Washington Physicians’ Guide to Health Law

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* [Naturopathy](http://legalguide.wsma.org.onexcale.net/other-health-care-professionals/naturopaths/naturopaths) (NEW)
* [National Practitioner Data Bank](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/national-practitioner-data-bank)v (UPDATED)
* [Disclosure And Protection Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/hippa/disclosure-and-protection-of-health-care-info) (UPDATED)
* [Gunshot Wounds](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/emergency-treatment/gunshot-wounds) (UPDATED)
* [Driver's License Certificate](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/drivers-license-certificate) (UPDATED)

***4th Edition - Edited by Denny Maher, JD, MD***

The Washington State Medical Association is proud to present the fourth edition of the Washington Physicians’ Guide to Health Law in a completely digital, online format. The content of the legal guide has been completely updated since the third edition, which was compiled in February, 2007. The chapters have been reorganized according to broad general topics and specific subtopics (see menus to the left). Because the Washington Physicians’ Guide to Health Law is now an online resource, the legal guide will be updated more regularly as the laws, regulations, or court cases which support the content change. In addition, we will add additional sections and chapters to the Washington Physicians’ Guide to Health Law whenever indicated. We hope that you will find this legal guide to be a useful tool for your practice, and easy to use. We welcome your comments and suggestions.

The content of the first three editions of the Washington Physicians’ Guide to Health Law, which forms the foundation of this edition, was compiled by Mary H. Spillane, Esq. and Jan C. Kirkwood, Esq., of the law firm of Williams Kastner PLLC.

Assistance and research for the third edition of the Washington Physicians Guide to Health Law was provided by Timothy C. Layton, Esq., formerly the WSMA Senior Director of Legislative, Regulatory, and Legal Affairs, Denny Maher, JD, MD, currently the WSMA Director of Legal Affairs, and by Mary Re Knack, Esq., Arissa Peterson, Esq., and Josephine B. Vestal, Esq. of Williams Kastner, and by Sheena R. Aebig, Esq.

The research and organization of the online fourth edition of the Washington Physicians’ Guide to Health Law was provided and supervised by Denny Maher, JD, MD, WSMA Director of Legal Affairs. Assistance and research were provided by Kathryn Kolan, Esq., WSMA Director of Legislative and Regulatory Affairs, and Erik Walters, Esq. Technical support and assistance at the WSMA has been provided by Graham Short, Aaron Milligan, and Cheryl Strother.

Special thanks go out to Jennifer Hanscom, Executive Director and CEO of the WSMA for her strong support for bringing the updated Washington Physicians’ Guide to Health Law to the WSMA website as an online resource, and to Tim Layton, Esq. for his efforts to help make the online legal guide a reality. Special tribute to Thomas J. Curry, former Executive Director and CEO of the WSMA, and John V. Arveson, former Director of Professional Affairs of the WSMA, whose foresight and dedication to the physicians of Washington State made the development and publication of the Washington Physicians’ Guide to Health Law possible in the first place.

For any questions related to the online Washington Physicians’ Guide to Health Law, please contact Denny Maher, JD, MD, at [dpm@wsma.org](mailto:dpm@wsma.org).

***NOTE***

The online version of the Washington Physicians’ Guide to Health Law is intended to serve as a general guide to certain provisions of Washington law which might affect a physician’s practice. It is not intended as a substitute for competent professional advice concerning specific problems or questions which might arise in a physician’s practice. Nor is it intended to be exhaustive or to set or define a standard of care. Rather, this online legal guide provides background in general information concerning certain provisions of state and Federal law.

In framing the answers to many of the questions in the Washington Physicians’ Guide to Health Law portions of various state and Federal statutes and regulations have been quoted in some places and have been paraphrased in others. While every effort will be taken to keep the online version of the Washington Physicians’ Guide to Health Law current and up to date, changes in the applicable statutes and regulations occur frequently, and new court decisions may affect the way statutes and regulations are interpreted. Therefore, legal counsel should always be consulted to determine the current state of the applicable law. The answers to questions in the Washington Physicians’ Guide to Health Law, and the statutes, regulations, and court decisions on which they are based, are not exhaustive. We always recommend that you obtain an independent legal opinion regarding questions of law which face your practice.

The principal focus of this online legal guide is on provisions of Washington law affecting the physician and his or her role as a physician, and not in other capacities where other statutes, rules and regulations may apply.

# Physicians

## Allopathic Physicians

### Licensure –Medical Doctors

**What basic qualifications must a physician meet to be eligible to obtain a medical license in Washington?**

The basic eligibility requirements for obtaining a medical license in Washington differ depending upon whether the physician is a graduate of a medical school in the United States or Canada or is a foreign medical graduate.

Physicians who are graduates of a medical school in the United States or Canada must meet at least the following basic requirements:

* Graduation from a school of medicine approved by the Medical Quality Assurance Commission (MQAC).
* Completion of two years of postgraduate medical training in a program acceptable to the MQAC. (Physicians graduating before July 28, 1985 need only one year of postgraduate training.)
* Proof of good moral character.
* Proof of physical and mental capability to safely practice medicine. (The MQAC may require a physician to submit to one or more examinations to determine that this requirement is met.)
* Successful completion of the national licensure examination of the United States Licensing Examination (USMLE), or by examinations accepted by the MQAC for reciprocity or waiver from other states or Canada (National Board of Medical Examiners (NBME), Federation of States Medical Boards Examination (FLEX), , or the Licentiate of the Medical Council of Canada (LMCC) (provided the licensee holds a valid LMCC certification obtained after 1969)).

