issued an Interpretive Statement to clarify that the term “temporary absences” in the rule means that the delegating physician may be absent for brief, intermittent or limited periods of time. The delegating physician’s absence from the site where the treatment occurs should not be an ongoing arrangement.

If you are away from the place where your delegate is using an LLRP device on patients for more than brief, intermittent or limited periods of time, you are circumventing the intent and the plain language of the rule. More importantly, you are subjecting your patients to unnecessary risk.

You can find that rule at <http://go.usa.gov/cp6R4>

You can find the Interpretive Statement at <http://go.usa.gov/cpd8h>

You can find the Physician Assistant rule at <http://go.usa.gov/cpd94>

Suicide Prevention Training Required

Revised Code of Washington (RCW) 43.70.442(5)(a) requires all physicians and physician assistants to take a one-time training in suicide assessment, treatment and management. The highlights:

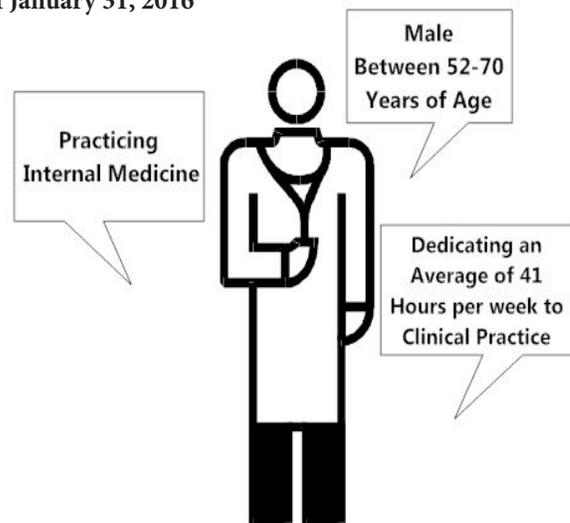
- The training must be at least six hours in length;
- It must be completed during the first full reporting period after January 1, 2016, or during the first reporting period after initial licensure;
- A licensee who has brief or limited patient contact is exempt;
- Until July 1, 2017, the Medical Commission must approve the training; after July 1, 2017, the training must be on the model list maintained by the Department of Health .

If you wish to get training approved, please contact Michael Farrell, Policy Development Manager, at michael.farrell@doh.wa.gov.

You can read the full RCW at <http://go.usa.gov/cvMje>

Who is your physician?

Data based on the demographic census information submitted as of January 31, 2016



Did you know?

You can complete your demographic census online!

The census is now required as part of your renewal application, but there is no need to wait until then to complete your census!

Please take a few minutes to complete the census so the workforce demographics is based on accurate data. Try it now: <http://go.usa.gov/2pkm>

PA News

James Anderson, PA-C, MPAS, DFAAPA Physician Assistant Member

Measuring medical provider competency is a very difficult thing to do. This is being reflected in the heated debates in many medical accrediting bodies, including current debate in the physician assistant (PA) profession.

Historically, PAs have had to pass a national certifying exam from the National Commission on Certification of Physician Assistants (NCCPA) at the time of graduation from PA school, with subsequent recertification exams every six years. When I first recertified in 2006, there was a “take-home” option, where a recertifying PA could take the exam using whatever resources that they wished, including study and discussion with colleagues. In addition to the recertification exam, PAs are also required to take 100 hours of continuing Medical Education (CME) every two years. The “take home” option is no longer available.

PA recertification exams are based on primary care skills, which has always posed a significant challenge for PAs like myself who have spent entire careers in specialty care. As a PA student, I had a deep commitment to working in primary care in underserved settings. In fact, I have not spent one day in such practice, instead primarily in pain and addiction.

“The high-stakes exams can literally end the career of a provider who does not pass the test”

Recently there has been a mini-revolution in medicine regarding recertification requirements. The American Board of Internal Medicine (ABIM) had quite a little mutiny in 2015, when member physicians pushed back hard against what they felt were increasingly onerous requirements, causing the ABIM to back down. Many of the claims by providers opposing recertification methods focus on the evidence that the recertification methods do little to promote or even measure competence.

