WASHINGTON
Medical Commission

Licensing. Accountability. Leadership.

Regular Meeting
March 4-5, 2021

2021 Meeting Schedule

The meeting dates for 2021 have been approved. Due to the COVID-19 event, these meetings may be done virtually instead of in person. Updates to the meeting locations will be made available via our GovDelivery and our Event Calendar at https://wmc.wa.gov/calendar.

Dates	Location	Meeting Type
January 14-15	Virtual	Regular Meeting
March 4-5	Virtual	Regular Meeting
April 8-9	Virtual	Regular Meeting
May 13-14	Virtual	Regular Meeting
July 8-9	TENTATIVE Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
August 19-20	TENTATIVE Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
Sept 30-Oct 2	TBD	Educational Conference
November 18-19	TENTATIVE Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting

2022 Meeting Schedule

WASHINGTON
Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 13-14	TBD	Regular Meeting
March 3-4	TBD	Regular Meeting
April 14-15	TBD	Regular Meeting
May 26-27	TBD	Regular Meeting
July 7-8	TBD	Regular Meeting
August 25-26	TBD	Regular Meeting
October 6-8	TBD	Educational Conference
November 17-18	TBD	Regular Meeting

2023 Meeting Schedule

WASHINGTON
Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 12-13	TBD	Regular Meeting
March 2-3	TBD	Regular Meeting
April 13-14	TBD	Regular Meeting
May 25-26	TBD	Regular Meeting
July 6-7	TBD	Regular Meeting
August 24-25	TBD	Regular Meeting
October 5-7	TBD	Educational Conference
November 16-17	TBD	Regular Meeting

FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Hearing	Respondent	SPECIALTY	Case No.	Counsel	AAG	Staff Atty	PANEL	Presiding Officer	Location	Panel Composition (as of 2/23/21)
23-Feb										
2021 March		*Commission Meeting 3/4/2021*								
8-Mar	JUTLA, Rajninder K., MD	BC- Anesthesiology & Pain Medicine	M2020-230	Pro Se	Anderson	Berg	A	Kuntz	TBD	**Curtis; Rodgers; Golden Panel Complete - THANK YOU!**
18-19 Mar	OSTEN, Thomas J., MD	Non-BC; self-designated Family Medicine	M2018-68	James B. Meade, II	Bahm	Karinen	B	Blye	TBD	Curtis;
29-Mar - 2-Apr	BRECHT, Kristine S., MD	BC - Family Medicine	M2019-94	Ketia B. Wick	Anderson	Wolf	B	Wareham	TBD	
2021 April		*Commission Meeting 4/8/2021*								
13-14 Apr	LEE, Gerald W., MD	BC- Internal Medicine	M2018-495	Jennifer Smitrovich Matthew Thomas	Anderson	Karinen	A	Herington	TBD	
19-20 Apr	WEBB, Chris R., MD	BC - Internal Medicine	M2018-81	D. Jeffrey Burnham	Pfluger	Glein	A	Wareham	TBD	
19-21 Apr	KIM, Jeong H., MD	BC- Internal Medicine	M2019-699	Jennifer Smitrovich	Bahm	Page Landstrom	A	Kavanaugh	TBD	Yu;
26-28 April	HAKKARAINEN, Timo W., MD	BC- Surgery	M2019-877	Katharine Brindley Michelle Q. Pham	Bahm	Wolf	A	Kavanaugh	TBD	
2021 May		*Commission Meeting 5/14/2021*								
14-May	RUSSELL, Trent J., PA-C	Physician Asst.	M2020-687	Connie Elkins McKelvey	Pfluger	Berg	B	Blye	TBD	
14-May	GREEN, Roland H., MD	Non-BC Self designated Internal Medicine	M2020-1037	Pro Se	Bahm	Karinen	A	Herington	TBD	
27-28 May	ROMAN CABEZAS, Alberto, MD	BC- Internal Medicine	M2019-259	Kenneth S. Kagan	Bahm	Wolf	A	Blye	TBD	Yu;
2021 June		*NO COMMISSION MEETING THIS MONTH*								
2-3 Jun	HARRIS, Anthony E., MD	BC- Neurological Surgery	M2020-711	Deanna Bui Scott O'Halloran	Defreyn	Wolf	B	Herington	TBD	
18-Jun	HADUONG, Quan, MD	BC-Anesthesiology	M2020-495 M2020-657	Adam Snyder Mallory Barnes-Ohlson	Defreyn	Page Landstrom	L	Herington	TBD	
21-23 Jun	CRANE, Samuel C., MD	BC- Family Medicine	M2019-85	Carol Sue Janes Amy Magnano	Defreyn	Karinen	B	Herington	TBD	
28-Jun	LU, Kang, MD	Non-BC Self-designated Radiology	M2019-822	Pro Se	Defreyn	Karinen	A	Kavanaugh	TBD	
2021 July		*Commission Meeting 7/8/2021*								
12-Jul	ANDERSON, Jodee M., MD	Non-BC Self designated Neonatal/Perinatal Medicine	M2019-1000	Connie McKelvey	Bahm	Wright	A	Herington	TBD	
21-23 Jul	JACKSON, George F., MD	BC- Psychiatry	M2019-365	James B. Meade, II	Brewer	Wolf	B	Blye	TBD	
2021 August		*Commission Meeting 8/19/2021*								
5-6 Aug	DE, Monya, MD	Non-BC Self designated Internal Medicine	M2020-396	Mark Kimball Farnoosh Faryabi	Pfluger	Little	B	Donlin	TBD	
2021 September		*NO COMMISSION MEETING THIS MONTH*								
20-23 Sept	ATTEBERRY, Dave S., MD	Non-BC Self-designated Neurological Surgery	M2015-1151 M2020-804	Stephen M. Lamberson	Defreyn	Karinen	A	Kavanaugh	TBD	

Commission Meeting Agenda
March 4-5, 2021

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for these meetings. Virtual public meetings, without a physical meeting space, will be held instead. The access links can be found below.

Thursday – March 4, 2012

Closed Sessions

8:00 am Case Reviews – Panel A
8:00 am Case Reviews – Panel B

Open Session

12:30 pm **Washington Physicians Health Program Annual Report**
Chris Bundy, MD, Executive Medical Director

Please join this meeting from your computer, tablet or smartphone:
https://global.gotomeeting.com/join/566143821

Closed Sessions

1:30 pm Case Reviews – Panel A
1:30 pm Case Reviews – Panel B

4:00 pm Policy Committee Meeting

Please **register** for this meeting at:
https://attendee.gotowebinar.com/rt/8455414155599218701
After registering, you will receive an email containing a link that is unique to you to join the webinar.

Agenda Items	Presented By:	Page #:
Policy – Practitioners Exhibiting Disruptive Behavior *Review and possible revisions.*	Mike Farrell	23
Procedure – Panel Composition *Periodic review and possible revisions.*	Mike Farrell	52
Policy – Self-Treatment or Treatment of Immediate Family Members *Periodic review and possible revisions.*	Mike Farrell	57
Guideline – Completion of Death Certificates by MDs and PAs *Periodic review and possible revisions.*	Mike Farrell	59

PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | **WMC.wa.gov**

Friday – March 5, 2021

Open Session

8:00 am –9:30 am **Business Meeting**

Please **register** for this meeting at:
https://attendee.gotowebinar.com/rt/391290213257502477
After registering, you will receive an email containing a link that is unique to you to join the webinar.

1.0 Chair Calls the Meeting to Order

2.0 Housekeeping

3.0 Chair Report

4.0 Consent Agenda

Items listed under the Consent Agenda are considered routine agency matters and will be approved by a single motion without separate discussion. If separate discussion is desired, that item will be removed from the Consent Agenda and placed on the regular Business Agenda. — Action

4.1 Minutes – Approval of the January 15, 2021 Business Meeting minutes. — Pages 9-12

4.2 Agenda – Approval of the March 5, 2021 Business Meeting agenda.

5.0 New Business

5.1 **Ethics for Commission Members** — Training
Heather Carter, AAG, will provide a refresher on ethics.

5.2 **Structure of Future Meetings** — Discussion/ Possible Action
The Commissioners will discuss how future meetings will be structured once the Governor's restrictions on gatherings is lifted.

6.0 Old Business

6.1 **Committee/Workgroup Reports** — Update
The Chair will call for reports from the Commission's committees and workgroups. Written reports begin on page 13.

See page 15 for a list of committees and workgroups.

6.2 **Nominating Committee** — Action
Announcement of committee members. The election for leadership will take place at the May 14, 2021 Business Meeting.

6.3 **Rulemaking Activities** — Update
Rules Progress Report provided on page 18.

6.4 **Lists & Labels Request** — Action
The Commission will discuss the requests received for lists and labels, and possible approval or denial of these requests. Approval or denial of these applications is based on whether the requestor meets the requirements of a "professional association" or an "educational organization" as noted on the application (RCW 42.56.070(9)).

PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | **WMC.wa.gov**

- Pierce County Medical Society — Pages 19-22

7.0 Public Comment

The public will have an opportunity to provide comments. ***If you would like to comment during this time, please limit your comments to two minutes. Please identify yourself and who you represent, if applicable, when the Chair opens the floor for public comment.***

8.0 Policy Committee Report

Dr. Karen Domino, Chair, will report on items discussed at the Policy Committee meeting held on March 4, 2012. See the Policy Committee agenda on page 1 of this agenda for the list of items to be presented.

Report/Action Begins on page 23

9.0 Member Reports

The Chair will call for reports from Commission members.

10.0 Staff Member Reports

The Chair will call for further reports from staff.

Written reports begin on page 60

11.0 AAG Report

Heather Carter, AAG, may provide a report.

12.0 Adjournment of Business Meeting

Open Sessions

9:45 am	Personal Appearances – Panel A Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/243475405	Page 68
9:45 am	Personal Appearances – Panel B Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/345525861	Page 69

Closed Sessions

Noon to 1:00 pm — Lunch Break

Open Sessions

1:15 pm	Personal Appearances – Panel A Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/243475405	Page 68
1:15 pm	Personal Appearances – Panel B Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/345525861	Page 69

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission (Commission) meetings. This agenda is subject to change. The Policy Committee Meeting will begin at 4:00 pm on March 4, 2012 until all agenda items are complete. The Commission will take public comment at the Policy Committee Meeting. The Business Meeting will begin at 8:00 am on March 5, 2021 until all agenda items are complete. The Commission will take public comment at the Business Meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | **WMC.wa.gov**

Business Meeting Minutes
January 15, 2021

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Virtual Meeting via GoToWebinar

Commission Members

James E. Anderson, PA-C
Toni Borlas, Public Member
Charlie Browne, MD
Jimmy Chung, MD, 2nd Vice Chair
Diana Currie, MD – Absent
Karen Domino, MD
Christine Blake, Public Member – Absent
April Jaeger, MD
Charlotte Lewis, MD
John Maldon, Public Member, Chair
Terry Murphy, MD
Alden Roberts, MD
Scott Rodgers, JD, Public Member
Theresa Schimmels, PA-C
Robert Small, MD
Claire Trescott, MD, 1st Vice Chair
Richard Wohns, MD
Yanling Yu, PhD, Public Member

Commission Staff

Jennifer Batey, Legal Support Staff Manager
Larry Berg, Staff Attorney
Amelia Boyd, Program Manager
Reneé Bruess, Investigator
Kayla Bryson, Executive Assistant
Jimi Bush, Director of Quality & Engagement
Adam Calica, Chief Investigator
Sarah Chenvert, Performance Manager
Gina Fino, MD, Investigator
Rick Glein, Director of Legal Services
George Heye, MD, Medical Consultant
Mike Hively, Information Liaison
Jenelle Houser, Legal Assistant
Kyle Karinen, Staff Attorney
Becca King, Administrative Assistant
Melissa McEachron, Director of Operations & Informatics
Joe Mihelich, Health Services Consultant
Freda Pace, Director of Investigations
Ariele Page Landstrom, Staff Attorney
Trisha Wolf, Staff Attorney

Others in Attendance

Alan Brown, MD, Pro Tem Commissioner
Chris Bundy, MD, Executive Medical Director, Washington Physicians Health Program
Heather Carter, Assistant Attorney General
Mary Curtis, MD, Pro Tem Commissioner
Katerina LeMarche, Washington State Medical Association
Gregory Terman, MD, Pro Tem Commissioner
Jennifer Van Atta, PA-C
Cori Tarzwell, DOH Policy Analyst

1.0 Call to Order

John Maldon, Public Member, Chair, called the meeting of the Washington Medical Commission (Commission) to order at 8:00 a.m. on January 15, 2021.

2.0 Housekeeping

Amelia Boyd, Program Manager, gave an overview of how the meeting would proceed.

DRAFT

PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | WMC.wa.gov

3.0 Chair Report

Mr. Maldon reported on the panel composition project and the results of the mid-term survey completed by the Commissioners who have participated.

Mr. Maldon reported on bills that were discussed at a recent meeting of the Legislative Committee.

Mr. Maldon spoke about the efforts of the Department of Health regarding providers that can or may be able to administer vaccines.

4.0 Consent Agenda

The Consent Agenda contained the following items for approval:

4.1 Minutes from the November 13, 2020 Business Meeting.
4.2 Agenda for January 15, 2021.

***Motion**:* The Chair entertained a motion to approve the Consent Agenda. The motion was seconded and approved unanimously.