**Physicians who are foreign medical graduates must meet at least the following basic requirements:**

* Successfully completed a resident course of professional instruction in a medical school equivalent to that required for applicants generally.
* Meet all of the requirements which must be met by graduates of the United States and Canadian schools of medicine (see above). However, if the foreign medical graduate provides proof satisfactory to the MQAC that he or she meets the following requirements, completion of two years of postgraduate training in a program acceptable to the MQAC is not required if the applicant:
  + Has been admitted as a permanent immigrant to the United States as a person of exceptional ability in sciences pursuant to the rules of the United States Department of Labor, or has been issued a permanent immigration visa, and
  + Has received multiple sclerosis certified specialist status from the Consortium of Multiple Sclerosis Centers, and
  + Successfully completed at least 24 months of training in multiple sclerosis at an educational institution in the United States with an accredited residency program in either neurology or rehabilitation.
* Successfully passed the examination given by the Educational Commission for Foreign Medical Graduates (ECFMG), or meets requirements in lieu thereof established by the MQAC.
* Be able to read, write, speak, understand and be understood in English.

Physicians wishing to obtain a medical license in Washington must file a completed application with the MQAC on a form approved by the MQAC, submit all required fees, furnish proof of all of the basic eligibility requirements for a license, and provide such other information as the MQAC may require.

A license will not be granted if the applicant has been prohibited from practicing medicine in another state because of an act of unprofessional conduct that is substantially equivalent to an act of unprofessional conduct as defined in Washington State until such time as the Medical Quality Assurance Commission has completed its own investigation into the matter.

For more information on licensure eligibility requirements, see the MQAC website at <http://www.doh.wa.gov/LicensesPermitsandCertificates/MedicalCommission/MedicalLicensing/Requirements.aspx#1>

**Are there licensing requirements for physicians regarding AIDS education?**

Yes. Prior to obtaining a license, a physician must have at least four hours of education and training on the prevention, transmission, and treatment of AIDS. The AIDS education and training must include—but is not limited to—etiology and epidemiology; testing and counseling; infection control guidelines; clinical manifestations and treatment; legal and ethical issues, including confidentiality; and psychosocial issues, including special population considerations. Upon licensing, a physician must provide a written declaration that he or she has completed the minimum AIDS education and training. Physicians must keep records documenting their AIDS training and describing what they learned for two years.

**May a physician who has already been licensed in another state or passed the National Board of Medical Examiners (NBME) examination have the examination requirement waived?**

Yes. The MQAC has the discretion to waive the examination requirement for a physician who has previously been licensed in another state or Canada. The physician must submit certified copies of the license and show that the standards, eligibility requirements and examination of the issuing state are at least equal to those in Washington. The MQAC also has discretion to waive the examination for a physician who has successfully passed the NBME, FLEX, USMLE, or examinations given by the other states or territories of the United States. Physicians who have taken the Licentiate of the Medical Council of Canada (LMCC) and hold a valid LMCC certification obtained after 1969 may be granted a license without examination.

**May a physician who has already been licensed in another state receive a temporary permit to practice medicine in Washington after his or her application is submitted but before it is processed?**

Yes, in some circumstances. Such a physician must file a completed license application form, indicate on the form the desire to obtain a temporary permit, and pay the application fee and the temporary practice permit fee. If the physician is licensed in another state with licensing standards substantially equivalent to Washington’s licensing standards, the MQAC then may issue that physician a temporary permit upon receipt of the AMA profile verifying the states in which the physician is or was licensed, receipt of the disciplinary action data bank report form, and receipt of verification from all states in which the physician is or was licensed that the physician has a license in good standing and is not subject to charges or disciplinary action for unprofessional conduct or impairment. A physician who receives a temporary practice permit may then practice medicine pending completion of the application process. The temporary permit, however, is good only for 90 days, or upon issuance of license or upon initiation of an investigation by the MQAC, whichever occurs first.

**Will the MQAC issue a temporary practice permit if there is a delay in obtaining results of a background check?**

Yes, provided certain conditions are met. The MQAC will issue a temporary practice permit if there is a delay in receiving the results of a national criminal background check, providing that the applicant for a medical license has met all other licensure requirements. The MQAC conducts background checks on all applicants for a medical license to assure safe patient care. The temporary practice permit is valid for six months. The temporary practice permit is no longer valid after a license is issued or action is taken on the application because of the background check.

**When must a physician’s license be renewed?**

Physicians must renew their medical licenses every two years. The renewal date is the physician’s birth date. At the time of renewal the MQAC requests licensees to submit information about their current professional practice, which may include practice setting, medical specialty, board certification, or other relevant data.

