# Policy: Interested Parties Meeting – 1st Revised

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Washington Medical Commission (WMC) meetings. This agenda is subject to change. The WMC will take public comment at the Policy: Interested Parties 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 doh.information@doh.wa.gov.

**Virtual via Teams Webinar: Registration link can be found below.**
***Commissioners and staff will attend virtually.***
**Physical location: 111 Israel Rd SE, TC2 Room 166, Tumwater, WA 98501**

## Thursday, January 30, 2025

### Open Session

| 10:00 am | Agenda | |
|---|---|---|
| To attend virtually, please **register** here: WMC Policy: Interested Parties | | |
| The goal of this meeting is to provide an opportunity for anyone to comment on and suggest changes to the WMC's policies, guidance documents, procedures, and interpretive statements. The WMC encourages the public to provide comments on the items on this agenda. To participate, please use the Raise Hand function or add your comments to the chat. Be sure to identify yourself and your affiliation, if applicable. If you prefer to submit written comments, please email them to medical.policy@wmc.wa.gov by 5 p.m. on **January 27, 2025**. | | |
| **Organizers:** Kyle Karinen, Executive Director & Micah Matthews, Deputy Executive Director | | |
| **1** | **Guidance Document: Sexual Misconduct and Abuse (GUI2017-03)**<br>*Review and discuss proposed revisions to the document as part of its scheduled four-year review process.* | Pages 3-8 |
| **2** | **Policy: Elective Educational Rotations (POL2020-01)**<br>*Review and discuss proposed revisions to the document as part of its scheduled four-year review process.* | Pages 9-10 |
| **3** | **Interpretive Statement: Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants**<br>*Review and discussion of current document.* | Pages 11-16 |
| **4** | **Interpretive Statement: Opioid Prescribing & Monitoring for Patients**<br>*Review and discussion of current document.* | Pages 17-20 |
| **5** | **Open Forum**<br>Interested parties are invited to share ideas for new policies or suggestions for reforming existing ones. Each speaker will have a two-minute comment period. Written comments are also welcome; please see below for details. | |
| **6** | **Written Comments**<br>These comments are provided for informational purposes at this meeting and will be presented at the next Policy Committee meeting for the Committee members' consideration. | Page 22 |

| Future Topics for Discussion | |
|---|---|
| The following items are next up for review. Feel free to provide comments regarding these items at medical.policy@wmc.wa.gov. | |
| **2025** | |
| **1** | Guidance Document: A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety (GUI2014-02) |
| **2** | Policy: Practitioners Exhibiting Disruptive Behavior (MD2021-01) |
| **3** | Procedure: Interactive and Transparent Development of Evidence-based Policies and Guidelines (PRO2018-02) |
| **2026** | |
| **1** | Guidance Document: Medical Professionalism (GUI2018-01) |
| **2** | Guidance Document: Practitioner competence (GUI2018-02) |
| **3** | Guidance Document: Overlapping and simultaneous surgeries (GUI2018-03) |
| **4** | Guidance Document: Reentry to Practice guideline (GUI2019-01) |
| **5** | Guidance Document: Reentry to Practice for suspended licenses guideline (GUI2019-02) |
| **6** | Guidance Document: Informed Consent and Shared Decision-Making (GUI2022-01) |
| **7** | Guidance Document: Ownership of Clinics by Physician Assistants MD2015-06 |
| **8** | Guidance Document: Medical marijuana authorization guidelines |
| **9** | Policy: Discrimination in Healthcare (POL2022-01) |
| **10** | Policy: Self-Treatment or Treatment of Immediate Family Members (POL2022-02) |
| **11** | Policy: Terminating the Practitioner-Patient Relationship (POL2022-03) |

Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

# Sexual Misconduct and Abuse

*"I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons."*[1]

**Guidance to Practitioners**

To help prevent sexual misconduct and abuse, and to help practitioners maintain good professional boundaries with patients and key third parties, the Commission strongly recommends that a practitioner:

