Message from the Chair

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

Greetings from the Medical Commission in this fast-paced Washington spring.

I am pleased to share with you that two notable Commission members will receive national awards from the Federation of State Medical Boards at the annual meeting in April. Former Commissioner Ellen Harder, PA-C, is receiving posthumously the lifetime achievement award for her years of service and foundational efforts contributed to the physician assistant profession. Her son John will accept the award on her behalf. Current Commissioner and past Chair Maj. Gen. Leslie Burger, MD will receive the John H. Clark leadership award for his numerous contributions and leadership in the field of medicine, licensure, regulation, and overall improvement in the profession of medicine. If any of you served in the military and were based at Madigan, in the VA, or on the east coast in the past 30 years, there is a good chance Dr. Burger was responsible for your health.

You may remember that past Chair Samuel Selinger, MD received this same award from FSMB in 2011 at the annual meeting in Seattle. We are pleased to be blessed with Commissioners, both past and present, of such caliber to receive national recognition from their peers. We can only hope to continue this tradition of excellence with your help. The Commission is currently recruiting for members to fill retiring Commissioner positions. We need high quality physicians, physician assistants, and public members to perform the work of protecting the public and enhancing the integrity of the profession. Please take a moment and consider serving. We are especially looking to fill needs in orthopedics, anesthesiology, and obstetrics/gynecology.

Continued on page 2

NOTICE OF RECRUITMENT

The Department of Health (DOH) is currently accepting applications to fill upcoming vacancies on the Medical Commission. 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 3
- One physician representing Congressional District 5
- One physician representing Congressional District 9
- One physician assistant member at Large
- Three public members at Large

To determine what congressional district you live in, please visit: http://www.redistricting.wa.gov/DistrictFinder/

Additional information regarding commission membership and a link to the governor's application: http://go.usa.gov/dFP. Applications, along with a current resume must be received by March 31, 2014.

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Mission

Promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rule making, and education.
The legislative session is winding down and by most accounts, this short session is relatively quiet. We look forward to further building relationships with members of the legislature from all parties in preparation for future legislative sessions and collaborative policy endeavors. One effort is updating licensure requirements for physicians; it has been several decades since they were updated. Part of the effort is to move the requirements to rule from statute. This will allow the Commission to update the licensure requirements as medical training for physicians improves.

We are pleased to be collaborating with the Department of Health on a possible quality improvement project for all professions. We are also working with the Department on a workgroup to facilitate practitioner surging in times of disaster. We recognize that for full and hesitation-free participation in these situations by physicians and physician assistants, the topic of indemnity must be sufficiently addressed.

I would like to take this opportunity to thank the members and staff of the Washington State Medical Association. In the time since I assumed the role as Chair, we have seen the growth of collaboration and relationship building between the Commission and the Association in the areas of legislation, promotion of policies, and a general increase in collegial relations. I know not all medical boards share this experience and I thank WSMA for their efforts to maintain the productive relationship.

Finally, I am pleased to announce that the Commission approved its guidelines for Professionalism and Electronic Media in non-clinical interactions. You can read the brief in this newsletter and the full guideline on the policy page of our website. The Commission is nearing completion of its policy relating to Telemedicine and we anticipate considering its adoption at the April business meeting. Once that is complete, the Commission Policy Committee will turn its attention to the subject of electronic medical records (EMR). We all agree that great efficiencies can be found in the appropriate use of EMRs, but only if it is clinically meaningful for the care of the patient. I am sure there will be much discussion around this subject in the coming year. I hope you will choose to participate by joining our listserv for updates, attending policy meetings to provide input, or applying to serve on the Commission as a representative of your profession.

Executive Director’s Report

Maryella E. Jansen
Executive Director

Responding to Patient Requests for Medical Records

Each week the Medical Commission reviews as many as 50 complaints from patients. Frequently, complaints to the Commission can be prevented. One way to keep patients from filing complaints with the Commission is to respond promptly to record requests. (15 working days RCW 70.02.080)

Am I required to respond to record requests?
Yes, the state Health Care Information Act gives patients, with few exceptions, the right to examine and copy their medical and billing records. RCW 70.02.030.