**What happens if a physician fails to renew his or her medical license?**

Failure to renew a license renders the license invalid. A physician who continues to practice medicine with an invalid license is engaged in the unauthorized practice of medicine, which is both a crime and unprofessional conduct which may subject the physician to disciplinary action.

If a license has expired because of failure to renew for one renewal cycle or less, a physician must pay the late renewal penalty fee, the current renewal fee, and the required substance abuse monitoring surcharge (to support the Washington Physicians Health Program (WPHP)), provide any required documentation or declaration, and comply with the MQAC continuing medical education (CME) requirements.

If a physician’s license has been expired for more than one renewal cycle, but less than three years or less, a physician must also file an abbreviated application form and pay all outstanding fees and penalty fees and comply with the other requirements listed above, pay an expired credential reissuance fee. In addition, the physician must provide written declarations that (i) no action has been taken by any state, the federal government, or hospital to restrict the physician’s practice of medicine, (ii) the physician has not voluntarily given up any credential or privilege, or has not had his or her practice restricted, in order to avoid formal action, and (iii) the CME and competency requirements of the past two years have been met.

If a physician’s license has been expired for more than three years the physician must satisfy all of the requirements above (for a licensed expired more than one renewal cycle but less than three years) but must also satisfy other competency requirements set forth by the MQAC, and provide proof of AIDS education, if not previously provided. In addition, the physician must furnish proof that the physician has completed two years of postgraduate training in a program acceptable to the MQAC.

**Are there continuing education requirements for renewal of a license?**

Yes. See CONTINUING MEDICAL EDUCATION.

**Does Washington issue any limited licenses?**

The MQAC may, without examination, issue a limited license to the following:

* Physicians who are licensed in another state or Canada, who have been accepted for employment by DSHS, the Department of Corrections (DOC), or any county or city health department, and who meet all of the basic qualifications for licensure. Such a license shall permit the physician to practice medicine only in connection with patients, residents, or inmates under the supervision and control of DSHS or the DOC, or in conjunction with the physician’s duties in employment with a city or county health department.
* Physicians who have submitted a completed application showing that they meet all of the basic requirements except for completion of two years of postgraduate medical training and who have been appointed as a resident physician in a program of postgraduate clinical training in this state approved by the MQAC.
* Physicians who have graduated from a recognized medical school, who have been licensed or otherwise privileged to practice medicine at their location of origin, and who have been invited to serve as a teaching-research member of the University of Washington School of Medicine or of a hospital or health care facility licensed in this state.
* Physicians who have graduated from a recognized medical school, who have been granted a license or other appropriate certificate to practice medicine in their location of origin, and who have been selected by the University of Washington School of Medicine or a hospital or health care facility licensed in this state to be enrolled in one of its designated fellowship programs.

Special rules and restrictions apply to the granting and scope of these limited licenses.

**Are there any physicians who are exempt from the licensure requirements?**

Yes. The following physicians are exempt from the licensure requirements:

* Commissioned medical officers serving in the United States armed forces or public health service and medical officers on duty with the Veterans Administration while engaged in their official duties.
* A physician licensed to practice medicine in Canada while practicing in any part of this state which shares a common border with Canada and is surrounded on three sides by water.

**Do medical students in Washington need to be licensed to practice medicine?**

No, as long as the person is a regular student in a school of medicine approved and accredited by the MQAC and only performs services pursuant to a regular course of instruction or assignments from his or her instructor or under the supervision and control of a licensed physician.

**What is a retired active physician license?**

A retired active physician license permits a physician who is already licensed to retire and continue to practice in emergent or intermittent circumstances provided that the physician provides services without compensation.

To obtain a retired active physician license, a physician must submit a letter to the MQAC with the license renewal declaring the physician’s intent to practice only on an intermittent or emergency basis as described above. Retired active licenses must be renewed every two years, but are renewed at a reduced rate. A retired active status licensee must report one hundred hours of continuing medical education at every renewal.

A physician with a retired active physician license who wishes to return to a full active license must notify the MQAC in writing of the change, pay all required fees, and meet the current requirements for licensure.

**Is a physician required to maintain professional liability insurance to obtain a license or for a license to remain effective?**

No. Insurance is not a requirement to obtain a license or for a license to remain effective. Some hospitals and clinics, however, may require that a physician have professional liability insurance as a condition of obtaining privileges.

**May retired physicians provide medical assistance during an emergency or a disaster?**

Yes. In 2006, the Washington State legislature authorized the Secretary of Health to issue a retired volunteer medical worker license to any person who:

* Held an active health care license within 10 years prior to his or her initial application for the retired volunteer medical worker license.
* Does not have any restrictions to practice due to violations of the Uniform Disciplinary Act.
* Registers with a local emergency services or management organization affiliated with the Emergency Management Division of the Military Department.