1. Consider having a chaperone present during examination of any sensitive parts of the body.
2. Be aware of any feelings of sexual attraction to a patient or key third party. Under no circumstances should a practitioner act on these feelings or reveal or discuss them with the patient or key third party. The practitioner should discuss such feelings with a supervisor or trusted colleague.
3. Be alert to signs that a patient or key third party may be interested in a romantic or sexual relationship. All steps must be taken to ensure that the boundaries of the professional relationship are maintained. This could include transferring the care of the patient.
4. Transfer care of a patient to whom the practitioner is sexually attracted to another health care provider. Recognizing that such feelings in themselves are not compatible with competent professional practice, a practitioner should seek help in understanding and resolving them without exposing them to or impacting the patient or key third party in any way.
5. Respect patient and/or key third party's dignity and privacy at all times.
6. Provide a professional explanation of the need for each of the various components of examinations, procedures, tests, and aspects of care to be given. This can minimize any misperceptions a patient might have regarding the practitioner's intentions and the care being given.
7. Communicate with a patient in a clear, appropriate and professional manner. A practitioner should never engage in communication with a patient or key third party that

[1] Excerpt from Hippocratic Oath, Fourth Century B.C.

could be interpreted as flirtatious, or which employ sexual innuendo, off-color jokes, or offensive language.

8. Refrain from discussing the practitioner's personal problems, or any aspect of the practitioner's intimate life with a patient or key third party.

**Background**

Sexual misconduct between practitioners and patients or key third parties detracts from the goals of the practitioner-patient relationship, exploits the vulnerability of the patient, and obscures the practitioner's objective judgment concerning the patient's health care.~~, and~~ It is a fundamental betrayal of trust and detrimental to the patient's well-being. Abusive behavior by a practitioner ~~can~~ harms ~~a~~ patients. The Washington Medical Commission (Commission) does not tolerate sexual misconduct or abuse in any form.

The Commission ~~first adopted a policy on sexual misconduct in 1992. The Commission revised the policy in 1996 and again in 2002. In 2006, the Commission established separate rules prohibiting sexual misconduct and prohibiting abuse.~~ maintains rules prohibiting sexual misconduct and abuse. The Commission issues these guidelines to increase practitioner awareness of the rules and to help practitioners maintain appropriate practitioner-patient boundaries.

**Definitions**

A "patient" is a person who is receiving health care or ~~treatment, or~~treatment or has received health care or treatment ~~without a termination of the physician-patient relationship~~. The determination of when a person is a patient is made on a case-by-case basis with consideration given to ~~a number of~~several factors, including the nature, extent and context of the professional relationship between the ~~physician~~ practitioner and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.[2]

A "practitioner" is a physician licensed under Chapter 18.71 or 18.71B RCW, ~~or~~ a physician assistant as licensed under Chapter 18.71A or 18.71C RCW, or a certified anesthesiologist assistant licensed under Chapter 18.71D RCW.

A "key third party" is a person in a close personal relationship with the patient and includes, but is not limited to spouses, partners, parents, siblings, children, guardians and proxies.[3]

**Former Patients or Key Third Parties**

As provided in the rules, a practitioner cannot engage in any of the above behaviors with a former patient or former key third party if the practitioner

(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or
(b) Uses or exploits privileged information or access to privileged information to meet the practitioner's personal or sexual needs.

[2] WAC 246-919-630(1)(a) and WAC 246-918-410(1)(a).
[3] WAC 246-919-630(1)(c) and WAC 246-918-410(1)(c).

## Guideline

The Commission ~~will~~ does not tolerate ~~a~~ practitioners engaging in sexual misconduct with a patient or key third party. As stated in the rules, a practitioner engages in sexual misconduct when ~~he or she~~they engage~~s~~ in the following behaviors with a patient or key third party, ~~whether or not it~~regardless of setting, professional or otherwise: ~~occurred outside the professional setting.~~

(a) Sexual intercourse or genital to genital contact;
(b) Oral to genital contact;
(c) Genital to anal contact or oral to anal contact;
(d) Kissing in a romantic or sexual manner;
(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;
(f) Examination or touching of genitals without using gloves, except for examinations of an infant or prepubescent child when clinically appropriate;
(g) Not allowing a patient the privacy to dress or undress;
(h) Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient or key third party is present;
(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;
(j) Soliciting a date;
(k) Communicating regarding the sexual history, preferences or fantasies of the physician.[4]

Commented [MM1]: Update with new rules update from OS to WMC rules.

Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW 9.94A.030.[5]

### Consent

A patient's or key third party's consent to, initiation of, or participation in sexual behavior or involvement with a practitioner does not change the prohibited nature of the conduct. ~~The~~ As the party in the professional relationship with the power imbalance, practitioner has full and sole responsibility to maintain proper professional boundaries at all times and in all settings. It is not a defense or a mitigating factor that the patient or key third party consented to, proposed, or initiated ~~the sexual~~sexual contact or the sexual or romantic relationship.