Can I deny a record request?
Yes, under certain limited circumstances, you can deny a request. You can, for example, deny a request when you reasonably conclude that knowledge of the health care information would be injurious to the health of the patient, or could be reasonably expected to cause danger to the life or safety on an individual. If you deny a request, you must segregate the health care information for which access is denied from information for which access cannot be denied and permit the patient to examine and copy the disclosable information. RCW 70.02.090(1).

Can I charge the patient for copying and mailing the records?
Yes, you may charge the patient up to $1.09 per page for the first thirty pages and eighty-two cents per page for all other pages. You may also charge a clerical fee of $24 for searching and handling. If you personally edit confidential information in the record, as required by statute, you can charge the usual fee for a basic office visit. Remember, you cannot deny a patient a copy of his/her records because the patient has not paid for the services received.

Can a patient ask me to correct the medical or billing record?
Yes, a patient may request in writing that you correct or amend the medical record. Within ten days of the request, you must either (1) make the correction or amendment; (2) inform the patient that the record no longer exists; (3) if you no longer maintain the record, provide the patient with the name and address of the person who maintains the record; or (4) inform the patient in writing of your refusal to correct or amend the record as requested and the patient’s right to add a statement of disagreement to the record. RCW 70.02.100.
**Coursework on Long-Acting Opioids Strongly Recommended for Prescribers**

**Jim McLaughlin, JD**  
**Staff Attorney**

The pain rules specify that “[l]ong-acting opioids, including methadone, should only be prescribed by a physician who is familiar with [the] risks and use” of these medications. WAC 246-919-858. In this section, the Commission recommends at least four hours of continuing medical education related to the prescribing of long-acting opioids.

The Medical Commission’s pain rules, found at WAC 246-919-850 through 863, were created in direct response to the dramatic increase in recent years in the number of deaths and hospital admissions related to prescription opioids. The rules recognize a particular danger and need for education associated with the prescription of long-acting (LA) opioids. This is consistent with the FDA’s focus on long-acting and extended release opioids in their Risk Evaluation and Mitigation Strategy (REMS). According to the FDA, long-acting/extended release (LA/ER) opioids have clearly emerged as the medications with the highest potential for harm, misuse, and abuse.

The Commission expressly mentions methadone in the rule because of its complicated pharmacology and the impact it has had during this epidemic. In the years preceding the pain rules, methadone constitutes a significant percentage of opioid-related deaths in the state of Washington, while comprising a relatively small percentage of the opioids prescribed. This medication has proved particularly dangerous when converting a patient from another opioid to methadone and vice versa.

One component of the FDA’s REMS requires opioid manufacturers to make training regarding LA/ER opioids available to prescribers at little or no cost. Initial information received by the Commission indicates that REMS courses offered in Washington have been sparsely attended. The Commission has also developed four hours of free online CME, one component of which addresses long-acting opioids, including methadone.

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1 The term “long-acting” (LA) is sometimes used to refer to medications, such as methadone, with a long half-life, and the term “extended release” (ER) to refer to the form of delivery designed to release the active medication over time, such as in OxyContin and MS Contin. The rules use the term long-acting to refer to both methods of achieving long-term pain relief.

That course and other resources are found at [http://go.usa.gov/jZUT](http://go.usa.gov/jZUT). The participation numbers for the Commission’s online course have been stronger than the REMS courses.

The Commission’s concern, communicated in the rules’ recommendation of specific education on long-term opioids, remains. This article is intended to serve as a reminder of the importance of being familiar with these medications before prescribing and the Commission’s strong recommendation that prescribers take at least four hours of related CME as a tool for developing familiarity.

