Washington Health Law Manual — Third Edition
Washington State Society of Healthcare Attorneys (WSSHA)

Chapter 9:
Professional Licensure of Individuals

Author: Donna Moniz
Organization: Johnson, Graffe, Keay, Moniz & Wick, LLP

Author: Michelle Taft
Organization: Johnson, Graffe, Keay, Moniz & Wick, LLP

Reference Date: The authors prepared this chapter from reference materials that were available as of September 30, 2014.

Biographies

Donna Moniz, RN, MN, JD, Author

Donna Moniz has many years of experience representing doctors, nurses, hospitals, and other health care providers. She is a partner with the firm Johnson, Graffe, Keay, Moniz & Wick, LLP. She has a nursing background and has cared for patients in hospitals, long term care facilities, clinics, and homes. She has over 24 years of experience representing health care providers in disciplinary and malpractice cases. She also regularly consults on other matters such as clinical care issues and medical staff privileges.

Ms. Moniz has nursing degrees from Catholic University of America in Washington, DC and from the University of Washington. Her law degree is from the University of Washington. She is an adjunct assistant professor at the University of Washington School of Nursing. She is a member of the American Health Lawyers Association, the American Association of Nurse Attorneys, the American Bar Association, and the Defense Trial Lawyers Association.

Michelle Taft, JD, Author

Michelle Taft is an attorney with the firm Johnson, Graffe, Keay, Moniz & Wick, LLP. Ms. Taft has a civil litigation practice emphasizing defense of medical negligence claims and health care law. She earned her BA from the University of Southern California in Economics and a JD from the University of Washington School of Law.

Acknowledgments

Angela Macey-Cushman contributed to prior versions of this chapter as an author.

Chapter Outline

9.1 Chapter Summary

This chapter provides an overview of the statutory scheme in Washington regarding professional licensure and discipline. This chapter discusses the categories of licensees in relation to the disciplining authority and addresses the promulgation and scope of regulations. This chapter also examines the legal responsibilities of licensees, the Department of Health (DOH), and private health care agencies. The discipline process is addressed, as well as the substance of disciplinary violations. Mandatory reporting and enforcement regarding unlicensed practice and various sanctions are described.

Each profession licensed under Washington's statutory scheme is responsible or accountable directly to the consumer for the conduct of the profession. This means that each provider is potentially subject to malpractice liability. In addition, the practitioner is subject to discipline either directly by DOH or through a professional board or commission.

9.2 Overview of Statutory Scheme

9.2.1 Overview of Title 18

Title 18 of the Revised Code of Washington (RCW) addresses the regulation of businesses and professions. The statute regulates over 80 professions, approximately half of which are health care professions. Title 18 also includes the Uniform Disciplinary Act (UDA), which is the primary vehicle for regulation and discipline of health professional.

9.2.2 Scope of Practice

Each chapter of Title 18 RCW sets forth the definition of the particular profession it addresses with some information about its scope of practice. Additional detail is provided in the regulations, with varying degrees of specificity. While the statutory schemes in some other jurisdictions address limited and unlimited licenses, this designation is not used in Washington. Rather, each separate chapter of Title 18 RCW tends to describe the profession, but carves out specific exceptions for other professions. For example, RCW 18.71.011 defines the scope of practice of medicine, but specifically prohibits the physician from engaging in chiropractic practice as defined in RCW 18.25.005.

9.2.3 Licensed, Certified, and Unlicensed Providers

Most health care providers are governed by specific sections of RCW 18. While most are licensed, some categories such as health care assistants are certified. Counselors may be registered or licensed. RCW 18.225 regulates Marriage & Family Therapists, Mental Health Counselors, and Social Workers. Speech therapists were not governed by any chapter of RCW Title 18 for many years before becoming regulated as Certified Speech and Hearing Professionals in 2003. Nursing assistants may be registered or certified.[1] As new healing professions develop, DOH may not immediately acknowledge or regulate them.

Many practitioners licensed under RCW Title 18 are directly accountable to the Secretary of Health ("Secretary") for discipline. Others are disciplined by way of a board or commission governing only one or a few categories of practitioners. All of the foregoing are referred to as "disciplining authority" under 1995 recodified language.

9.3 Scope of Regulation

9.3.1 Regulation in Washington Administrative Code (Disciplining Authority)

Regulations set forth in the Washington Administrative Code provide additional detail with respect to licensing, limitations on professional fees, specific standards of practice or conduct allowed or prohibited and scope of practice. To determine the grounds for discipline in any particular profession, one must examine both the requirements of the UDA and the specific statutory and regulatory sections under which a professional is licensed. For example, pharmacists are subject to the UDA, but specific requirements set forth in RCW 18.64.160 govern the pharmacist's knowing violation of any state or federal law, rule, or

[1] RCW 18.88A.030(4).

regulation governing the possession, use, distribution, and dispensing of drugs. These matters are also addressed under the UDA.

Many practitioners licensed under RCW Title 18 are directly accountable to the Secretary of Health ("Secretary") for discipline. Others are disciplined by way of a board or commission governing only one or a few categories of practitioners. All of the foregoing are referred to as the "disciplining authority" under the 1995 re-codified language.

9.3.2 Enforcement Mechanics

Each disciplining commission (or board) has a specified number of members who are health care professionals in the same discipline(s) which the commission governs, as well as one or more public members. Licensees who have allegedly violated statutory or regulatory provisions may have discipline initiated by the board or commission or by the Secretary, depending on their category of licensure. For example, a nurse practicing outside the scope of the nursing license would be subject to charges and discipline initiated by the Nursing Commission. A licensed midwife alleged to have violated standards or practiced outside the scope of midwifery would be subject to charges and discipline initiated by the Secretary or the Secretary's designee.

9.4 Responsibilities of Licensees, Department of Health, and Employers

9.4.1 Licensees

9.4.1.1 Must Determine Criteria for Licensure and Meet Them

Licensees are held legally responsible to determine the criteria for licensure and to meet those criteria. New graduates who seek to become licensees or licensees from other states who move to Washington must either qualify for interim permits, where available, or comply with licensing requirements and obtain the license prior to practicing their profession. Those who fail to do so will risk a charge of practicing without a license.

9.4.1.2 Must Comply with Renewal Notices

Licensees must be aware of the license renewal date, which is generally the licensee's date of birth. The state system sends one renewal notice by mail. DOH does not accept responsibility for assuring that the renewal notice is sent or that it is sent to the correct address. The licensee is responsible for keeping DOH informed of a current address and for renewing the license, whether or not the notice was received. Health professionals may renew their licenses on the DOH website, via mail or in person. Failure to renew within certain time limits may result in fines, loss of license, or having to take a refresher course to renew.