Retired volunteer medical workers may only practice when there is a declared emergency, disaster, or authorized training event that has been given a mission number by the Department of Emergency Management, and the local organization for emergency services or management has activated the retired volunteer medical worker. The retired volunteer medical worker may only work the duties assigned, must be supervised, and may only perform the duties that were associated with their previous medical practice. In order to apply for a retired volunteer medical worker license a physician must meet the requirements listed above, submit an application to the Department of Health, and submit proof of current registration as a volunteer emergency worker with a local organization for emergency services or management. Retired volunteer medical workers will be required to maintain competency requirements that are established by the Secretary of Health. A retired volunteer physician must complete a basic first-aid course, a bloodborne pathogens course and a CPR course every three years in order to renew his or her license. A physician who holds a retired volunteer medical license, and is registered as an emergency worker, is immune from liability for his or her actions while providing assistance in an emergency or disaster, or while participating in an approved training exercise or reparation for an emergency or disaster. This immunity does not apply to acts of gross negligence or willful or wanton misconduct. See [Emergency Medical Services](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/emergency-treatment/emergency-medical-services)and [Good Samaritan Law](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/emergency-treatment/good-samaritan-law).

### CME

**What are the continuing medical education (CME) requirements for licensed physicians in Washington?**

Licensed physicians must have 200 credit hours of CME every four years.

There are five categories of creditable CME activities approved by the Medical Quality Assurance Commission (MQAC). All 200 credits may be earned in Category I, but only up to 80 credits may be earned from any one of the remaining categories.

The categories are:

* Category I CME activities with accredited sponsorship.
* Category II CME activities with non-accredited sponsorship.
* Category III Teaching physicians or other allied health professionals.
* Category IV Books, papers, publications, and exhibits (10 credits may be claimed for each publication, paper, exhibit, or book chapter that is authored and published).
* Category V Self-directed activities (i.e., self-assessment, self-instruction, specialty board examination preparation, quality of care review, utilization review).

In lieu of the 200 CME hours, MQAC will accept a current Physician’s Recognition Award from the American Medical Association or a current certificate from any specialty board approved by the American Board of Medical Specialties (ABMS) that the specialty board considers as equivalent to the 200 hours of CME required under Washington law.

Certification or recertification from an approved specialty board within the four years preceding license renewal will also be accepted by MQAC as the equivalent of 200 CME hours.

**Must a physician who wishes to maintain a retired active license meet CME requirements?**

Yes. A physician with a retired active license must report 100 hours of CME at each renewal, which is every two years.

**How does a physician report CME credits?**

Every four years, upon renewing his or her license, a physician must sign the affidavit of CME compliance located on the back of the license renewal form.

On occasion, MQAC may require additional documentation. A physician should maintain records—such as course or program certificates of training or transcripts—proving compliance with the CME requirements for at least four years.

**Is compliance with the CME requirements monitored?**

Yes. Up to 25% of practitioners are randomly audited for CME compliance after their credentials are renewed. It is the practitioner’s responsibility to submit documentation of completed CME activities at the time of the audit. Failure to comply with the audit documentation request or failure to supply acceptable documentation within sixty days may result in disciplinary action.

**Are there any different CME requirements for osteopathic physicians?**

Yes. Osteopathic physicians need 150 credit hours of CME every three years. There are two main categories of CME activities for osteopathic physicians, each with subsections. The categories are:

* Category I A minimum of 60 credit hours is mandatory under this category.
  + I-A: Formal educational programs sponsored by nationally recognized osteopathic or medical institutions, organizations, and their affiliates.
  + I-B: Preparation in publishable form of an original scientific paper and initial presentation before a qualified postdoctoral audience.
  + I-C: Serving as a teacher, lecturer, preceptor, or moderator-participant in any formal educational program (maximum 45 credit hours per three year period).
* Category II
  + II-A: Home study (maximum of 90 credit hours per three-year period).
  + II-B: Preparation and personal presentation of a scientific exhibit at a county, regional, state, or national professional meeting (maximum of 30 credit hours per three-year period).
  + II-C: All other programs and modalities of continuing professional education, including observation at medical centers, programs dealing with experimental and investigative areas of medical practice, and programs conducted by non-recognized sponsors (maximum of 30 credit hours per three-year period).

In lieu of the 150 CME hours, the Board of Osteopathic Medicine and Surgery (BOMS) will accept certification of compliance with the requirements for CME of the American Osteopathic Association, receipt of the American Medical Association Physician’s Recognition Award, or a current certification of CME from medical practice academies. Original certification or recertification within the previous six years by a specialty board will also satisfy the CME requirement.

**How does an osteopathic physician report CME credits?**

Every three years, upon renewing his or her license, the osteopath must submit an affidavit stating compliance with the CME requirements.

### Unauthorized Practice of Medicine

**How is the practice of medicine defined?**

An individual is practicing medicine if he or she does one or more of the following:

* Offers or undertakes to diagnose, cure, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality.
* Administers or prescribes drugs or medicinal preparations to be used by any other person.
* Severs or penetrates the tissues of human beings.
* Uses the term “Doctor of Medicine,” “physician,” “surgeon,” “M.D.,” or any combination of those terms used in conduct pertaining to the diagnosis or treatment of human diseases or conditions on cards, books, papers, signs, or other written or printed means of providing information to the public unless use of the term(s) includes a description of another branch of the healing arts for which the individual has a license.

**What is the unauthorized practice of medicine?**

Any person, including a physician, who practices medicine without a valid license or a valid exemption from the licensure requirements is engaged in the unauthorized practice of medicine. Furthermore, any licensed health care provider, including a physician, who practices beyond the scope of practice authorized by his or her license is engaged in the unauthorized practice of medicine.