~~It is improper for a practitioner who engages in sexual misconduct with a patient or key third party to make efforts to avoid full and sole responsibility by pointing to the patient's or key third party's consent or initiation, or by making any other attempt to shift responsibility to the patient, for example, by asserting that the patient or key third party was seductive or manipulative.~~

Commented [MM2]: Previous paragraph fully prohibits and places responsibility. This is a qualifier that confuses the issue. Suggest deleting.

### Termination of Practitioner-Patient Relationship

Best practice for practitioners licensed with the Commission is to never enter a relationship of a non-professional, romantic, or sexual nature with a patient or key third party. Once the

[4] WAC 246-919-630 (physicians), WAC 246-918-410 (physician assistants).
[5] Id.

practitioner-patient relationship has been established, the practitioner has the burden of showing that the relationship no longer exists. The mere passage of time is not determinative of the issue. Because of the varying nature of types of practitioner-patient relationships, variety of settings, differing practice types, and imbalance in power between practitioner and patient, individual analysis by the Commission is essential. As stated in the rules, the Commission will analyze each case individually and will consider ~~a number of~~several factors including, but are not limited to, the following:

(a) Documentation of formal termination;
(b) Transfer of the patient's care to another health care provider;
(c) The length of time that has passed;
(d) The length of time of the professional relationship;
(e) The extent to which the patient has confided personal or private information to the physician;
(f) The nature of the patient's health problem;
(g) The degree of emotional dependence and vulnerability of the patient or key third party.

Some practitioner-patient relationships may never effectively terminate because of the nature and extent of the relationship. As such, there is never an acceptable time when relationships of a sexual or romantic nature may occur in such instances. An example of one such specialty is psychiatry, where the national association has determined there is never an ability for the practitioner to engage in a non-therapeutic relationship of any kind with the patient or key third party. These relationships ~~may~~ will always raise concerns of sexual misconduct whenever there is sexual contact.[6]

~~**Former Patients or Key Third Parties**~~
~~As provided in the rules, a practitioner cannot engage in any of the above behaviors with a former patient or former key third party if the practitioner~~

~~(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or~~
~~(b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.~~

[6] Two opinions from the Washington Supreme Court provide guidance on the issue of whether a person is a current patient. In *Haley v. Medical Disciplinary Board,* 117 Wn.2d 1062 (1991), the court held that a patient whose contact with the surgeon was limited to the removal of her spleen and two follow up appointments was not a patient six months after the last follow up when a sexual relationship began. The court said that if the surgeon had been in another specialty that typically has an ongoing relationship with the patient, such as a family practitioner or an ob-gyn, the court would have found differently. In *Heinmiller v. Dept. of Health,* 127 Wn.2d 595 (1995), the same court found that a social worker who began a sexual relationship with a patient one day after terminating the professional relationship had sex with a client in violation of RCW 18.130.180(24).

### Diagnosis and Treatment

Sexual misconduct does not include conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.

### Abuse

The Commission ~~will~~ does not tolerate a practitioner abusing a patient. As stated in the rules, a practitioner abuses a patient when ~~he or she~~they:

(a) Makes statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;
(b) Removes a patient's clothing or gown without consent;
(c) Fails to treat an unconscious or deceased patient's body or property respectfully; or
(d) Engages in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.[7]

~~**Discipline**~~

~~Upon a finding that a practitioner has engaged in sexual misconduct or abuse, the Commission will impose one or more sanctions set forth in RCW 18.130.160. In some cases, revocation may be the appropriate sanction. In others, the Commission may restrict and monitor the practice of a practitioner who is actively engaging in a treatment program. When imposing sanctions, the Commission must first consider what sanctions are necessary to protect the public. Only after this is done may the Commission consider and include sanctions designed to rehabilitate the practitioner.~~

**Commented [MM3]:** This is pretty common knowledge and is likely assumed. Suggest deleting.

~~**Recommendations to Practitioners**~~

~~To help prevent sexual misconduct and abuse, and to help practitioners maintain good practitioner-patient boundaries, the Commission strongly recommends that a practitioner:~~

