



Message from the Chair

Michelle Terry, MD Chair, Physician at Large

The Medical Commission is continuing its mission to advocate for strategies that allow physicians and physician assistants to provide optimal care to patients, in order to protect the public from medical errors and unanticipated outcomes.

On September 30 and October 1, 2015 the Medical Commission presented “Communication: The Way to Patient Safety”, as the theme of its annual educational conference at the DoubleTree hotel in Tukwila WA, where 143 attendees over two days learned best practices for models of communication in relationship centered care with patients. A notable speaker lineup included Commissioner Dr. Mimi Pattison, as well as University of Washington School of Medicine faculty members Drs. John Scott, Sam Mandell, Joseph Hwang, Tom Gallagher and Larry Mauksch M.Ed, who in sum expressed many practical techniques to enhance communication with patients. To further augment the attendees’ learning experience, there were several demonstrative presentations from patient advocates, hospital administrators, and commission staff members that together provided all assembled a 360 degree perspective on the challenges and opportunities available to enhance patient/provider communication. The conference materials can be found here: <http://go.usa.gov/cgvGd>

On November 6, 2015 commission staff members, commissioners and members of the public participated in a presentation on implicit bias given by Washington State Assistant Attorney General, Meghann McCann. Implicit bias, also known as implicit social cognition, refers to the attitudes or stereotypes that affect our perceptions, actions, and judgments in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily, and without an individual’s awareness or intent. Project Implicit was founded in 1998 by three scientists - Tony Greenwald

(University of Washington), Mahzarin Banaji (Harvard University), and Brian Nosek (University of Virginia) - is both a non-profit organization and international collaboration among researchers who are studying implicit social cognition/implicit bias. The goal of the organization is to educate the public about hidden biases and to provide a “virtual laboratory” for collecting data on the internet. To take an Implicit Association Test ,(IAT), and review your personal bias around many common community situations, please follow the link: <https://implicit.harvard.edu/implicit/takeatest.html>

Realizing everyone has unconscious bias, the University of Washington School of Medicine, Center for Equity Diversity and Inclusion ,(CEDI), has developed several strategies to “interrupt unconscious bias” by encouraging individuals to routinely pause in clinical situations, in order to then verify and validate information, prior to making statements or taking action. CEDI also endorses mindfulness training, by encouraging individual providers to reflect in the moment by asking “What am I feeling?”, “What assumptions am I making?”, and “What’s informing my decision making?” while in the process of delivering medical care.

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Mission

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

So what do these efforts around communication and implicit bias trainings have to do with the business of the Medical Commission? The Washington State Department of Health, and its partners including the Medical Commission, work to identify and address the factors that lead to health disparities among racial, ethnic, gender, geographic, socioeconomic, and Lesbian, Gay, Transgender, Bisexual and Queer (LGBTQ) community groups so barriers to health equity can be removed. Within the Medical Commission the Health Equity Workgroup chaired by James Anderson, PA-C, provides several resources available at <http://go.usa.gov/cgUwT>. The Health Equity Workgroup website presents information on selected topics for providers interested in learning more about assessing and addressing health inequities. It is an intention of the Medical Commission to support evidenced-based educational information for physicians and physician assistants who care for patients, in order to support a healthier Washington for everyone.

Docinfo Tool Provides Consumers Physician Licensure, Disciplinary Data

A free online resource from the Federation of State Medical Boards (FSMB) provides consumers with physician disciplinary, licensure and medical specialty information. FSMB has launched an online resource to provide consumers with background information on the more than 900,000 actively licensed physicians in the United States.

The Docinfo physician search tool (www.docinfo.org) draws data from the FSMB's Physician Data Center, the nation's most comprehensive database of physician licensure and disciplinary information.

The tool is easy to use. Consumers simply enter their physician's name and state to receive a report including this information:

- Whether or not the physician has been disciplined by a state medical board
- States in which the physician is actively licensed
- Medical school
- Location information (city, state)
- Specialty Certification information (provided by the American Board of Medical Specialties and the American Osteopathic Association)

If a medical board has sanctioned a physician, the report will provide a link to the appropriate state medical board website.