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**Save the Date!**

**Commission Educational Conference**

**October 1-2, 2014 in Tumwater, WA**

[http://go.usa.gov/jZUT](http://go.usa.gov/jZUT)

**PA NEWS**

**Theresa M. Schimmels, PA-C**  
**Physician Assistant**

**Let’s Talk Rule Changes!**

Did you know the Commission is updating your current physician assistant rules? As a practicing PA in WA, you should know a new law passed in 2013 (HB 1737) which has allowed us to open and update the Commission rules pertaining to PA practice. Do you even know what PA Rules are?

The Department of Health Medical Quality Assurance Commission (MQAC) writes rules for healthcare practices. These rules establish guidelines and interpretation of the laws passed by our state legislature. The laws consist of definitions such as:

RCW 18.71A.010 (1) “Physician assistant” means a person who is licensed by the commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services.

*PA News continued on page 4*
A Conflict of Interest

A 56-year-old woman visited a physician's office because she was experiencing abdominal discomfort and right upper quadrant pain. In the course of his evaluation of the patient the physician decided the patient should have a complete blood count and a routine “metabolic panel.” He wrote the order and referred her to the laboratory in his office building. The patient's laboratory values were returned as normal and her symptoms eventually resolved. However, she subsequently learned that the cost of her laboratory tests was approximately three times higher than charged in other laboratories in her community, and that the physician was a majority owner of the laboratory to which he referred the patient. The patient filed a complaint with the Commission.

Ordinarily the Commission does not investigate issues involving patient billing, but in this instance an investigation was instituted because there was concern the physician was guilty of unprofessional conduct.

Most physicians are aware of the general prohibition on “rebates” for referrals. The law (RCW 19.68) dates to 1949. The main provision on prohibiting rebates (RCW 19.68.010(1)) forbids (among others) physicians from paying anything of value in return for a referral AND prohibits physicians from receiving anything of value in return for referring patients. The law could be read to prohibit a variety of relationships between physicians and entities such as hospitals, surgery centers, radiology facilities, and laboratories, where a referring physician who refers a patient to that facility may derive an indirect financial benefit. And attorneys on either side of a particular issue that could fall under the statute could spend substantial time and money arguing an interpretation favorable to their clients.

Fortunately, with respect to the patient's complaint above, there is clarity on what physicians can or cannot do when they have an ownership interest in a laboratory. If physicians choose to refer their patients to a laboratory for blood, urine tests, etc., in which the physician has any financial interest, the physician must: 1) disclose to the patient, in writing, the fact that the physician has a financial interest in the laboratory; 2) provide the patient with a list of appropriate alternate facilities; 3) inform the patient that he/she has the option to use such alternate facilities.
facilities; AND 4) assure the patient he/she will not be treated differently by the physician if the patient chooses one of the alternate facilities. Failure to comply with these requirements could have criminal consequences, as violation of the general anti-rebate law, specifically with regard to laboratories, is a misdemeanor.

From the Commission's point of view, regardless of whether there is a criminal prosecution, prudence would dictate that a physician who has a financial interest in a laboratory provide his/her patients with a clear, large-type (i.e. not buried at the bottom of a form), meaningful disclosure satisfying all the requirements of the statute. Even for a rural practice, the physician needs to come up with a list of alternatives which provide a meaningful choice for the patient given the unique nature of the tests ordered for a specific patient. For example, unless there is a critical time-sensitive need for the results, the rural physician does not want to be in the position of (in effect) telling the patient: "I need the blood work tomorrow. There is a laboratory across the street of which I own a 30% interest. The next closest laboratory is 40 miles away. And, by the way, your bill from my lab will be $500 and the one 40 miles away will bill you $150." For each type of physician practice, and in each geographic location, there may be real factors that limit choice of laboratories for patients, but in the end, common sense will go a long way should the physician come under scrutiny by the Commission.

