Medical Quality Assurance Commission
Update!
www.doh.wa.gov/medical
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Message from the Chair

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

It has been my pleasure to serve as the Medical Quality Assurance Commission's Chair for the past two years. It has been an eye opening experience to watch the Commission begin a pilot program and develop into an efficient organization. The work done by the Commission and staff is a great source of pride for me and should be to you, the licensees of Washington State.

I would first like to acknowledge the Commission's many award recipients. Dr. Mimi Pattison, Dr. Bruce Cullen, Dr. Leslie Burger and Dr. Samuel Selinger have all received awards and acclamation from the Federation of State Medical Boards (FSMB).The Administrators in Medicine (AIM) awarded our previous Executive Director, Maryella Jansen, and prior Chief Investigator, James Smith, with lifetime achievement awards in 2013.

In 2014, the Medical Commission received the AIM Best of Boards honorable mention for our social media policy. In 2013 received the Best of Boards award for our pain rules education program. Since 2012, we adopted non-cancer pain management rules that are nationally recognized and established rules that protect the public health, such as non-surgical medical cosmetic procedures and office based surgery. We are one of the first medical boards in the nation to adopt guidelines on social media, telemedicine, and the electronic medical health record (EMHR).

As I complete both my term as Chair and my service on the Commission, I pass the gavel to my successor, Dr. Michelle Terry. She is ready, willing and able to steer the Commission in its ongoing change efforts and protect public health. I wish her the best of luck in future endeavors as Chair and I can leave knowing that the Commission is being led by an extraordinary physician and person.

For those of you who are unfamiliar with my work outside of the Commission, I am a board certified emergency medicine physician. After 15 years at Olympia Emergency Services, I am retiring. As I reflect on my years as a physician, I would like to share the experience I had with my last three patients:

One of my last patients was a young child, suffering from a methadone overdose. The pharmacist filled the prescription with methadone instead of methylphenidate. The child was admitted for a 24

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

hour observation period, and subsequently discharged.

The next patient was an elderly male with renal cell carcinoma, gastric cancer, Chronic Obstructive Pulmonary Disease (COPD), hypertension, and cardiomyopathy presented with multiple automatic implanted cardioverter-defibrillator (AICD) discharges. Despite amiodarone bolus and lidocaine bolus he continued to have multiple appropriate shocks from his AICD. The patient, his wife and his daughter all asked me to turn off his AICD. After a long family conference, I turned off his AICD and he passed peacefully, with his family at his bedside.

The last patient of my career as an emergency physician was a middle aged male with syncope. He was undiagnosed as an alcoholic and suffered from black stools and a bedside ultrasound revealed trace ascites. His initial hematocrit measurement was 15. The patient then "cut loose" with 1,000 cc emesis of blood and clots. I initiated a massive transfusion protocol. I began a protonix and sandostatin bolus and drip. The patient was sedated and intubated. Due to a delay in the arrival of gastroenterologist, I placed a Sengstaken-Blakemore tube. By the time he was scoped, the varices had been tamponaded and there was no active bleeding. The patient is doing well; he has been extubated and was discharged home after an eight unit transfusion.

My last patient could have been a sore throat, a sprained ankle, a follow-up for hypertension, a young girl wondering if she was pregnant, or a "frequent flyer" with a multitude of chronic complaints, but I will always remember my last patient.

At the Medical Commission, we are in the business of protecting the public. At some point in your own medical career, you may find yourself the respondent of a complaint or malpractice claim. You must not let it affect your motivation to continue performing the miraculous acts that we encounter every day. Just as firefighters are willing to risk their lives in burning buildings knowing that no amount of training or equipment can eliminate the potential risks, the same is true for those who respond to medical emergencies, a sick child or an infectious disease. Whether you are practicing pediatrics, family or internal medicine, cardiology or pathology it is your selfless dedication to patient care that makes you heroes. I encourage you to not let a complaint or claim define you or your career. You give far more than I could ever imagine, drawing on extraordinary inner strength and sense of duty.