5.0 Old Business

5.1 Committee/Workgroup Reports

These reports were provided in writing and included in the meeting packet. The below is in addition to the written reports.

Micah Matthews, Deputy Executive Director, reported that the Commission held an educational webinar on telemedicine on October 30, 2020 and encouraged everyone to watch the recording available on the Commission's website.

5.2 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet. Ms. Boyd reported that the first workshop for the chapter 246-918 WAC regarding physician assistants rulemaking was held on January 13, 2021. She stated it went well and that the next workshop would be held in March or April.

5.3 Lists & Labels Request

The following lists and labels requests were discussed for possible approval or denial. Approval or denial of these requests is based on whether the entity meets the requirements of a "professional association" or an "educational organization" as noted on the application (RCW 42.56.070(9)).

- University of Washington

  Motion: The Chair entertained a motion to approve the request. The motion was seconded and approved unanimously.

- Public Health – Seattle and King County TB Control Program

  Motion: The Chair entertained a motion to approve the request. The motion was seconded and approved unanimously.

6.0 Public Comment

There were no public comments.

7.0 Policy Committee Report

Dr. Karen Domino, Policy Committee Chair, reported on the items discussed at the Policy Committee meeting held on January 14, 2021:

Consent Agenda

Items listed under the Consent Agenda are considered routine Policy Committee matters and will be approved by a single motion without separate discussion. If separate discussion is desired, that item will be removed from the Consent Agenda and placed on the regular Policy Committee Agenda.

Rescind the following interpretive statements due to their inclusion in the recent update of the physicians chapter 246-919 WAC:

- *IS 2006-02, Sexual Misconduct Rules Clarification: Gloves*
- *IS 2008-01, Licensing on Physician Applicants Who Have Not Practiced for an Extended Amount of Time*
- *MD2015-01-IS, Delegation of the use of laser, light, radiofrequency, and plasma devices as applied to the skin— regarding 'temporary absence of the delegating physician*
- *MD2016-01-IS, CME for MDs with Retired Active Licenses*

Dr. Domino reported that the Committee recommended approval of the Consent Agenda.

> ***Motion:*** The Chair entertained a motion to approve Consent Agenda. The motion was approved unanimously.

Guideline – Transmission of Time Critical Medical Information (TCMI)—"Passing the Baton"

Dr. Domino explained that this document was presented at a previous meeting. It was deferred for additional edits. She explained what the amendments were and stated that the Committee recommended approval of this document with those amendments.

> ***Motion:*** The Chair entertained a motion to approve the guideline with the noted revisions. The motion was approved unanimously.

Guideline – Communicating Test Results to Patients

Dr. Domino explained that this document was presented at a previous meeting. It was deferred for additional edits. She explained what the amendments were and stated that the Committee recommended approval of this document with those amendments.

> ***Motion:*** The Chair entertained a motion to approve the guideline with the noted revisions. The motion was approved unanimously.

Policy – Practitioners Exhibiting Disruptive Behavior

Dr. Domino explained that this document was due for its four-year review. She reported that the Committee had several suggested revisions and so it will be brought back at a future meeting. She stated if anyone had suggestions for this document to send them to Mike Farrell, Policy Development Manager.

PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | **WMC.wa.gov**

DRAFT

8.0 Member Reports

Yanling Yu, PhD, Public Member, reported that the Washington Patient Safety Coalition will hold a conference in October with a focus on health equity and disparities.

Jimmy Chung, MD, stated that the Lunch & Learn – Cultural Agility: A Path Toward Overcoming Harmful Implicit Bias presented on January 14, 2021 was valuable for individuals as well as the Commission as a whole. He also stated we should be thinking about how to apply the principles presented on a personal level and broadly across the Commission.

9.0 Staff Reports

The reports below are in addition to those available in the packet.

Melanie de Leon, Executive Director gave an update on the building access badge project. She stated that Department of Health has a new Secretary of Health, Umair A. Shah, MD, MPH. Lastly, she reported that Commissioner Dr. Diana Currie will present on behalf of the Commission at the upcoming symposium put on by the Federation of State Medical Boards. Her presentation will be about what the Commission is doing to eliminate and understand implicit bias.

10.0 AAG Report

Heather Carter, AAG, reminded the Commissioners that they cannot lobby as a Commissioner but can as a private citizen.

11.0 ADJOURNMENT

The Chair called the meeting adjourned at 9:11 am.

Submitted by

Amelia Boyd, Program Manager

John Maldon, Public Member, Chair
Washington Medical Commission

Approved March 5, 2021

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | **WMC.wa.gov**

DRAFT

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Committee/Workgroup Reports: March 2021

Reduction of Medical Errors Workgroup – Chair: Dr. Chung
Staff: Mike Farrell

John Maldon, Jimmy Chung, MD, and Mike Farrell are presenting a webinar on March 25 on the Commission's support for Communication and Resolution Programs, and the certification process.

Annual Educational Conference Workgroup – Chair: Toni Borlas
Staff: Jimi Bush

We are continuing to provide CME for our licensees.

Our past events are available for CME on demand on our webpage. Events include:

- 2020-2021 Flu Updates Webinar
- CDC Immunization Updates 2020 Webinar
- COVID-19 Vaccine Safety Webinar
- Immunization Requirements Webinar
- LGBTQ+ Healthcare Needs
- Safety First: The Importance of Interpreters & Translated Documents in Preventing Patient Harm
- Transforming Primary Care for Lesbian, Gay, Bisexual, and Transgender People: A Collaborative Quality Improvement Initiative
- UW Studies COVID-19 Presence to Inform Smart Policy Decisions

Upcoming CME events

- 5 Ways to Save Time When Applying for your WA state MD / PA License: March 10th
- The Future of Communication and Resolution Programs: March 25th
- Opioid Prescribing: What you need to know for 2021: TBD
- Achieving Health Equity for Black Moms and Babies: TBD

Please let Jimi know if you have a suggestion for an upcoming CME topic.

Commissioner Education Workgroup – Chair: None at this time
Staff: Melanie de Leon

Working on survey to send out to Commissioners.

Osteopathic Manipulative Therapy Workgroup – Chair: None at this time
Staff: Micah Matthews

Workgroup will reconvene after 2021 legislative session to consider any legislative or policy impacts.

Health Equity Advisory Committee – Chair: Dr. Jaeger **Staff: Jimi Bush**
Participation has increased in the meetings, but we have not received comments that require approval from the policy committee at this time. The next meeting is scheduled for end of march and will cover: 1) Death Certificate 2) Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice 3) Reentry to Practice 4) Reentry to Practice for Suspended Licensees More information is available on the committee webpage.

Office-Based Surgery Rules Workgroup – Chair: Dr. Domino **Staff: Mike Farrell**
Meetings will be scheduled in 2021.

Healthcare Disparities Workgroup – Chair: Dr. Currie **Staff: Melanie de Leon**
Meeting scheduled for March 3, 2021. Dr. Currie accepted an invitation to be on FSMB's *Ad Hoc* Task force on Health Equity and Medical Regulation.

Committees & Workgroups

Executive Committee
John Maldon, Public Member, Chair
Dr. Trescott, 1st Vice Chair
Dr. Chung, 2nd Vice Chair
Dr. Domino, Policy Committee Chair
Dr. Roberts, Immediate Past Chair
Melanie de Leon
Micah Matthews
Heather Carter, AAG

Policy Committee
Dr. Domino, Chair (B)
Dr. Roberts (B)
Christine Blake, Public Member (B)
Jim Anderson, PA-C (A)
John Maldon, Public Member (B)
Scott Rodgers, Public Member (A)
Heather Carter, AAG
Melanie de Leon
Mike Farrell
Amelia Boyd

Newsletter Editorial Board
Dr. Currie
Dr. Chung
Dr. Wohns
Jimi Bush, Managing Editor
Micah Matthews

Legislative Subcommittee
Dr. Roberts, Chair
John Maldon, Public Member
Dr. Terman, Pro Tem Commissioner
Christine Blake, Public Member
Dr. Wohns
Melanie de Leon
Micah Matthews

Panel L
John Maldon, Public Member, Chair
Dr. Browne
Dr. Roberts
Christine Blake, Public Member
Dr. Chung
Theresa Schimmels, PA-C
Dr. Trescott
Dr. Barrett, Medical Consultant
Marisa Courtney, Licensing Supervisor
Ariele Page Landstrom, Staff Attorney
Micah Matthews

Finance Workgroup
Dr. Roberts, Immediate Past Chair, Workgroup Chair
John Maldon, Current Chair
Dr. Trescott, 1st Vice Chair
Dr. Chung, 2nd Vice Chair
Melanie de Leon
Micah Matthews
Jimi Bush

Annual Educational Conference Workgroup
Toni Borlas, Chair
Theresa Schimmels, PA-C
Dr. Domino
Jimi Bush, Organizer

Commissioner Education Workgroup
Dr. Domino
Dr. Chung
Dr. Roberts
Toni Borlas, Public Member
Scott Rodgers, Public Member
Dr. Terman, Pro Tem Commissioner
Melanie de Leon
Amelia Boyd
Jimi Bush

Committees & Workgroups

Reduction of Medical Errors Workgroup
Dr. Chung, Chair
John Maldon, Public Member
Dr. Roberts
Dr. Domino
Dr. Jaeger
Christine Blake, Public Member
Scott Rodgers, Public Member
Melanie de Leon
Mike Farrell

Osteopathic Manipulative Therapy Workgroup
Dr. Roberts
Dr. Currie
John Maldon, Public Member
Micah Matthews
Michael Farrell
Amelia Boyd
Heather Carter, AAG

Health Equity Workgroup
Dr. Jaeger, Co-Chair
Dr. Roberts, Co-Chair
Yanling Yu, Public Member
Micah Matthews
Jimi Bush
Anjali Bhatt

Office-Based Surgery Rules Workgroup
Dr. Domino
Dr. Roberts
John Maldon, Public Member
Mike Farrell
Ariele Page Landstrom
Melanie de Leon
Amelia Boyd

Healthcare Disparities Workgroup
Dr. Currie, Chair
Dr. Browne
Dr. Jaeger
Christine Blake, Public Member
Melanie de Leon

Collaborative Drug Therapy Agreements Rulemaking Committee
Dr. Roberts, Chair
Dr. Chung
Dr. Small
John Maldon, Public Member
Tim Lynch, PQAC Commissioner
Teri Ferreira, PQAC Commissioner
Melanie de Leon
Micah Matthews
Kyle Karinen, Staff Attorney
Amelia Boyd
Heather Carter, AAG
Laruen Lyles, Executive Director, PQAC
Christie Strouse, Deputy Director, PQAC
Lindsay Trant, DOH Rules Coordinator

PQAC E-prescribing Rulemaking Committee
Christine Blake, Public Member
Dr. Browne
Dr. Small
Melanie de Leon
Amelia Boyd
TBD, Staff Attorney
Heather Carter, AAG

Stem Cells Rulemaking Committee
TBD, Chair
TBD
Yanling Yu, Public Member
Micah Matthews
Mike Farrell
Amelia Boyd
Heather Carter, AAG

Committees & Workgroups

Opioid Prescribing – Patient Exemptions Rulemaking Committee
Dr. Roberts, Chair
Dr. Small
Dr. Terman, Pro Tem Commissioner
James Anderson, PA-C
Melanie de Leon
Mike Farrell
Amelia Boyd
Heather Carter, AAG

Telemedicine Rulemaking Committee
Christine Blake, Public Member, Chair
Toni Borlas, Public Member
Dr. Small
Dr. Roberts
Dr. Lewis
Dr. Wohns
Dr. Jaeger
Dr. Lisa Galbraith, BOMS
Dr. Kim Morrissette, BOMS
Micah Matthews
Stephanie McManus
Mike Farrell
Amelia Boyd
Tracie Drake, Program Manager, BOMS

PA Chapter 246-918 WAC & HB 2378 Rulemaking Committee
James Anderson, PA-C, Chair
Theresa Schimmels, PA
TBD, Public Member
Melanie de Leon
Mike Farrell
Amelia Boyd
Heather Carter, AAG

SB 6551 – IMG Licensing Rulemaking Committee
TBD, Chair
TBD
TBD, Public Member
Micah Matthews
Ariele Landstrom, Staff Attorney
Marisa Courtney, Licensing Supervisor
Dawn Thompson
Becca King
Stephanie Mason
Rick Glein, Staff Attorney
Amelia Boyd
Heather Carter, AAG

Please note, any committee or workgroup that is doing any stakeholder work or getting public input must hold open public meetings.