Executive Director's Report Melanie de Leon, JD, MPA Executive Director

Last week, I participated in an historic event – the first meeting of the Interstate Medical Licensure Compact Commission. Two representatives from each of the eleven states who have passed this legislation gathered in Chicago October 27-28 to begin forming the administrative framework to breathe life into this compact. You may be aware that the Governor-appointed Washington State Medical Commission endorsed the Compact in September 2014.

The Commission's first order of business was to elect officers and adopt temporary bylaws. The Commission elected the following officers:

- Chair: Ian Marquand (Montana Medical Board)
- Vice Chair: Jon Thomas, MD (Minnesota Medical Board)
- Secretary: Diana Shepard, CMBE (West Virginia Board of Osteopathic Medicine)
- Treasurer: Brian Zachariah, MD (Illinois State Medical Board)

Next, the Commission brainstormed what actions needed to occur to launch the compact with the goal of issuing its first license by mid-July 2016. To complete these actions, the Commission appointed members to several committees to include:

- Rules and bylaws Committee to identify areas for initial rulemaking by the Commission, as well as whether or not revisions or additions to the bylaws are needed
- Funding and Budget Committee to look not only at establishing a budget for the organization, but to seek ways to secure other funding sources for the Commission's startup.
- Technology Committee to focus on what will be needed to establish an information system.
- Personnel Committee to begin the process of finding and hiring an executive director.
- Coordinating Committee, established in lieu of an Executive Committee, to allow the entire Commission to weigh in on many still-to-be made decisions critical to the Commission's success. An Executive Committee will most likely be created at a later date.

The next Commission meeting will be held on December 18 to hear the progress the committees have made and determine next steps. As additional states enact the Compact, new representatives will be added to the Commission – we are working hard to have Washington be included as one of those new representatives soon. For more information or if you would like to support this legislative effort in some way, please feel free to contact our Legislative Director via email: Micah.Matthews@doh.wa.gov.

Uniform Disciplinary Act Spotlight

Mimi Winslow, JD

Public Member

Physicians and physician assistants want to provide quality care and act ethically and professionally, consistent with their training and oath to protect the public health. Which of the following conduct is not considered unprofessional conduct by the Uniform Disciplinary Act (UDA), RCW 18.130.180?

1. Incompetence or negligence which results in injury to a patient or creates an unreasonable risk of patient harm?
2. Restriction of an individual's license by competent authority in any other state or federal jurisdiction?
3. Aiding or abetting unauthorized practice by another person?
4. Failure to cooperate with the disciplining authority?
5. Current misuse of alcohol, controlled substances, or legend drugs?

In fact, all of the above are included in the UDA, as are eighteen additional statutory prohibitions. When the Commission held its June and August 2015 meetings in Spokane and Vancouver, we invited local licensees to meet Commissioners during the midday break to ask questions about how the Commission operates. It became clear that some licensees are unaware that the Commission has the statutory authority to require them to cooperate in the investigation of a complaint of unprofessional conduct.

RCW 18.130.180 specifies that failure to cooperate includes:

(8)(a) Not furnishing any papers, documents, records, or other items;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplinary authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplinary authority seeking to perform practice reviews at facilities utilized by the license holder.

You can read the complete statute regarding unprofessional conduct here: <http://go.usa.gov/cguCe>

Most complaints against practitioners end up, after full and thoughtful investigation and review, not resulting in disciplinary action. But if a licensee does not answer the investigator's questions, make medical records available where appropriate, or otherwise engage in the process, the legislature has mandated that this failure is an independent violation of the UDA, even if the investigation determines that the actual care provided is within the standard of care.

So if you are contacted by representatives of the Commission investigating a complaint, do not ignore the letters or phone calls. You are free to consult with your attorney in the course of responding, but turning your back on requests for the information that will allow the Commission to determine whether the complaint is merited or not, is risky.

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

Did you know?

You can complete your demographic census online!

The Commission has been asked to develop demographic data on our healthcare providers. 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. The census is now required as part of your renewal application, but there is no need to wait until then to complete your census! It can now be completed online.

Please take a few minutes to complete the demographic census so the decisions made about your future work environment can be based on accurate data.