The physician in the above case was offered, and signed, a Stipulation to Informal Disposition which stated that he could avoid being formally charged with a violation of the RCW by having his license placed on temporary probation, by agreeing in the future to comply with the law regarding laboratory ownership as outlined above, by making a presentation to his physician colleagues about lessons learned, and by paying a fine.

**Did you know?**

*You can complete your demographic census for renewal online!*

*Try it now: [http://go.usa.gov/2pkm](http://go.usa.gov/2pkm)*

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**NOTICE OF RECRUITEMENT**

**February 2014**

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 3
- One physician representing Congressional District 5
- One physician representing Congressional District 9
- One physician assistant member at Large
- Three public members at Large

To determine what congressional district you live in, please visit [this web site](http://www.redistricting.wa.gov/DistrictFinder/).

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: [http://go.usa.gov/dFP](http://go.usa.gov/dFP).

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 **March 31, 2014**.

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.
**Commissioner Spotlight**

**New Appointments**
The Medical Commission welcomes our newest members and reappointments from the Governor in November 2013.

**William M. Brueggemann Jr., MD**
Governor Inslee appointed Dr. William ‘Marty’ Brueggemann, Jr. to the Medical Commission in November 2013, representing the Fourth Congressional District. Dr. Brueggemann is a graduate of Western Washington University where he earned a B.S. in Human Biology, and the Medical College of Wisconsin. He is board certified in Emergency Medicine, and has worked at Yakima Valley Memorial Hospital for almost a decade. He was Medical Staff Vice President for the year 2013 and is serving as Chief of Staff for 2014.

Dr. Brueggemann is a very active individual, who enjoys almost any outdoor activity. His hobbies include skiing, scuba diving and competing in marathons and triathlons both at home and abroad. Fly fishing is his biggest passion, and it is one of the reasons he chose to work in Yakima. He is married and has three young children.

**Charlotte W. Lewis, MD**
Governor Inslee appointed Dr. Charlotte Lewis to the Medical Commission in November 2013, representing the Seventh Congressional District. Charlotte earned a B.S. in Nutrition Science from UC Davis, and went on to earn a M.S. in Clinical Nutrition from Cornell. She earned her medical degree from the University of California and her MPH at the University of Washington. After completing her residency at Harbor-UCLA Medical Center, she became board certified in Pediatrics.

Dr. Lewis works as a pediatrician at Seattle Children’s Hospital where she served as co-chair of the work-life balance committee for the last five years. Additionally, she is a faculty member and clinical scholar at the University of Washington School of Medicine. Dr. Lewis co-authored numerous publications and gives presentations related to pediatric dental care. She served as a reviewer for several medical journals, and holds teaching positions in pediatrics and dentistry at the University of Washington. She has two young children.

**Mark L. Johnson, MD**
Governor Inslee reappointed Dr. Mark Johnson to the Medical Commission to represent the First Congressional District. His term expires in June 2017.

**Michael M. Concannon, JD**
Governor Inslee reappointed Mr. Michael Concannon to the Medical Commission as a public member. His term expires in June 2017.

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**Commission Policy Reminder**

**MD2013-03 Self-Treatment or Treatment of Immediate family members**
In the past several months the Commission issued legal actions against providers relating to the medical treatment of immediate family members. These actions prompted several requests for clarification from licensees on the stance of the Commission relating to these issues. The Commission reauthorized a policy relating to self-treatment or treatment of immediate family members. The policy supersedes a policy adopted in MD2008-02 and is taken largely from the statement of the American Medical Association, E-8.19 Self-Treatment of Immediatly Family Members.

The Commission’s position is professional objectivity may be compromised when an immediate family member or the practitioner is the patient; the practitioner’s personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Practitioners should be aware that RCW 18.130.180 (6) prohibits a practitioner from prescribing controlled substances to him or herself.