9.4.1.3 Must Know and Comply with Standards of Practice and Licensure

The licensee must know and comply with standards of practice whether or not they are set forth in statutes or regulations. DOH, boards, and commissions uniformly require this level of compliance with generally accepted standards of practice in the community. Washington courts have found that due process is not violated where the legislature has designed a combination of prosecutorial, investigative, and adjudicative functions by empowering commissions to develop, monitor and enforce these standards of practice for healthcare professionals.[2]

All licensees must practice within the scope of their licenses. This is a challenging requirement, given that the scope is often not defined with substantial specificity and the provision of health care services develops and changes over time. The complexity of health care, delivered by more and more team members, increases as health care delivery systems develop. Also, practices differ depending on whether the practitioner cares for patients in large cities or in remote, outlying areas. The licensee is thus held responsible for practicing within the scope of accepted standards, even though the disciplining authority may not have set out specific guidelines.

[2] *Ancier v. State Dpt. of Health*, 140 Wn. 2d 564, 579, 166 P.3d 829 (2007).

One case that explored the scope of practice issue considered whether a certified registered nurse anesthetist was authorized to administer and order controlled substances as part of anesthesia.[3] The nursing statutes and regulations merely referred to the scope and practice standards delineated by the American Association of Nurse Anesthetists (AANA), a professional organization which is not a licensing agency. In defining a nurse anesthetist's scope of practice, the AANA included the administration and ordering of controlled substances for anesthesia and pain control as an authorized practice. Nonetheless, the State Board of Nursing (now the Nursing Commission) charged the nurse anesthetists with practicing outside the scope of their licenses. The anesthetists ultimately prevailed by convincing the Board that their practice was within the historic as well as the legal scope of practice of nurse anesthetists in Washington and elsewhere.

9.4.2 Department of Health

DOH generally regulates health professions. As indicated above, some disciplines are regulated directly while others are regulated by boards or commissions, which are self-governing bodies. The Secretary does not override decisions made by boards or the decision of commissions in disciplinary cases. In the event of an appeal from a board, a commission, or the Secretary, the appeal is made directly to the Superior Court.

9.4.2.1 Commitment to Public Safety

Commitment to public safety is the primary responsibility of DOH and its professional agencies. Prosecutors are called upon constantly to make charging decisions as well as strategic and settlement decisions that are fair under the circumstances. Most often, such decisions are made with the consultation or direction of the disciplinary authority's reviewing member, who represents the state agency's interests. Ideally, these decisions are influenced primarily by concern for the public welfare and without regard to the political and economic power of the respondent or the licensee.

9.4.2.2 Allocation of Resources

In determining which cases to pursue and to what degree, the prosecutor in conjunction with the state agency/client must make prudent decisions about the beneficial use of public resources in a manner that is most efficient. When cases will have little effect on public safety, such as incidents of unavoidable or virtually unrepeatable human errors with trivial results, the waste of limited public resources should be avoided.

9.4.2.3 Public Disclosure

Like other public agencies, DOH is subject to Washington's broad Public Records Act, codified at RCW 42.56. When the requests are reasonably tailored, disciplinary authorities may provide information including their disciplinary guidelines, an index of significant decisions, the text of any Final Order of a Health Law Judge, and most of the investigation file for any matter that has proceeded to a Statement of Charges, except where a protective order has been issued. Medical records are generally not provided.

9.4.3 Employers/Agencies

9.4.3.1 Ensure that Care is Being Given by Licensed Providers

Employers must ascertain that care is actually being given by licensed providers. There is a rare but constant risk of imposters. Some people have managed to glean limited amounts of knowledge, so as to convince employers that they are qualified professionals when they are, in fact, not. More common are instances in which a practitioner has graduated from an accredited program or received a certificate from an advanced program, but has not yet succeeded in obtaining a license from the state. Employers who fail to verify licensure are vulnerable to charges of promoting unlicensed practice. Individual supervisors who hire such persons may be vulnerable

[3] *In re: The License to Practice Nursing of William Douglas Anundson, R.N., Ann B. Crusius, R.N., Walter Scott Gray, R.N., and David K. Grenon, R.N.*, PM 6613, PM 6614, PM 6615 and PM 6777 (Board of Nursing, 1992). Throughout this chapter this case is referred to as the "*Gray* case."

to charges as well. The Department of Health offers an online Provider Credential Search that allows employers to search for healthcare providers by name or credential number.[4]

9.4.3.2 Check for Significant Discipline or Complaint History

Employers are responsible for checking for a significant discipline or complaint history. The employer should contact DOH to determine who has been disciplined and in what cases duplicate licenses have been issued. The online Provider Credential Search offered by the DOH indicates whether a healthcare provider's license is subject to an enforcement action and provides information pertaining to that action. Periodic checks should be made to detect whether a provider is practicing with a stolen license or is on probation and not meeting probationary requirements.

9.4.3.3 Interface with Department on Investigations

On occasion, employers will be required to respond to or cooperate with Department investigations. The nature and extent of investigative authority possessed by DOH is subject to some dispute. Generally, DOH has authority to conduct investigations and practice reviews, issue subpoenas, and take depositions.[5] The extent to which information may be compelled without formal process, however, remains an open question. DOH takes the view that its investigators may demand copies of medical records without complying with the Health Care Information Act and without issuing a subpoena.

In a 2005 case, *Client A. v. Yoshinaka*, the Psychology Board initiated an investigation based on a complaint by a non-patient about the provider's care of her son and the son's wife. The appellate court held that the Department violated the UDA by investigating without first obtaining a determination of merit from the Psychology Board. A part of the investigation involved a request for confidential therapy records.[6] In determining that the Department had violated the UDA, the Division One Court of Appeals stated:

> We recognize that there may be complaints involving real danger to the public in which the State must have the ability to access information expeditiously. When properly followed, the procedural safeguards provided by the UDA and the requirement in RCW 70.02.050(2)(a) that providers disclose health records without patient consent only under enumerated circumstances, strike an appropriate balance between adequately allowing the State to obtain pertinent records when needed while preventing it from having unfettered access to health records. First, an investigation should not be conducted, and records should not be obtained, until the Board determines that the complaint merits investigation, consistent with RCW 18.130.080. Second, the Board should obtain only the records that are reasonably related to the violation alleged in the complaint, consistent with RCW 70.02.050(2)(a). And third, the Board must ensure that the privacy of health records obtained in an investigation is protected, as required in RCW 42.17.312, RCW 70.02.050(3) and WAC 246–08–390.