I encourage all of you, at some point in your career to give back to your profession by service to your community; whether it is to your local health care community or your state commission, serving in underprivileged communities or countries, or for emergency physicians, just serving in "Emergistan" on a daily basis. Serving on the Commission has provided me with an opportunity for professional growth, education and lasting professional relationships. With gratitude for all of the outstanding physicians, physician assistants, nurses, members of the public, and everyone on the medical teams I have had the pleasure of working with, thank you.

Did you know?

You can complete your demographic census for renewal online!

The Commission has been asked to develop demographic data, and we will be asked for the results by State and Federal policy makers, and other interested parties, as they make decisions about the future structure of the medical workforce. We have roughly a 60 percent response rate to our census. Please take a few minutes to fill out the demographic census so the decisions made about your future work environment can be based on accurate data.

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

Executive Director's Report

Melanie de Leon, JD, MPA
Executive Director

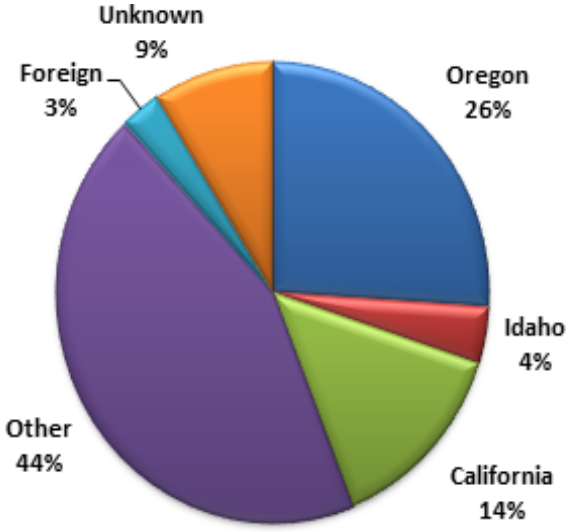
Who are you?

What does the "face" of medicine look like in Washington State? For the past several years, we have been gathering demographic information to find the answer to that question. You may have noticed that when you are completing your renewal, we ask you for some information to give us a better picture of who you are. Of our 30,000 licensees, about 62 percent of you have voluntarily provided us with this information, so the following data reflects almost two-thirds of the state's physicians and physician assistant population.

Physicians

- 67.8 percent of you are male; 32.2 percent female.
- 11 percent are over the age of 70, but the majority of you are between 51-69 years old.
- Over 65 percent of you obtained your medical degree in the U.S., but not in Washington.
- Only 16 percent received a medical degree in Washington. However, over 76 percent of you live in Washington.

For those who don't live in Washington here is where you live:

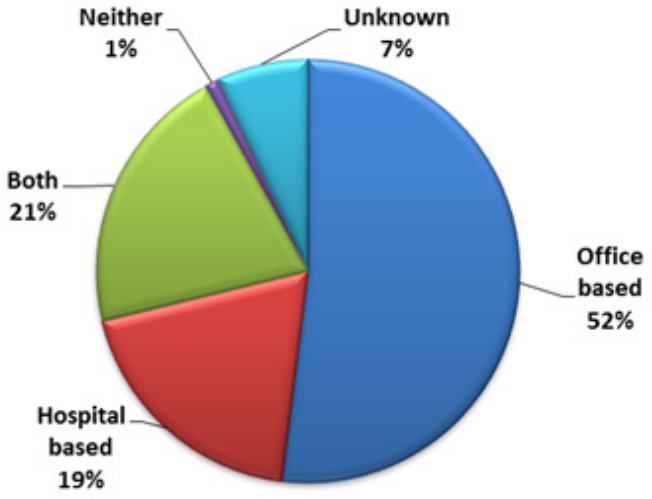


- 90 percent of you are board certified.
- 11.4 percent of you are in solo practice.

Physician Assistants

- 54.2 percent of you are female; 45.8 percent male.
- 2.6 percent are over the age of 70, but the majority of you are between 33-50 years old.
- Only 39 percent of you obtained your physician assistant license in Washington, but 87.5 percent of you live and practice in Washington; the remaining majority live in Idaho or Oregon.

Your clinical practice is primarily:



SAVE THE DATE
September 30th -October 1,2015
DoubleTree, Tukwila

Medical Commission Educational Conference
Free and open to all. More information to come

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

PA News: Applying Old Rules to New Paradigms: Assuring Ethical Practice in Businesses Owned by Non-Physicians.