**May a physician be disciplined in connection with the unauthorized practice of medicine?**

Yes. In connection with the unauthorized practice of medicine, a physician may be disciplined for the following, among other things:

* Engaging in the unauthorized practice of medicine.
* Aiding or abetting an unlicensed person to practice medicine.
* Failing to adequately supervise auxiliary staff to ensure that they do not engage in the unauthorized practice of medicine.
* Aiding or abetting a licensed health care provider in engaging in the practice of medicine beyond the scope of practice of the provider’s licensure.

See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct).

**Is the unlicensed practice of medicine a crime?**

Yes. The unlicensed practice of medicine constitutes a gross misdemeanor for a single violation and a Class C felony for each subsequent violation.

**Can a person who practices medicine without a license be fined?**

Yes. A civil fine not exceeding $1,000 for each day a person engages in the unlicensed practice of medicine may be imposed.

## Osteopathic Physicians

### Licensure – Osteopathic Physicians

**What basic qualifications must an osteopathic physician meet to be eligible to obtain a license in Washington?**

Washington requires the following basic eligibility requirements for obtaining an osteopathic medical license:

* Graduation from an accredited school of osteopathic medicine approved by the Board of Osteopathic Medicine and Surgery (Board).
* Completion of at least one year of postgraduate training in a program approved by the Board.
* Proof of physical and mental capability to safely practice osteopathic medicine. (The Board may require an osteopathic physician to submit to one or more examinations to determine that this requirement is met.)
* Proof that the applicant has not been guilty of any conduct which would constitute grounds for denial, suspension or revocation of a license.
* Successful completion of the examination prepared or approved by the Board.

Osteopathic physicians wishing to obtain an osteopathic medical license in Washington must file a completed application with the Board on a form approved by the Board, submit all required fees, furnish proof of all of the basic eligibility requirements for a license, and provide such other information as the Board may require.

**What examination is required to obtain licensure as an osteopathic physician?**

Applicants for licensure as osteopathic physicians must pass the Federation of State Licensing Board (FLEX) with a minimum score of 75 on each component of the FLEX I and II examination, or satisfactorily pass the United States Medical Licensing Examination (USMLE) with a minimum score as established by the coordinating agencies (the Federation of State Medical Boards of the United States and the National Board of Medical Examiners), and obtain at least a 75% overall average on a board-administered examination on osteopathic principles and practices. Note: All applications for osteopathic physician license by USMLE examination in Washington must be received in the Office of Health Professions Quality Assurance Division of the Department of Health no later than September 12 for the following December examination, and March 29 for the following June examination.

An applicant who has passed all parts of the examination given by the National Board of Osteopathic Examiners may be granted a license without further examination.

**May an osteopathic physician who has already been licensed in another state have the examination requirement waived?**

Yes. The Board has the discretion to waive the examination requirement for an osteopathic physician who has previously been licensed in another state. The osteopathic physician must submit a certified copy of the license, certify that the standard of requirements adopted by the issuing state is substantially equal to those provided for in Washington, and pay the required fee. However, the Board is not permitted to waive the examination requirement for any physician who has been licensed in another state but who has previously failed the examination held in Washington.

**May an osteopathic physician who has already been licensed in another state receive a temporary permit to practice osteopathic medicine in Washington after his or her application is submitted but before it is processed?**

Yes. To obtain a temporary practice permit, an osteopathic physician who is licensed to practice in another state must file a completed license application form, indicate on the form the desire to receive a temporary permit, and pay the application and temporary practice permit fee.

The Board may issue a temporary permit upon receipt of the following:

* Documentation from the state where the applicant is licensed that the licensing standards used were substantially equivalent to Washington’s standards.
* A completed application form on which the applicant indicates he or she wishes to receive a temporary permit and application and temporary permit fees.
* Verification of all state licenses, whether active or inactive, indicating that the applicant is not subject to charges or disciplinary action for unprofessional conduct or impairment.
* Verification from the Federation of State Medical Board’s disciplinary action data bank that the applicant has not been disciplined by a state board or federal agency.

The temporary practice permit expires upon issuance of a license or 180 days after issuance of the temporary permit, whichever occurs first.

**Are there licensing requirements for osteopathic physicians regarding AIDS education?**

Yes. Prior to obtaining a license, an osteopathic physician must have at least four hours of education and training on the prevention, transmission, and treatment of AIDS. The AIDS education and training must include—but is not limited to—etiology and epidemiology; testing and counseling; infection control guidelines; clinical manifestations and treatment; legal and ethical issues, including confidentiality; and psychosocial issues, including special population considerations. Upon licensing, an osteopathic physician must provide a written declaration that he or she has completed the minimum AIDS education and training. Osteopathic physicians must keep records documenting their AIDS training and describing what they learned for two years.

**When must an osteopathic physician’s license be renewed?**

Osteopathic physicians must renew their licenses annually on the licensee’s birth date.