Another complaint often heard in organizations where this controversy exists is that the high-stakes exams can literally end the career of a provider who does not pass the test. Data shows that many providers in a variety of organizations, including physician assistants, are leaving the practice of medicine early either because they did not pass a test that is often irrelevant to their specialty practice, or because they find preparation for such high-stakes examinations to be far too great of a burden.

This issue is red-hot right now in the PA profession, as the NCCPA certifying body pushes for additional exams, while members clamor for less. A good summary can be found on the website of the American Academy of Physician Assistants (AAPA), which is weighing in with sizeable heft

against more burdensome testing. You can read about the controversy at <http://news-center.aapa.org>. The AAPA, as is clear from their red-banner heading, senses that this is an issue that can bring together a variety of PAs. Many PAs, including my specialty organization the Society of Physician Assistants in Addiction Medicine (SPAAM), see this as an opportune time to rethink the way recertification occurs, and to take a longer look at data that shows little evidence to support the notion that recertification tests add value to PAs or our patients. SPAAM, for example, is one of many organizations pushing for a “one and done” approach, where PAs would certify once in order to obtain certification, then would maintain certification thereafter with traditional CME.

My most recent recertification in 2013 underscores the burden the primary care focused recertification test can be for specialty PAs. Studying for such a test took more than 100 hours, and the test itself had almost nothing to do with the specialty that I practice. And the stakes were high: If I didn’t pass this test (which is almost entirely unrelated to my practice), I could have lost my certification, my privileging at local hospitals, and ultimately my job and career. Fortunately, I did pass, but the pressured process had no small impact on my sanity, and on the sanity of those unfortunate to be around me during this process.

Some PAs opine that the NCCPA’s move to more testing, which would bring income to the NCCPA, may be in part driven but what appears to be a failed recent attempt on the part of NCCPA to advance specialty certification. NCCPA spent quite a bit of time and money on rolling out what they call “Certificate of Added Qualifications” testing, and the response has reportedly been abysmal on the part of PAs. Some close to the action now speculate that this was a large financial blow to the NCCPA, and may be driving their move to add more expensive tests.

How all of this plays out, both for physician and PA organizations, is to be seen, but physicians and PAs are clearly no longer willing to sit on the sideline and let the experts determine what maintenance of certification should look like. Hopefully, this process will result in less onerous means of certification maintenance, and in actually finding ways to promote recertification processes that are shown to add value not just to the administering organizations, but to physicians, PAs, and ultimately to the public we care for.

Completion of Death Certificates: A Professional Responsibility

Mimi Pattison, MD

Congressional District 6

The Medical Quality Assurance Commission has recently created guidelines for physicians and physician assistants to follow when they complete death certificates.

The Commission has received complaints that physicians and physician assistants (certifying clinicians) fail to complete death certificates in a timely manner or fail to accurately list the cause of death on the death certificate. The Commission takes this matter very seriously.

Under RCW 70.58.170, a funeral director or person having the right to control the disposition of human remains, must present the death certificate to the physician, physician assistant or nurse practitioner last in attendance upon the deceased. The certifying clinician then has two business days to certify the cause of death according to his or her best knowledge and sign or electronically approve the certificate, unless there is good cause for not doing so.

The death certificate is a public legal document that must contain precise and accurate information. The death certificate serves medical, statistical, and legal functions. The cause and manner of death is coded to national and World Health Organization standards using the International Classification of Diseases, 10th Revision. This coded data, collected by all states, is used by the Center for Disease Control (CDC), local health jurisdictions, and researchers to calculate life expectancy and mortality rates by race, age, sex, educational attainment, veteran status, and geographic area. The data is also used to determine which medical conditions receive research and development funding, to set public health goals, monitor disease outbreaks, and to measure health status at local, state, national, and international levels.