James Anderson, PA-C
Physician Assistant Member

MDs and PAs face numerous ethical challenges every day in their practice. The ability to avoid ethical pitfalls is built on a foundation of the training that PAs and MDs receive during their education, and the ongoing continuing education process throughout their career. Attention to professionalism and ethical conduct is essential to provide high quality, sensitive, and respectful care to patients. In an average clinical day for a PA or MD, they face a countless array of decision points related to conflict of interest and ethical/professional care. These include billing, documentation, interactions with colleagues and staff, selection of words and phrases to be used when talking with patients, interactions with vendors and the public, dealing with inquiries about patient information, use of social media, and navigating potentially complex decisions about screening, exams and plans of care. All of these are areas where lack of attention to detail and sub-par decision-making can lead to ethical breaches and patient harm. Safe PA-MD practice requires constant vigilance in the ethical and professionalism arena.

As with the above areas of risk, the interactions between PAs and MDs are also a possible area in which ethical and professional lapses can compromise patient care. In rare cases, PAs and MDs work in settings where the PA is the owner of the clinic or business, and the PA employs the supervising physician. There are many areas in the medical and business world where similar dynamics occur, such as when an institution or facility hires an auditor to assess their practices. While the business/facility is the employer in such situations, it would be widely considered to be unethical for the facility to fire an auditor if they did not agree with the feedback. It would be considered to be unethical for a facility to attempt to influence the findings of an auditor or individual.

Most clinics and medical facilities are not owned by either MDs or PAs, but instead by a variety of other businesses and organizations. Such organizations hire physicians and medical directors to lead the medical practice. It would be a conflict of interest and an ethical breach for a facility to dictate medical practice to a medical employee, just as it would be an ethical violation for a PA owner to undermine the decision making authority of an employed supervising physician. Solid grounding in ethical and professional principles is what should prevent such situations from occurring.

Such is the case in the uncommon setting where a PA owns a practice and hires an MD who is then the supervising physician. As with the above areas of risk, such situations require standard ethical and professional principles to assure quality care for patients. The state of Washington's Physician Assistant Delegation Agreement and Standardized Procedures Reference and Guidelines (http://go.usa.gov/39V9G) clearly spells out details and requirements of the partnership between the physician and PA, as do state WAC (http://go.usa.gov/39VXW) and the RCW (http://go.usa.gov/39V53). Ethical practice of PAs and MDs requires knowledge of, adherence to, and compliance with these rules and laws, regardless of ownership. Failure to adhere to these, just as failure to follow ethical and legal standards in the many other situations involving PAs and MDs, risks harm to the public and therefore might be cause for disciplinary action against PAs and MDs.

The current regulations and the state's Uniform Disciplinary Act (http://go.usa.gov/39V5T) provide a solid and comprehensive tool for maintaining accountability of medical providers, their ethical conduct and regulations about PA-MD practice.

In the end, the public deserves the best care from every PA and MD, where the highest ethical and professional standards are maintained, and where those standards are applied to the constantly shifting social and legal landscape. These standards are the best assurances of patients receiving ethical, professional, and evidence-based care, free of conflict of interest, no matter who may own a clinic or facility.

Electronic Health Records

William Gotthold, MD
Congressional District 8

Most physicians are aware of the concept, and the general assumption, that if an exam or a procedure is not documented, it did not occur. The opposite, if an exam or procedure was documented then it was performed, is also generally accepted. The chart is considered to be the final arbiter on what occurred.

With handwritten or dictated records, charting is an active process. Much of the work that is actually performed may not be charted because it does not seem relevant to the final note placed into the chart. The final note, generally has the useful information about the visit, and the next reader could assume the record is as accurate as the patient's provided history and the physician's examination skills could make it. This note usually includes a provisional diagnosis, a treatment plan including the justification in choice of plan, and expected follow-up. An accurate description of the clinical situation, along with future expectations, provides the patient and future doctors with information that enhances patient safety. Some physicians are better than others at creating a clear and accurate chart note, but the idea that it was generally true was accepted.