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

A Valuable Practice Tool: The Prescription Monitoring Program

Warren B. Howe, MD

Congressional District 2

Over the past few years, Washington State has developed a Prescription Monitoring Program (PMP) to help track prescribing and dispensing of DEA-controlled medications. This has been part of a vigorous effort to improve patient safety in the face of alarming statistics regarding death and injury resulting from use and misuse of prescribed controlled drugs. PMP has now evolved to such a level of utility and efficiency that the Commission heartily recommends its use, along with the Agency Medical Director's Group (AMDG) Interagency Guideline on Prescribing Opioids for Pain, by all practitioners who prescribe controlled medications (<http://go.usa.gov/c4c2T>).

The PMP requires that, with a few minor exceptions, dispensers of specified controlled medications must submit detailed information regarding each prescription to the Department of Health for entry into the program registry. Once entered, the data is available by search to authorized and properly registered persons or entities, such as prescribers, dispensers, law enforcement entities and the Medical Commission. Generally, data about a dispensed prescription is available in the PMP about 10 days after it is dispensed. Prescribers may view data related to individual patients and their own (DEA number-related) prescribing records. Patients may obtain a report of their own personal PMP data from the Department of Health (DOH).

Uses and benefits of the PMP are many:

Prescriber checking new patient record

- Review history of controlled medication use
- Identify patient's other prescribers of controlled medications
- Recognize patients at risk for abuse/misuse of controlled medication(s)
- Recognize potential drug interactions
- Coordinate care with other prescribers listed on the report

Prescriber checking established patient record

- Check compliance with treatment instructions and/or contracts
- Verify that prescribed drugs and quantities are appropriate
- Identify multiple prescribers or dispensers
- Recognize potential drug interactions

- Review record with patient to demonstrate concern for appropriate use of prescribed medication
- Detect emerging patterns of abuse, non-compliance or potential safety issues
- PMP printout in patient record can bolster documentation
- Coordinate care with other prescribers listed on the report

Prescriber checking own prescription dispensation record

- Detect fraudulent prescriptions using DEA number
- Monitor trends in use of controlled substances by prescriber's patient population
- Identify potential topics for Continuing Medical Education (CME)

Access to the PMP database is restricted to authorized "master" account registrants: actual prescribers and dispensers, and their authorized delegates. To save time and encourage availability of PMP data at the time of patient visits, a "master" registrant may delegate access to associated delegate account holders whose access is directly related to their employment relationship to the "master" account holder. Thus, PMP data can be accessed and print outs placed in the patient record by credentialed office assistants at the time of patient visits, without the prescriber having to do the actual search.

The Medical Commission often uses prescriber print outs, either for specific patients or for the entire practice of a prescriber, in investigating and evaluating complaints related to overprescribing, diversion, misuse or adverse effects of controlled substances. This information can be very valuable to the Commission's deliberations, and usually can provide an excellent picture of a prescriber's habits regarding the use of controlled drugs. A prescriber who detects irregularities in his or her PMP record should report that to DOH online, promptly using the DOH PMP website (<http://go.usa.gov/c4cJP>), for both personal and public protection.

Registering to use the PMP is quite easy. The instructions for doing so, and a host of instructional and supplemental information about the program is available on the PMP website: www.wapmp.org or from the DOH PMP page. These sites provide links and suggestions for obtaining more information, or for contacting program experts for guidance and answers to questions.

The Medical Commission now considers the PMP as an important adjunct in the safe and effective prescription of controlled medications. Prescribers who adopt its regular use are taking an effective step to improve their practice and their care of patients. In its investigations, the Commission views evidence that the prescriber uses the PMP as a positive attribute. All physicians and physician assistants who prescribe controlled medications should register for, learn to use and regularly employ this valuable tool.

If you are interested in viewing the relevant statutes for PMP, please visit <http://go.usa.gov/c4xgV> or <http://go.usa.gov/c4x4k>.

Search and Rescue Washington: A Washington State Pilot Prescriber Support Initiative

Search and Rescue Washington is a new awareness campaign and resource hub developed for Washington State by the Partnership for Drug-Free Kids to help medication prescribers identify prescription medication abuse and addiction among their patients.