**What happens if an osteopathic physician fails to renew his or her medical license?**

Failure to renew an osteopathic license shall invalidate the license to practice osteopathic medicine and surgery, and the osteopathic physician may not practice until the license is returned to active status.

An active license that has been expired for less than one year may be brought current by payment of renewal fees, penalty fees, and any applicable surcharges and compliance with current continuing education and competency requirements.

If the license has been expired for more than one year but less than three years, to obtain reinstatement the osteopathic physician must complete an abbreviated application form, pay all renewal fees, penalty fees, applicable surcharges, and the expired credential reissuance fee, provide a written declaration that he or she has not voluntarily given up any license or privilege and has not been restricted in the practice in lieu of or to avoid formal action, and provide a written declaration that continuing education and competency requirements for the two most recent years have been met, and provide any other written declarations or documentation that may be required.

Any osteopathic physician whose license has expired for over three years and who has been in active practice in another United States jurisdiction must submit verification of active practice from any other United States jurisdiction, do the same things as an osteopathic physician whose license has been expired for more than one year but less than three years, must submit verification of active practice from another United States jurisdiction to obtain reinstatement, and if not previously provided, must provide proof of AIDS education as discussed above.

An osteopathic physician whose license has expired for more than three years and who has not been in active practice in another United States jurisdiction may be required, in the Board’s discretion, to be re examined.

**Are there continuing education requirements for renewal of license?**

Yes. See [Continuing Medical Education](http://legalguide.wsma.org.onexcale.net/physicians/allopathic-physicians/continuing-medical-education).

**Are there any osteopathic physicians who are exempt from the licensure requirements?**

Yes. The following osteopathic physicians are exempt from the licensure requirements:

* Commissioned medical officers serving in the United States government or military service or employed by a federal agency who practice osteopathic medicine, in the discharge of official duties.
* An osteopathic physician serving a period of clinical postgraduate medical training in a postgraduate program approved by the Board, as long as the performance of such services are pursuant to a course of instruction and are supervised by licensed personnel.

**Do osteopathic medical students in Washington need to be licensed?**

No, as long as the person is a student in an accredited school of osteopathic medicine and surgery approved by the Board and the student only performs services pursuant to a course of instruction or assignments from his or her instructor and under the supervision and control of a licensed osteopathic physician or a medical doctor.

# Other Health Care Professionals

## Physicians Assistants

### Osteopathic Physician Assistants

**What is an osteopathic physician assistant?**

An osteopathic PA is a health care provider who is licensed by the Board of Osteopathic Medicine and Surgery (Board) to practice osteopathic medicine to a limited extent only under the supervision and control of an osteopathic physician. The osteopathic PA must be physically and mentally capable of practicing osteopathic medicine with reasonable skill and safety. All osteopathic PAs must wear identification or a badge identifying him or herself as an osteopathic PA at all times when meeting or treating patients.

**What is the difference between an osteopathic physician assistant (PA) and a certified osteopathic physician assistant (PA-C)?**

A certified osteopathic physician assistant (PA-C) is an individual who has successfully completed an accredited and approved physician assistant program and has passed the National Commission on Certification of Physician Assistants examination. Effective July 1, 1999, an individual applying for a license as a physician assistant must have graduated from an accredited and approved physician assistant program and must be certified by successful completion of the national board examinations. Applicants for an interim permit will have one year from issuance of the interim permit to successfully complete the examination.

An osteopathic physician assistant (PA) is an individual who successfully completed an accredited and approved osteopathic physician assistant program and was licensed in Washington State prior to July 1, 1999: An osteopathic PA may also be an individual who holds an interim permit prior to passing the certification.

**What must a osteopathic physician do to utilize a PA in the osteopathic physician’s practice?**

An osteopathic physician who wishes to use a licensed osteopathic PA must obtain approval from the Board. Before commencing practice, a licensed osteopathic PA must apply to the Board for permission to be employed or supervised by an osteopathic physician or physician group. The osteopathic physician or physician group and the licensed PA must jointly submit to the Board a practice arrangement plan which delineates the manner and extent to which the osteopathic PA will practice and be supervised.

A licensed osteopathic PA may practice osteopathic medicine only with the Board’s approval of the practice arrangement plan and only to the extent permitted by the Board. A licensed osteopathic PA who has not received approval of the practice arrangement plan may not practice.

**May an osteopathic PA practice in a manner inconsistent with an approved practice arrangement plan?**

No. The Board may take disciplinary action against an osteopathic PA who practices outside the approved practice arrangement plan.

**May an osteopathic physician assistants sign documents ordinarily signed by a licensed physician?**

Yes. An osteopathic physician assistant may sign and attest to any document that might ordinarily be signed by a physician, including (but not limited to) birth and death certificates.

**Can military experience be used to become licensed as a PA in Washington?**

Yes. An applicant for a license as an osteopathic physician assistant who has military training or experience satisfies the training or experience requirements to become licensed as a an osteopathic physician assistant unless the Board of Osteopathic Medicine and Surgery determines that the military training or experience is not substantially equivalent to the standards of this state.

**What is the supervising osteopathic physician’s liability for the acts and omissions of an osteopathic PA?**

Both the supervising osteopathic physician and the osteopathic PA retain professional and personal responsibility for the acts and omissions of the osteopathic PA.