WMC Rules Progress Report								Projected filing dates		
Rule	**Status**	**Date**	**Next step**	**Complete By**	**Notes**	**Submitted to RMS**	**SBEIS Check**	**CR-101**	**CR-102**	**CR-103**
Clinical Support MDs & PAs (formerly Technical Assistance)	Commission approved rescinding CR-102	1/17/2020	One more workshop	TBD	Keep Osteo updated.			Complete	TBD	TBD
Telemedicine	CR-101 filed	9/17/2019	Workshops	TBD	Keep Osteo updated.			Complete	TBD	TBD
Stem Cells	CR-101 Filed	4/21/2020	Workshops	TBD	Keep Osteo updated.			Complete	TBD	TBD
Opioid Prescribing - LTAC, SNF patient exemption	CR-101 filed	3/26/2020	Workshops	TBD				Complete	January 2021	April 2021
Collaborative Drug Therapy Agreements (CDTA)	CR-101 filed	7/22/2020	Workshops	TBD				Complete	January 2022	April 2022
Emergency Licensing Rules	Secretary Review	3/26/2020	File CR-105	TBD	Holding until proclamation is lifted.					
Chapter 246-918 WAC & HB 2378	CR-101 filed	11/19/2020	Workshops	April 2021	Collaborate with Osteo on HB 2378			Complete	June 2021	September 2021
ESHB 1551 - HIV/AIDS	CR-103 Submitted	2/9/2021	File CR-103	March 2021						March 2021
SB 6551 - IMG licensing	CR-101 filed	8/6/2020	Workshops	TBD				Complete	July 2021	December 2021

Updated: 2/23/2021

Washington State Department of
Health
Health Professions Quality Assurance

Application for Approval to Receive Lists

This is an application for approval to receive lists, not a request for lists. You may request lists after you are approved. Approval can take up to three months.

RCW 42.56.070(8) limits access to lists. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A "professional association" is a group of individuals or entities organized to:
  - Represent the interests of a profession or professions;
  - Develop criteria or standards for competent practice; or
  - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An "educational organization" is an accredited or approved institution or entity which either
  - Prepares professionals for initial licensure in a health care field or
  - Provides continuing education for health care professionals.

☒ We are a "professional association" ☐ We are an "educational organization."

Mary A. Eversole | 253.572.3667 | Mary@pcmswa.org
Primary Contact Name ↥ | Phone ↥ | Email ↥

Tanya McClain tanya@pcmswa.org | Www.pcmswa.org
Additional Contact Names (Lists are only sent to approved individuals) ↥ | Website URL↥

Pierce County Medical Society | 91-0366010
Professional Assoc. or Educational Organization ↥ | Federal Tax ID or Uniform Business ID number ↥

223 Tacoma Ave S | Tacoma WA 98040
Street Address ↥ | City, State, Zip Code ↥

To recruit medical volunteers to support COVID-19 vaccination efforts in Pierce County
1. How will the lists be used? ↥

MD, DO, PA
2. What profession(s) are you seeking approval for? ↥

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.

Email to: PDRC@DOH.WA.Gov
Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865
Fax to: PDRC - 360-586-2171

Signature ↥ Date ↥

If you have questions, please call (360) 236-4836.

For Official Use Only

Approved: ______ 5-year ______ one-time

Denied: ______

Authorizing Signature: ______

Printed Name: ______

Title: ______ Date: ______

Internal Revenue Service

Date: January 22, 2004

Pierce County Medical Society
223 Tacoma Ave S
Tacoma, WA 98402

Department of the Treasury
P. O. Box 2508
Cincinnati, OH 45201

Person to Contact:
Steve Brown 31-07422
Customer Service Representative
Toll Free Telephone Number:
8:00 a.m. to 6:30 p.m. EST
877-829-5500
Fax Number:
513-263-3756
Federal Identification Number:
91-0366010

Dear Sir or Madam:

This is in response to your request of January 22, 2004 regarding your organization's tax-exempt status.

In May 1978 we issued a determination letter that recognized your organization as exempt from federal income tax. Our records indicate that your organization is currently exempt under section 501(c)(6) of the Internal Revenue Code.

All exempt organizations (unless specifically excluded) are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more paid to each employee during a calendar year. Your organization is also liable for tax under the Federal Unemployment Tax Act for each employee to whom it pays $50 or more during a calendar quarter if, during the current or preceding calendar year, it had one or more employees at any time in each of 20 calendar weeks or it paid wages of $1,500 or more in any calendar quarter.

If your organization's character, method of operation, or purposes change, please let us know so we can consider the effect of the change on the organization's exempt status. Also, your organization should inform us of all changes in its name or address.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, if its gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of $20 a day, up to a maximum of $10,000, when a return is filed late, unless there is reasonable cause for the delay.

Because your organization is not an organization described in section 170(c) of the Code, donors may not deduct contributions made to your organization. You should advise your contributors to that effect.

Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Internal Revenue Code. If your organization is subject to this tax, it must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter we are not determining whether any of your organization's activities are unrelated trade or business as defined in Code section 513.

Pierce County Medical Society
91-0366010

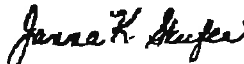
Section 6104 of the Internal Revenue Code requires you to make your organization's annual return available for public inspection without charge for three years after the due date of the return. The law also requires organizations that received recognition of exemption on July 15, 1987, or later, to make available for public inspection a copy of the exemption application, any supporting documents and the exemption letter to any individual who requests such documents in person or in writing. Organizations that received recognition of exemption before July 15, 1987, and had a copy of their exemption application on July 15, 1987, are also required to make available for public inspection a copy of the exemption application, any supporting documents and the exemption letter to any individual who requests such documents in person or in writing. For additional information on disclosure requirements, please refer to Internal Revenue Bulletin 1999 - 17.

As this letter could help resolve any questions about your organization's exempt status, you should keep it with the organization's permanent records.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

This letter affirms the exempt status of your organization.

Sincerely,



Janna K. Skufca, Acting Director, TE/GE
Customer Account Services

PIERCE COUNTY NEEDS YOU!

VOLUNTEERS NEEDED

VACCINATE PIERCE COUNTY!

as covid-19 vaccine phases roll out volunteers are needed to help administer the vaccine

OPPORTUNTIES VARY

COMPLETE THIS FORM TO REGISTER

State of Washington
Washington Medical Commission

Policy

Title:	Practitioners Exhibiting Disruptive Behavior		MD2021-0x
References:	N/A		
Contact:	Washington Medical Commission		
Phone:	(360) 236-2750	E-mail:	Medical.commission@wmc.wa.gov
Effective Date:			
Supersedes:	MD2012-01		
Approved By:			

PROPOSED

Background

Most physicians and physician assistants enter the field of medicine for altruistic reasons and have a strong interest in caring for and helping other human beings. The majority of practitioners carry out their duties with high levels of professionalism and recognize that quality care requires teamwork, communication and a collaborative work environment. However, several studies show that behavior that impedes teamwork and communication, and interferes with patient care—often referred to as disruptive behavior—may be prevalent in somewhere between 1 and 5% of practitioners. [1]

Disruptive behavior has been defined as "an aberrant style of personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to interfere with the process of delivering good care."[2] Disruptive behavior comprises a wide variety of behaviors including overt actions such as verbal outbursts and physical threats, as well as passive activities such as failing to respond to repeated calls, not performing assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.[3] A list of examples of disruptive behavior can be found in appendix A.

Disruptive behavior interferes with the ability to work with other members of the health care team, disrupts the effectiveness of team communication, and has been shown to be a root cause in a high percentage of anesthesia-related sentinel events.[4] The consequences of disruptive behavior include job dissatisfaction for physicians, nurses and other staff; voluntary turnover; increased stress; patient complaints; malpractice suits; medical errors; and compromised patient safety.

Disruptive behavior is not a diagnosis and should not be used to label a practitioner who has an occasional reaction out of character for that individual. The disruptive label should refer to a pattern of inappropriate behavior that is deep-seated, habitual, and pervasive.[5]

Disruptive behavior may be a sign of an illness or a condition that may affect clinical performance. Studies have shown that physicians demonstrating disruptive behavior have subsequently been diagnosed with a range of psychiatric disorders and medical disorders with significant psychiatric symptoms, most of which were treatable.[6] Referral for evaluation of impairment can identify health conditions, distress and other psychosocial factors that may be contributing to the disruptive behavior. If this is the case, an effective treatment and monitoring plan may resolve the disruptive behavior.[7] On the other hand, ruling-out impairment can provide reassurance in proceeding with progressive remediation. The Washington Physicians Health Program accepts referrals for disruptive behavior and will tailor its approach and recommendations based on the presence or absence of an impairing health condition.

When the practitioner exhibiting disruptive behavior is part of an organization where the behavior can be identified, the organization should take steps to address it early before the quality of care suffers, or complaints are lodged. The best outcome is frequently accomplished through a combination of organizational accountability, individual treatment, education, a systems approach and a strong aftercare program.[8] The Joint Commission has developed a leadership standard that requires leaders to develop a code of conduct that defines behaviors that undermine a culture of safety, and to create and implement a process for managing such behaviors.[9] Psychiatrist Norman Reynolds, MD, has developed a set of strategies to manage this behavior and provides advice on the construction of medical staff policies and a program of remediation.[10]

While organizations may be the best place to address disruptive behavior, state medical boards may also play a role when the behavior is brought to their attention. The Federation of State Medical Boards recommends that legislatures amend the practice acts of state medical boards to include disruptive behavior as a grounds for disciplinary action, explaining that it is imperative that state medical boards have the power to investigate complaints of disruptive behavior and to take action to protect the public.[11]

The Commission has taken disciplinary action against several practitioners who exhibited disruptive behavior. In some cases, the basis for the action is that the conduct constitutes unprofessional conduct under RCW 18.130.180(4) because it is negligence that creates an unreasonable risk that a patient may be harmed. The Commission has also taken action under RCW 18.130.180(1) when it deemed that the conduct amounted to acts of moral turpitude relating to the profession.

In one case, the Commission took action against a physician engaging in disruptive behavior under RCW 18.130.170(1) on the theory that the practitioner had a mental condition that prevented him from practicing with reasonable skill and safety. The Washington State Court of Appeals, in a published opinion issued in 2017, upheld the Commission order imposing discipline for disruptive behavior, favorably citing the Commission's prior policy on disruptive behavior, and rejecting the respondent's argument that a diagnosable mental condition was required to proceed under RCW 18.130.170(1).[12]

PROPOSED

Policy

The Commission considers disruptive behavior to be a threat to patient safety. If the Commission receives a complaint or report that a practitioner has engaged in disruptive behavior, the Commission may investigate a complaint and, if warranted, take disciplinary action against the practitioner to protect the public.

Disciplinary action may be based on the belief that the disruptive behavior constitutes unprofessional conduct under RCW 18.130.180(4)(negligence that creates an unreasonable risk of harm), RCW 18.130.180(1) (moral turpitude relating to the profession) or another subsection of RCW 18.130.180.

The Commission may also issue a statement of charges under RCW 18.130.170(1) if there is evidence that the practitioner is unable to practice with reasonable skill and safety due to a mental or physical condition. This statute does not require that the practitioner have a diagnosable mental condition.[13]

If the Commission is unsure whether the practitioner has a mental or physical condition that may impact his or her ability to practice with reasonable skill and safety, the Commission may choose to order the practitioner undergo a mental or physical examination under RCW 18.130.170(2). The results of such an examination may provide evidence to support a statement of charges under RCW 18.130.170(1).

The Commission may refer the practitioner to the Washington Physician Health Program at any point in the process, beginning with making a recommendation during the initial investigation up to imposing a requirement in a disciplinary order.

PROPOSED

Appendix A

Aggressive behaviors:

- Yelling
- Foul and abusive language
- Threatening gestures
- Public criticism of coworkers
- Insults and shaming others
- Intimidation
- Invading one's space
- Slamming down objects
- Physically aggressive or assaultive behavior

Passive-aggressive behaviors:

- Hostile avoidance or the "cold shoulder" treatment
- Intentional miscommunication
- Unavailability for professional matters, e.g., not answering pages or delays in doing so
- Speaking in a low or muffled voice
- Condescending language or tone
- Impatience with questions
- Malicious gossip
- Racial, gender, sexual, or religious slurs or "jokes"
- "Jokes" about a person's personal appearance, e.g., fat, skinny, short, ugly
- Sarcasm
- Implied threats, especially retribution for making complaints[14]

PROPOSED

---

[1] Williams, B. W., and Williams M.V. The Disruptive Physician: A Conceptual Organization, *Journal of Medical Licensure and Discipline.* 2008; 94(3):13.
[2] Lang, D., and others. *The Disabled Physician: Problem-Solving Strategies for the Medical Staff.* Chicago, Ill.: American Hospital Publishing, Inc., 1989. *See also* Neff, K., Understanding and Managing Physicians with Disruptive Behaviors, pp. 45 – 72 (2000).
[3] The Joint Commission. Behaviors that undermine a culture of safety. *Joint Commission Sentinel Event Alert.* 2008; issue 40 (updated September 2016).
[4] *Id*.
[5] Reynolds, N., "Disruptive Physician Behavior: Use and Misuse of the Label, Journal of Medical Regulation, Vol. 98, No. 1, p. 9-10 (2012).
[6] Williams and Williams, p. 14.
[7] Reynolds, p. 19.
[8] Williams and Williams, p. 17.
[9] The Joint Commission, Leadership Standard Clarified to Address Behaviors that Undermine a Safety Culture. *See also* Reynolds at pp. 14-17 for an excellent discussion of strategies for managing disruptive behavior.
[10] Reynolds, pp 14-19.

[11] Federation of State Medical Boards. *Report of Special Committee on Professional Conduct and Ethics.* 2000. https://www.fsmb.org/siteassets/advocacy/policies/report-of-the-special-committee-on-professional-conduct-and-ethics.pdf

[12] *Neravetla v. Department of Health*, 198 Wn. App. 647, 394 P.2d 1028 (2017).