The Commission strongly discourages prescribing controlled substances to family members. We encourage you to read the policy in its entirety to fully understand the concerns of the Commission in this area: [http://go.usa.gov/BnqY](http://go.usa.gov/BnqY)
The WPHP Report

By Charles Meredith, MD
Medical Director

Distressed Physicians and Disruptive Behaviors

The practice of medicine has been and will always be a very stressful task, particularly in the current, changing regulatory and economic landscape. When distressed, physicians can react in many different ways. In recent years, disruptive physician behavior, including acts of verbal abuse or intimidation, has come under increased scrutiny. Such behavior can be a single unusual event, or a recurrent reaction to feeling overwhelmed.

In medicine, the problem of physicians acting out in disruptive and abusive ways, primarily to ancillary staff, is not new. Hollywood has capitalized on this stereotype, whether it be ER, St. Elsewhere, or any other television medical drama. However, this stereotypical behavior does truly occur throughout our profession. In fact, in July 2008 the Joint Commission issued a sentinel event alert regarding physicians who engage in intimidating and/or disruptive behaviors.

The Joint Commission noted that such behaviors can create an environment of fear, discourage open communication among a healthcare team, greatly increase the likelihood of preventable errors and adverse outcomes, and increase patient dissatisfaction. The Joint Commission mandated that all healthcare organizations and hospitals implement a behavioral code of conduct by January 1, 2009. The hospital/organization code of conduct should define acceptable and disruptive and inappropriate behavior and establish a process for responding to and managing inappropriate behavior when it occurs. [The Commission has a policy addressing these issues: http://go.usa.gov/KbhF.-Ed.]

The Washington Physicians Health Program (WPHP) has taken many referrals for disruptive physician behavior since the Joint Commission’s requirements took effect. We encourage organizations to manage such behaviors internally when they first occur, through supportive but firm discussion. The goal of such a discussion is to explicitly communicate that such behaviors are not tolerated in the organization, to outline the consequences that will ensue if the behavior is not extinguished, and to offer resources for support for a provider who has acted out of character due to a recent increase in distress.

It is our experience at WPHP that during very stressful situations, many physicians are capable of unprofessional behavior such as yelling, arguing with other staff, or slamming objects. The majority of these same physicians are also embarrassed and remorseful after these outbursts, and with firm guidance, they do not happen again. If such behavior recurs, we recommend a more formal conversation with several members of hospital/organization leadership and a supportive physician mentor. During this meeting, it should be made clear that recurrence of such behavior would indicate the presence of a problematic pattern of misbehavior, rather than one or two uncharacteristic reactions.

If a pattern of recurrent disruptive behavior is established through another behavioral outburst, WPHP can be a valuable resource for these individuals. While some individuals may lack insight into their role in these events, we often see that individuals with a high level of narcissistic or obsessive-compulsive personality traits can be prone to high levels of anxiety in situations of uncertainty. Often, they may overreact and lash out at those around them. While such reactions create fear and distrust throughout the healthcare team, they help alleviate the anxiety of the distressed physician leader. Of course these behaviors cannot be allowed to continue and a provider who does not successfully modify their behavior may face a report to the Medical Quality Assurance Commission, loss of hospital privileges, or loss of employment. Ironically, these narcissistic and obsessive-compulsive personality traits can be an asset in the practice of medicine, providing a physician with confidence and making him or her detail oriented.

A referral to WPHP is most appropriate when a true pattern of recurrent disruptive behavior has been established in a physician. If the next step involves significant disciplinary action, such as loss of hospital privileges or a report to the MQAC, an aggressive behavior modification plan through WPHP can be highly effective. At this point, the hospital/organization has separated out the providers who can modify their behavior without assistance from those providers unable and/or unwilling to do so. Over the past several years, we’ve acquired significant experience working with skilled therapists and behavioral coaches to help such physicians develop the communication and coping skills necessary to preserve their careers and better control their emotional reactions when distressed. Feel free to contact our Medical Director at any time at (800) 552-7236 for more information on our services in this area.
Commission Guideline Introduction

**MD2014-02: Professionalism and Electronic Media**

The Medical Commission monitored the rise of social media usage by health professionals in recent years. While the rise of institution-based policies is encouraging, to a large extent they do not address a key usage segment: the non-clinical interaction of patient and practitioner. The rise of social media usage in society at large and increasing connectivity of medical practice challenged the Commission to re-examine the issue of professionalism, boundaries, and non-clinical interactions.