Search and Rescue assists prescribers by providing patient support tools to identify, prevent and respond to medication misuse and abuse. These tools include:

- Opioid Risk Assessment Tool
- Video case studies to support prescribers in assessing potential misuse among established and new patients
- SAMHSA's Treatment Locator.

Search and Rescue aligns with and supports the existing Washington State Prescription Drug Monitoring Program (PMP) by encouraging prescribers to register and use the PMP along with the tools and resources on the Search and Rescue site.

The Partnership for Drug-Free Kids believes prescribers play a critical role in preventing medication abuse. Search and Rescue assists prescribers by providing patient support tools to identify, prevent and respond to medication misuse and abuse.

Please visit: www.searchandrescuewashington.org

PA News

James Anderson, PA-C Physician Assistant Member

My wife and I love Paris, and we were able to come again and see this beautiful city, where we are as I write this. We left Seattle November 12, arriving in Paris on Friday, November 13. We were pretty beat when we arrived. We kicked around the neighborhood of our hotel, trying to stay awake as late as we could to get into a normal sleep pattern. By 8 p.m. we were both hallucinating from jet lag and called it a day.

When we awoke around 7 a.m. on Saturday morning, my wife turned on her phone and exclaimed "Wow, there are a lot of texts and messages...one of them is asking if we're OK and it says something about an explosion."

It didn't take long to learn of the horrors that had taken place about three miles from us as we slept. We've been in that area, sat in cafe patios all over the city just as some of the victims were that night, and it was hard to think about the people, many just like us, who died.

As we processed the events, glued to CNN Europe, I saw a picture on an online French news site that really grabbed me. It was a picture of a cafe terrace where some of the massacre occurred. There were overturned bistro tables and chairs, and on the ground were two bodies, each covered head to toe by sheets, hands and shoes visible on the edges. Over them stood French emergency personnel, three of them totally engaged in their work as they intently listened to their colleague, perhaps the MD or supervisor in charge. One team member stood sideways to the camera, looking back over his shoulder at the bodies, a grim look on his face.

I started thinking about the universal challenges that we, as medical providers all over the globe including physician assistants and physicians in Washington, face as we work to provide the highest levels of care in some unimaginably stressful situations. While our colleagues in emergency medicine face some of the most extreme stressors, any MD or PA faces the high risk of encountering extremely stressful events and interactions, both with our patients and related to trauma or delivering catastrophic news to patients and their families.

For example, think of the dermatology PA who is charged with telling a patient that what they thought was an innocent mole is in fact late stage malignant melanoma. Or the MD working in oncology facing the task of telling a patient that there are no further treatment options for their aggressive metastatic cancer. The emergency medicine physician who must tell parents that their child is dead

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from what the parents hoped was a minor injury. Think of the military PAs and medics, who were the founders of our profession, and the terrible things that they have encountered and still see to this day.

The list of possible such encounters goes on and on. Physician assistants and physicians alike can be ambushed by such situations, and in these moments, staying focused and on top of our games to assure that our decision-making is solid and of the highest quality can be difficult. In such times, we are at high risk of performing at levels lower than our usual best.

So what can we do to help assure we can work through such stress and trauma and maintain high levels of function? Physicians and physician assistants tend to think we can slog through any challenge, and often we think we can go it alone if we have to.

The Washington Physicians Health Program (WPHP) is a great resource for PAs and MDs facing concerns about the impact of work-related stress on our performance. One excellent resource is their Mindfulness for Healthcare Professionals program. I've not taken it, but am hearing great things about it from providers who have. Most physician assistants and physicians also have access to Employee Assistance Programs through our workplaces, and these also can be a good place to turn for the PA or MD who wonders if they may be experiencing stressors that may be affecting their care. In most settings, these concerns can be expressed and explored without occupational jeopardy.

Finally, any of us who may be involved in PA or MD education can be effective with our medical education colleagues in advocating for inclusion, or increased presence of training focused on preventing stress related burnout or decreased performance. Curriculum enhancement related to recognizing symptoms of post-traumatic stress in our work, and where to turn when we or others around us recognize these symptoms should be addressed in our training. From my PA school experience, and from what I hear from other PAs and MDs, these issues are not addressed enough in medical education, leaving all of us (and the patients we serve) vulnerable.