[13] *Id*.

[14] This list comes from Reynolds, p. 9.

PROPOSED

State of Washington
Medical Quality Assurance Commission

Policy

Title:	Practitioners Exhibiting Disruptive Behavior		MD2012-01
References:	N/A		
Contact:	Michael Farrell, Policy Development Manager		
Phone:	(509) 329-2186	E-mail:	michael.farrell@doh.wa.gov
Effective Date:	February 24, 2012; Reaffirmed May 13, 2016		
Approved By:	W. Michelle Terry, MD, FAAP, Chair (signature on file)		

Conclusion

Disruptive behavior by physicians and physician assistants is a threat to patient safety and clinical outcomes. The Medical Quality Assurance Commission (Commission) will take appropriate action regarding practitioners who engage in disruptive behavior.

Background

Disruptive behavior by physicians has long been noted but until recently there has been little consensus that such behavior has an adverse effect on patient safety or clinical outcomes, and therefore the behavior has often been tolerated. This was particularly true when the physician appeared to be clinically competent. However, in the past ten years it has been generally recognized that disruptive behavior poses a potential threat to patient safety.[1] The Joint Commission has said that "intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments."[2]

Definition and Examples

The American Medical Association has defined disruptive behavior as "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.)"[3] The Joint Commission describes

[1] Williams, B. W., and Williams M.V., The Disruptive Physician: A Conceptual Organization, Journal of Medical Licensure and Discipline, Vol. 94, No. 3, 12-20, 2008.
[2] The Joint Commission, Sentinel Event Alert, Issue 40, July 9, 2008.
[3] American Medical Association, E-9.045 Physicians with disruptive behavior (Electronic Version). AMA Policy Finder 2000. Cited in Williams and Williams, J. Med. Lic. & Disc.
Vol. 94, No. 3, p.12, 2008

intimidating and disruptive behaviors as including overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.

Dr. Kent Neff, a psychiatrist and recognized expert in this field, describes disruptive behavior as "an aberrant style of personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to interfere with the process of delivering good care."[4] Examples of disruptive behavior may include:

- Profane or disrespectful language
- Demeaning behavior
- Sexual comments or innuendo
- Inappropriate touching, sexual or otherwise
- Racial or ethnically oriented jokes
- Outbursts of anger
- Throwing instruments or charts
- Criticizing hospital staff in front of patients or other staff
- Negative comments about another physician's care
- Boundary violations with staff or patients
- Comments that undermine a patient's trust in a physician or hospital
- Inappropriate chart notes, e.g., criticizing a patient's hospital treatment
- Unethical or dishonest behavior
- Difficulty in working collaboratively with others
- Failure to respond to repeated calls
- Inappropriate arguments with patients, families
- Poor response to corrective action

Most health care professionals enter their discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The majority of physicians carry out their duties professionally and maintain high levels of responsibility. However, several studies and surveys identify the prevalence of disruptive behavior among physicians as somewhere between 1 and 5%.[5] "The importance of communication and teamwork in the prevention of medical errors and in the delivery of quality health care has become increasingly evident."[6] Such behavior disrupts the effectiveness of team communication and has been shown to be a root cause in a high percentage of anesthesia-related sentinel events.[7] The consequences of disruptive behavior include job dissatisfaction for staff, including other physicians and nurses, voluntary turnover, increased stress, patient complaints, malpractice suits, medical errors, and

---

[4] Neff, K., Understanding and Managing Physicians with Disruptive Behaviors, pp. 45 – 72
[5] Op. cit., Williams and Williams, p. 13
[6] Ibid.
[7] Ibid.

compromised patient safety. Moreover, disruptive behavior may be a sign of an illness or condition that may affect clinical performance. Studies have shown that physicians demonstrating disruptive behavior have subsequently been diagnosed with a range of Axis I and II psychiatric disorders, major depression, substance abuse, dementia, and non-Axis I and II disorders such as anxiety disorder, attention-deficit hyperactivity disorder, obsessive-compulsive disorder, sleep disorder, and other illnesses, most of which were treatable.[8]

Policy

When the practitioner exhibiting disruptive behavior is part of an organization where the behavior can be identified, the organization should take steps to address it early before the quality of care suffers, or complaints are lodged. The best outcome is frequently accomplished through a combination of organizational accountability, individual treatment, education, a systems approach and a strong aftercare program.[9] The Joint Commission has developed a leadership standard that addresses disruptive and inappropriate behaviors by requiring a code of conduct that defines unacceptable, and disruptive and inappropriate behaviors and a process for managing such behaviors.[10]

When the Commission receives a complaint concerning a practitioner exhibiting inappropriate and disruptive behavior, the Commission will consider such behavior as a threat to patient safety that may lead to violations of standards of care or other medical error. The Commission may investigate such complaints and take appropriate action, including possible suspension, to promote and enhance patient safety.

[8] Williams and Williams, p. 14.
[9] Williams and Williams, p. 17.
[10] Op. cit.,The Joint Commission.

Filed
Washington State
Court of Appeals
Division Two

April 11, 2017

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

SHANTANU NERAVETLA, M.D., Appellant, v. DEPARTMENT OF HEALTH, STATE OF WASHIGNTON, Respondent.	No. 48394-7-II PUBLISHED OPINION

MELNICK, J. — Shantanu Neravetla, M.D. appeals the Department of Health, Medical Quality Assurance Commission's (MQAC) final order requiring him to undergo a psychological evaluation if he seeks licensure in Washington. MQAC found that Neravetla had a "mental condition" that affected his ability to practice with reasonable skill and safety.

We conclude that MQAC did not err in its interpretation of the term "mental condition" and that the statute at issue[1] is not unconstitutionally vague. Further, MQAC did not violate Neravetla's due process rights, sufficient evidence exists to support the decision, MQAC's decision was not arbitrary and capricious, and the presiding officer did not violate the appearance of fairness doctrine. We do not review the summary judgment motion denial or consider the evidentiary issues raised. We affirm.

---

[1] RCW 18.130.170.

FACTS

In June 2011, Neravetla began a one-year residency program at Virginia Mason Medical Center (VMMC) in Seattle. In the initial weeks of the program, the residency program director, Dr. Larry Keith Dipboye Jr., received complaints about Neravetla's performance. They related to his professionalism, accountability, attendance, communication, and patient care. Dipboye and Gillian Abshire, the manager of the Graduate Medical Education program, gave Neravetla a verbal warning. Nonetheless, Neravetla continued to have issues with attendance and communication. VMMC gave Neravetla a written warning and placed him on probation. A social worker also filed a patient safety alert with VMMC because of Neravetla's "belligerent" interactions with a nurse. Administrative Record (AR) at 1962.

Dipboye and VMMC then required Neravetla to attend coaching sessions and a class with Dan O'Connell, Ph.D., a psychologist and communication skills coach. O'Connell found Neravetla to be "bitterly angry, with little insight and little ability to reflect on his own behavior in relationships with others." Clerk's Papers (CP) at 25.

On February 9, 2012, VMMC referred Neravetla to the Washington Physicians Health Program (WPHP) for a mental status evaluation. The referral occurred because of Neravetla's interaction with the nurse in the patient safety alert incident and Neravetla's failure to take accountability for his actions or adequately process direct feedback on his behavior.

Two doctors from the clinical staff at WPHP evaluated Neravetla. Both doctors found Neravetla to be disconnected and non-responsive to queries. They also found him to be "confused, defensive, angry, and upset, raising his voice with the interviewers." CP at 25. He also brought WPHP's receptionist to tears. Based on their assessments, WPHP referred Neravetla to obtain a

comprehensive evaluation at Pine Grove Behavioral Health Center, one of three recommended evaluators.

Neravetla presented himself to Pine Grove without informing WPHP. Psychiatrist, Teresa Mulvihill, M.D., and psychologist, Ed Anderson, Ph.D., evaluated him. Anderson evaluated Neravetla as “defensive, lacking insight, blame-shifting, and denying and minimizing how his internship was at risk at VMMC.” CP at 26. The Pine Grove evaluators made their evaluation based on their interactions with Neravetla, and information provided by both VMMC and Neravetla. Pine Grove diagnosed Neravetla with an “Occupational problem (disruptive behavior) (Axis I); and prominent obsessive-compulsive and narcissistic traits (R/O personality disorder NOS with obsessive-compulsive and narcissistic traits) (Axis II).”[2] CP at 26. The Pine Grove evaluators did not feel comfortable recommending that Neravetla return to his residency and recommended that before that occurred, he participate in an intensive six-week residential treatment. Pine Grove did not diagnose Neravetla with any mental illness.

WPHP reported Neravetla to MQAC. WPHP indicated its concern about Neravetla’s ability to practice medicine because Neravetla had had no contact with WPHP and WPHP did not know where Neravetla was. WPHP did not know Neravetla had gone to Pine Grove for an evaluation. Subsequently, the residency program terminated Neravetla and VMMC held a grievance hearing. Neravetla’s limited license expired in July 2012.

On March 18, 2013, MQAC issued charges against Neravetla. It alleged that sanctions should be imposed because Neravetla was “unable to practice with reasonable skill and safety pursuant to RCW 18.130.170(1).” AR at 5.

[2] MQAC did not find that Neravetla suffered from a personality disorder.

Neravetla denied the allegations and asserted that no grounds existed to impose sanctions. He asserted defenses, including that he did not suffer from any mental disorder[3] and that MQAC lacked jurisdiction.

Neravetla filed a motion for summary judgment before MQAC, arguing that substantial evidence did not exist to prove he could not practice with reasonable skill and safety because of a mental condition. He included expert reports that concluded he had never been diagnosed with any mental illness and that he was fit for duty.

The presiding officer[4] denied Neravetla's motion for summary judgment because genuine issues of material fact existed regarding Neravetla's ability to practice with reasonable skill or safety because of a mental condition.

MQAC held a hearing on the charges. At the beginning of the hearing, the presiding officer asked a member of MQAC's panel, Dr. Thomas Green, a former VMMC employee, whether he could hear and assess the case in an impartial manner. Green stated that although he did know some of the people involved in the case, he had no doubt about his ability to give Neravetla a fair hearing. Green agreed to voice any concerns about his impartiality throughout the proceedings.

After hearing testimony, MQAC entered a final order and findings of fact and conclusions of law.[5] MQAC made specific credibility determinations in its findings of fact. MQAC determined that the clinic staff from WPHP were credible because their descriptions of their

---

[3] Neravetla initially said he did not suffer from a narcissistic personality disorder, but later expanded it to any mental disorder.

[4] MQAC hearings are adjudicated by five MQAC members, with a presiding officer who is a "health law judge." AR at 1835.

[5] Neravetla does not assign error to any finding of fact. Findings of fact are verities on appeal. *Tapper v. Emp't Sec. Dep't*, 122 Wn.2d 397, 407, 858 P.2d 494 (1993).

interactions with Neravetla were consistent. In addition, it found Pine Grove's staff and O'Connell to be credible.

MQAC accepted Anderson's conclusion that Neravetla suffered from the condition of Disruptive Physician Behavior, an occupational problem. Neravetla's demeanor as testified to by witnesses, was consistent with the diagnosis. MQAC found that this occupational problem interfered with Neravetla's ability to communicate and work with others, and if continued, would impede his ability to practice medicine safely. His occupational problem rose to the level that patient care would be adversely affected.

MQAC's conclusions of law stated in relevant part:

> 2.4 The Department proved by clear and convincing evidence that [Neravetla's] ability to practice with reasonable skill and safety was sufficient impaired by an occupational problem to trigger the application of RCW 18.130.170(1). . . .
> 2.5 In determining the appropriate sanctions, public safety must be considered before the rehabilitation of [Neravetla]. RCW 48.130.160. . . .
> 2.6 The Department requests that [Neravetla] be ordered to comply with the Pine Grove treatment recommendations. The Commission declines to do this.

CP at 32-33. The final order provided that if Neravetla sought licensure in Washington for a health care credential, he "shall undergo a psychological evaluation by a WPHP approved evaluator and follow whatever recommendations are contained in that evaluation." CP at 33.

Neravetla filed a petition for judicial review to set aside MQAC's final order. The superior court affirmed the MQAC decision. Neravetla appeals.

ANALYSIS

I. MENTAL CONDITION

Neravetla argues that MQAC committed legal error by creating an "Amorphous and Arbitrary" standard for the term "Mental Condition." Br. of Appellant at 26. He also argues that

MQAC conflated the requirement that he have a mental condition that prevents him from practicing safely with unprofessional conduct.[6] We disagree.

A. LEGAL PRINCIPLES

We review this case under the Administrative Procedure Act (APA),[7] and directly review the agency record. *Ames v. Health Dep't Med. Quality Health Assurance Comm'n*, 166 Wn.2d 255, 260, 208 P.3d 549 (2009). We may reverse an administrative order (1) if it is based on an error of law, (2) if it is unsupported by substantial evidence, (3) if it is arbitrary or capricious, (4) if it violates the constitution, (5) if it is beyond statutory authority, or (6) when the agency employs improper procedure. *Ames*, 166 Wn.2d at 260; RCW 34.05.570(3) (a), (b), (c), (d), (e), (h), (i).