The death certificate also serves several different functions for the person's family, loved ones, and estate. It is legal proof of death and serves as a historical reference to an individual; recounting name, dates, places of birth and death, parent's names, as well as other useful demographic information. Providing accurate and timely cause and manner of death information is a final act of care for the decedent, their family, and their loved ones.

Certifying clinicians should meet the standard of care in completing all the information to the best of their ability. This must be done in a timely manner. The certifier must certify the cause and manner of death if he or she pronounced the death, were the first medical certifier to observe the decedent, were the primary care provider for the decedent and recently treated the decedent, or is covering for another physician who is unavailable.

If the certifier does not have enough information to accurately and precisely fill out the cause and manner of death, the certifier may consult with another clinician, clinician's records, or the medical examiner.

Deaths known or suspected of having been caused by injury or poisoning must be reported to the medical examiner or coroner. The medical examiner or coroner will make the decision as to who completes the cause and manner of death.

The spaces on the death certificate for the cause of death should represent the logical sequence of events that explains why the patient died. The immediate cause of death should be on the top line and should be the condition that occurred closest to the time of death. Mechanism of death, such as cardio-pulmonary arrest or asystole should not be listed. The specific disease, condition, or injury that set in motion the events leading to death should then be listed. It is acceptable to render a medical opinion on the cause of death and qualify the etiology by use of words such as 'probable' or 'presumed'; or, as a last resort, state the cause of death as 'unknown'.

The best estimate of the interval between the presumed onset of each condition and death must be provided. The terms 'approximate' or 'unknown' may be used. Indicate if the time interval is unknown.

Conditions that were present at the time of death and may have contributed to death but did not result in the immediate cause of death should be listed in the box "Significant Conditions Contributing to Death."

If additional medical information or autopsy findings become available that would change the cause of death originally reported, the original death certificate should be amended by the certifying clinician by filing an Affidavit of Correction with the Department of Health.

Certifying clinicians are encouraged to review the entire guideline for additional important information.

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



What would you like to see from the Medical Commission newsletter?

Send Comments and suggestions to jimi.bush@doh.wa.gov

Physician Burnout – is it Getting Better, or Worse?

Charles Meredith, MD
Medical Director, WPHP

It depends who you ask or where you look. Two recent pieces in the literature present opposing views.

Burnout is an unpleasant, but typically transient, psychological state to which physicians and other medical providers appear to be fairly vulnerable. It is defined as a triad of depersonalization, emotional exhaustion and sense of low personal accomplishment. In essence, affected physicians can feel so overworked and so overtaxed by the stressors around them that they find it difficult to connect emotionally with their colleagues and their patients. They also experience a sense of emotional exhaustion, and a demoralizing sense that they are not, or cannot, help the patients before them.

Research demonstrates that environmental stressors as well as personal characteristics can serve as a vulnerability to burnout. Increased work hours and frequency of call nights are correlated with increased prevalence of burnout. Although this work appears somewhat anecdotal, experts have noted that individuals with naturally higher levels of empathy seem to be more at risk to experience this phenomenon.

Sustained burnout limits our effectiveness as physicians, as we lose touch with our natural empathy.

Perhaps patients sense this, as burnout tends to be correlated with lower patient satisfaction scores, higher error rates, and less ideal outcomes. In terms of other professional consequences, burnout has been linked to increased risk of premature retirement. In terms of personal consequences, meeting criteria for sustained burnout is correlated with higher likelihood of also meeting criteria for a comorbid alcohol use disorder or comorbid depressive episode.

In 2012, Shanafelt and colleagues published anonymous survey data that they had collected from the membership of the American Medical Association (AMA). Using validated screening instruments on this large subject pool, their data indicated that in the prior year, 46 percent of respondents experienced at least one of the three components of burnout at a high level, compared to 28 percent of the general U.S. working population.