In the new world of electronic medical records, great emphasis has been placed on the ease of documenting a complete history and examination. Enhanced billing is also a selling point for many vendors. Based on the complaint case records the Medical Commission is reviewing, many visits are recorded as a complete and thorough evaluation of the patient, no matter the reason for the visit. It appears that historical information is often pulled from an old chart without verifying if this information stored in the computer program is still accurate. Templates that document a thorough physical exam can be useful, but only if they reflect the actual exam findings.

If these new record systems are driving physicians to do a complete work up of the patient at every visit, that may be a good thing. If instead, the systems are allowing documentation that is out of date, untrue, or did not occur, there is a significant risk to the patient and physician.

Most important to physicians and patients is the idea that what is in the chart is as true as the physician can make it. If it becomes clear that the documentation is inaccurate because it is driven by templates and automatic completion of various sections, the chart as a record of the encounter, and as a defense against a complaint, will lose its historical position as a true record.

Most physicians have very little influence over the electronic record system that they are given to use, and the difficulties of complex documentation and data entry are well known to the physicians on the Commission. However, physicians still hold the responsibility for making the chart note as true a record of the encounter as possible. This protects the patient at future visits, and maintains the reputation of the chart as evidence of what actually happened.

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**

Could My Patient Have a Tick-Borne Disease? Information for Health Care Practitioners in Washington State

Melissa Kemperman, MPH
Nikki Poulin, MPH
Washington State Department of Health

While most tick-borne diseases are rare in Washington, health care practitioners may encounter cases exposed locally or through travel to other regions. It is important to be aware of diagnosis and treatment aspects. For reported incidences in Washington or nationwide, please refer to http://go.usa.gov/3X7Rw or http://go.usa.gov/3X7Re.

Ticks are medically important disease vectors of Lyme disease (LD) and other tick-borne diseases (TBDs). People exposed to ticks in some Pacific Northwest areas may be at risk for TBDs (Figure 1). This article reviews TBDs of concern in Washington State (WA) (http://go.usa.gov/39VNY) associated with *Ixodes* and *Dermacentor* tick genera: LD, anaplasmosis, babesiosis, and Rocky Mountain spotted fever (RMSF).

Figure 1 Tick- Borne Diseases of Concern in WA	 Ixodes	 Dermacentor	 Rhipicephalus	 Ornithodoros
Lyme Disease	✓			
Anaplasmosis	✓			
Babesiosis	✓			
RMSF		✓	✓	
Tularemia		✓		
TBFR				✓

Images Courtesy of the U.S. CDC and Prevention and WA DOH

Diseases from *Ixodes* Ticks

Ixodes pacificus (Western blacklegged tick) is the Pacific Northwest vector for LD, anaplasmosis, and possibly babesiosis. In WA, *Ixodes* are usually encountered in wooded or brushy areas of western counties and eastern slopes of the Cascades. *Ixodes* ticks are found in all counties of western WA, and the bacteria that cause LD or anaplasmosis have been detected in a small percentage of ticks from nine counties.

LD (http://www.cdc.gov/lyme/) is caused by *Borrelia burgdorferi* bacteria. Early in infection, about three-fourths of patients have an erythema migrans (EM) rash, an expanding, sometimes "bulls-eye" appearing lesion. A small (<5 cm), non-expanding lesion appearing within hours of a bite indicates hypersensitivity to tick saliva, not EM rash. Disseminated infection can cause multiple EM lesions or rheumatologic, nervous system, or cardiac manifestations.

Anaplasmosis (http://www.cdc.gov/anaplasmosis/) and babesiosis (http://go.usa.gov/39VUm) are acute febrile illnesses caused by intracellular pathogens (*Anaplasma phagocytophilum* bacteria, which infect white blood cells, and *Babesia* parasites, which infect red blood cells, respectively). These diseases can be severe and fatal, especially in persons with immune compromise. Both can be acquired through blood transfusion from asymptomatically infected blood donors.

Diseases from *Dermacentor* Ticks

Dermacentor variabilis and *Dermacentor andersoni* (American dog tick, Rocky Mountain wood tick) can transmit the agents of RMSF and tularemia. *Dermacentor* ticks are found in wooded or grassy areas and are especially prevalent in eastern WA. RMSF cases are reported in WA, most of which were exposed out-of-state, but the widespread distribution of *Dermacentor* ticks in WA suggests potential local risk.