When reviewing an administrative agency decision, we review issues of law de novo. *Ames*, 166 Wn.2d at 260. We may "then substitute our judgment for that of the administrative body on legal issues." *Ames*, 166 Wn.2d at 260-61. However, we should "accord substantial weight to the agency's interpretation of the law it administers—especially when the issue falls within the agency's expertise." *Ames*, 166 Wn.2d at 261.

"[T]he challenger has the burden of showing the department misunderstood or violated the law, or made decisions without substantial evidence." *Univ. of Wash. Med. Ctr. v. Dep't of Health*,

---

[6] We accepted an amicus curiae brief from the Legal Aid Society-Employment Law Center. Amicus raises many issues not raised by Neravetla. We may, but usually do not, reach arguments raised only by amicus. *State v. Duncan*, 185 Wn.2d 430, 440, 374 P.3d 83 (2016). We do not reach the issues raised solely in the amicus curiae brief.

MQAC filed a brief in response to amicus curiae's brief. Neravetla filed a motion to strike MQAC's appendix in its response brief to amicus curiae's brief. We grant Neravetla's motion to strike.

[7] Ch. 34.05 RCW.

164 Wn.2d 95, 103, 187 P.3d 243 (2008). "We do not reweigh the evidence." *Univ. of Wash. Med. Ctr.*, 164 Wn.2d at 103.

We review "a challenge to an agency's statutory interpretation and legal conclusions de novo under the error of law standard." *Greenen v. Wash. State Bd. of Accountancy*, 126 Wn. App. 824, 830, 110 P.3d 224 (2005). "If a statute's meaning is plain, then the court must give effect to the plain meaning as expressing what the legislature intended." *Campbell v. Dep't of Soc. & Health Servs*., 150 Wn.2d 881, 894, 83 P.3d 999 (2004). We evaluate a statute's plain language to determine legislative intent. *Greenen*, 126 Wn. App. at 830. "Under the plain meaning rule, courts derive the meaning of a statute from the 'wording of the statute itself.'" *Strain v. W. Travel, Inc.*, 117 Wn. App. 251, 254, 70 P.3d 158 (2003) (quoting *Rozner v. City of Bellevue*, 116 Wn.2d 342, 347, 804 P.2d 24 (1991)).

"A statute is ambiguous when, either on its face or as applied to particular facts, it is fairly susceptible to different, reasonable interpretations." *Strain*, 117 Wn. App. at 254. If the plain language is ambiguous, we "may review the statute's legislative history, including legislative bill reports, to help determine a statute's intent." *Greenen*, 126 Wn. App. at 830. We examine the statute as a whole and its statutory interpretation must not create an absurd result. *State v. Larson*, 184 Wn.2d 843, 851, 365 P.3d 740 (2015)..

B. MQAC CORRECTLY INTERPRETED THE LAW

1. The Term "Mental Condition"

Neravetla argues that MQAC incorrectly interpreted the term "mental condition" too broadly and that it must mean a diagnosable mental illness. We disagree.

The term "mental condition" is contained in RCW 18.130.170(1) which states:

> If the disciplining authority believes a license holder may be unable to practice with reasonable skill and safety to consumers by reason of any mental or physical condition, a statement of charges in the name of the disciplining authority shall be served on the license holder and notice shall also be issued providing an opportunity for a hearing. *The hearing shall be limited to the sole issue of the capacity of the license holder to practice with reasonable skill and safety.* If the disciplining authority determines that the license holder is unable to practice with reasonable skill and safety for one of the reasons stated in this subsection, the disciplining authority shall impose such sanctions under RCW 18.130.160 as is deemed necessary to protect the public.

(Emphasis added).

Another section of this statute illustrates that the legislature recognized that a diagnosable mental illness is not synonymous with a mental condition. "A determination by a court of competent jurisdiction that a license holder is mentally incompetent or an individual with mental illness is presumptive evidence of the license holder's inability to practice with reasonable skill and safety." RCW 18.130.170(2)(f). The unambiguous plain language of the statute shows that a mental condition is not the equivalent of a diagnosable mental illness. The plain language provides that any mental condition that causes the license holder to be unable to practice safely would satisfy the statute. RCW 18.130.170(1). The goal of the statute is to protect consumers and insure that the license holder practices with reasonable skill and safety.

MQAC's policy statement defines disruptive behavior as "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.)" AR at 1107. MQAC's policy statement defines disruptive behavior as including conduct that interferes with one's ability to work with other members of the health care team. In addition, the statement provides examples of disruptive behavior including: difficulty working collaboratively with others, failing to respond to repeated calls, and responding poorly to corrective action. MQAC's policy statement states that hospitals should address a

practitioner exhibiting disruptive behavior "before the quality of care suffers, or complaints are lodged." AR at 1108. MQAC's policy statement provides support for its interpretation and conclusion that disruptive behavior can limit a practitioner's ability to practice with reasonable skill and safety.

Therefore, we conclude that MQAC did not err in its interpretation of the term "mental condition." Neravetla's occupational problem, disruptive physician behavior, would satisfy the requirements of the statute's provision despite not being a diagnosable mental illness in the Diagnostic and Statistical Manual.

2. MQAC Did Not Conflate Mental Condition with Unprofessional Conduct

Neravetla also argues that MQAC conflated the requirement that he have a mental condition that prevents him from practicing safely with unprofessional conduct. He claims this conflation constitutes a legal error because MQAC made conclusions that would only be appropriate under the latter statute that governs unprofessional conduct. We disagree.

RCW 18.130.180 lists approximately twenty-five types of "conduct, acts, or conditions [that] constitute unprofessional conduct for any license holder." However, none of the options listed relates to the alleged actions and behavior of Neravetla or the charges asserted against him. Neravetla does not identify which part of RCW 18.130.180 MQAC conflated with RCW 18.130.170.[8] MQAC focused on Neravetla's mental condition and his ability to safely treat the public and not whether he committed an act or conducted himself in an unprofessional manner.

[8] The only option that could possibly be related is: "Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed." RCW 18.130.180(4). Yet, Neravetla was not accused of incompetence, negligence, or malpractice, nor was there a specific event focused on by MQAC to establish one of the three.

Therefore, we conclude that MQAC did not err by its interpretation of the statute and that the argument that MQAC conflated the requirements of the statutes is without merit.

II. VAGUENESS

Neravetla argues that RCW 18.130.170 is unconstitutionally vague if the term "mental condition" includes undefined disruptive behavior because it opens the door for doctors to be charged for almost any type of conduct. He argues that if under RCW 18.130.170 disruptive behavior can be characterized as a mental condition, the statute is unconstitutionally vague. We disagree and conclude that the statute is not unconstitutionally vague.

The protections of due process apply to medical disciplinary proceedings. *Haley v. Med. Disciplinary Bd.*, 117 Wn.2d 720, 739, 818 P.2d 1062 (1991). A vague statute offends due process. *In re Disciplinary Proceedings Against Curran*, 115 Wn.2d 747, 758, 801 P.2d 962 (1990). "Therefore, any statute under which sanctions may be imposed for unprofessional conduct must not be unconstitutionally vague." *Haley*, 117 Wn.2d at 739.

Statutes are presumed to be constitutional. *Haley*, 117 Wn.2d at 739. "The party challenging a statute's constitutionality on vagueness grounds has the burden of proving its vagueness beyond a reasonable doubt." *Haley*, 117 Wn.2d at 739. "A statute is void for vagueness if it is framed in terms so vague that persons 'of common intelligence must necessarily guess at its meaning and differ as to its application.'" *Haley*, 117 Wn.2d at 739 (quoting *Connally v. Gen. Constr. Co.*, 269 U.S. 385, 391, 46 S. Ct. 126, 70 L. Ed. 322 (1926)). The purpose of the vagueness doctrine is to ensure that citizens receive fair notice as to what conduct is proscribed, and to prevent the law from being arbitrarily enforced. *City of Seattle v. Eze*, 111 Wn.2d 22, 26, 759 P.2d 366 (1988).

"Some measure of vagueness is inherent in the use of language." *Haley*, 117 Wn.2d at 739. "[A] statute is not unconstitutionally vague merely because a person cannot predict with complete certainty the exact point at which his actions would be classified as prohibited conduct." *Eze*, 111 Wn.2d at 27. "[T]he common knowledge and understanding of members of the particular profession to which a statute applies may also provide the needed specificity to withstand a vagueness challenge." *Haley*, 117 Wn.2d at 743.

In *In re Ryan*, 97 Wn.2d 284, 287, 644 P.2d 675 (1982), Ryan challenged the discipline rules for the Washington State Bar Association, and argued that the terms "mental illness or other mental incapacity" were too vague to withstand constitutional challenge. In rejecting his argument, the court upheld the rules because "the mental condition must cause the attorney to be unable to conduct his/her law practice adequately. . . . Thus, the Bar must establish that an attorney is unable to conduct the practice of law adequately because of insanity, mental illness, senility, excessive use of alcohol or drugs, or other mental incapacity." *Ryan*, 97 Wn.2d at 288. The court further reasoned that "[g]iven the inherently uncertain nature of mental illness and the broad ranges of the practice of law, we fail to perceive how a more definite standard could be articulated, and Ryan has suggested none." *Ryan*, 97 Wn.2d at 288.

Here, the statute for physician discipline is similar because the mental condition must render the physician unable to practice medicine safely. Reading the statute as a whole, a person of common intelligence would likely conclude that the term does not require an actual diagnosable mental illness, only a mental condition that affects a person's ability to work with patients safely. Therefore, we conclude that the statute is not unconstitutionally vague.

III. Due Process Violations

Neravetla argues that the statement of charges violated his right to notice because it did not apprise him of the substance of the issues.[9] He argues that the substance of the proceedings changed to focus on his conduct and not whether he had a mental condition, so he was prejudiced in his ability to prepare evidence to counter MQAC's case. However, Neravetla fails to show how the alleged lack of notice prejudiced him. He only argues in his brief that at the prehearing conference he asked for more time to conduct more discovery and find additional witnesses and documents; MQAC denied the request.

In addition, he argues that the final order violates due process because it is impossible for him to comply with it. Because Neravetla received proper notice and because he could have complied with the order, we disagree.

A. Legal Principles

"Procedural due process imposes constraints on governmental decisions which deprive individuals of 'liberty' or 'property' interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment." *Mathews v. Eldridge*, 424 U.S. 319, 332, 96 S. Ct. 893, 47 L. Ed. 2d 18 (1976). "A medical license is a constitutionally protected property interest which must be afforded due process." *Nguyen v. Dep't of Health Med. Quality Assurance Comm'n*, 144 Wn.2d 516, 523, 29 P.3d 689 (2001). "[T]he applicability of the constitutional due process guaranty is a question of law subject to de novo review. *Durland v. San Juan County*, 182 Wn.2d 55, 70, 340 P.3d 191 (2014).

[9] It is not disputed that Neravetla held a protected property interest.

B. NOTICE OF THE ALLEGATIONS

Neravetla's argument that he did not receive notice of the charges is without merit. In a case involving disciplinary proceedings against an attorney, the charging document "must state the respondent's acts or omissions in sufficient detail to inform the respondent of the nature of the allegations of misconduct." *In re Disciplinary Proceeding Against Marshall*, 167 Wn.2d 51, 70, 217 P.3d 291 (2009) (internal quotations omitted). Due process requires that a respondent "be notified of clear and specific charges and . . . be afforded an opportunity to anticipate, prepare, and present a defense." *Marshall*, 167 Wn.2d at 70 (internal quotations omitted).

Here, Neravetla was apprised of the charges against him. The charging document stated that sanctions should be imposed because Neravetla was "unable to practice with reasonable skill and safety pursuant to RCW 18.130.170(1)." AR at 5. The statement of charges included a quote of RCW 18.130.170(1) that clearly identified Neravetla's inability to practice safely occurred because of a mental or physical condition. Neravetla claims he was only charged with a mental disorder, but he was actually charged with a mental condition. He also claims that the evidence focused on conduct, but that was evidence of a mental condition. In addition, the "alleged facts" section of the document explicitly described the facts MQAC relied on in asserting charges, including that he had an "occupational problem/disruptive behavior." AR at 4. Neravetla does not identify how this was insufficient other than the arguments we reject above. MQAC did not assert any other mental condition at the hearing, and therefore, Neravetla received adequate notice of the charges he faced. Accordingly, we conclude that Neravetla received sufficient notice of the charges against him.

C. IMPOSSIBILITY OF COMPLIANCE WITH FINAL ORDER

Neravetla argues that the order violates his due process rights because it is impossible for him to comply. He asserts that the order's sanctions are "conditioned upon (1) Dr. Neravetla getting another residency position, and (2) getting that position in Washington." Br. of Appellant at 45. He claims he is unable to satisfy the order unless those preconditions are met. We disagree with Neravetla's interpretation of the order; he can comply with it.

The order provides: "In the event that [Neravetla] seeks licensure in the state of Washington for a health care credential, [Neravetla] shall undergo a psychological evaluation by a WPHP approved evaluator and follow whatever recommendations are contained in that evaluation." CP at 33. The order does not require Neravetla to seek another residency in Washington. It merely states what he must do if he seeks licensure in Washington for a health care credential. Because Neravetla can comply with the order, it does not violate his due process rights and his argument fails.

IV. INSUFFICIENT EVIDENCE

Neravetla argues that substantial evidence did not support the finding that he could not practice medicine with reasonable skill and safety.[10] We disagree.