By all accounts the French emergency personnel were brave and efficient, and did their jobs at the highest of levels. Here's to that, here's to their healing following the things they witnessed. Here's to the healing of all MDs and PAs as we move through and past our patient's traumas and stressors. Here's to us maintaining insights about our own condition, to us seeking help when we need it, and to a future world where victims, families, survivors, PAs, MDs, and all our colleagues in the health care system are spared what happened on November 13, 2015, here in Paris.

WPHP Report **If I'm unhappy with the practice of medicine, what can I really do about that?** **Charles Meredith, MD**

The Washington Physicians Health Program was created in 1986 to identify and assist doctoral level healthcare providers who were thought to have become temporarily impaired by a medical condition to the extent that they could not practice medicine with appropriate safety to patients. In these situations, examples of an untreated illness causing concern for impairment typically include substance use disorders, psychiatric mood disorders, and age-associated cognitive disorders among others. While no one really knows the prevalence of "impairment" among physicians and physician assistants, most experts in physician health think it is roughly 1% or less. But that does not mean that the other 99% of us are doing fine with our personal health and are happily engaged in our careers.

It's commonly accepted that among physicians and physician assistants, the annual prevalence of provider burnout ranges from 30-45%, whether you are a trainee, graduate, or faculty.¹ Burnout is unpleasant, manifesting as a triad of depersonalization, emotional exhaustion and a sense of low personal accomplishment. In essence, providers can feel so beaten down, they find it difficult to relate emotionally to their colleagues or their patients to the degree they expect of themselves, and to the degree that their patients expect.

While we may have individual personal vulnerabilities to burnout, there are a number of systems level factors that heighten our vulnerability. Presence of burnout is correlated with increased work hours and increased frequency of call nights, among other factors.² Large medical organizations have become aware that provider burnout is a problem that affects their bottom line. Sustained burnout is correlated with increased risk of premature retirement, presumably due to loss of satisfaction with the profession.³

Merrit-Hawkins survey data from 2014 indicates that 39% of surveyed physicians are making some effort to leave medicine prematurely secondary to their dissatisfaction with the profession. 44% 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 being independent business owners.⁴ Environmental factors most commonly cited as playing a role in this dissatisfaction are multiple. These include feeling constrained by technological changes and clunky Electronic Medical records (EMRs) that they are mandated

to use, increased paperwork demands, and spending inordinate amounts of time on the phone seeking pre-authorization from the insurance industry for a crucial medication or diagnostic test.

So what is anyone doing about this? Well, if you've read this column in the MQAC newsletter over the past several years, you've become aware that the Washington Physicians Health Program has focused on offering health-related programming to providers, designed to improve their resilience and optimize their ability to cope effectively with such external stressors. Such programming includes mindfulness-based meditation workshops and a modality called compassion cultivation training. (More information is available at www.wphp.org). Various medical institutions are doing the same via their intramural wellness programs and medical staff assistance programs.

But what critics rightfully point out is that these health programs are targeted at the motivated individual and don't solve the environmental problem; they merely assist the individual provider in building their resilience so that they become better able to "tolerate the problem." And most people practicing medicine agree that "there is a problem."

So what is the best avenue open to us? During the last year while promoting some of WPHP's wellness offerings targeting burnout and health coping, our staff has received feedback from several physicians that what they really want is something quite a bit different from wellness support. Rather, these critics asked for organizational advocacy so that they can reclaim control of their profession. At a conceptual level, this makes sense, but is outside the role of a wellness organization like the WPHP. And truthfully, no organization is going to do all the advocacy work for us, unless we get directly involved.

In order to make a difference, by far the best place to turn is to our membership organizations. Locally, these would include the Washington State Medical Association (WSMA) (www.wsma.org/), Washington Academy of Physician Assistants (www.wapa.com), county medical societies and our specialty societies. Nationally, it includes the American Medical Association (AMA), American Academy of Physician Assistants (AAPA) and our national specialty societies. While legislative change can be slow, these groups have a political lobby that legislators have to take seriously

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:
jimi.bush@doh.wa.gov

and remain the most effective way we as individuals can change the administrative burden that has indolently taken over the practice of medicine over the last 25 years.