In the December 2015 issue of Mayo Clinic Proceedings, Shanafelt's group has published a more recent replication of their 2012 study. Utilizing the same protocol, they've demonstrated that the prevalence of burnout among U.S.

physicians has risen to 54 percent while it has held steady for the general U.S. working population at 28 percent. The odds ratio for suffering burnout in the next year, compared to the general public, has risen from 1.36 to 1.97 for U.S. physicians in what appears to be the last three years.

So it seems the situation is worsening. While we are likely not the only high-risk occupations group, physicians are more vulnerable to burnout than U.S. citizens in general and more vulnerable than we were at the start of this decade.

In contrast, select data from The Physicians Foundation Surveys conducted biennially since 2008 by Merritt-Hawkins may suggest the opposite, that the situation may have recently peaked and is getting better. Data from the most recent surveys indicated that 39 percent of surveyed physicians are considering making some effort to leave medicine prematurely secondary to their dissatisfaction with the profession, particularly those within five years of traditional retirement age. 44 percent are considering limiting their hours to part-time or moving to non-clinical work, while increasing numbers are gravitating towards direct pay "concierge practices" or simply moving out of becoming independent business owners.

"The prevalence of burnout among U.S. physicians has risen to 54%"

However, compared to 2008, fewer physicians (29 percent) reported some regret over their choice of medicine as a career. Increasing numbers (50 percent) reported that they would recommend this profession to their children, and increasing numbers (44 percent) rated their work morale as generally positive. While the differences are not dramatic, younger physicians, female physicians, employed physicians and primary care physicians tended to report higher career satisfaction than other demographic groups. While these percentages are far from ideal, trends in the Physicians Foundation survey data suggest that physician dissatisfaction may have peaked and be trending downwards.

Lastly, physicians frequently cite implementation of burdensome Electronic Medical Records (EMR) as a primary driver of their dissatisfaction with medicine today. However, anecdotal data suggest that a significant minority of early career physicians find their present day EMR to be an asset rather than a hindrance in providing clinical care for their patients.

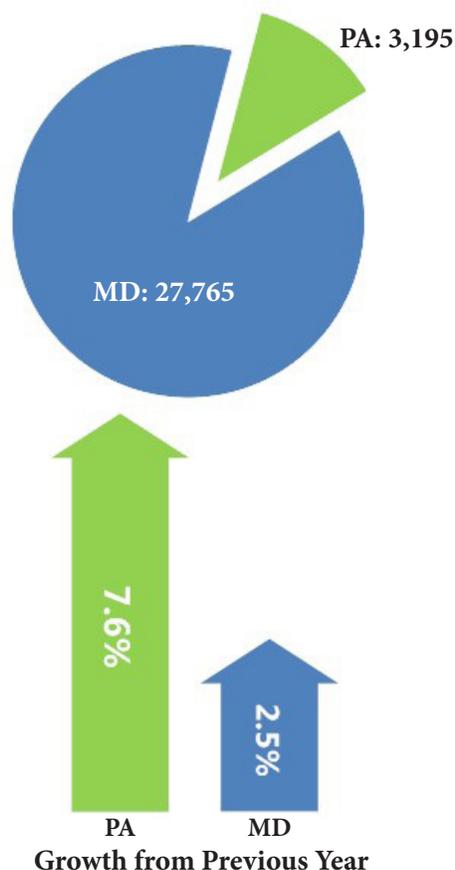
2016 Demographics Update

Here's where physician and physician assistant population totals stood as of January 31, 2016

What should we conclude from the conflicting data? Is the house of medicine irreparably damaged or is it simply in the midst of a painful but necessary remodel? Should we move out and seek more comfortable shelter or stay put and look forward to a house better suited to the demands of a modern health care system? In September 1989, the American Journal of Public Health published an editorial on the 1978 Group Health and 1986 Ontario physician strikes. Ironically, reading about the ills of years past suggests that perhaps the more things change, the more they stay the same. It may be that each era decries the end of the "good old days" only to see the emergence of a hopeful new generation of idealists with the heart and enthusiasm to invigorate and energize change.