RMSF (http://go.usa.gov/39VuV), a potentially severe and fatal disease, is caused by *Rickettsia rickettsii*, which infects endothelial cells lining small blood vessels. Fever is usually followed by a maculopapular rash that starts on extremities and becomes petechial if untreated. RMSF can also be carried by *Rhipicephalus sanguineus* (brown dog ticks), which are notorious for infesting dog kennels or human dwellings.

Tularemia (http://www.cdc.gov/tularemia/index.html) is also endemic to WA and can be acquired in numerous ways, including *Dermacentor* tick bites.

Other TBDs

Tick-borne relapsing fever (TBRF) http://go.usa.gov/35Rx9 is endemic in eastern WA, with greatest risk in high-altitude, tick-infested dwellings. Up to 12 TBRF cases are reported in WA each year.

Diagnosis and Treatment
In addition to laboratory testing, patient history is an important aspect of TBD diagnosis. Detailed information about TBD diagnosis and treatment is available from the U.S. Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/ticks/diseases/.Absence of a known tick bite does not preclude a TBD diagnosis, as many bites are undetected.
Helpful information to gather includes:

- Residence on or near wooded, brushy, or grassy land
- Recent outdoor activities
- Recent travel outside WA
- Contact with tick-infested or outdoor pet
- Recipient of blood transfusion, organ or tissue

Doxycycline is one of the most common antibiotics for anaplasmosis, RMSF, and adults with early localized LD. For suspected RMSF, treatment within first five days of illness is crucial to prevent severe disease and should not be delayed for test results or dental staining concerns. For LD, other antibiotics (e.g., amoxicillin, cefuroxime axetil) may be indicated by patient characteristics or disease stage. Babesiosis is treated with a combination of quinine plus clindamycin or atovaquone plus azithromycin.

Current evidence does not indicate persistence of *B. burgdorferi* after appropriate antibiotic treatment for LD. Post-LD syndrome can occur in some patients treated for objective late manifestations but is likely due to a post-infectious inflammatory response or unrelated process. Long-term or repeated treatment with antibiotics for "chronic LD" is not supported by science-based evidence and can lead to adverse events or missed opportunities for alternate diagnoses.

Public Health Agencies' Roles
For suspected TBD diagnoses in patients exposed within WA, the Department of Health (DOH) encourages practitioners to contact their local health jurisdictions (LHJs) to submit clinical specimens to WA DOH for laboratory confirmation. Most TBDs are notifiable conditions in WA. Prompt reporting to LHJs is crucial to help public health officials assess TBD patterns and inform practitioners and the public of TBD risk.

For More Information
CDC's Tickborne Diseases of the United States:

- Pintable: http://go.usa.gov/39pCB
- iOS App: http://go.usa.gov/39pCw

Infectious Diseases Society of America clinical practice guidelines for LD, anaplasmosis, and babesiosis:

- http://www.idsociety.org/lyme/

WA DOH tick webpage:

- http://go.usa.gov/39prx

Commissioner Spotlight

Alden Roberts, MD (District 3, term expires 06/2018)
On February 20th 2015, Governor Inslee appointed Dr. Alden Roberts to the Medical Commission. A native of Louisiana, he received his MD from Louisiana State University before completing his general surgery residency at the University of Southern California. Dr. Roberts has worked in private practice with the Burbank Surgery Medical Group,Vancouver General Surgeons, Columbia Surgical Group and the Northwest Permanente Primary Care Physicians and Surgeons. In addition to his role as commissioner, Dr. Roberts is the chief medical officer of the PeaceHealth Columbia Network in Vancouver, WA.

2015 Elected Leadership
The Medical Commission has elected a new slate of executive officers. In August, Dr. Michelle Terry will become Chair of the Commission, Dr. Mark Johnson will be the 1st Vice Chair and Dr. Warren Howe will serve as 2nd Vice-Chair.