~~1. Consider having a chaperone present during examination of any sensitive parts of the body.~~
~~2. Be aware of any feelings of sexual attraction to a patient or key third party. Under no circumstances should a practitioner act on these feelings or reveal or discuss them with the patient or key third party. The practitioner should discuss such feelings with a supervisor or trusted colleague. Under no circumstances should a practitioner act on these feelings or reveal or discuss them with the patient or key third party.~~
~~3. Transfer care of a patient to whom the practitioner is sexually attracted to another health care provider. Recognizing that such feelings in themselves are neither wrong nor abnormal, a practitioner should seek help in understanding and resolving them.~~
~~4. Be alert to signs that a patient or key third party may be interested in a sexual relationship. All steps must be taken to ensure that the boundaries of the professional relationship are maintained. This could include transferring the care of the patient.~~
~~5. Respect a patient's dignity and privacy at all times.~~

[7] WAC 246-919-640 (physicians), WAC 246-918-420 (physician assistants).

6. ~~Provide a professional explanation of the need for each of the various components of examinations, procedures, tests, and aspects of care to be given. This can minimize any misperceptions a patient might have regarding the practitioner's intentions and the care being given.~~
7. ~~Communicate with a patient in a clear, appropriate and professional manner. A practitioner should never engage in communication with a patient or key third party that could be interpreted as flirtatious, or which employ sexual innuendo, off-color jokes, or offensive language.~~
8. ~~Refrain from discussing the practitioner's personal problems, or any aspect of the practitioner's intimate life with a patient.~~

| | |
|---|---|
| Guideline Number: | ~~GUI2017-03~~GUI2025-04 |
| Date of Adoption: | ~~June 30, 2017~~TBD |
| ~~Reaffirmed/~~Updated: | ~~May 14, 2021~~TBD |
| Supersedes: | ~~MD2002-05~~GUI2017-03 |

# Policy

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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 doh.information@doh.wa.gov.

| | |
|---|---|
| **Title:** | Elective Educational Rotations |
| **Policy Statement Number:** | TBD |
| **Document Number:** | |
| **References:** | RCW 18.71.030(6) and (8), RCW 18.71.230, Chapter 18.130 RCW |
| **Contact:** | Washington Medical Commission |
| **Phone:** | (360) 236-2750 |
| **Email:** | medical.policy@wmc.wa.gov |
| **Effective Date:** | TBD |
| **Supersedes:** | POL2020-01 |
| **Approved By:** | ,Chair |

## Policy

Medical students, ~~and~~ residents, and fellows in post-graduate medical training who are completing an elective educational rotation in the state of Washington are exempt from licensure for the specific purpose of completing the rotation.

RCW 18.71.030 lists exemptions to the requirement to have a license to practice medicine, and states, in part:

> Nothing in the chapter shall be construed to . . . prohibit:
> ...
> (6) The practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within this state;
> ...
> (8) The practice of medicine by a person serving a period of postgraduate medical training in a program of clinical medical training sponsored by a college or university in this state or by a hospital accredited in this state, however, the performance of such services shall be only pursuant to his or her duties as a trainee.

The lack of a license requirement does not exempt those trainees covered by this policy from accountability by the Commission. Per RCW 18.71.230, any person practicing in the state of Washington under exemptions in RCW 18.71.030(5) through (12) is subject to

disciplinary action by the Washington Medical Commission. Any complaints received by the Commission on trainees, licensed or not, are processed according to the relevant procedure: Complaints against students, residents, fellows WMC

Therefore, medical students, ~~and~~ residents, and fellows who are in post-graduate medical training who are completing an elective educational rotation in Washington State are exempt from licensure for the specific purpose of completing the rotation.

# Interpretive Statement

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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 doh.information@doh.wa.gov.

| | |
|---|---|
| **Title:** | Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants |
| **Interpretive Statement Number:** | INS2025-XX |
| **Document Number:** | |
| **References:** | RCW 18.71.800; RCW 18.71A.800; WAC 246-919-850 through WAC 246-919-985; WAC 246-918-800 through WAC 246-918-935 |
| **Contact:** | Washington Medical Commission |
| **Phone:** | (360) 236-2750 |
| **Email:** | medical.policy@wmc.wa.gov |
| **Effective Date:** | TBD |
| **Supersedes:** | INS2019-01, INS2023-03 |
| **Approved By:** | ,Chair |

## Description of the Issue

The Washington Medical Commission (Commission) is aware of concerns by practitioners that the Commission's opioid prescribing rules are inflexible and do not allow for variation based on patient presentation. The Commission is also aware that some practitioners are refusing to see or continue to treat patients who have taken or are currently using opioids.