Practitioners have historically had the benefit of filters in their communications with or regarding patients. An author could intercept a letter mailed to the editor prior to printing; Ascertaining the location of a patient required an address, a map, and knowledge of geography; Researching the background of a patient was a task given to law enforcement, not a search engine or a social networking site. Finally, the practitioner had the benefit of time and single copies of communication to act as an outside editor. Perhaps that is the greatest change in this communication evolution: the required understanding that everyone must develop their internal Editorial Board and use it effectively. This concept is made more complex in that professionals of all classes are held to the higher standard of professionalism, with medical professionals held to that highest of standards: First, do no harm.

We understand that the technologies and methodologies will evolve along with the social acceptability of each media resource. While we are seeing mass adoption of Facebook by one demographic, we simultaneously observe a mass exodus by a younger subset. Society as a whole is trying to determine if it will accept early adopters testing wearable technology whose only logical conclusion is implants. The Commission is not attempting to pass judgment on any particular electronic media channel. Instead, we encourage you to take moment and ask:

- If what you are doing is clinically relevant;
- If you serve the patient-practitioner relationship better by simply sitting down and talking to the patient personally.

The Commission determined that the six cautions and following core principles are enough to provide basic guidance to practitioners in the realm of non-clinical interactions using electronic media, with the goal of keeping their professionalism intact. We encourage you to read the full guideline and make use of the included bibliography: [http://go.usa.gov/BnTh](http://go.usa.gov/BnTh)

**Six Cautions**

Don’t lie; Don’t pry; Don’t steal; Don’t reveal; Don’t cheat; Can’t delete.

**Core Principles**

- First, do no harm;
- Place your patients’ interests above your own;
- Always adhere to the same principles of professionalism online as offline;
- Maintain professional boundaries at all times;
- Do not misuse information gained through the physician-patient relationship or from patient records;
- Do not do anything which you would hesitate to note in a patient’s chart or to explain to patients, their family members, your colleagues, the news media, or your medical review board.

**Did you know?**

You can check the status of any license holder in the state of Washington? You can also view the legal documents if the license has disciplinary action.

Try it now: [http://go.usa.gov/VDT](http://go.usa.gov/VDT)
**Legal Actions**

**November 1, 2013 - January 31, 2014**

Below are summaries of interim suspensions and final actions taken by the Commission last quarter. Statements of Charges, Notices of Decision on Application, Modifications to Orders and Termination Orders are not listed. We encourage you to read the linked opinion 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/DKQP](http://go.usa.gov/DKQP)