Yoshinaka remains good law in Washington and is a reflection of the court's attempt to balance the Board's need for information and the public safety risk with disclosing patients' medical records without their permission. Under the Health Insurance Portability and Accountability Act **(**HIPAA**)**, such requests should be honored only if it is relevant and material to a legitimate law enforcement inquiry and if it is specific and limited in scope based on the purpose for the request.[7] Employers are responsible for asserting any applicable privilege. Thus, the facility or agency

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[4] WASHINGTON DEPARTMENT OF HEALTH, PROVIDER CREDENTIAL SEARCH, available at http://www.doh.wa.gov/LicensesPermitsandCertificates/ProviderCredentialSearch (last visited August 19, 2014); WASHINGTON STATE DEPARTMENT OF HEALTH, FREQUENTLY ASKED QUESTIONS regarding the Provider Credential Search Web Site, https://fortress.wa.gov/doh/providercredentialsearch/Documents/FAQ.pdf (last visited August 19, 2014).

[5] RCW 18.130.060(4).

[6] *Client A. v. Yoshinaka*, 128 Wn. 2d 833, 116 P. 3d 1081 (2005).

[7] 45 C.F.R. § 164.512(f)(1)(ii)(C).

should assert the physician/patient privilege or protections for medical records involving drug and alcohol treatment of the provider, whenever appropriate. In addition, peer review or quality assurance protections may be asserted depending on the situation.[8]

Further, in the absence of a patient-signed release or a court order, a facility should not release medical records, particularly if they involve issues of treatment for substance abuse or alcoholism. In this situation, federal law clearly preempts the authority of the disciplining body.[9] Employers concerned about possible licensing or regulatory violations, including in particular drug diversion, may obtain assistance from DOH in order to investigate complaints.

9.5 Disciplinary Procedure

9.5.1 Overview of Constitutional Rights

The constitutions of both Washington state and the United States require due process before the government can revoke a licensee's professional license. Under the familiar passages of the U.S. Constitution's 5th and 14th Amendments and the Washington Constitution's Article I, Section 3, the state may deprive no person of "life, liberty, or property, without due process of law." Revoking the professional license is a governmental decision depriving individuals of "liberty" or "property" interests and therefore requires due process.

Notice to the individual and a hearing before an impartial decision-maker are the two required components of procedural due process. Washington's Administrative Procedures Act allows the courts to overturn any administrative order that is unconstitutional.[10] Prior to any disciplinary hearing, due process requires that the professional licensee receive both adequate notice that the state intends to limit the license and the opportunity to oppose the state's proposed action. As to the fairness of having a disciplinary board function as both investigator and adjudicator, Washington courts have concluded that without more proof of a biased hearing, the combination of these functions in one board does not violate due process.[11]

9.5.2 Investigation

Most complaints to DOH lead to investigations of varying kinds. Occasionally, there will simply be a follow-up inquiry or a request for information from the licensee. At other times, the investigation may last over a period of months or years and will include questioning numerous witnesses as well as obtaining past employment records of the licensee. Sometimes a chart, prescription or practice review will also be a part of that assessment.

Under the 1997 UDA amendments, not all letters to DOH will rise to the level of a complaint meriting investigation. All letters are subject to review to determine whether investigation is warranted. Pending this review, the letter is not a public record. If closed without an investigation, the matter is not reflected on the practitioner's computerized record as an open or closed complaint. However, the reason for closing (such as "no merit") and information on the incident would still be available under Washington's Public Disclosure Act. Whether or not there is an investigation, DOH maintains that the complainant's identity remains privileged unless a waiver has been signed or the complaint was made in bad faith.[12]

Under the 1997 UDA amendments, DOH must notify the licensee when a complaint letter is received, unless notification would impede an effective investigation. Investigators are required to advise licensees of their right to an attorney prior to obtaining a written statement regarding the issues in the case. In addition, the investigator must inform witnesses or potential witnesses, in writing, that their statement may be released to the licensee or other person under investigation if charges are issued. The investigation always results in the compilation of an investigative file for the reviewing member of the disciplining authority.

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[8] Washington law protecting peer review materials and hospital quality assurance appears at RCW 4.24.240, RCW 4.24.250, and RCW 70.41.200 (amended in 2007 with an effective date of July 1, 2009).
[9] *See* 42 C.F.R. § 2.13(b).
[10] RCW 34.05.570(3)(a).
[11] *See Washington State Medical Disciplinary Board* v. Johnston, 99 Wn.2d 466, 663 P.2d 457 (1983).
[12] RCW 43.70.075.

This entire file may be requested during discovery. However, up to the time of a charging decision, disciplinary authorities have historically taken the position that they are obligated to protect the medical record and other materials under RCW 42.56.210. Because the Washington State Whistleblower Protection statute protects the identity of whistleblowers unless DOH determines that the complaint was not made in good faith, if DOH is not presently inclined to include "not made in good faith" as one of its reasons for closing without an investigation, every complaint's identity would be protected indefinitely unless waived. Investigations have generally taken between a month and a year to complete, but may take longer.

9.5.3 Charging

Charging decisions are made by one member of a commission or board, or by the Secretary's designee for a particular program. The disciplining authority will generally obtain input from a professional, if a professional practice issue is involved. The Secretary's designee makes charging decisions regarding unlicensed practice. The licensee or other respondent is notified by certified mail of the charges. The charges will describe the allegations regarding conduct and the alleged statutory violations and will generally allege that license revocation is appropriate. The respondent has 20 days within which to file an answer and request a hearing. If the 20-day limit results in a hardship to the respondent, the respondent may request an additional extension, for good cause, for up to 60 days. Failure to answer and request a hearing constitutes a default and the disciplining authority may enter a decision based on the information available. The information mailed with the Statement of Charges typically includes a scheduling order to set deadlines for pre-hearing discovery and conferences. This Order and the establishment of an Adjudicative Clerk's Office for central recording and filing achieve prehearing procedural efficiency once charges are filed.[13]

9.5.4 Summary Suspension

DOH may take emergency action ordering summary suspension of a license or restriction or limitation of the licensee's practice pending proceedings by the disciplining authority in accordance with RCW 18.130.050(7). Further restrictions on a summary suspension authority are set forth in Washington's APA. In some cases, courts may find the agency did not meet criteria and order the agency to grant a hearing rather than summarily suspend. There are situations mandated by statute where DOH has no discretion, but must suspend the practitioner's license based on another authority's determinations. For example, under RCW 18.130.127, if the practitioner is certified by the Department of Social and Health Services (DSHS) and is reported to DOH for noncompliance with a child support order, license suspension is automatic. Reinstatement of the license requires the practitioner to present, during the suspension period, a release issued by DSHS stating the practitioner is in compliance.