## Interpretive Statement

The Intent and Scope section of both the physician opioid prescribing rule, WAC 246-919-850, and the physician assistant opioid prescribing rule, WAC 246-918-800, states that appropriate pain management is the responsibility of the treating practitioner and the inappropriate treatment of pain, including lack of treatment, is a departure from the standard of care. The Commission encourages practitioners, especially those in primary care, to view pain management as a part of standard medical practice for all patients and to become knowledgeable about assessing pain and effective treatments.

It is important to note that the rules are not inflexible and recognize the importance of sound clinical judgment. Those concerned about the use of the word "shall" within the rules are encouraged to review the Intent and Scope Section. This opening provision describes the purpose of the rules and sets the tone for interpretation and application of the entire opioid prescribing rule set by the Commission.

## Background

In 2011, the Commission established rules for managing chronic, noncancer pain to alleviate practitioner uncertainty, encourage better pain management, and assist practitioners in providing appropriate medical care for patients. Since 2011, the Legislature and Commission have made changes on the management of chronic pain to improve patient care and safety.

In 2018, at the direction of the Legislature,[1] the Commission created new rules regarding opioid prescribing for acute nonoperative, acute perioperative, and subacute pain, including the use of multimodal pharmacologic and nonpharmacological therapies as possible alternatives to opioids. The Commission made minor modifications to the existing rules for managing chronic pain as well.

In 2020, at the direction of the Legislature, the Commission revised its rules to require a physician to inform a patient that the patient has the right to refuse an opioid prescription for any reason and to require documentation and clarification regarding honoring that refusal.[2]

Additionally, in 2022, the Commission amended the rules to state the rules do not apply to the treatment of patients in nursing homes, long-term acute care facilities, residential treatment facilities, and residential habilitation centers.[3]

## Analysis

The opioid prescribing rules for physicians (WAC 246-919-850) and physician assistants (WAC 246-918-800) describe the Commission's intent and scope of the rules as follows:

> The [commission] recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.
>
> The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages [practitioners] to view pain management as a part of quality medical practice for all patients with pain, including acute, perioperative, subacute, and chronic pain. All [practitioners] should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as become knowledgeable about the statutory requirements for prescribing opioids, including co-occurring prescriptions. Accordingly, these rules clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.
>
> Inappropriate pain treatment may result from a [practitioner's] lack of knowledge about pain management. Fears of investigation or sanction by federal, state, or local agencies

[1] Engrossed Substitute House Bill 1427.
[2] RCW 18.71.810; WAC 246-919-865(1)(e); WAC 246-918-815(1)(d).
[3] WAC 246-919-851(5); WAC 246-918-801(5).

may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The commission recognizes that controlled substances including opioids may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness, trauma or surgery. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain.

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not the same as opioid use disorder.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate prescribing of controlled substances, including opioids, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that [practitioners] incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

[Practitioners] should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a [practitioner]-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The commission will judge the validity of the [practitioner's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

These rules are designed to assist [practitioners] in providing appropriate medical care for patients. The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The

variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these rules will not guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist [practitioners] in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

For more specific best practices, the [practitioner] may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease Control and Prevention, or the Bree Collaborative.

## Commonly Asked Questions

*1. What is episodic care and how does it apply to my practice?*

For the purpose of these rules, episodic care usually includes patients seen in an emergency department or urgent care facility for chronic pain when complete medical records are not available. Additionally, patients seen in an ambulatory care setting with complaints associated with chronic pain whose complete medical records are not available would also be covered by this rule. However, some healthcare systems and clinics may have an associated urgent care facility with complete availability of medical records. These facilities would be excluded from the definition of episodic care for the purposes of these rules.

*2. Does the rule define the entire standard of care for the management of pain?*

No. The contents of the rules do address some important elements of the standard of care for pain management, but they do not define the entire standard of care. The rules are not exhaustive. The standard of care (current practice guidelines articulated by expert review) will continue to control circumstances and issues not addressed by the rule.