Michelle Terry, MD, Chair (Physician At Large)
Dr. Michelle Terry is a native of Texas, she earned her BA from Stanford University and her MD from Baylor College. She completed her residency in pediatrics at Seattle Children's Hospital. Presently she is a clinician in the division of Hospital Medicine at Children's. She also holds an appointment at the University of Washington (UW) School of Medicine as a clinical professor. Dr. Terry previously served as a primary care pediatrician at the UW Medicine Neighborhood Clinics. Dr. Terry serves as a medical consultant to the Fostering Well Being Care Coordination Unit within the Department of Social and Heath Services. Dr. Terry is married with three children

Mark Johnson, MD, 1st Vice-Chair (District 1)
Dr. Johnson graduated from Yale University in 1970 and completed his MD from UW in 1974. Dr. Johnson completed his surgical residency at Virginia Mason Hospital, where in his final year he served as Chief Resident. In 1979 he returned to his hometown of Mount Vernon and joined the Skagit Valley Medical Center. Over the next 35 years Dr. Johnson practiced general surgery, served as president of the Medical Center and Surgical Head of the Cancer Committee before retiring in 2014. Dr. Johnson is spending his retirement with his wife of 44 years, 3 children and 6 grandchildren.

Warren B. Howe, MD, 2nd Vice-Chair (District 2)
Dr. Warren Howe is the newly elected 2nd Vice-Chair for the Medical Commission. He received his MD from Washington University in St. Louis. Dr. Howe served as a physician in the U.S. Navy, holding the rank of Lieutenant Commander before entering private practice where he spent 21 years in family medicine. In 1992 he moved to Bellingham and became a team physician at Western Washington University specializing in sports medicine. Semiretired in 2011, he is now enjoying spending his time with his wife and two grown daughters.

WPHP Report: How Common is Provider "Impairment?"

Charles Meredith, MD

Truth be told, no one knows. Despite a lack of definitive data, it has been suspected by many in the field of physician health that somewhere between 1-2% of health providers may meet the definition of "impairment" in the course of a year. Per WAC 246.16.220, the definition of impairment is "inability to practice with reasonable skill and safety due to a mental or physical condition." By law, these events can be reported to the Washington Physicians Health Program in lieu of the Medical Quality Assurance Commission. At WPHP, these events can be addressed confidentially through referral to appropriate treatment and via clinical monitoring, as opposed to via disciplinary action.

The most common illnesses likely to precipitate an episode of provider impairment are probably substance use disorders, major depressive disorder and bipolar mood disorder. It does not appear that recurrent major depressive disorder or bipolar mood disorder are more or less common in physicians than they are in the general public. Prevalence of bipolar mood disorder ranges from 0.8-1.8% in the U.S., whereas twelve month prevalence of major depressive disorder is 7% in the U.S.and lifetime prevalence if experiencing at least a single depressive episode ranges from 12-18%.[1]

Older prevalence data suggested that roughly 2% of physicians in the course of a year met criteria for substance abuse.[2] More recent data indicates this is likely an underestimate in physicians, and no rigorous data is yet available specific to physician assistants. Utilizing multiple validated screening instruments, a recent anonymous survey of the membership of the American College of Surgery revealed that 13.9% of male surgeons in the U.S. and 25.6% of female surgeons in the U.S. had met criteria for either alcohol abuse or alcohol dependence in the prior year.[3] These same investigators replicated this same study design with the membership of the American Medical Association (AMA), and their findings seemed to generalize across specialties.Among the AMA respondents, 12.9% of male physicians and 21.4% of female physicians met diagnostic criteria for alcohol abuse or dependence.[4] In both studies, presence of an alcohol use disorder was positively correlated with screening positive for burnout, screening positive for depression, disclosing a recent bout of suicidal ideation, and increased likelihood of having made a major medical error in the past three months. In the AMA study, it appeared that 2.7% of respondents met criteria for cannabis abuse, and 1.5% disclosed either misuse of prescription opioids or illicit use of opioids.

The medical literature reveals that surgical performance is impaired 90 minutes after intoxication by alcohol,[5] as well as the following day.[6] The effects of cannabis intoxication on physician performance is not well-studied, but older data indicates that a 19mg dose of THC leads to impaired performance in experienced pilots in a flight simulator task twenty four hours after consumption.[7] Furthermore, these pilots were unaware of the substance-induced shortcomings of their performance in the simulator.