Is the conflicting data mapping a changing of the guard in medicine? Burnout is directly proportional with physician age while our physician workforce ages with the baby boomer generation. Is this why burnout is increasing to some extent and making it feel as though our general situation is deteriorating? Are small and early trends suggesting that things are improving and that the future generation of medicine is less pessimistic, better at balancing work and leisure, and more accepting of the current state, having no basis for negative comparisons? Or is this just a brief anomaly? Only time and future data collections will tell.

Physician / PA Active Population



WPHP Mindfulness Workshops for Healthcare Providers

Mindfulness is designed to reduce stress and improve resiliency. Healthcare professionals report that adopting a mindfulness program improves communication with coworkers and patients, decreases isolation and results in greater satisfaction at work and at home. These WPHP wellness programs are open to any physician, dentist, veterinarian, physician assistant, or podiatrist. No past or current involvement with WPHP is necessary to participate. Spouses and partners are also encouraged to attend. Cost is \$200 for four evening sessions and one afternoon session. For more information or to register, please visit www.wphp.org or contact us at wellness@wpwphp.org or 1-800-552-7236. Programs are professionally facilitated by Mindfulness Northwest.

Seattle Workshop Spring 2016

- April 24, 6-8:30pm
- May 1, 6-8:30pm
- May 8, 6-8:30pm
- May 15, 1-7 pm
- May 22, 6-8:30pm

Kirkland Workshop Spring 2016

- April 25, 6-8:30pm
- May 2, 6-8:30pm
- May 9, 6-8:30pm
- May 15, 1-7 pm
- May 23, 6-8:30pm

Spokane Workshop Spring 2016

- April 20, 6-8:30pm
- April 27, 6-8:30pm
- May 4, 6-8:30pm
- May 7, 1-7 pm
- May 11, 6-8:30pm

Legal Actions

October 1, 2015 – December 31, 2015

Below are summaries of interim suspensions and final actions taken by the Commission. Statements of Charges, Notices of Decision on Application, Modifications to Orders and Termination Orders are not listed.

We encourage you to read the legal document for a description of the issues and findings. All legal actions are updated quarterly and can be found with definitions on the Commission website: <http://go.usa.gov/bkNH>