*3. Is the 120 mg. MED "consultation threshold" a maximum dose under the rules?*

No. The 120 mg morphine equivalent dose (MED) threshold is a triggering dose, intended to alert the practitioner to the fact that prescribing at this dose or higher significantly increases the potential for morbidity and mortality, and requires a consultation with a pain specialist unless the practitioner or circumstances are exempted under the rules. The articulation of this dose in the rules is consistent with the Legislature's requirement in RCW 18.71.450[4] to adopt rules that contain a dosage amount that must not be exceeded without pain specialist consultation.

Some have referred to the 120 mg MED threshold (or "triggering") dose as a "maximum dose". The rules do not provide a maximum dose. They simply require, absent an exemption, that the practitioner obtain a pain specialist consultation before continuing to

[4] ESHB 2876, effective June 10, 2010.

prescribe opioids at a level that is associated with significant increases in opioid-related overdoses and deaths.

### *4. Is the 120 mg. MED "consultation threshold" the minimum dosage at which a consultation should be obtained under the rules?*

No. A practitioner should obtain a consultation when warranted. In WAC 246-919-930(2) and WAC 246-918-880(2), the threshold for mandatory consultation is set at 120 mg MED for adult patients. However, WAC 246-919-930(1) and WAC 246-918-880(1) reference, more generally, additional evaluation that *may* be needed to meet treatment objectives. This section makes specific reference to evaluation of patients under age 18 who are at risk, or who are potential high-risk patients. However, other circumstances may call for a consultation with a pain management specialist for patients who have not yet met the "consultation threshold" dose.

## Specific Guidance from the Rules

WAC 246-919-955 and 246-918-905 provide specific guidance to the practitioner to do the following with new patients on high dose opioids:

- Maintain the patient's current opioid doses until an appropriate assessment suggests that a change is indicated (see second bullet point).
- Evaluate over time if any tapering can or should be done.
- New patients on high dose opioids are exempt from mandatory pain specialist consultation requirements for the first three months of newly established care if:
    - The patient was previously being treated for the same conditions;
    - The patient's dose is stable and nonescalating;
    - The patient has a history of compliance with written agreements and treatment plans; and
    - The patient has documented function improvements or stability at the presenting dose.

WAC 246-919-950 clearly explains that tapering would be expected for chronic pain patients when:

- The patient requests tapering;
- The patient experiences an improvement in function or pain;
- The patient is noncompliant with the written agreement;
- Other treatment modalities are indicated;
- There is evidence of misuse, abuse, substance use disorder, or diversion;
- The patient experiences a severe adverse event or overdose;
- There is unauthorized escalation of doses;
- The patient is receiving an authorized escalation of dose with no improvement in pain or function.

A practitioner treating a patient on a stable, nonescalating dose with positive impact on function would not be required to seek additional consultation with a pain specialist. Additionally, there is no upper MED limit in Washington State or federal law. The Commission's opioid prescribing rules represent the only legal requirement and cite a 120

mg MED “consultation threshold” for allopathic physicians and physician assistants who are not considered pain management specialists under the rule. The rules do not prohibit practitioners from referring a patient to a pain specialist before patients reach the “consultation threshold,” nor do they prevent a practitioner from self-imposing a smaller MED limit for their patients.

For practitioners not considered pain management specialists treating patients over the 120 mg MED “consultation threshold,” there are several options to satisfy the exemption to the consultation requirement, including but not limited to:

- Receiving a peer-to-peer consult with a pain management specialist;
- Participating in an electronic (audio/video) case consult with the University of Washington (UW) Telepain, the Washington Health Care Authority (HCA) Opioid Hotline, or other pain consulting service;
- Documenting in a chart note the attempt to get a consult but the lack of success in attaining one; and
- Successfully completing a minimum of twelve category I continuing education hours in chronic pain management within the previous four years with at least two of those hours dedicated to substance use disorders.

The practitioner should document the outcomes, reasoning, and discussions with the patient as outlined in the rules and described in this interpretive statement in the patient’s medical record as part of the normal course of medical practice.