A supervising osteopathic physician may be disciplined for aiding and abetting the unlicensed practice of medicine if the osteopathic PA is permitted to practice medicine beyond the scope of practice approved by the Board.

**May an osteopathic PA prescribe legend drugs?**

Yes. An osteopathic PA may prescribe legend drugs, when approved by the Board and designated by the supervising osteopathic physician on an approved practice plan, for a patient who is under his or her care or the care of the supervising osteopathic physician. The supervising osteopathic physician must assume full responsibility for review of the osteopathic PA’s prescription writing practices on an ongoing basis.

**May an osteopathic PA prescribe controlled substances?**

Upon approval of the Board and when designated by the supervising osteopathic physician on an approved practice plan an osteopathic PA certified by the National Commission on Certification of Physician Assistants (PA-C) may issue prescriptions for drugs contained in Schedule II through V. A non-certified osteopathic PA may issue prescriptions for Schedule III through V controlled substances.

**Whose DEA number must an osteopathic PA use if approved by the Board of Osteopathic Medicine and Surgery to prescribe controlled substances?**

On written prescriptions for Schedule II through V controlled substances, an osteopathic PA who is approved by the Board to prescribe controlled substances must sign a prescription with his or her own name, and include the osteopathic PA’s DEA registration number or, if none, the sponsoring osteopathic physician’s DEA registration number, followed by the letters “P.A.” or “P.A.-C” and the PA’s license number.

**May an osteopathic PA practice in a location other than where the supervising osteopathic physician is located?**

Yes. An osteopathic PA may practice at a remote site upon approval by the Board. A remote practice site means a setting physically separate from the supervising osteopathic physician’s primary practice location or setting where the osteopathic physician is present less than 25% of the practice time of the osteopathic PA. Such approval may be provided if:

* There is a demonstrated need for such utilization.
* Adequate provision exists for immediate communication between the supervising osteopathic physician or alternate physician and the osteopathic PA.
* The supervising physician spends at least 10% of the documented and scheduled practice time of the osteopathic PA in the remote office site.
* The names of the supervising osteopathic physician and the osteopathic PA must be prominently displayed at the entrance to the clinic or in the reception area.
* No osteopathic PA holding an interim permit may be utilized in a remote practice site.

**Must an osteopathic physician review and countersign chart entries made by the osteopathic PA?**

Yes, to some degree. The osteopathic PA and supervising osteopathic physician must ensure that the supervising osteopathic physician timely reviews all reports of abnormalities and significant deviations, including the patients’ charts. The supervising osteopathic physician or designated alternate must review and countersign all charts of a licensed osteopathic PA within 7 working days for the first 30 days of practice. Thereafter, the supervising osteopathic physician or designated alternate must review and countersign 10% of the charts of the osteopathic PA within 7 working days. Every chart of a holder of an interim permit must be reviewed and countersigned by the supervising osteopathic physician or designated alternate within 2 working days.

**What should a supervising osteopathic physician do when unable to supervise due to a temporary absence?**

The supervising osteopathic physician must identify a designated alternate supervisor who will perform the supervisory responsibilities in the supervising osteopathic physician’s absence.

### Physician Assistants

**What is a physician assistant (PA)?**

A PA is a health care provider who is licensed by the Medical Quality Assurance Commission (MQAC) to practice medicine to a limited extent only under the supervision and control of a physician and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. All PAs must wear identification or a badge identifying him or herself as a PA at all times when meeting or treating patients.

**What is the difference between a physician assistant (PA) and a certified physician assistant (PA-C)?**

A certified physician assistant (PA-C) is an individual who has successfully completed an accredited and approved physician assistant program and has passed the initial national boards examination.

A physician assistant (PA) is an individual who either:

* Successfully completed an accredited and approved physician assistant program, is eligible for the national boards examination, and was licensed in Washington State prior to July 1, 1999;
* Qualified based on work experience and education and was licensed prior to July 1, 1989;
* Graduated from an international medical school and was licensed prior to July 1, 1989; or,
* Holds an interim permit.

Effective July 1, 1999, an individual applying for a license as a physician assistant must have graduated from an accredited and approved physician assistant program and must be certified by successful completion of the national board examinations. Applicants for an interim permit will have one year from issuance of the interim permit to successfully complete the examination.

**May physician assistants sign documents ordinarily signed by a licensed physician?**

Yes. Both a PA and a PA-C may sign and attest to any document that might ordinarily be signed by a physician, including (but not limited to) birth and death certificates.

**Can military experience be used to become licensed as a PA in Washington?**

Yes. An applicant for a license as a PA who has military training or experience satisfies the training or experience requirements to become licensed as a PA unless the Medical Quality Assurance Commission determines that the military training or experience is not substantially equivalent to the standards of this state.

**What must a physician do to utilize a PA in the physician’s practice?**

A physician who wishes to use a licensed PA must obtain approval from the MQAC. Before commencing practice, a licensed PA must apply to the MQAC for permission to be employed or supervised by a physician or physician group. The physician or physician group and the licensed PA must jointly submit to the MQAC a practice arrangement plan which delineates the manner and extent to which the PA will practice and be supervised. A new practice plan must be submitted if a PA who is currently credentialed desires to become associated with another physician.