9.5.5 Discovery

Discovery is available to parties in accordance with the APA, including necessary depositions and formal requests for production. In some cases, disputes occur regarding the number or scope of depositions to be taken in a matter. A Health Law Judge will make a determination if counsel are unable to agree on discovery related issues. Typically, fewer and shorter depositions are taken than in a comparable civil litigation case. As soon as charges are filed, a formal request for the entire investigation file should be made. The response may include a list of items withheld on a claim of privilege. These may be contested on motion to the health law judge

9.5.6 Settlement

Settlement is the outcome in the majority of cases brought by DOH or other disciplining authority. DOH's most recent UDA Biennial Report reported that from 2011 to 2013, a total of 20,717 complaints were filed with DOH and led to 9621 investigations, but only 2604 complaints resulted in disciplinary action. Of the 2604 complaints resulting in disciplinary action, 24% resulted in settlement via Agreed Orders, 26% resulted in default orders, 27% were resolved via informal dispositions, 17% were resolved via notices of decision on applications, and only 6% were resolved through final orders following a hearing.[14]

[13] RCW 18.130.090.

[14] WASHINGTON STATE DEPARTMENT OF HEALTH: 2011-2013 UNIFORM DISCIPLINARY ACT BIENNIAL REPORT, available at: http://www.doh.wa.gov/Portals/1/Documents/2000/UDAReport2011-2013.pdf (last visited August 19, 2014).

As in civil litigation, settlement is expedient when there is either a clear-cut violation or enough evidence supporting the view that one occurred to warrant some discipline. Cases may not be settled where they involve significant issues of law such as the *Gray* case (involving nurse anesthetists) described in section 9.4.1.3, above. Significant disagreements over factual issues will prevent settlement. For example, when DOH alleges sexual abuse which the respondent completely denies, a hearing will result. The respondent would contest the case in order to clear the record. As in civil litigation cases, if the parties cannot agree on an appropriate compromise, a hearing will determine the licensee's discipline.

Settlement may be achieved either by written or phone negotiation between the Assistant Attorney General assigned to the case and the respondent or respondent's counsel. In each case the reviewing commission or board or the program manager must approve the settlement. If settlement is not reached, the respondent may choose to have a settlement conference either in person or by phone with the reviewing member of the disciplining authority.

Mediation is another potential avenue for settlement, where attorneys for both the practitioner and DOH agree that the matter should be settled, but entrenched positions of one or both parties have prevented settlement from occurring. Former reviewing commission members or pro tem judges may be available for mediation. On occasion, Office of Professional Standard Judges may also be available to mediate matters.

For physicians, settlements may profoundly damage or destroy their careers. All discipline, whether formal or not must be reported to the National Practitioner Data Bank. Hospitals determining privileges, employers, malpractice insurers, and third party payers all refer to the Data Bank for information about physicians. Any of these may use the discipline as a basis for denying privileges, employment, coverage, or third party reimbursement.[15] Drug related discipline may lead to loss of Drug Enforcement Administration (DEA) approval for prescribing controlled substances.[16]

9.5.7 Hearing

Hearing procedures are governed by the APA. Disciplining authorities are specifically empowered to administer oaths, review evidence, issue and enforce subpoenas, and take depositions. Under the APA, strict rules of evidence do not apply. Admissible evidence under RCW 34.05.452 is "the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs." However, in many ways, hearings under the APA are similar to trials.

The burden of proof in professional disciplinary varies based on the license at issue. In the case of *Nguyen v. State of Washington*, the state Supreme Court held that a physician's license is a property interest that may not be taken by the state without due process of law, requiring the "clear and convincing" burden of proof.[17] In 2005, the case *Ongom v. State of Washington* extended this treatment to nursing assistant licensure, requiring the "clear and convincing" burden in disciplinary actions affecting nursing assistants.[18] However, *Ongom* was expressly overruled by *Hardee v. State Department of Social and Health Services*, in which the Court held that a home child care license was subject to the "preponderance of the evidence" burden, a lower burden of proof than the "clear and convincing evidence" burden.[19] The *Hardee* Court explained that, "The significance of the private interest at stake directly corresponds to the rigor of the burden placed on the State."[20] Although a professional license is a property interest that requires due process, not all occupations require an identical personal investment, and disciplinary proceedings against

[15] DEPT. OF HEALTH AND HUMAN SERVICES (HHS), HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA), FACT SHEET ON THE NATIONAL PRACTITIONER DATABANK (February 2014), available at: http://www.npdb.hrsa.gov/resources/reports/2012NPDBAnnualReport.pdf (last visited August 19, 2014).
[16] RCW 69.50.304.
[17] *Nguyen v. State of Washington, et al.*, 144 Wn.2d 516, 29 P.3d 689 (2001).
[18] *Ongom v. State, Dep't of Health, Office of Professional Standards*, 159 Wn.2d 132, 148 P.3d 1029 (2006).
[19] *Hardee v. State Dpt. of Social and Health Services*, 172 Wn. 2d 1, 256 P.3d 339 (2011).
[20] *Id*. at 8.

physicians affect a greater property interest than a home child care or nursing assistant license.[21] This is because some professional licenses, such as a physician's license requires a greater investment by the licensee, therefore requiring a higher burden.[22]

The *Hardee* Court established a principle that the burden of proof required at a disciplinary hearing will be based on the type of license at issue. However, the Court has not set a dividing line as to where the burden of proof shifts from the lower "preponderance of the evidence" burden to the higher "clear and convincing evidence" burden. Thus, licensees must infer that professional licenses that require more schooling and training, such as a bachelor's or graduate degree, will be treated to a higher burden of proof than licenses that require lesser education or training.

Hearings provide a licensee with similar procedures as superior court trials. These include an unbiased tribunal, notice of the proposed action the grounds asserted for it, an opportunity to present the tribunal with reasons why the proposed action should not be taken, the right to call witnesses during the hearing, the right to discovery, the right to have a decision based only on the evidence presented at the hearing, the right to counsel, the making of a record of the proceedings, public attendance of the proceedings, and judicial review.[23] Therefore, hearings should be approached in the same manner as a superior court trial because the licensee's ability to practice his or her profession is at stake. Similar preparation and presentation of witnesses is required. Unless there is a significant strategic reason to waive them, opening statements and closing arguments should be presented. Witnesses may be called and experts utilized, as needed. While they may be more sophisticated about the health care industry generally, the individual board or commission members presiding at the hearing may have no experience in the particular subspecialty involved. Similarly, hearings may be held before administrative law judges with little or no health care background. In such cases, general education on the relevant medical issues will assist the judge in understanding the case. In the absence of a jury, less formal evidentiary requirements will apply. However, declarations or statements may not be used unless stipulated to by both sides. Witnesses may be presented by telephone testimony, as long as each party retains the opportunity to participate and cross-examine the witnesses.