# Interpretive Statement

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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 doh.information@doh.wa.gov.

| | |
|---|---|
| **Title:** | Opioid Prescribing & Monitoring for Patients |
| **Interpretive Statement Number:** | INS2025-XX |
| **Document Number:** | |
| **References:** | RCW 18.71.800; RCW 18.71A.800; WAC 246-919-850 through WAC 246-919-985; WAC 246-918-800 through WAC 246-918-935 |
| **Contact:** | Washington Medical Commission |
| **Phone:** | (360) 236-2750 |
| **Email:** | medical.policy@wmc.wa.gov |
| **Effective Date:** | TBD |
| **Supersedes:** | INS2019-02, INS2023-04 |
| **Approved By:** | ,Chair |

## Description of the Issue

The Washington Medical Commission (Commission) is aware that some practitioners are refusing to see or continue to treat patients who have taken or are currently using opioids. To help underscore and clarify the need for patient access and the rights of patients for treatment, the Commission issues this interpretive statement for patient and practitioner use.

## Interpretive Statement

The Intent and Scope section of both the physician opioid prescribing rule, WAC 246-919-850, and the physician assistant opioid prescribing rule, WAC 246-918-800, states that appropriate pain management is the responsibility of the treating practitioner and that the inappropriate treatment of pain, including lack of treatment, is a departure from the standard of care. The Commission encourages practitioners, especially those in primary care, to view pain management as a part of standard medical practice for all patients and to become knowledgeable about assessing pain and effective treatments.

The Commission interprets physician rules WAC 246-919-850 to 246-919-985 and corresponding physician assistant rules WAC 246-918-800 to WAC 246-918-935 as encouraging practitioners to not exclude, undertreat, or dismiss a patient from a practice solely because the patient has used or is currently using opioids in the course of normal medical care. While in most circumstances a practitioner is not legally required to treat a particular patient, the refusal to see or continue to treat a patient merely because the patient has taken or is currently using opioids is contrary to the clear intent of the

Commission's rules governing opioid prescribing. Ending opioid therapy or initiating a forced tapering of opioids to a particular morphine equivalent dose (MED) level for reasons outside of abuse or clinical efficacy or improvement in quality of life and/or function would violate the intent of the rules.

## Background

In 2011, the Commission established rules for managing chronic, noncancer pain to alleviate practitioner uncertainty, encourage better pain management, and assist practitioners in providing appropriate medical care for patients. Since 2011, the Legislature and Commission have made changes on the management of chronic pain to improve patient care and safety.

In 2018, at the direction of the Legislature, the Commission created new rules regarding opioid prescribing for acute nonoperative, acute perioperative, and subacute pain, including the use of multimodal pharmacologic and nonpharmacological therapies as possible alternatives to opioids.[1] The Commission made minor modifications to the existing rules for managing chronic pain as well.

In 2020, at the direction of the Legislature, the Commission revised its rules to require a practitioner to inform a patient that the patient has the right to refuse an opioid prescription for any reason.[2]

Additionally, in 2022, the Commission amended the rules to state the rules do not apply to the treatment of patients in nursing homes, long-term acute care facilities, residential treatment facilities, and residential habilitation centers.[3]

## Analysis

The opioid prescribing rules for physicians (WAC 246-919-850) and physician assistants (WAC 246-918-800) describe the Commission's intent and scope of the rules as follows:

> The [commission] recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.
>
> The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages [practitioners] to view pain management as a part of quality medical practice for all patients with pain, including acute, perioperative, subacute, and chronic pain. All [practitioners] should become knowledgeable about assessing

[1] Engrossed Substitute House Bill 1427.
[2] RCW 18.71.810; WAC 246-919-865(1)(e); WAC 246-918-815(1)(d).
[3] WAC 246-919-851(5); WAC 246-918-801(5)

patients' pain and effective methods of pain treatment, as well as become knowledgeable about the statutory requirements for prescribing opioids, including co-occurring prescriptions. Accordingly, these rules clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate [practitioner] uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from a [practitioner's] lack of knowledge about pain management. Fears of investigation or sanction by federal, state, or local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating [practitioner's] responsibility. As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis. The commission recognizes that controlled substances including opioids may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness, trauma or surgery. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain.

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the [practitioner]. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. [Practitioners} should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not the same as opioid use disorder.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate prescribing of controlled substances, including opioids, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that [practitioners] incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

[Practitioners] should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a [practitioner]-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The commission will judge the validity of the [practitioner treatment of the patient based on available documentation, rather than solely on the quantity and duration of

medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

These rules are designed to assist [practitioners] in providing appropriate medical care for patients. The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these rules will not guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist [practitioners] in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

For more specific best practices, the [practitioner] may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease Control and Prevention, or the Bree Collaborative.