<table>
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<tr>
<th>Practitioner</th>
<th>Action</th>
<th>Date</th>
<th>Cause of Action</th>
<th>Commission Action</th>
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<tbody>
<tr>
<td>Clark, James E., MD</td>
<td>Agreed Order</td>
<td>11/14/13</td>
<td>The Respondent failed to comply with a STID when he violated a contract with the Washington Physicians Health Program (WPHP).</td>
<td>Indefinite probation; Respondent must maintain compliance with his WPHP contract; $2000 fine; compliance appearances.</td>
</tr>
<tr>
<td>(MD00030484) King County</td>
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<tr>
<td>Cohen, Mitchell L., MD</td>
<td>Final Order</td>
<td>1/20/14</td>
<td>The Respondent conducted an Internet search of a patient for non-clinical reasons three days post diagnostic procedure.</td>
<td>Ethics course.</td>
</tr>
<tr>
<td>(MD00028854) King County</td>
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<tr>
<td>Dienst, William L., MD</td>
<td>Agreed Order</td>
<td>11/20/13</td>
<td>Police and administrative staff found Respondent smoking marijuana in his call room at the hospital. He was the only physician on duty.</td>
<td>Five-year probation; contract with WPHP; $2000 fine; practice reviews; medical recordkeeping course; compliance appearances.</td>
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<tr>
<td>(MD00025927) Okanogan County</td>
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<tr>
<td>Hong, Kenneth, MD</td>
<td>Agreed Order</td>
<td>11/14/13</td>
<td>The Respondent’s medical management of and medical recordkeeping for his patients were inadequate.</td>
<td>Five-year probation; censure; medical record-keeping and prescribing courses; $14,000 fine; practice reviews; compliance appearances.</td>
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<tr>
<td>(MD00016461) King County</td>
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<tr>
<td>Lanzer, William L., MD</td>
<td>Agreed Order</td>
<td>11/14/13</td>
<td>The Respondent failed to comply with a prior order by violating his monitoring contract with the WPHP.</td>
<td>Surrender of license.</td>
</tr>
<tr>
<td>(MD00022061) King County</td>
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<tr>
<td>Perry, John C., MD</td>
<td>Agreed Order</td>
<td>1/10/14</td>
<td>The Respondent is unsafe to practice due to a mental condition.</td>
<td>License suspended indefinitely.</td>
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<tr>
<td>(MD00025747) Franklin County</td>
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</tr>
<tr>
<td>Ram, Pushpa S., MD</td>
<td>Final Order</td>
<td>1/28/14</td>
<td>The Respondent is unsafe to practice due to a physical and mental condition.</td>
<td>License revoked.</td>
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<tr>
<td>(MD00023159) Spokane County</td>
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<tr>
<td>Smith, Timothy J., MD</td>
<td>Agreed Order</td>
<td>1/29/14</td>
<td>The Respondent used methamphetamine.</td>
<td>Surrender of license.</td>
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<td>(MD00018800) King County</td>
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<tr>
<th>Informal Actions</th>
<th>Disposition</th>
<th>Date</th>
<th>Alleged</th>
<th>Order Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhuta, Amar V., MD (MD00043839)</td>
<td>Informal Disposition</td>
<td>11/14/13</td>
<td>Respondent's charting was substantially delinquent, sometimes for months.</td>
<td>Two-year probation; WPHP evaluation; medical recordkeeping course; practice reviews; $1000 costs; compliance appearances.</td>
</tr>
<tr>
<td>Butler, Michael J., MD (MD00017240)</td>
<td>Informal Disposition</td>
<td>1/9/14</td>
<td>Respondent mismanaged the chronic pain of two patients, and breached physician-patient boundaries by hugging and kissing one of those patients.</td>
<td>Four-year probation; psychological evaluation; chaperone for female patients; restriction against managing chronic, non-cancer pain; CME in opioid prescribing; $1000 costs; practice reviews.</td>
</tr>
<tr>
<td>Finkleman, Lowel C., MD (MD00017086)</td>
<td>Informal Disposition</td>
<td>11/14/13</td>
<td>Respondent's recordkeeping was below the standard.</td>
<td>Prescribing course; record-keeping requirements; cannot supervise more than one PA; $1000 in costs; practice reviews.</td>
</tr>
<tr>
<td>Moore, Kenneth, PA (PA10003031)</td>
<td>Informal Disposition</td>
<td>1/9/14</td>
<td>Alleged: Respondent allegedly failed to understand the rapidity that ulcerative colitis could progress into sepsis while treating a patient in a clinical team care environment.</td>
<td>CME in diagnosis and management of sepsis, colitis, necrotizing fasciitis; paper on CME; paper on teamwork in co-managed patient care setting; practice group presentation; $750 costs; compliance appearances.</td>
</tr>
<tr>
<td>Shultis, Michael, PA (PA60205742)</td>
<td>Informal Disposition</td>
<td>1/9/14</td>
<td>Respondent requested and received controlled substances from physician assistant coworkers without examination or documentation. Respondent also acknowledged that he used marijuana.</td>
<td>Probation; comply with WPHP; no remote site practice; $1000 costs; compliance appearances.</td>
</tr>
<tr>
<td>Schulze, Paula, MD (MD00021853)</td>
<td>Informal Disposition</td>
<td>1/9/14</td>
<td>Alleged: Respondent is physically disabled and unable to practice medicine for the foreseeable future.</td>
<td>Will not renew medical license.</td>
</tr>
</tbody>
</table>