Neravetla did not assign error to the agency's findings of fact in the final order, therefore, they are verities on appeal. *Tapper v. Emp't Sec. Dep't*, 122 Wn.2d 397, 407, 858 P.2d 494 (1993). We must determine whether the findings in turn support the conclusions of law and judgment. *Nguyen*, 144 Wn.2d at 530. Because the findings of fact are verities, we address only whether the findings of fact support MQAC's conclusions of law.

[10] Neravetla is actually challenging MQAC's conclusion of law and claiming that it does not flow from the findings of fact.

MQAC's conclusion of law 2.4 provides: "The Department proved by clear and convincing evidence that [Neravetla's] ability to practice with reasonable skill and safety was sufficient[ly] impaired by an occupational problem to trigger the application of RCW 18.130.170(1)." CP at 32.

Numerous findings support MQAC's conclusion of law. O'Connell, whose testimony MQAC adopted, described Neravetla as "bitterly angry, with little insight and little ability to reflect on his own behavior in relationships with others." CP at 25. MQAC also adopted the testimony of the WPHP evaluators in its findings. They experienced Neravetla to be "confused, defensive, angry, and upset, raising his voice with the interviewers." CP at 25. In addition, at Pine Grove, Anderson experienced Neravetla as "defensive, lacking insight, blame-shifting, and denying and minimizing how his internship was at risk at VMMC." CP at 26.

MQAC accepted the final opinion from Pine Grove that Neravetla had an occupational problem, disruptive physician behavior. MQAC found that this occupational problem interfered with Neravetla's ability to communicate and work with others, and if continued, it would impede his ability to practice medicine safely. His occupational problem rose to the level that patient care was affected. Accordingly, its conclusion of law that Neravetla's disruptive physician behavior, a mental condition, prevented him from practicing with reasonable skill and safety flows from the findings of fact.

Therefore, we conclude sufficient evidence exists to support MQAC's decision and order that Neravetla's ability to practice with reasonable skill and safety was sufficiently impaired by an occupational problem, disruptive physician behavior, to trigger the application of RCW 18.130.170(1).

V. ARBITRARY AND CAPRICIOUS DECISION

Neravetla argues that MQAC's decision was arbitrary and capricious because it relied on unreliable hearsay and conflicting information to support its ruling. In addition, he argues the decision was arbitrary and capricious because the panel disregarded the testimony of his witnesses. He further argues that the panel arbitrarily discounted positive collateral information about him. We disagree with Neravetla and conclude that MQAC's order was not arbitrary and capricious.

Under RCW 34.05.570(3)(i), we shall grant relief from an agency order if the order is arbitrary and capricious. An agency order is arbitrary or capricious "if it is willful, unreasoning, and issued without regard to or consideration of the surrounding facts and circumstances." *Manke Lumber Co. v. Cent. Puget Sound Growth Mgmt. Hr'gs Bd.*, 113 Wn. App. 615, 623, 53 P.3d 1011 (2002). Action taken by a disciplinary board after giving a licensee ample opportunity to be heard, "'exercised honestly and upon due consideration,'" is not arbitrary and capricious even if an erroneous conclusion has been reached. *Keene v. Bd. of Accountancy*, 77 Wn. App. 849, 860, 894 P.2d 582 (1995) (quoting *Med. Disciplinary Bd. v. Johnston*, 99 Wn.2d 466, 483, 663 P.2d 457 (1983)). The scope of review under this standard is "very narrow" and the party seeking to demonstrate that the action is arbitrary and capricious "must carry a heavy burden." *Pierce County Sheriff v. Civil Serv. Comm'n of Pierce County*, 98 Wn.2d 690, 695, 658 P.2d 648 (1983).

Here, Neravetla argues that the order was arbitrary and capricious because MQAC found there was insufficient evidence to make a determination as to what actually happened in his residency, but then also found on the same information that he engaged in disruptive behavior. He also argues that the panel identified hearsay testimony about events that occurred during Neravetla's residency to be unreliable, but then made conclusions premised on the same information.

Although Neravetla does not identify the statements he challenges, our independent review of the record is that MQAC made the following finding of fact. "There was conflicting testimony, much of it hearsay, concerning [Neravetla's] conduct, performance, attendance, and professionalism while in the residency program at VMMC. With the exception of Dr. O'Connell's testimony, which the Commission finds credible, and [Neravetla's] own admission of missing certain classes, the Commission makes no finding regarding [Neravetla's] conduct during his residency except to note that [Neravetla] had difficulty in relationships with some of his supervisors." AR at 1604.

MQAC accepted Pine Grove's diagnosis that Neravetla had an occupational problem, disruptive physician behavior. Neravetla misinterprets MQAC's finding and what it was based on. Therefore, Neravetla's argument is without merit.

Next, Neravetla argues that the decision was arbitrary and capricious because MQAC disregarded the testimony of all of his expert witnesses. This argument is without merit, because we do not review credibility determinations. *State v. Camarillo*, 115 Wn.2d 60, 71, 794 P.2d 850 (1990).. The panel below is in the best position to determine whether a witness is credible. *See Camarillo*, 115 Wn.2d at 71. In addition, MQAC did find Neravetla and his witnesses to be credible, it just gave less weight to their testimony for reasons articulated in the final order. Regardless, even if the panel discounted favorable evidence, it may do so.

Neravetla fails to show the MQAC order is invalid for any reason specified by the controlling statute. Therefore, we conclude that the decision was not arbitrary and capricious.

VI. Appearance of Fairness Doctrine

Neravetla argues that the presiding officer violated the appearance of fairness doctrine by allowing a former employee of the involved hospital, Green, to remain on the panel.[11] He argues that the presiding officer should have conducted an independent inquiry into whether Green could remain impartial. We conclude that the presiding officer did not violate the appearance of fairness doctrine.

A medical professional's license represents a property interest and cannot be revoked without due process. *Johnston*, 99 Wn.2d at 474. A basic requirement of due process is a "'fair trial in a fair tribunal.'" *Withrow v. Larkin*, 421 U.S. 35, 46, 95 S. Ct. 1456, 43 L. Ed. 2d 712 (1975) (quoting *In re Matter of Murchison*, 349 U.S. 133, 136, 75 S. Ct. 623, 99 L. Ed. 942 (1955)). A biased decision maker violates this basic requirement, which applies to administrative agencies as well as courts. *Withrow*, 421 U.S. at 47. The appearance of fairness doctrine "provides additional protection because it requires that the agency not only act fairly but must also do so with the appearance of fairness." *Clausing v. State*, 90 Wn. App. 863, 874, 955 P.2d 394 (1998). Pursuant to this doctrine, a judge must recuse herself "if [she] is biased against a party or [her] impartiality may reasonably be questioned." *State v. Dominguez*, 81 Wn. App. 325, 328, 914 P.2d 141 (1996). However, a party claiming bias must produce "[e]vidence of a judge's actual or potential bias . . . before the appearance of fairness doctrine will be applied." *Dominguez*, 81 Wn. App. at 329.

---

[11] Although Neravetla specifically argues that the presiding officer, and not Green, violated the appearance of fairness doctrine, his arguments seem to center on Green's involvement. Even though Neravetla does not argue it, nothing in the record demonstrates that Green could not be fair and unbiased in hearing the evidence and deciding the case.

"Under the appearance of fairness doctrine, proceedings before a quasi-judicial tribunal are valid only if a reasonably prudent and disinterested observer would conclude that all parties obtained a fair, impartial, and neutral hearing." *Johnston*, 99 Wn.2d at 478. But the presumption is that administrative decision makers perform their duties properly and the party claiming a violation must present specific evidence to the contrary, not speculation. *Faghih*, 148 Wn. App. at 843.

Neravetla fails to demonstrate how the presiding officer violated the appearance of fairness doctrine. Although VMMC previously employed Green and he acknowledged he knew the names of some of the witnesses, Neravetla did not demonstrate that Green had an actual or potential bias. Accordingly, there is no evidence in the record to show that either the presiding officer or the panel was partial. Therefore, Neravetla's argument fails.

VII. ERRORS BY PRESIDING OFFICER

Neravetla argues that the presiding officer committed multiple prejudicial errors including denying his motion for summary judgment, refusing to admit his experts' reports, and excluding probative evidence. We do not consider any of these arguments.

A. MOTION FOR SUMMARY JUDGMENT

Neravetla argues that the presiding officer erred by denying his motion for summary judgment. Where a denial of summary judgment is based on existence of disputed material facts, we will not review it when raised after a trial on the merits. *Weiss v. Lonnquist*, 173 Wn. App. 344, 354, 293 P.3d 1264 (2013).

Here, the presiding officer denied Neravetla's motion for summary judgment because issues of material fact remained. MQAC held a trial on the merits of the issue thereafter. Therefore, we do not review MQAC's denial of the summary judgment motion.

B. EXCLUSION OF EXPERTS' REPORTS

Neravetla argues that the presiding officer refused to allow him to submit three expert witnesses' reports as exhibits, and he would only allow the reports to be admitted if he did not conduct direct examination of his witnesses.

Despite Neravetla's assertions, he did not actually offer the reports into evidence. The presiding officer broached the topic on his own before Neravetla began presenting his case. But the presiding officer made no ruling on the reports' admission, and therefore, there is nothing for us to review. In addition, the presiding officer did not limit Neravetla's ability to conduct direct examination of his witnesses.

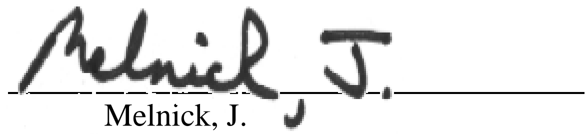
C. OTHER EVIDENTIARY ISSUES

Neravetla argues that the presiding officer excluded probative evidence and that he prohibited him "from introducing into evidence various documents." Br. of Appellant at 49. Neravetla also argues that the presiding officer "allowed Department attorneys to utilize documents handed to them by VMMC's counsel" that were not disclosed to him beforehand.

Neravetla's brief cites to the record only in regard to the exclusion of testimony from one witness, Dr. John Roberts. Neravetla wanted to call Roberts as a rebuttal witness. The presiding officer asked him to make a proffer. Neravetla said that Roberts would testify consistently with other prior testimony that Neravetla was accepting of feedback. He claimed the testimony was to rebut the allegations by Anderson that Roberts did not know of Dipboye's concerns. The presiding officer did not allow him to testify because the testimony would not have been inconsistent with what Anderson testified to, and did not qualify as rebuttal testimony. Neravetla does not identify other documents he claims were excluded.

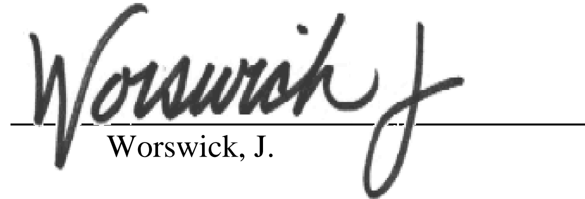
Neravetla does not cite to any law to support his arguments nor does he provide any reasoning as to why the presiding officer's actions were error. Accordingly, we do not consider the evidentiary issues. *Bercier v. Kiga*, 127 Wn. App. 809, 824, 103 P.3d 232 (2004); RAP 10.3(a)(6).

We affirm.

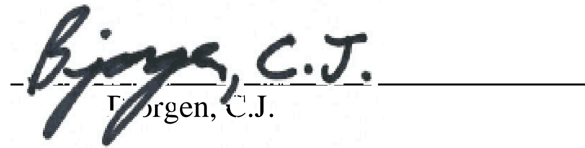


Melnick, J.

We concur:



Worswick, J.



Bjorgen, C.J.

Panel Composition

Purpose

This document establishes a procedure for assembling a panel of Commission members to make disciplinary decisions. RCW 18.130.050(18) permits a board or commission to establish panels of at least three members to make a disciplinary decision. RCW 18.130.060(2) permits a board or commission to request the Secretary to appoint pro tem members to participate as members of a panel, but requires the chairperson of a panel to be a regular member of the board or commission. Consistent with this statute, a reference to a "regular" member of the Commission in this procedure means a current Governor-appointed member of the Commission. The procedure is organized according to the disciplinary decision being made.

Procedure

Decision to Authorize an Investigation

The Commission convenes a panel every week to review complaints and decide whether to investigate the complaint or to close the complaint as "below threshold." This panel will be composed as follows:

1. The panel will consist of three or more members.
2. The chairperson must be a regular member of the Commission.
3. A majority of the panel members must be regular Commission members.
4. At least two clinical members must be on the panel.

Case Reviews

The Commission uses panels to review cases that have been investigated and to decide whether to close these cases or take informal or formal disciplinary action. This includes a panel that convenes by phone or in person to authorize the Attorney General's Office to make a motion for summary action. A case review panel will be composed as follows:

1. The Panel will consist of three or more members.
2. The chairperson must be a regular Commission member.
3. A pro-tem member may present a case, or may participate in the discussion, but may not vote on a case.
4. The Reviewing Commission Member may present the case and make a recommendation, but will not vote.

5. If an issue in the case is whether respondent met the standard of care, at least 50% of the panel must consist of physicians or physician assistants.