## Examples

### Existing Patient

A patient with a longstanding history in a medical practice develops an injury or condition that becomes a pain condition requiring chronic opioid therapy. Generally, a practitioner who refuses to treat the condition properly, including the appropriate utilization of opioids when opioids are clearly indicated, would be practicing below the standard of care. Similarly, a practitioner who refers the patient to a pain management specialist as defined by Commission rule but refuses to continue or support the pain management treatment plan designed by the specialist while responding to all other aspects of patient care, would generally be practicing below the standard of care. Finally, electing to terminate the patient from the practice because their regular care involves pain management or opioid therapy would be generally be practicing below the standard of care.

### New Patient

The Commission's opioid prescribing rules provide incentives for practitioners to take new patients into their practice who are on existing opioid therapy regimens.

WAC 246-919-955 and 246-918-905, and the corresponding physician assistant rules, provide specific guidance to the practitioner to do the following with new patients on high dose opioids:

- Maintain the patient's current opioid doses until an appropriate assessment suggests that a change is indicated (see second bullet point).
- Evaluate over time if any tapering can or should be done.
- Be aware that new patients on high dose opioids are exempt from mandatory pain specialist consultation requirements for the first three months of newly established care if:

- The patient was previously being treated for the same condition(s);
- The presenting dose is stable and nonescalating;
- There is a history of compliance with written agreements and treatment plans; and
- There is documented function improvements or stability at the presenting dose.

### Tapering

A patient on opioid therapy, chronic or otherwise, is on a stable nonescalating dose. A practitioner has observed the patient's function and quality of life to be positive. However, citing reasons related to state or federal law or desire to have the patient below a certain MED per day, the practitioner initiates a tapering schedule without receiving the patient's consent or considering the patient's function or quality of life. This would be a clear violation of the Commission opioid prescribing rules.

WAC 246-919-950 clearly explains that tapering would be expected for chronic pain patients when one or more of the following occurs:

- The patient requests tapering;
- The patient experiences an improvement in function or pain;
- The patient is noncompliant with the written agreement;
- Other treatment modalities are indicated;
- There is evidence of misuse, abuse, substance use disorder, or diversion;
- The patient experiences a severe adverse event or overdose;
- There is an unauthorized escalation of doses; or
- The patient is receiving an authorized escalation of dose with no improvement in pain or function.

A practitioner treating a patient on a stable nonescalating dose with positive impact on function would not be required to seek additional consultation with a pain specialist. Additionally, there is no upper MED limit in Washington State or federal law. The Commission's opioid prescribing rules represent the only legal requirement for licensed allopathic physicians and physician assistants in Washington state and set a 120 mg MED consultation threshold for practitioners who are not considered pain management specialists under the rule. The rules do not prohibit practitioners from referring a patient to a pain specialist before patients reach the "consultation threshold," nor do they prevent a practitioner from self-imposing a smaller MED limit for their patients.

The practitioner should document the outcomes, reasoning, and discussions with the patient as outlined in the rules and described in this interpretive statement in the patient's medical record as part of the normal course of medical practice.

**From:** Kenneth Partlow
**To:** WMC Medical Policy
**Subject:** The disruptive MD
**Date:** Wednesday, January 22, 2025 3:03:39 PM

---

External Email

Sirs and Madams,

I have already sent a letter to your attorney about my time as a disruptive MD. He told me he would get the letter to you so I won't send it again.

My concern is the disempowerment of physicians.

I speak as a surgeon and disagree with your opening statement that disruptive behavior is a risk to patient safety.

The psychologists, who I assume are consulting for the WMC, have no deep knowledge of the operating room and its interactions and their conclusions, like that of many of the consultants I hired to analyze our business, are likely to be both superficial and expensive.

In your model, disruptive behavior is never seen as a positive. Rather it's always selfish, and the result of mental illness or (pejorative) manipulative behavior that leads to a bad outcome for the patient.

By adopting this policy without the appropriate meta-analysis support, the committee is behaving like a psychologist not like a doctor and is furthering the ability of those with no extended responsibility for the care of the individual patient to be able to manipulate doctors for potential emotional or personal reasons. Thus adding more burdens to the beleaguered MDs of Washington State.

The cancel culture is gradually fading away. Don't admit it into the hospital.

Ken Partlow, MD