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Formal Actions				
Capwell, Robin R. MD00024463 King	Final Order	12/10/15	Final Order of Default (failure to respond).	Indefinite Suspension.
Craigg, Gerald B. R. MD00044814 Walla Walla	Agreed Order	11/5/15	Violation of pain rules, failure to document, and substandard prescribing practices that contributed to patient death.	Five years oversight, restriction on prescribing Schedule II and III narcotics and Schedule IV controlled substances, \$1,000 cost recovery, and competency assessment.
Gillman, John F. MD60265170 Pierce	Agreed Order	11/5/15	Sexual misconduct and boundary violations involving a patient.	Probation, license restriction with required chaperone use, submission of clinical patient logs, boundaries course, \$5,000 cost recovery, personal appearances, and multidisciplinary evaluation.
Hamill, John W. MD00040582 Cowlitz	Interim Agreed Order	11/6/15	Violation of pain rules.	Restriction on prescribing Schedule II controlled substances, Schedule III narcotics, and Schedule IV benzodiazepines.
Hutsinpilller, Molly MD00033833 Spokane	Agreed Order on Modification	11/9/15	Substance abuse.	Probation, compliance with WPHP Agreement, \$400 cost recovery, and petition to terminate only after release from Utah Stipulation and Order.
Mouravev, Rostislav MD00043224 (Out of State)	Final Order	11/24/15	Material misrepresentations in license application.	Revocation.
Ortolano, Alexander M.MD00043823 Benton	Agreed Order	10/16/15	Deficient obstetrics and gynecology practice involving multiple patients, and resulting in a high risk of patient harm.	Four years oversight, practice restrictions and requirements, preceptorship, personal appearance, CME, paper with presentation, competency and professional assessment, and notification at practice facilities.
Riedesel, Deborah E. PA10001253 King	Agreed Order	11/10/15	Substance abuse and failure to comply with treatment recommendation.	Surrender.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Informal Actions				
Escobar, Susan MD00041997 Snohomish	Informal Disposition	11/10/15	Alleged: Respondent violated pain rules by prescribing high doses of opioid medication to multiple patients without effective assessment and monitoring.	Oversight, discontinue treating non-cancer chronic pain patients, create documentation plan, boundaries course, practice reviews, \$2,000 cost recovery, and personal appearances.
Hennessey, Stephen D. MD00025264 Thurston	Informal Disposition	11/10/15	Alleged: Substandard surgical skills caused severe patient harm or death.	Restriction against performing surgery and \$1,000 cost recovery.
Lietzke, Christiana MD60423996 (Michigan)	Informal Disposition	11/12/15	Alleged: Consent Order and Stipulation by Michigan Board of Medicine.	Compliance with Michigan Order, submission of reports, and 30-day notice prior to practice of medicine in state of Washington.
Sterling, Ronald M. MD00038889 King	Informal Disposition	11/10/15	Alleged: Substandard chronic pain treatment involving multiple patients, and boundary violations with two patients.	Probation, recordkeeping course, boundaries course, opioid prescribing course, compliance with pain rules, practice reviews, \$1,000 cost recovery, and personal appearances.
Wang, James J. MD00040747 Snohomish	Informal Disposition	11/9/15	Alleged: Substandard diagnosis and surgical treatment.	Monitoring, personal appearances, \$1,000 cost recovery, and paper on complex cervical spine fractures.

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 be subject to sanctions, including terms and conditions 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.

Commission Rule-Making

Daidria Pittman

Program Manager

Sexual Misconduct – Allopathic Physicians

A hearing regarding WAC 246-919-630, Sexual Misconduct related to allopathic physicians, was held November 4, 2015. A quorum of the Commission approved the draft rule at the hearing. The CR-103 process is nearly complete.

Sexual Misconduct – Allopathic Physician Assistants

A hearing regarding WAC 246-919-630, Sexual Misconduct related to allopathic physician assistants, was held November 4, 2015. A quorum of the Commission approved the draft rule at the hearing. The CR-103 process is nearly complete.

Safe and Effective Analgesia and Anesthesia

Administration in Office-Based Surgical Settings

The CR-101 to revise WAC 246-919-601(5) was filed with the Office of the Code Reviser on March 11, 2015 (Washington State Register (WSR) #15-07-033). The Commission is considering revising WAC 246-919-601(5) to eliminate the list of entities and instead, identify the criteria the Commission will use to approve entities that facilities must be accredited or certified by, before surgery may take place. The CR-102 is in progress.

Suicide Prevention Training – Engrossed Substitute House Bill (ESHB) 1424

The CR-101 for allopathic physicians was filed with the Office of the Code Reviser on October 6, 2014 (WSR# 14-21-030) and the CR-101 for allopathic physician assistants was filed with the Office of the Code Reviser on August 17, 2015 (WSR# 15-17-076). These rule-making documents were filed pursuant to the requirements under ESHB 1424 (Chapter 249, Laws of 2015), that require allopathic physicians, allopathic physician assistants and other health care providers to complete a one-time training in suicide assessment, treatment, and management to help lower the suicide rate in Washington State. The CR-102 is in progress.

Maintenance of Licensure

The CR-101 to revise WAC 246-919-421 through 470 was filed with the Office of the Code Reviser on February 23, 2015 (WSR 15-06-014). The Commission is considering developing rules establishing requirements for allopathic physicians to engage in professional development to ensure continuing competency. A stakeholder workshop was held on May 13, 2015. The CR-102 is in progress.