9.5.8 Appeal

An appeal from an adverse decision of the hearing panel must be filed within the same 30-day time limit that applies to court decisions. The appeal may be filed in the Superior Court for Thurston County or in the county in which the respondent resides or principally conducts business. There may be strategic reasons for selecting one county over another.

The appeal is an appeal on the record. As in other administrative cases, it is imperative that the complete record of facts and evidence be made at the agency level. Generally, new evidence and new issues may not be added during the course of an appeal. Findings of fact made by the agency are upheld unless clearly erroneous. The burden of proof is on the challenging party to prove that there is not substantial evidence, or sufficient quantity to persuade a fair minded person of the truth of the declared premises, to support a Hearing Examiner's factual finding. Conclusions of law are reviewed de novo.[24] The judgment of the agency is given great deference, especially in areas involving the professional specialty.

9.5.9 Tactical Considerations

Obviously, the system works best, for both the public and the individual licensee, when laws are applied with a good measure of wisdom and fairness. Just as in civil litigation, disputes are settled most effectively when the lawyers can work together to achieve a solution acceptable to the parties. Neither the licensee's nor the state's financial resources should be wasted on substantive or procedural matters that are not essential. Protecting patient privacy is in the interest of all concerned. Increased awareness of privacy due

[21] It. at 13.
[22] *Id.*
[23] *Id.* at 11.
[24] *Nghiem v. State*, 73 Wn. App. 405, 410, 869 P.2d 1086 (1994); *Christianson v. Snohomish Health Dist.*, 82 Wn. App. 284, 287, 917 P.2d 1093 (1996).

to HIPAA has led to revised procedures, such as redacting patient identity information from documents produced during discovery, and sometimes protective orders are required.

If necessary, the implications of the case for other parties, such as health care institutions and the community generally, must be considered. Likewise, respondents' attorneys must consider what is best for the public, along with their client's desires, in a particular case.

9.6 Substantive Violations

9.6.1 Substandard Clinical Care

Clinical care that does not meet generally accepted professional standards is one type of substantive violation of the UDA. This violation is defined in RCW 18.130.180(4) as incompetence, negligence, or malpractice which result in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The alleged malpractice need not actually hurt a patient. It may constitute one case or a general pattern of care. The individual licensing acts and regulations may give additional detail about specific substantive requirements for clinical care. However, substandard clinical care may be alleged based on generally accepted professional standards. Unlike in medical malpractice cases, allegations of substandard clinical care do not require the support of an expert's testimony before charges may be brought.

9.6.2 Conduct Beyond Scope of License

Conduct beyond the scope of a license also gives rise to potential discipline. For example, an Advanced Registered Nurse Practitioner (ARNP) licensed under RCW 18.79 may be qualified to suture minor wounds. However, if an ARNP decided to perform elective plastic surgery it would be practice beyond the scope of the ARNP's license. Whether or not the patient was actually harmed, the conduct would be subject to discipline. As discussed above in section 9.4.1.3, it is sometimes difficult to determine whether the scope of practice has been exceeded. Nevertheless, maintaining a current knowledge and functioning within the scope of practice is the practitioner's responsibility.

9.6.3 Impairment

Specific provisions of the UDA will permit disciplinary action against licensees with certain impairments or allow the enforcing authorities to seek and monitor the effectiveness of constructive alternatives.

9.6.3.1 Physical, Mental, Drug or Alcohol Abuse

Physical health problems, mental illness, and drug or alcohol abuse may lead to disciplinary action. RCW 18.130.180(23) applies to current misuse of alcohol, controlled substances or legend drugs. In other words, a provider who is currently misusing prescription drugs or illegal drugs may be subject to discipline. Drug diversion is also grounds for discipline, whether or not the drugs are used by the licensee. Providers may not prescribe controlled substances for themselves.

9.6.3.2 Alternatives to Discipline for Impaired Professionals

Under RCW 18.130.175, disciplining authorities may refer license holders to approved voluntary substance abuse monitoring programs in lieu of discipline. If the licensee consents to the program and successfully completes it, no discipline will result. If the licensee fails to enter the program or fails the program, the license holder may be disciplined for the original conduct, as well as subsequent violations.

Different programs address the needs of impaired practitioners. The Washington Physicians Health Program (WPHP) is available to MDs, DOs, podiatrists, physician assistants (PAs), dentists, and veterinarians. The Washington Recovery Assistance Program for Pharmacy is available only to pharmacists, pharmacy assistants, and pharmacy technicians. Other professions are covered by the Washington Health Professional Services Program.[25]

[25] 2011-2013 UNIFORM DISCIPLINARY ACT BIENNIAL REPORT, *supra*, p. 38.

9.6.4 Sexual Misconduct

9.6.4.1 General Policies

Abuse of a client or patient, or sexual contact with a client or patient, is prohibited under RCW 18.130.180(24). RCW 18.130.062 requires the Secretary to act as sole disciplinary authority for complaints that allege only sexual misconduct. The intent of the law is to encourage prompt action when a provider has engaged in sexual misconduct even if there are not any issues involving clinical expertise or standard of care. The appropriate board or commission reviews each complaint and retains responsibility for those cases that also involve clinical expertise or standard of care issues. The boards and commissions transfer cases that involve only sexual misconduct to the Secretary for discipline. Between 2011 and 2013, 27 cases were referred to the Secretary.[26]

Both the Medical and the Nursing Quality Assurance Commissions have promulgated regulations regarding sexual contact with patients. Sanctions in this area are based on the view that patient abuse or sexual contact changes the provider/patient relationship from one that benefits the client to one that benefits the provider. Boundaries are blurred and the patient may become a victim. The policy of the Medical Commission is that some physician/patient relationships never terminate because of the nature and extent of the relationship. Therefore, sexual misconduct could occur when there is sexual contact between a physician and former patient, especially when the relationship is in the psychiatric or mental health realm. Note that the patient and provider may be of either sex or the same sex. The fact that a patient may initiate the sexual contact does not absolve the provider from responsibility.