Hearing on a Statement of Charges or a Notice of Decision on Application

A hearing panel[1] sits for a hearing after the issuance of a Statement of Charges or a Notice of Decision on Application. A health law judge presides and prepares the order. A hearing panel will be composed as follows:

1. The Panel will consist of three or more members.
2. At least one member will be a physician.
3. At least half of the panel must consist of regular Commission members (a three-person panel may include one pro-tem member; a four or five-person panel may include two pro-tem members).
4. The chairperson must be a regular Commission member.
5. The panel should include a public member, but must include a public member for sexual misconduct.
6. The panel should not consist of members who served on the panel that ordered the Statement of Charges.
7. The Reviewing Commission Member may not sit on the panel.[2]
8. It is preferred that the panel includes a Commission member with experience in the clinical practice area at issue or the same specialty as the respondent.
9. In sexual misconduct cases, the panel must include a public member and must include members of both sexes.
10. The panel may include Commission members who served on a panel that ordered a summary action or who served on a show cause panel.
11. If an issue in the case is whether respondent met the standard of care, at least 50% of the panel must consist of physicians and/or physician assistants.
12. Before a Commission member, whether a regular member or a pro-tem member, serves on a hearing panel, the member should, whenever possible, complete a Commission training program and be approved by the Commission Executive Committee.[3]

Hearing on Motion for Summary Action

The Commission must convene a panel to consider a motion to take summary action against a respondent.[4] A health law judge presides and prepares the order.

A summary action panel will be composed as follows:

---

[1] Formal hearings are governed by the RCW 34.05, RCW 18.130.100, and WAC 246-11. These laws do not address the composition of a hearing panel.
[2] RCW 18.130.050(11).
[3] The Commission may implement a training program as it deems necessary. The Commission Executive Committee will determine whether individual members have completed the training program and are qualified to serve as on a panel at a hearing on a Statement of Charges or a Notice of Decision on Application.
[4] Summary actions are governed by RCW 34.05.479, RCW 18.130.050(8), and WAC 246-11-300-350. These laws do not address the composition of a panel.

1. The panel will consist of three members.
2. The panel may contain no more than one pro tem member who has previously served at least one full four—year term as a regular member of the Commission.
3. A pro-tem member who has not served at least one term as a regular member of the Commission may not serve on a summary suspension panel.
4. The panel may include members of the panel that ordered the Statement of Charges and authorized the Attorney General's Office to make the motion for summary action.
5. The Reviewing Commission Member may not sit on the panel.
6. If an issue in the case is whether respondent met the standard of care, at least two members of the panel must consist of physicians or physician assistants.

Show Cause Hearing

A respondent who has been summarily suspended or restricted has the right to ask a show cause panel[5] to reconsider the summary action. A health law judge presides and prepares the order. Ideally, a show cause panel will consist of the same members who served on the summary action panel. Because of the tight time constraints, it may not be possible for the summary action panel members to serve on the show cause panel.

In such a case, the show cause panel will be composed as follows:

1. The panel will consist of three members.
2. A pro-tem member who has not previously served at least one term as a regular member of the Commission may not serve on a show cause panel.
3. The panel may consist of members of the panel that ordered the Statement of Charges.
4. The Reviewing Commission Member may not sit on the panel.
5. If an issue in the case is whether respondent met the standard of care, at least two members of the panel must consist of physicians or physician assistants.

Hearings on Challenges to Notices of Intent to Order Mental or Physical Examinations

The Commission may issue an order requiring a respondent to undergo a mental or physical evaluation under RCW 18.130.170(2)(a). To begin the process, the Commission issues a Notice of Intent to Order Mental or Physical Examination. A respondent may challenge the Notice of Intent by submitting a written response and relevant documents. The statute provides that a panel of the Commission that has "not been involved with the allegations against the license holder" will review the respondent's written material and decide whether the examination is justified. A health law judge presides and prepares the order.

A panel reviewing a challenge to a Notice of Intent will be composed as follows:

1. The panel will consist of three members.

[5] RCW 18.130.135, RCW 18.130.050(9) and WAC 246-11-340 govern the show cause process. These laws do not address the composition of a show cause panel.

2. The panel may contain no more than one pro tem member who has previously served at least one term as a regular member of the Commission.
3. No panel member who was involved in the allegations can serve on this panel, in accordance with RCW 18.130.170(2)(b). This may eliminate any person who is on the same panel as the Reviewing Commission Member.
4. The Reviewing Commission Member may not sit on the panel.

Hearings on a Petition for Modification or Termination of an Order and on a Petition for Reinstatement of a License

When a respondent petitions for a modification or termination of an order, or reinstatement of a license, a panel convenes to consider the petition. A health law judge *may* preside and prepare the order. A panel considering a petition for a modification or termination of an order or a petition for reinstatement of a license will be composed as follows:

1. The panel will consist of three or more members.
2. The chairperson must be a regular Commission member.
3. A majority of panel members must be regular Commission members.
4. The Reviewing Commission Member may not sit on the panel.
5. It does not matter whether members of this panel participated in the case by sitting on the charging panel, the hearing panel, a compliance review panel, or any other panel that made a decision at some point in the case.

Hearing on Review of Revocation of Physician's License

Under RCW 18.71.019, when the Commission revokes the license of a physician following a hearing, the physician may request a review of the revocation order "by the remaining members of the commission not involved in the initial investigation." The Commission adopted a rule setting forth the process in WAC 246-919-520.

WAC 246-919-520(4) provides that a review panel will review the final order and be "composed of the members of the commission who did not:

(a) Review the initial investigation and make the decision to issue a statement of charges against the respondent in this matter; or
(b) Hear the evidence at the adjudicative proceeding and issue the final order revoking the respondent's license.

In addition to the requirements of WAC 246-919-520, the review panel cannot include the RCM or pro tem members.

Exception: This procedure is intended to provide guidelines for composing panels. In rare cases, with the specific permission of the Commission Chair, staff may deviate from this procedure, except when mandated by statute.

Date of Adoption:	January 28, 2016
Reaffirmed/Updated:	N/A
Supersedes:	Panel Composition Procedure, adopted November 15, 2013

PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | **WMC.wa.gov**

State of Washington
Washington Medical Commission

Policy

Title:	Self-Treatment or Treatment of Immediate Family Members	MD2013-03
References:	American Medical Association Code of Ethics, E-8.19 Self-Treatment of Immediate Family Members	
Contact:	Washington Medical Commission	
Phone:	(360) 236-2750	E-mail: medical.commission@wmc.wa.gov
Effective Date:	February 22, 2013, Reaffirmed as written May 19, 2017	
Supersedes:	MD2008-02	
Approved By:		

The Washington Medical Commission (commission) believes that practitioners generally should not treat themselves or members of their immediate families.[1] 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 may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the practitioner is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients.

When treating themselves or immediate family members, practitioners may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a practitioner's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the practitioner.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another practitioner or decline a recommendation for fear of offending the practitioner. In particular, minor children will generally not feel free to refuse care from their

[1] This policy is taken largely from the ~~statement of the~~ American Medical Association Code of Ethics Opinion 1.2.1~~, E-8.19 Self-Treatment of Immediate Family Members~~.

parents. Likewise, practitioner may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified practitioner available, practitioners should not hesitate to treat themselves or family members until another practitioner becomes available. In addition, while practitioners should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Documentation of these encounters should be included in the patient's medical records.

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.

PROPOSED

Guideline

WASHINGTON Medical Commission

Licensing. Accountability. Leadership.

Completion of Death Certificates by Physicians and Physician Assistants

The Washington Medical Commission (Commission) adopted Guideline MD 2016-01, "Completion of Death Certificates by Physicians and Physician Assistants," in January 2016. In September 2016, the Washington State Department of Health, Center for Health Statistics, adopted Guideline CHS D-10 "Completion of Death Certificates" for all medical certifiers to follow when completing death certificates.

The Commission rescinds its guideline, and urges all physicians and physician assistants to follow the guideline issued by the Washington State Department of Health, Center for Health Statistics. This guideline can be found here:

http://www.doh.wa.gov/Portals/1/Documents/5600/422-134-GuidelineCompletionOfDeathCertificates.pdf

Number:	GUI2017-01
Date of Adoption:	February 24, 2017
Reaffirmed / Updated:	None.
Supersedes:	None.

PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@wmc.wa.gov | WMC.wa.gov

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Staff Reports: March 2021

Melanie de Leon, Executive Director

Staff Updates:

- Bonita James, Healthcare Investigator, is retiring at the end of March, however February 26th will be her last working day. She has spent 30 years working for the state.
- Kelsey Hunter, Healthcare Services Consultant 2, fills a vacant position in Licensing.
- We are recruiting for a vacant Compliance Officer position, a Paralegal 1 and an investigator to replace Bonita.
- We are also adding and filling three positions on a temporary basis in our Licensing Unit to insure adequate coverage for the upcoming busy licensing season. March 19th is "match" day, so we need to be ready.

Seven commissioners are currently piloting using DOH-issued laptops for their commission work. After the March meeting we will assess their feedback to determine next steps.

We need to have more public members participate in the weekly CMT calls – even doing one a quarter would help immensely.

Recurring: Please submit all Payroll and Travel Reimbursements within 30 days of the time worked or travelled to allow for processing. Request for reimbursement items older than 90 days will be denied. Per Agency policy, requests submitted after the cutoff cannot be paid out.

Amelia Boyd, Program Manager

Recruitment

The following Commissioner terms ended June 30, 2020:

- Congressional District 6 – Claire Trescott, MD – eligible for reappointment
- Congressional District 8
- Physician-at-Large – Karen Domino, MD – eligible for reappointment

Recommendations have been sent to the Governor's office.

We also have vacancies in the following positions:

- Congressional District 2
- Public Member

The recommendations for both positions have been sent to the Governor's office.

On June 30, 2021 we will have the following vacancies:

- Congressional District 1 – Jimmy Chung, MD – eligible for reappointment
- Congressional District 7 – Charlotte Lewis, MD – not eligible for reappointment

Amelia Boyd, Program Manager continued

- Physician Assistant – Theresa Schimmels, PA-C – not eligible for reappointment
- Public Member – Christine Blake – eligible for reappointment

The application deadline for these positions is March 31, 2021.

We are also seeking physicians with the following specialties to serve as Pro Tem Members:

- Radiologist
- Psychiatrist
- Ophthalmologist

If you know anyone who might be interested in serving as a Pro Tem, please have them email me directly at amelia.boyd@wmc.wa.gov.

Rules

We have 9 rulemaking efforts in progress. For more information, please see the Rules Progress Report in this packet.

Melissa McEachron, Director of Operations and Informatics

Subpoenas for Records and other Compulsory Records Responses: In January and February, the team completed or partially completed record responses for tort actions, the Office of Inspector General, HHS, requests under MOU with Medicare Fraud Control, AGO, private law firm(s), the DEA, and the Department of Justice.

The team:

- Scanned 10,000 pages of case files and medical records; and
- Redacted 2,500 pages of records, primarily case files.

Archiving: Preparing electronic case files for archiving continues at a fast pace. Electronic files from Case Management Team meetings are now prepared for archiving weekly. The next challenge is preparing select groups of scanned licensing applications for electronic archiving.

Demographics: Updated census reports are available on our website. Census reports are updated quarterly.

Morgan Barrett, MD, Medical Consultant

Compliance is recruiting to fill the HSC 2 Compliance Officer position that is vacant.

George Heye, MD, Medical Consultant

2020 Case Assignment Totals Per RCM

Commissioners							
Anderson	12	Currie	16	Maldon	18	Small	25
Blake	15	Domino	20	Murphy	23	Trescott	27
Borlas	11	Howe	12	Roberts	38	Vervair	7
Browne	14	Jaeger	27	Rodgers	17	Wohns	9
Chung	26	Lewis	25	Schimmels	30	Yu	13

Pro Tems					
Ashleigh	8	Cheung	2	Flugstad	7
Brown	6	Curtis	18	Soltes	2
Brueggemann	1	Fairchild	5	Terman	18

Rick Glein, Director of Legal Services

Summary Suspensions:

In re Jessica Wolin, MD, Case No. M2020-699. On January 28, 2021, a Health Law Judge (HLJ), by delegation of the Commission, ordered that Dr. Wolin's medical license be suspended pending further disciplinary proceedings. The Statement of Charges (SOC) alleges that, in July 2020, the Michigan Department of Licensing and Regulatory Affairs Board of Medicine issued a Consent Order suspending Dr. Wolin's license to practice indefinitely based on Dr. Wolin's diversion of controlled substances from her employer hospital. Dr. Wolin has filed an Answer to the SOC requesting a hearing on this matter.

In re Richard M. Krebs, MD, Case No. M2020-933. On February 19, 2021, a HLJ, by delegation of the Commission, ordered that Dr. Krebs' medical license be suspended pending further disciplinary proceedings. The SOC alleges that on or about April 2, 2020, the Oregon Medical Board accepted the surrender of Dr. Krebs' medical license while under investigation for dishonesty, diversion of controlled substances, use of a controlled substance without a valid prescription, and misrepresentation. Dr. Krebs has 20 days from date of service to file an Answer to the SOC.

Orders Resulting from SOCs:

In re Alan Bunin, MD, Case No. M2020-713. Final Order of Default (Failure to Respond)*. On August 5, 2020, the Commission served a SOC alleging that Dr. Bunin diagnosed a patient with dementia, without sufficient information regarding the patient's history and mental status, and subsequently wrote a letter regarding the patient's cognitive functioning, stating he had "significant dementia", which caused an adverse financial impact for the patient. Dr. Bunin did not file a response within the time allowed. This matter came before a HLJ in January 2021. The HLJ concluded sufficient grounds existed to take disciplinary action against Dr. Bunin's license and ordered that his medical license be indefinitely suspended**.