While the prevalence of addictive and behavioral illnesses that can cause impairment among physicians and physician assistants is higher than we perhaps originally thought, the clinical literature has also shown that this group has excellent recovery outcomes when participating in supportive monitoring through a physician health program. If you or someone you know is struggling with one of these common illnesses, please consider making a confidential call (1-800-552-7236) to the WPHP to inquire how we can be of assistance.

References

1) American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* Fifth edition. 2013.
2) Hughes et al., Prevalence of Substance Use Among US Physicians. *JAMA*. 1992; 267(17): 2333-2339.
3) Oreskovich et al., Prevalence of Alcohol Use Disorders Among American Surgeons. *Archives of Surgery*. 2012; 147(2): 168-174.
4) Oreskovich et al., The Prevalence of Substance Use Disorders in American Physicians. *American Journal on Addictions.* 2015; 24(1): 30-38.
5) Dorafshar et al., Effects of a Moderate Dose of Alcohol on Simulated Laparoscopic Surgical Performance. *Surgical Endoscopy.* 2002; 16: 1753-1758.
6) Gallagher et al., Persistent Next-Day Effects of Excessive Alcohol Consumption on Laparoscopic Surgical Performance. *Archives of Surgery.* 2011; 146(4): 419-426.
7) Yesavage et al., Carry-over Effects of Marijuana Intoxication on Aircraft-Pilot Performance: A Preliminary Report. *American Journal of Psychiatry.* 1985; 142(11): 1325-1329.

Legal Actions

February 1, 2015 – April 30, 2015

Below are summaries of interim suspensions and final actions taken by the Commission last quarter. Statements of Charges, Notices of Decision on Application, Modifications to Orders and Termination Orders are not listed. We encourage you to read the legal document for a description of the issues and findings. All legal actions are updated quarterly and can be found with definitions on the Commission website: http://go.usa.gov/bkNH

Practitioner	Type of Action	Date	Cause of Action	Commission Action
Formal Actions				
Thomas, John G. (MD00030424) Chelan County	Default Order	2/13/15	Sexual misconduct with patients, drug diversion for personal use from hospital, self-prescribing of controlled substances.	Indefinite Revocation
Wyttenbach, William H. (MD00024626) Florida	Default Order	2/13/15	Actions in other states based upon inadequate performance as a pain clinic's medical director, failure to self-report to MQAC.	Indefinite Suspension
Cahill, Deborah (MD00022279) King County	Agreed Order	3/26/15	Unable to practice with reasonable skill and safety.	Indefinite Suspension
Ross, Timothy R. (MD00019932) Clark County	Default Order	3/26/15	Surrender of Oregon license, surrender of DEA registration, convictions of failing to record dispensing of hydrocodone, failure to self-report to MQAC.	Indefinite Suspension
Informal Actions				
Privette Hackney, Katie N. (PA10004637) Thurston County	Stipulation to Informal Disposition	2/13/15	Alleged: substandard interpretation of an EKG, insufficient documentation of consult, failure to recognize need for immediate care.	Continuing education, personal appearance, 2 years of monitoring, $750 reimbursement, 2,000 word paper on the evaluation and management of unstable angina/ acute coronary syndrome.
Baker, Donald A. (MD00017954) Idaho	Stipulation to Informal Disposition	3/26/15	Alleged: License surrender in Idaho	Surrender of License
Oliver, David A. (MD00039475) Skagit County	Stipulation to Informal Disposition	3/26/15	Alleged: Unable to treat patients with reasonable skill and safety.	Restricted to performing physical examinations within the VA in preparation for disability ratings
Lee, Chee Y. (MD60334244) Florida	Stipulation to Informal Disposition	3/26/15	Alleged: Reprimand in Florida, falsified a prescription for his own use.	Course work; $1000 reimbursement. 1,000 word paper on diversion of prescription medication, compliance with Florida Board's requirements.