As part of its new "Healthy Doctors, Healthier Patients" initiative, WSMA is devoting political advocacy energy to promoting legislation that will decrease the administrative burden that is forcing us to spend more time with our keyboards and with insurance payer call centers than we get to spend with our patients.

Health-related organizations like WPHP can help interested individuals improve their resilience so they are better able to function optimally given these environmental stressors. But to change the environmental stressors facing us, we need to participate in our respective membership groups. Without your active participation in such an organization, that lobby power is less effective at fixing our broken system. Consider this the next time the thought crosses your mind that the current practice of medicine seems to have changed from what you originally signed up for.

References

1. Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, West CP, Sloan J, Oreskovich MR. Burnout and Satisfaction With Work-Life Balance Among US Physicians Relative to the General US Population. *Arch Intern Med.* 2012;172(18):1377-1385.
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3. Sharma A, Sharp DM, Walker LG, Monson JR: Stress and burnout among colorectal surgeons and colorectal nurse specialists working in the National Health Service. *Colorectal Dis.* 2008; 10:397- 406.
4. The Physicians Foundation. 2014 Survey of America's Physicians Practice Patterns and Perspectives. Available at http://www.medmgtservices.com/wp-content/uploads/2014/10/2014_Physicians_Foundation_Biennial_Physician_Survey_Report.pdf

Request a Commissioner!

The Medical Commission actively conducts educational presentations around the state to educate the public and the licensees of Washington State. 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 to present via webinar, contact us!

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

Legal Actions

May 1st, 2015 – July 31st, 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
Summary Actions				
Gillman, John F. MD60265170 Pierce	Summary Order	7/28/2015	Sexual misconduct and boundary violations involving a patient.	Restriction from treating female patients.
Ortolano, Alexander M. MD0003823 Benton	Summary Order	7/28/2015	Pattern of substandard obstetrics and gynecology practice involving multiple patients, and resulting in a high risk of patient harm.	Suspension.
Craigg, Gerald B.R. MD00044814 Spokane	Summary Order	8/12/2015	Violation of pain rules and substandard prescribing practices that contributed to patient death.	Restriction from prescribing Schedule II and III narcotics, and Schedule IV controlled substances.
Kammeyer, Ann C. MD00019609 Marysville	Summary Order	9/9/2015	Violation of pain rules, failure to document, and substandard prescribing practices that contributed to patient death.	Suspension.
Formal Actions				
Meline, Lewis J. MD00041815 Spokane	Agreed Order	8/5/2015	Boundary violations and lack of documentation related to treatment of family members and personal associates.	Minimum 3-years oversight, \$2,500 fine, and satisfy terms to address boundaries and ethics issues.
Ng, Yolanda W. MD60150783 (Out of state)	Agreed Order	8/20/2015	Unable to practice with reasonable skill and safety due to misuse of controlled substances.	Indefinite suspension with ability to petition to modify Order after satisfying terms.
Friend, Lena MD60281106 Island	Final Order	8/28/2015	Final Order of Default (failure to respond)	Indefinite suspension.
Warkenthien, Kurt MD060242443 Pierce	Final Order	9/22/2015	Final Order of Default (failure to respond)	Indefinite suspension.
McGuckin, James F. MD00047625 (Out of state)	Agreed Order	10/2/2015	Performed inefficacious treatment to treat CCSVI in MS patients.	Agreement not to perform CCSVI procedure in WA, attend ethics course, \$17,500 fine, re-application of license in lieu of renewal, and refund to cash-paying patients.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Young, Philip A. MD00044851 King	Agreed Order	10/2/2015	Performed facial plastic surgical procedures resulting in serious operative and post-operative complications.	Probation, minimum 5-years oversight, practice restrictions, proctoring evaluation of practice skills, continuing education courses, \$25,000 fine.
Informal Actions				
Amstadter, Stephani J. MD60031114 King	Informal Disposition	8/20/2015	Alleged: Respondent is unable to practice with reasonable skill and safety.	Comply with WPHP monitoring contract, must practice in group setting, and personal appearances.
Hoagland-Scher, John E. MD00023236 Thurston	Informal Disposition	8/20/2015	Alleged: Three and a half years absence from clinical practice raised competency concerns about Respondent's skills.	Minimum 2-years oversight, mentoring by Commission-approved physician, quarterly reports, and personal appearances.
Anderson, Charles T. MD00041818 Lewis	Informal Disposition	8/20/2015	Alleged: Respondent prematurely discharged patient suffering an allergic reaction which caused severe airway constriction that contributed to patient death.	Minimum 2-years oversight with 6-month probation, \$1,000 fine, continuing education courses, paper, and personal appearances.
Martin, Dan H. MD00026455 Pierce	Informal Disposition	9/22/2015	Alleged: Respondent voluntarily resigned hospital privileges and is effectively at the end of his career as a physician.	Voluntary Surrender.
Thibert, Mark A. MD00048052 (Out of state)	Informal Disposition	9/29/2015	Alleged: Failure to review lab results resulted in delay in patient's care.	Develop and submit written protocol addressing lab work results, and \$1,000 fine.
Heithaus, Angela MD00035728 King	Informal Disposition	10/2/2015	Alleged: Respondent attempted to self-prescribe controlled substances.	Paper, \$1,000 fine, and ethics course.
Findlay, Robert F. MD00025190 Pierce	Informal Disposition	10/2/2015	Alleged: Respondent failed to provide differential diagnosis of melanoma and refer patient to oncologist.	Continuing education course, \$1,000 fine, and research paper.