Rick Glein, Director of Legal Services continued

In re Duane S. Bietz, MD, Case No. M2020-228. Final Order of Default (Failure to Respond)*. On November 18, 2020, the Commission served a SOC alleging that Dr. Bietz committed unprofessional conduct under RCW 18.130.180(5) when the Oregon Medical Board issued a Default Final Order revoking Dr. Bietz' license to practice medicine in the state of Oregon. Dr. Bietz did not file a response within the time allowed. This matter came before a HLJ in January 2021. The HLJ concluded sufficient grounds existed to take disciplinary action against Dr. Bietz' license and ordered that his medical license be indefinitely suspended**.

In re Hamid Roodneshin, MD, Case No. M2020-705. Final Order of Default (Failure to Respond)*. On August 24, 2020, the Commission served a SOC alleging failure to cooperate with the Commission by not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the Commission. Dr. Roodneshin did not file a response within the time allowed. This matter came before a HLJ in January 2021. The HLJ concluded sufficient grounds existed to take disciplinary action against Dr. Roodneshin's license and ordered that his medical license be indefinitely suspended**.

In re Kenneth F. Wenberg, MD, Case No. M2020-696. Final Order of Default (Failure to Respond)*. On August 10, 2020, the Commission served a SOC alleging violations of RCW 18.130.180(1) (dishonesty) and RCW 18.130.180(17) (felony conviction). Dr. Wenberg did not file a response within the time allowed. This matter came before a HLJ in January 2021. The HLJ concluded sufficient grounds existed to take disciplinary action against Dr. Wenberg's license and ordered that his medical license be indefinitely suspended**.

In re Bruno Kolodziej, MD, Case No. M2020-551. Final Order of Default (Failure to Respond)*. On December 21, 2020, the Commission served a SOC alleging that Dr. Kolodziej committed unprofessional conduct under RCW 18.130.180(5) when the Virginia Board of Medicine issued an Order revoking Dr. Kolodziej's license to practice medicine in the Commonwealth of Virginia. Dr. Kolodziej did not file a response within the time allowed. This matter came before a HLJ in February 2021. The HLJ concluded sufficient grounds existed to take disciplinary action against Dr. Kolodziej's license and ordered that his medical license be indefinitely suspended**.

In re Rodolfo N. Trevino, MD, Case No. M2018-828. Corrected Final Order of Default (Failure to Respond)*. On September 9, 2020, the Commission filed a SOC at which time Dr. Trevino's medical license was expired, subject to renewal. The SOC alleges Dr. Trevino's controlled substances prescribing practices placed patients at an unreasonable risk of harm or did in fact result in harm. Dr. Trevino did not file a response within the time allowed. The matter came before a HLJ in February 2021. The HLJ concluded sufficient grounds existed to take disciplinary action against Dr. Trevino's license and ordered that his medical license be indefinitely suspended**.

In re Michael J. Pascale, MD, Case No. M2019-233. Agreed Order. On July 29, 2020, the Commission filed a SOC alleging Dr. Pascale admitted to diverting controlled substances for

personal use. On January 14, 2021, the Commission accepted entry of an Agreed Order in which Dr. Pascale agreed to fully comply with his current monitoring agreement with WPHP, dated January 10, 2019, until his is discharged with WPHP approval. Dr. Pascale also agreed to pay a $1,000 fine and personally appear before the Commission. Dr. Pascale may petition to terminate the Agreed Order after WPHP determines further substance use monitoring is no longer necessary.

In re Kevin W. Cardwell, PA, Case No. M2020-831. Agreed Order. On December 10, 2020, a HLJ, by delegation of the Commission, ordered that Mr. Cardwell's physician assistant license be suspended pending further disciplinary proceedings. The SOC alleges that Mr. Cardwell surrendered his Oregon license while under investigation for unprofessional conduct. On February 3, 2021, the Commission accepted entry of an Agreed Order in which Mr. Cardwell will successfully complete an in-person course in medical ethics and a paper on the subject. Mr. Cardwell must pay a fine of $5,000, personally appear before the Commission, and cause his supervising physician to submit written reports. Mr. Cardwell may petition to terminate the Agreed Order two years from its effective date and after successful completion of all terms and conditions.

In re Mohammad H. Said, MD, Case No. M2020-53. Final Order. On May 12, 2020, the Commission summarily suspended the license of Dr. Said. The SOC alleges that Dr. Said suffers from a health condition that poses a substantial risk of impairment and is probably unable to practice with reasonable skill and safety. A virtual hearing was held October 7-8, 2020, regarding the merits of the SOC. A Final Order was issued on January 28, 2021, which ordered that Dr. Said's license remain indefinitely suspended. Dr. Said may seek reinstatement after submitting to a comprehensive neuropsychological evaluation. The evaluator shall submit a written report directly to the Commission indicating under what conditions Dr. Said would be safe to resume practice. Reinstatement of Dr. Said's license is at the sole discretion of the Commission.

*Either party may file a petition for reconsideration within ten days of service of the order. RCW 34.05.461(3); 34.05.470. A petition for judicial review must be filed and served within 30 days after service of the order. If a petition for reconsideration is filed, the 30-day period does not start until the petition is resolved. RCW 34.05.542; 34.05.470(3).
**A person whose license has been suspended under chapter 18.130 RCW may petition the disciplining authority for reinstatement. RCW 18.130.150.

Virtual Hearings:
In re Julia Barnett, MD, Case No. M2019-821. On November 16, 2020, the Commission summarily suspended Dr. Barnett's medical license pending further disciplinary proceedings. The Statement of Charges alleges that Dr. Barnett violated the standard of care in her management of patients as the medical director of a correctional facility. A virtual hearing was held in this matter January 28-30, February 13, and February 20, 2021 regarding the

Rick Glein, Director of Legal Services continued

merits of the SOC. A Final Order is expected to be issued by the Health Law Judge (HLJ) by the end of May 2021.***

***The HLJ has 90 days after the conclusion of the hearing to issue a decision.

Meeting Attendance:
On January 27, Rick, Ariele, and Kyle met virtually with Dr. Chris Bundy, Washington Physicians Health Program (WPHP), for their quarterly meeting to discuss processes which lead to a productive relationship between WMC and WPHP and offer joint feedback in our ongoing mission of patient safety and enhancing the integrity of the profession through discipline and education.

Freda Pace, Director of Investigations

Good day Commissioners! I have a few new process changes that started February 1st.

CMT: In a collaborative effort to minimize implicit bias in our internal review process for complaints submitted to the Washington Medical Commission, all complaints included in our CMT packet will be redacted. Information that will be redacted:

- ✓ Complainant's name, address, phone number and email address;
- ✓ Respondent's name, address, phone number and email address; and
- ✓ Facility's name, address and phone number

Also effective February 1st, for those cases authorized for investigation after CMT, the named respondent will receive a redacted copy of the complaint within 21 days. There are a few exceptions cases where this new process will not apply, such as sexual misconduct cases.

2021 CMT Statistics – Quarter 1					
January					
Date	**New cases**	**Authorized**	**Authorized %**	**Closed BT**	**BT %**
1/6	25	3	12.00%	22	88.00%
1/13	25	6	24.00%	19	76.00%
1/20	34	10	29.41%	24	70.59%
1/27	30	12	40.00%	18	60.00%
Total	***114***	***31***	***27.19%***	***83***	***72.81%***
February					
Date	**New cases**	**Authorized**	**Authorized %**	**Closed BT**	**BT %**
2/3	30	13	43.33%	17	56.67%
2/10	36	11	30.56%	25	69.44%
2/17	29	14	48.28%	15	51.72%
Total	***95***	***38***	***40.00%***	***57***	***60.00%***

Freda Pace, Director of Investigations continued

Speaking of CMT, we have plenty of vacant slots available for the next several months. Please visit our SharePoint and sign up. If you have any questions about the sign up process, feel free to reach out to Chris Waterman directly – chris.waterman@wmc.wa.gov.

Mike Farrell, Policy Development Manager

Nothing to report outside of the items on the policy committee agenda.

Jimi Bush, Director of Quality and Engagement

We are working hard to help licensing be prepared for their busy season, including making educational resources for recent graduated and new licensees. If you know of a opportunity where we can educate licensees on the licensing process, please let me know.

Below are the Performance Metrics for the 2020 annual year and its comparison to 2019.

Metric	2019	2020
Applications Received	3270	3484
Credentials Issued	2771	2938
Complaints Received	1560	1364
% of complaints authorized for an investigation	36%	26%
Investigations completed	752	487
Cases Presented at Panel	757	607
% of cases closed within 360 days	91.18%	94.24%
STIDS Authorized and Signed	53	42
Final Orders	2	4
Stipulation to Practice Under Conditions	0	1
Default orders	7	6

Marisa Courtney, Licensing Manager

Total licenses issued from 1/01/2021- 2/23/2021- 236

Credential Type	Total Workflow Count
Physician And Surgeon County/City Health Department License	0
Physician And Surgeon Fellowship License	1
Physician And Surgeon Institution License	0
Physician And Surgeon License	119
Credential Type	**Total Workflow Count**
Physician and Surgeon License Interstate Medical Licensure Compact	41
Physician And Surgeon Residency License	3
Physician And Surgeon Teaching Research License	0
Physician And Surgeon Temporary Permit	4
Physician Assistant Interim Permit	0
Physician Assistant License	68

Marisa Courtney, Licensing Manager – continued	
Physician Assistant Temporary Permit	0
Totals:	**236**

Information on Renewals: January Renewals: 72.43% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	17	17
MD	959	351	1310
MDIN	0	1	1
MDRE	0	1	1
MDTR	1	3	4
PA	138	45	183
	72.43%	**27.57%**	**100.00%**

Panel A
Personal Appearance Agenda

Friday, March 5, 2021

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for these meetings. Virtual public meetings, without a physical meeting space, will be held instead.

Please join this meeting from your computer, tablet or smartphone:

https://global.gotomeeting.com/join/243475405

Panel Members:

- Jimmy Chung, MD, Panel Chair
- James Anderson, PA-C
- Charlie Browne, MD
- Charlotte Lewis, MD
- Yanling Yu, PhD, Public Member
- Scott Rodgers, Public Member
- Robert Small, MD
- Richard Wohns, MD
- Alan Brown, MD, Pro-Tem
- Mary Curtis, MD, Pro-Tem

Compliance Officer: Kayla Bryson

Time	Respondent	Case
9:45am	**Michael E. Garnett, MD** Attorney: Christopher J. Mertens	M2019-1128 (2019-6974) RCM: Robert Small, MD SA: Trisha Wolf
10:30am	**Lance J. Ferrin, MD** Attorney: Pro Se	M2018-317 (2017-9001) RCM: Jimmy Chung, MD, SA: Kyle Karinen
11:15 a.m.	**Jeffery L. Smith, PA-C** Attorney: Pro Se	M2018-195 (2017-5694) RCM: James Anderson, PA-C SA: Gordon Wright
	Lunch Break	
1:15 p.m.	**Joseph P. Kincaid, MD** Attorney: Ronald A. VanWert	M2019-824 (2019-2361) RCM: Richard Wohns, MD SA: Rick Glein
2:00 p.m.	**Lee C. Hein, MD** Attorney: Pro Se	M2016-407 (2016-2338 et al.) RCM: James Anderson, PA-C SA: Ariele Page Landstrom

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

WASHINGTON
Medical Commission
Licensing. Accountability. Leadership.

Panel B
Personal Appearance Agenda

Friday, March 5, 2021

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for these meetings. Virtual public meetings, without a physical meeting space, will be held instead.

Please join my meeting from your computer, tablet or smartphone:

https://global.gotomeeting.com/join/345525861

Panel Members: April Jaeger, MD, Panel Chair

Toni Borlas, Public Member
Diana Currie, MD
Karen Domino, MD
Christine Hearst, Public Member
John Maldon, Public Member
Terry Murphy, MD
Alden Roberts, MD
Theresa Schimmels, PA-C
Claire Trescott, MD

Compliance Officer: Mike Kramer

9:45am	**Pierre Soffe, MD** Attorney: Steven J. Dixson	M2017-200 (2016-10892) RCM: William Brueggemann, MD SA: Ariele Page Landstrom
10:30am	**Patrick Z. Pearce, MD** Attorney: James B. King	M2017-1012 (2018-16198 et al.) RCM: Alden Roberts, MD, Toni Borlas SA: Colleen Balatbat
11:15 a.m.	**Julie A. Raekes, MD** Attorney: Christopher J. Mertens	M2019-818 (2019-3089) RCM: Gregory Terman, MD SA: Larry Berg
	LUNCH BREAK	
1:15 pm	**Jackie S. Shuey, PA-C** Attorney: Jennifer M. Veal	M2018-589 (2017-13615 et al.) RCM: Theresa Schimmels, PA-C SA: Trisha Wolf
2:00 pm	**Justin W. Sassone, PA-C** Attorney: James B. King	M2018-459 (2017-15174) RCM: Gregory Terman, MD SA: Ariele Page Landstrom

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.