Goyal, Maheep (MD00044152) Pennsylvania	Stipulation to Informal Disposition	3/26/15	Alleged: Misread of CT study, failure to diagnose a calcified mass in the appendix with surrounding inflammation.	$800 costs; develop peer review plan for diagnostic radiologist to over read abdominal and non-abdominal pelvic CT scans, review interpretive reports, and report in writing to MQAC.
Burke, John T. (MD00021209) Skagit County	Stipulation to Informal Disposition	3/26/15	Alleged: Missed detection of a cerebellar abnormality in a CT can.	$1000 costs; develop peer review plan for diagnostic radiologist to over read CT head scans and report in writing to MQAC.
Bunin, Alan (MD00010954) King County	Stipulation to Informal Disposition	2/12/15	Alleged: Illegible, incomplete, and unstructured approach to medical charting.	Probation; will use electronic, accurate, adequate and structured charting; $2000 costs, practice reviews, compliance appearances.
Moreau, Louis G. (MD00044584) Hawaii	Stipulation to Informal Disposition	2/12/15	Alleged: Inadvertent injury to an artery while performing a laparoscopic adrenalectomy, causing loss of a kidney.	$1,000 costs, scope of practice limited to non-surgical out of state practice.
Midence, Gerardo (MD00042019) Idaho	Stipulation to Informal Disposition	2/12/15	Alleged: Under discipline with the Idaho Medical Board for inappropriate touching of a teenager.	Probation; professional boundaries course; no solo practice; submit to polygraph examination every six months; participate in therapy. Quarterly status reports to MQAC, additional restrictions if respondent practices in WA.
Starritt, Rita E. (MD60284812) California	Stipulation to Informal Disposition	2/12/15	Alleged: Disciplined in Colorado for sub-standard care and charting, and noncompliance with laws relating to medical marijuana.	Restricted from signing medical marijuana authorizations in WA.

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
The first stakeholder workshop regarding WAC 246-919-630, Sexual Misconduct related to allopathic physicians, was held on January 7, 2015. The draft language was presented for discussion. The final draft language was presented and approved at the Commission's February 13, 2015 Business Meeting. The drafting of the CR-102 is in process.

Sexual Misconduct – Allopathic Physician Assistants
The CR-101 to revise the Sexual Misconduct rule (WAC 246-918-410) was filed on April 22, 2015 (Washington State Register (WSR) #15-09-139). The Commission is considering updating the sexual misconduct rule to establish clearer standards of conduct for allopathic physician assistants. The Commission's experience with investigating and enforcing the current rule has raised the need to clarify what acts constitute sexual misconduct by allopathic physician assistants under the Commission's authority. Updating the sexual misconduct rule will establish clearer standards of conduct and will help the Commission be consistent in its enforcement activities to more fully comply with RCW 18.130.062 and Executive Order 06-03.

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 (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 Commission may also add an appeals process. The proposed rule will allow the Commission flexibility in a rapidly-changing landscape to add or delete entities from a list maintained by the Commission using the criteria rather than using the rule making process. A stakeholder workshop was held on March 25, 2015. The draft language for this rule is in process. Additional stakeholder workshops will be held in the near future.

Medical Commission Vital Statistics

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

Actions in Fiscal 2014

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

Medical Commission Meetings 2015

Date	Activity	Location
June 25-26	Regular Meeting	Davenport Hotel 10 S. Post Street Spokane, WA 99201
August 20-21	Regular Meeting	The Heathman Lodge 7801 NE Greenwood Drive Vancouver, WA 98662
Sept. 30-Oct. 2	Educational Conference	DoubleTree Southcenter 16500 Southcenter Pkwy Tukwila, WA 98188
November 5-6	Regular Meeting	Puget Sound Educational Service District (PSESD), 800 Oakesdale Ave SW Renton, WA 98057-5221

All Medical Commission meetings are open to the public

Other Meetings

Washington State Medical Association (WSMA)	Annual Meeting Sept. 26-27 2015	Spokane, WA

Washington State Department of Health

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

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

Medical Commission Contact Information

Applications:	A–L	360-236-2765
	M–Z	360-236-2767
Renewals:		360-236-2768
Complaints:		360-236-2762
		medical.complaints@doh.wa.gov
Complaint Form:		http://go.usa.gov/dGT
Legal Actions:		http://go.usa.gov/DKQP
Compliance:		360-236-2781
Investigations:		360-236-2759
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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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