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 Washington Administrative Code (WAC) 246-919-630, Sexual Misconduct related to allopathic physicians, was held November 4, 2015. A quorum of the Commission approved the draft rule language at the hearing. The CR-103 process will begin soon.

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 language at the hearing. The CR-103 process will begin soon.

Safe and Effective Analgesia and Anesthesia

Administration in Office-Based Surgical Settings

The CR-101 to revise WAC 246-919-601(5) was filed on March 11, 2015, Washington State Register (WSR) #15-07-033. The Commission will consider 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 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 were filed to create a new section to establish continuing education and training requirements for suicide assessment, treatment, and management. These rulemakings were filed pursuant to the requirements under Engrossed Substitute House Bill 1424 (Chapter 249, Laws of 2015), that requires 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. The WSR # is 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 March, June and August business meetings, the Commission approved or updated the following policies and guidelines:

Updated Policies

2015-04: Possession and Administration of Naloxone

2015-05: Stipulations to Informal Disposition

Updated Guidelines

2015-06: Ownership of Clinics by Physician Assistants

2015-08: A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety

2015-09: Physician and Physician Assistants' Use of Electronic Medical Records (EMRs)

All Commission policies, guidelines, and interpretive statements are available at <http://go.usa.gov/dG8>, where they can be downloaded in PDF form.

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.

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
January 7-8	Regular Meeting WPHP Report	Puget Sound Educational Service District (PSESD), Blackriver Training & Conference Center 800 Oakesdale Ave SW, Renton, WA 98057-5221
February 11-12	Regular Meeting	Capital Event Center (ESD 113) 6005 Tyee Drive SW, Tumwater, WA 98512
March 31- April 1	Regular Meeting	Skamania Lodge 1131 SW Skamania Lodge Way, Stevenson, WA 98648
May 12-13	Regular Meeting	Puget Sound Educational Service District (PSESD), Blackriver Training & Conference Center 800 Oakesdale Ave. SW, Renton, WA 98057-5221
June 23-24	Regular Meeting	Red Lion Wenatchee 1225 N Wenatchee Ave., Wenatchee, WA 98801
August 11-12	Regular Meeting	Puget Sound Educational Service District (PSESD), Blackriver Training & Conference Center 800 Oakesdale Ave., SW Renton, WA 98057-5221
October 5-7	Educational Conference	TBD
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



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

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

Medical Commission Contact Information

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

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Washington State Medical Commission Newsletter–Winter 2015

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