Policy Corner

At its November 2015 and January 2016 business meetings, the Commission approved or updated the following guidelines:

- MD2015-10 “Re-entry to Practice” Guideline
- MD2015-11 “Re-entry to Practice for Suspended Licensees” Guideline
- MD2015-13 “Treating Partners of Patients with Sexually Transmitted Chlamydia and Gonorrhea” Guideline
- MD2016-01 “Completion of Death Certificates by Physicians and Physician Assistants” Guideline

All Commission policies, guidelines and interpretive statements are available at <http://go.usa.gov/dG8>.

Medical Commission Vital Statistics

- 21 members: 13 MDs, 2 PAs, 6 public members;
- 47 staff, \$14.8 M biennial budget
- 31,000 licensed physicians and physician assistants
- 99.6% of complaints processed on time in FY 2015
- 83% of investigations completed on time in FY 2015
- 88.5% of legal cases completed on time in FY 2015
- 98% of orders complied with sanction rules

Actions in Fiscal Year (FY) 2015

- Issued 2,587 new licenses;
- Received 1,476 complaints/reports;
- Investigated 815 complaints/reports;
- Issued 73 disciplinary orders;
- Summarily suspended or restricted 11 licenses;
- Actively monitoring 192 practitioners;
- 42 practitioners completed compliance programs.

Save the Date!
October 5-6
Seattle Airport Marriott

Medical Commission 2016 Educational Conference.

Free and open to all. For more information or questions, please contact jimi.bush@doh.wa.gov.

To view the presentation videos from the 2015 Conference, please visit <http://go.usa.gov/cw39A>

NOTICE OF RECRUITMENT

The Department of Health (DOH) is currently accepting applications to fill upcoming vacancies on the Washington State Medical Quality Assurance Commission (commission). The commission helps make sure physicians and physician assistants are competent and provide quality medical care.

We are looking for people willing to study the issues and make decisions in the best interest of the public. Our member selection reflects the diversity of the profession and provides representation throughout the state. The commission has openings for:

- One physician representing Congressional District 6
- One physician representing Congressional District 8
- Two physicians at large

To determine what congressional district you live in, please visit <http://go.usa.gov/c2XCw>.

The commission consists of 21 members appointed by the governor. It meets about eight times a year, usually on Thursday and Friday every six weeks. There is an expectation to review multiple disciplinary cases between meetings, and additional meetings or hearings are often necessary. Additional information regarding commission membership and a link to the governor's application can be found at: <http://go.usa.gov/c2XrH>.

Please take the time to review the valuable information on commission membership available at the above website. Applications, along with a current resume must be received **by April 29, 2016**.

If you have any questions about serving on the commission, please contact Julie Kitten, Operations Manager, at Post Office Box 47866, Olympia, Washington 98504-7866, by email at julie.kitten@doh.wa.gov, or call (360) 236-2757.

Medical Commission Meetings 2016

Date	Activity	Location
March 31- April 1	Regular Meeting	Skamania Lodge 1131 SW Skamania Lodge Way, Stevenson, WA 98648
May 12-13	Regular Meeting	Capital Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater, WA 98512
June 23-24	Regular Meeting	Red Lion Wenatchee 1225 N Wenatchee Ave., Wenatchee, WA 98801
August 11-12	Regular Meeting	Capital Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater, WA 98512
October 5-7	Educational Conference	Seattle Airport Marriott 3201 South 176th Street, Seattle, WA 98188
November 3-4	Regular Meeting	Capital Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater, WA 98512
Medical Commission meetings are open to the public		
Other Meetings		
April 28-30, 2016	Federation of State Medical Boards Annual Meeting	San Diego, CA
October 1-2, 2016	Washington State Medical Association Annual Meeting	Seattle, WA



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

Washington State Medical Commission Newsletter–Spring 2016

Jimi R. Bush, MPA, Managing Editor: jimi.bush@doh.wa.gov

Medical Commission Contact Information

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

Medical Commission Members

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