The Nursing Care Quality Assurance Commission sets forth a regulation prohibiting sexual misconduct, defining it broadly as sexual or romantic conduct with a client or family member. As set forth in WAC 246-840-740(4)(b), considerations in these cases include, but are not limited to, the following:

- The amount of time that has passed since nursing services were terminated;
- The nature and duration of the nurse/client relationship, the extent to which there exists an ongoing nurse/client relationship following the termination of services, and whether the client is reasonably anticipated to become a client of the nurse in the future;
- The circumstances of the cessation or termination of the nurse/client relationship;
- The former client's personal history;
- The former client's current or past mental status, and whether the client has been the recipient of mental health services;
- The likelihood of an adverse impact on the former client and others;
- Any statements or actions made by the nurse during the course of treatment suggesting or inviting the possibility of sexual or romantic conduct; and
- Where the conduct is with a client's immediate family member or significant other, whether such a person is vulnerable to being induced into such relationship due to the condition or treatment of the client or the overall circumstances.[27]

The Medical Commission describes in detail what conduct is prohibited and when the patient relationship terminates.[28] The Commission also states that it is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.[29]

9.6.4.2 Illustrative Examples

The *Haley v. Medical Disciplinary Board* case expanded the grounds on which a licensee could be disciplined due to sexual misconduct, based on the view that public protection is the primary purpose

[26] 2011-2013 Uniform Disciplinary Act Biennial Report, *supra*, p.18.
[27] WAC 246-840-740(4)(b).
[28] WAC 246-919-630.
[29] WAC 246-919-630(6).

of professional discipline. Dr. Haley, a 66 year-old general surgeon, challenged the Medical Disciplinary Board's right to prohibit sexual contact between a physician and a former patient. For this surgeon, the issues were different from those of a psychiatrist or mental health professional. Ultimately, the court upheld the discipline of Dr. Haley, finding that he had engaged in sexual conduct with a 16-year-old female patient, supplied her with alcoholic beverages, alienated her from her parents, and set her up in an apartment on her own. The Washington Supreme Court found that the doctor's relationship constituted exploitation of the patient, a juvenile, for sexual gratification and therefore constituted moral turpitude. This finding indicated Dr. Haley's unfitness to practice by raising concerns about his propensity to abuse his professional position.[30]

Another physician's license was revoked for ten years based on the patient's testimony regarding the physician's conduct during examination, inappropriate sexual contact, and inappropriate sexual questioning. Reinstatement of the license, following the ten-year revocation period, would require proof of rehabilitation.[31]

In another reported case, a social worker had her license suspended indefinitely based on her sexual relationship with a female client.[32] Although the client and social worker terminated their therapeutic relationship voluntarily the day before they began an intimate, long-term sexual relationship, the disciplining administrative agency found that the therapeutic relationship had, in fact, continued. Additional elements of the relationship were determined to be abusive. The license suspension was upheld by the Washington Supreme Court.

In April 2006, the Seattle Times published a series of articles on sexual misconduct by health care providers. In response, then Governor Gregoire pledged sweeping changes including background checks, national practitioner databank checks, and imposing stricter qualifications for registered counselors. She also vowed to the DOH and 16 boards and commissions to develop a uniform definition of sexual misconduct.[33]

9.6.4.3 Criminal Sanctions

The Washington State criminal code has been revised to include special categories of second degree rape and indecent liberties for perpetrators who are health care providers. The Code provides that a person is guilty of rape in the second degree when sexual intercourse occurs between a health care provider and patient and the intercourse occurs during a treatment session, consultation, interview, or examination.[34] The defendant may attempt to prove as an affirmative defense that the client or patient consented to intercourse with the knowledge that it was not for the purpose of treatment. RCW 9A.44.100(1)(d) provides that a person is guilty of indecent liberties when there is other sexual contact between a perpetrator who is a health care provider and a victim who is a client or patient and the contact occurs during a treatment session, consultation, interview, or examination.

9.6.5 Patient Abuse

Patient abuse may be alleged when a patient suffers non-accidental injury, sexual abuse or negligent treatment in accordance with RCW 70.124.020(9). This problem is purported to occur more frequently in nursing homes, although it is certainly not limited to that population. Whenever physical restraint of a patient is required, the issue of appropriate force may be raised. Emotional abuse is somewhat more difficult to describe and is not defined in the UDA. The UDA section addressing patient abuse, RCW 18.130.180(24), also addresses sexual contact with patients, but most of the case law interpreting the statute (as described above in section 9.6.4) deals with sexual misconduct. The lack of reported case law on

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[30] *Haley v. Medical Disciplinary Board*, 117 Wn.2d 720, 818 P.2d 1062 (1991); *see* RCW 18.130.010.
[31] *Ngheim*, 73 Wn. App at 413-14.
[32] *Heinmiller v. Dep't of Health* , 127 Wn.2d 595, 903 P.2d 433 (1995), *reconsideration denied*, *amended by* 909 P.2d 1294 (Wash. 1996), *cert. denied*, 518 U.S. 1006, 116 S. Ct. 2526, 136 L.Ed. 2d 1051(1996).
[33] Michael J. Berens, *Gregoire Pledges to Reform Health-Care Licensing*, SEATTLE TIMES, Apr. 30, 2006, *available at* http://seattletimes.nwsource.com/html/localnews/2002962246_harm30m.html.
[34] RCW 9A.44.050(d).

general patient abuse leaves this area in need of further development. Such guidance would assist both practitioners and disciplining bodies in distinguishing simple rudeness or poor bedside manner from emotional abuse of patients. Health care providers must report suspected child abuse. Failure to do so may be a misdemeanor in accordance with RCW 70.124.030 – .070.

9.6.6 Fraudulent Practices

Misrepresentation or fraud in any aspect of the conduct of the profession violates the UDA and the standards of practice. The practitioner may not promote for personal gain any unnecessary or ineffective drug, device, treatment, procedure, or service. False, fraudulent, or misleading advertising is also prohibited by the UDA. Additionally, unprofessional conduct is deemed to include violations of the Anti-Rebate Statute,[35] which prohibits payment rebate, refund, or request for rebate in connection with referral of patients or clients to another person or business or in connection with the services of any kind. Whenever there is a referral to an agency in which the referring practitioner has a financial interest, this information must be disclosed. Any criminal or civil cases involving false claims or billing fraud may lead to disciplinary action as well.