**Stipulated Findings of Fact, Conclusions of Law and Agreed Order** — a settlement resolving a Statement of Charges. This order is an agreement by a licensee to comply with certain terms and conditions to protect the public.

**Stipulated Findings of Fact, Conclusions of Law and Final Order** — an order issued after a formal hearing before the commission.

**Stipulation to Informal Disposition (STID)** — a document stating allegations have been made, and containing an agreement by the licensee to take some type of remedial action to resolve the concerns raised by the allegations.

**Ex Parte Order of Summary Suspension** — an order summarily suspending a licensee's license to practice. The licensee will have an opportunity to defend against the allegations supporting the summary action.
Medical Commission Vital Statistics

- 21 members: 13 MDs, 2 PAs, 6 public members;
- 39 staff, $14.7M biannual budget;
- 29,397 licensed physicians and physician assistants;
- 99.9% of complaints processed on time in 2013;
- 91.5% of investigations completed on time in 2013;
- 94.7% of legal cases completed on time in 2013;
- 100% of disciplinary orders complied with Sanction Rules.

Actions in Fiscal 2013

- Issued 2,429 new licenses;
- Received 1,493 complaints/reports;
- Investigated 911 complaints/reports;
- Issued 86 disciplinary orders;
- Summari ly suspended or restricted 15 licenses;
- Actively monitoring 181 practitioners;
- 44 practitioners completed compliance programs.

Policy Corner

At the January 10, 2013 business meeting the Commission approved/updated the following policies:

- Professionalism and Electronic Media.

To view the most current policies and guidelines for the Commission, please visit our website: http://go.usa.gov/dG8

Recent Licensee Congratulations

The Washington State Medical Commission wishes to congratulate and welcome all of the recent licensees to the state.

A list of recent licensees is updated quarterly on the Commission website and may be found on our website: http://go.usa.gov/dG0

Medical Commission Meetings 2014

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 3-4</td>
<td>Regular Meeting</td>
<td>Puget Sound Educational Service District (PSESD), Blackriver Training &amp; Conference Center 800 Oakesdale Ave SW Renton, WA 98057-5221</td>
</tr>
<tr>
<td>May 15-16</td>
<td>Regular Meeting</td>
<td>Department of Health 310 Israel Rd SE, 152/153 Tumwater, WA 98501</td>
</tr>
<tr>
<td>June 26-27</td>
<td>Regular Meeting</td>
<td>PSESD Renton, WA</td>
</tr>
<tr>
<td>August 21-22</td>
<td>Regular Meeting</td>
<td>DOH Tumwater, WA</td>
</tr>
<tr>
<td>October 1-3</td>
<td>Educational Conference</td>
<td>Capital Event Center ESD 113 6005 Tyee Road SW Tumwater, WA 98512</td>
</tr>
<tr>
<td>November 6-7</td>
<td>Regular Meeting</td>
<td>PSESD Renton, WA</td>
</tr>
</tbody>
</table>

All Medical Commission meetings are open to the public.

Other Meetings

- Administrators in Medicine (AIM) Annual Meeting April 23, 2014 Denver, CO
- Federation of State Medical Boards Annual Meeting April 24-26, 2014 Denver, CO

Do you have ideas or suggestions for future Commission newsletters? Is there something specific that you think we should address or include?

Please submit suggestions to: micah.matthews@doh.wa.gov
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