9.7 Enforcement

9.7.1 Unlicensed Practice

The Secretary has the authority to investigate and issue cease and desist orders, as well as injunctions for unlicensed practice. The Secretary issues a notice of intention to issue a cease and desist order when the Secretary has reason to believe that there is unlicensed practice. The person to whom such a notice is issued may request an adjudicative proceeding to contest the charges. The request must be filed within 20 days. Failing to file such a request constitutes a default, which will lead to a permanent cease and desist order and may include a civil fine. If there is a finding that the public interest will be irreparably harmed by a delay, the Secretary may immediately issue a temporary cease and desist order.

9.7.1.1 Reporting Required

Reporting of apparent unlicensed practice is not specifically required by RCW 18.130.070. However, some boards do require such reporting. For example, nurses are required to report nurse imposters, those practicing with a non-renewed license, and those practicing as a nurse practitioner when not licensed as an Advanced Registered Nurse Practitioner to the Nursing Care Quality Assurance Commission.[36]

9.7.1.2 Enforcement

Enforcement with respect to unlicensed practice is assigned to the Secretary. The Secretary may impose a civil fine as well as a cease and desist order. In addition, the Attorney General, the county prosecuting attorney, or a board/commission may maintain an action in the name of the state to enjoin any person from practicing a licensed profession without a license.[37] Criminal prosecution for practicing without a license is possible as well.[38] A single incident of unlicensed practice constitutes a gross misdemeanor, while subsequent violations constitute a class C felony.[39]

9.7.2 Sanctions

9.7.2.1 Probation and Other Sanctions

Occasionally, providers are denied licenses or licensees are subject to license revocation. However, the vast majority of licensees who are disciplined receive some disposition short of revocation. The range of options available to a disciplining authority is outlined in RCW 18.130.160. Informally, there may be an agreement to discontinue a contested practice. Otherwise, the range of discipline involves

[35] RCW 19.68.010.
[36] WAC 246-840-730
[37] RCW 18.130.190(6).
[38] RCW 18.130.190(5).
[39] RCW 18.130.197(7).

censure, reprimand, or probation with certain restrictive conditions, and often payment of an administrative fine, remedial education, and/or treatment.

Stipulations to informal disposition (STID's) may be negotiated in some cases, although Commissions seem to limit their use to fairly minor issues. Although viewed as a less harsh sanction than those imposed after a formal hearing, they are reportable. Further, third-party payers often view such stipulations, along with the "admitted" facts normally accompanying them, as grounds for their own suspension or revocation of a practitioner's place on the payer's provider panel.

In STID's, as in final orders, sanctions will typically relate to the charges filed. For example, if there are concerns about medication administration, a medication course may be required. Equally common are orders to research or complete a report on topics related to the charges. Similarly, in cases involving mental health concerns, therapy or medication may be required during probation to ensure that the practitioner is able to practice safely. Practitioners with substance abuse issues may be ordered to undergo therapy, attend Alcoholics Anonymous or Narcotics Anonymous meetings, and submit to random urine testing.

License holders who have committed unprofessional conduct are subject to sanctions under WAC 246-16-800 through WAC 246-16-890, which provides a schedule of sanctions for unprofessional conduct as required by RCW 18.130.390. Unprofessional conduct subject to this schedule of sanctions includes practicing below the standard of care, sexual misconduct, physical and emotional abuse, diversion of controlled substances, substance abuse, and criminal convictions. WAC 246-16-800 through WAC 246-16-890 lays out specific guidelines for these types of unprofessional conduct sanctions, the severity of the unprofessional conduct determining the severity of the sanctions.

9.7.2.2 Mitigating Factors

The disciplining authority may consider mitigating factors.[40] A variety of factors may be considered in determining sanctions for a particular professional. Such factors may include the number of times the particular conduct has occurred, the time since it occurred last, any remedial measures or corrective action taken by the provider and any punishment already administered. DOH has not been sympathetic to the defense that the professional did not know the particular conduct was improper. In one reported case, a dentist was unsuccessful in appealing disciplinary action, even though he had been unaware of his failure to comply with a regulation requiring reporting of a patient's hospitalization.[41]

9.7.3 Alternatives to Discipline

RCW 18.130.175 approves and establishes detailed requirements for the voluntary substance abuse monitoring programs described above in section 9.6.3.2. Licensees may be referred or self-referred to a voluntary substance abuse monitoring program approved by the disciplining authority. Generally, intensive drug or alcohol treatment programs will be the initial phase for an active user. Once accepted into the program, a licensee will be required to abstain from all drug and alcohol use, and usually be urine tested for compliance. Substance abuse as defined in RCW 18.130.175(5) means the impairment, as determined by the disciplining authority, of a license holder's professional services by an addiction to, a dependency on or the use of, alcohol, legend drugs, or controlled substances. The statute provides immunity from liability for those involved in the monitored treatment program, as well as those reporting information about an impaired license holder.[42]

9.8. Mandatory Reporting

9.8.1 When Required

In 2006, the Washington State Legislature directed DOH to adopt rules about mandatory reporting of healthcare practitioners who commit unprofessional conduct or unable to practice safely. The legislature added additional mandatory reporting requirements in 2008. The mandatory reporting rules are located in

[40] WAC 246-840-720 allowing for the consideration of mitigating circumstances in NQAC cases.
[41] *Tomlinson v. State of Washington, Dental Disciplinary Board*, 51 Wn. App. 472, 754 P.2d 109 (1988).
[42] RCW 18.130.175(7).

WAC Chapter 246-16 and cover reports about all practitioners regulated by the department Secretary, board a or commission. They require reporting by healthcare practitioners, employers, and healthcare facilities.[43]

RCW 18.130.070(1) gives disciplining authorities the power to adopt rules requiring any person regulated by the authority to report a conviction, determination, or finding that a license holder has committed an act which constitutes unprofessional conduct or to report information that indicates that a licensee may not be able to practice with reasonable skill and safety as the result of a mental or physical condition. For example, the Nursing Commission, in accordance with WAC 246-839-730, requires mandatory reporting of unprofessional conduct, inability to practice with reasonable skill or safety, or a physical or mental condition impeding practice. Physicians are also subject to mandatory reporting under RCW 18.130.070. Under RCW 18.71.0195 the contents of reports of practicing physicians are confidential and exempt from public disclosure, but they may be reviewed by investigators or the practitioner, who may then submit an additional explanatory statement or other information. RCW 18.130.070 also provides additional information regarding what particular acts must be reported. Failure to report within 30 days of notice constitutes grounds for disciplinary action.[44]

Under the Federal Health Care Quality Improvement Act, when final actions relating to unprofessional conduct affect clinical privileges for more than 30 days, a data bank report is required.[45] Hospitals are required to report to the state Medical Quality Assurance Commission findings of unprofessional physician conduct which lead to restriction or termination of privileges. RCW 70.41.201 contains additional requirements for reporting many types of health care providers when their practice is restricted, suspended, limited, or terminated based on a finding of unprofessional conduct. Likewise, voluntary resignation or practice limitation while under investigation or in exchange for not conducting an investigation is also reportable.[46]

9.8.2 What is Adequate Evidence

When to report is a matter of judgment. Some cases involve clear evidence such as patient abuse or termination of a provider's position. However, there have been cases where personality differences, lack of communication, or simple rudeness have given rise to reports. Aside from those areas in which there is clear statutory direction, providers should use discretion and seek the advice of counsel in order to determine what to report and whether there is evidence of professional misconduct. Mere rumors are not enough.

9.8.3 Sanctions for Failure to Report

In defining unprofessional conduct, RCW 18.130.180 includes some specific violations that could occur in connection with a failure to report. Such violations could lead to the same disciplinary actions described above in Section 9.8.1 and in RCW 18.130.160. Specifically, interference with investigations or disciplinary proceedings in specific statutory circumstances could trigger the finding of unprofessional conduct by a license holder or applicant.

9.8.4 Immunity for Reporting

RCW 18.130.300 provides immunity from civil suit for persons providing information to the disciplinary authority when required to do so. Hospitals are required to report findings of unprofessional physician conduct leading to restriction or termination of privileges.[47] As set forth in *Dutton v. Washington Physician's Health Program*, the disciplining authority itself is immune from liability under the same section. The immunity of the Commission is absolute as a quasi-judicial entity.[48] The *Dutton* court also

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[43] DEPARTMENT OF HEALTH: HEALTH PROFESSIONS MANDATORY REPORTING, *available at* http://www.doh.wa.gov/LicensesPermitsandCertificates/FileComplaintAboutProviderorFacility/HealthProfessionsMandatoryReporting (last visited August 21, 2014).
[44] RCW 18.130.070(4)(b).
[45] Federal Health Care Quality Improvement Act, 42 U.S.C. § 11133(a).
[46] RCW 70.41.210(1)-(3).
[47] RCW 70.41.210.
[48] *Dutton v. Washington Physician's Health Program*, 87 Wn. App. 614, 93 P.2d 298 (1997).

found that the Washington Physicians Health Program enjoyed qualified immunity from suit for good faith reporting. Depending on the circumstances, good faith may be determined by summary judgment.

9.8.5 Mandatory Reporting of Malpractice Settlements and Judgments for Physicians

Those making payments on behalf of physicians are required to report malpractice settlements to the Medical Quality Assurance Commission under the Federal Health Care Quality Improvement Act.[49] Professional liability insurers are required to send complete reports of all malpractice settlements or monetary payments as a result of claims against an insured physician accused of medical negligence to the Commission. Such reports are required within 60 days of the date of a settlement or verdict.

9.8.6 Interstate Reporting System

Disciplinary actions regarding health care provider licenses are reported to counterpart licensing boards in other states or associations of state licensing boards. As a result of such reporting, other states in which the licensee holds a license are likely to take similar action against the licensee. To illustrate, Washington's RCW 18.130.180(5) provides that suspension, revocation, or restriction of a person's license to practice the profession in another state or jurisdiction is conclusive evidence for such a revocation, suspension, or restriction in Washington. However, sanctions may vary from state to state. Nonetheless, providers must be cautioned that suspension or revocation of a license will probably affect licenses in all states. The issues giving rise to discipline must be addressed in the state where the issues originally arose.

9.9 Trends in Discipline

DOH investigatory and disciplinary trends change as law and medicine evolve. Recent developments in technology, changes in regulations and the number of baby boomers entering retirement age have all played a part in shaping current disciplinary trends.

9.9.1 The Aging Physician

As advances in medicine have led to longer lifespans, many Baby Boomers entering retirement age have chosen to retire later in life. With this trend the number of complaints against older providers has risen. Many of these complaints stem from age-related problems that affect providers' ability to care for patients. For example, DOH has increasingly investigated complaints where providers with arthritis and other physical conditions are having medical staff perform physical tasks that should be performed by the provider. DOH is also seeing more providers with dementia and memory-related issues who have chosen to remain in practice, to the detriment of their patients. In some instances, providers experiencing age-related issues may self-limit their practices to avoid harming patients and avoid DOH discipline. However, retirement may be appropriate in other instances.

9.9.2 Chronic Pain Prescriptions

In 2010 the Washington Legislature passed new laws after 2008 statistics showed that drug overdose deaths exceeded car accident deaths. The Nursing Commission, the Board of Osteopathic Medicine, and the Medical Commission responded by creating equivalent Morphine Equivalent Dose (MED) rules. The rules have strict MED requirements for non-cancer pain prescriptions. These rules specify that a provider must obtain a pain consult in order to write prescriptions exceeding the MED limit for non-cancer pain patients, with two exceptions: 1) if the provider does 12 CME's in treating chronic pain and 2) if the provider documents multiple attempts to obtain a pain consult with no success. The provider may decline to follow the recommendations of the pain consult if the provider documents their careful reasoning. The introduction of these rules resulted in a 23% reduction in overdose death since they were enacted.

9.9.3 HIPAA and Social Media

Many providers do not understand the breadth of HIPAA, which severely limits the use of patient information for non-treatment purposes. This is becoming a problem with advances in technology and social media. Where providers use information obtained through the provider-patient relationship to access patient social media profiles, providers risk discipline. In one case, a physician used information obtained in a clinical setting to find a patient on Google. Through Google, the provider accessed the patient's Facebook page and accidently sent the patient a "friend request." The patient filed a complaint, and the

[49] Federal Health Care Quality Impairment Act, 42 U.S.C. §1395, 42 U.S.C. §11133(a).

provider was disciplined. Providers should be aware that HIPAA is extremely limiting, and providers should avoid using patient information for non-treatment purposes.

9.9.4 The Disruptive Doctor

As medicine moves away from the paternalistic approach to treatment, hospitals will report providers whose behavior problems impact patient care. This has led to a rise in disciplinary actions taken against providers with personality disorders. In 2014, a complaint was filed against a physician who was diagnosed with severe, untreated narcissistic personality disorder. DOH revoked the physician's license indefinitely and precluded him from filing a petition for modification for five years. Providers should be aware that DOH does not tolerate disruptive behaviors, even when caused by mental health disorders that negatively impact patient care.