A licensed PA may practice medicine only with the MQAC’s approval of the practice arrangement plan and only to the extent permitted by the MQAC. A licensed PA who has not received approval of the practice arrangement plan may not practice.

**May a PA practice in a manner inconsistent with an approved practice arrangement plan?**

No. Whenever a PA practices in a manner inconsistent with the practice arrangement plan approved by the MQAC, the MQAC may take disciplinary action.

**What is the supervising physician’s liability for the acts and omissions of a PA?**

Both the supervising physician and the PA retain professional and personal responsibility for the acts and omissions of the PA.

A supervising physician may be disciplined for aiding and abetting the unlicensed practice of medicine if the PA is permitted to practice medicine beyond the scope of practice approved by the MQAC.

**May a PA prescribe legend drugs?**

Yes. A PA may prescribe legend drugs, when approved by the MQAC and assigned by the supervising physician, for a patient who is under the care of the supervising physician. A certified physician assistant may prescribe legend drugs when approved by the MQAC.

**May a PA prescribe controlled substances?**

A PA may not prescribe controlled substances unless specifically approved by the MQAC. A certified physician assistant may prescribe controlled substances.

**Whose DEA number must a PA use if approved by the MQAC to prescribe controlled substances?**

On written prescriptions for Schedule II through V controlled substances, a PA who is approved by the MQAC to prescribe controlled substances must include the PA’s DEA registration number or, if none, the sponsoring physician’s DEA registration number, followed by the letters “P.A.” (or if the PA is a certified PA, the letters “P.A.-C”), and the PA’s license number.

**May a PA practice in a remote location other than where the supervising physician is located?**

Yes, but only under limited circumstances and with MQAC approval. A physician assistant who holds an interim permit may not practice in a remote location. The MQAC may approve a PA’s practice in a remote site if:

* There is a demonstrated need for such utilization.
* Adequate provision exists for immediate communication between the supervising physician and the PA.
* The responsible sponsoring or supervising physician spends 10% of the PA’s practice time in the remote site, or in the case of part-time or unique practice settings, demonstrates that adequate supervision is being maintained by an alternate method.
* The names of the sponsoring or supervising physician and the PA are prominently displayed at the entrance to the clinic or in the reception area.

**Must a physician review and countersign chart entries made by a PA?**

Chart entries made by a physician assistant must be reviewed and countersigned within two working days, unless another time period is permitted by the MQAC. Countersignature of chart entries made by a certified physician assistant is not required.

**What should a supervising physician do when unable to supervise due to a temporary absence?**

The supervising physician must identify a designated alternate supervisor who will take over supervisory and review responsibilities in the supervising physician’s absence.

**What are the responsibilities of a nonsupervising physician who utilizes or advises a PA?**

A nonsponsoring physician who knowingly requests a PA to render care to a patient or knowingly consults with a PA is responsible for the care provided by the PA.

**What happens if the sponsoring or supervising physician’s practice is limited by disciplinary action?**

To the extent the sponsoring or supervising physician’s practice has been limited by disciplinary action, the PA’s practice is similarly limited while working under that physician’s sponsorship or supervision.

**Are there requirements for continuing medical education for PAs?**

Yes. Physician assistants must complete one hundred (100) hours of continuing medical education every two (2) years.

## Nurses

**What are the various types of nurses who may be licensed in Washington?**

There are three types of nurses licensed by the Nursing Care Quality Assurance Commission (NCQAC): Advanced Registered Nurse Practitioners (ARNPs), Registered Nurses (RNs), and Licensed Practical Nurses (LPNs). Each type of nurse has a different scope of practice.

**What is an Advanced Registered Nurse Practitioner?**

An ARNP is a registered nurse who has undergone a formal graduate education program and has achieved national specialty certification to assume primary responsibility for continuous and comprehensive management of a broad range of patient care, concerns, and problems. ARNPs function within his/her scope of practice according to the NCQAC-approved certification program and standards of care developed by professional organizations. ARNPs are qualified to assume primary responsibility for the care of their patients.

ARNPs are expected to use independent judgment as well as collaborative interaction with other health care practitioners when indicated in the assessment and management of wellness and conditions appropriate to the ARNP’s area of specialization.

**What general functions may an ARNP perform?**

Acting within the scope of the ARNP’s knowledge, experience, and practice, a licensed ARNP may:

* Examine patients and establish diagnoses by patient history, physical examination, and other methods of assessment;
* Admit, manage, and discharge patients to and from health care facilities;
* Order, collect, perform, and interpret diagnostic tests;
* Manage health care by identifying, developing, implementing, and evaluating a plan of care and treatment for patients;
* Prescribe therapies and medical equipment;
* Prescribe medications when granted authority by the NCQAC;
* Refer patients to other health care practitioners, services, or facilities; and
* Perform procedures or provide care services that are within the scope of practice of the ARNP according to the NCQAC approved certification program.

**What designations and certifications of ARNPs are recognized in Washington?**

The NCQAC recognizes three designations of ARNPs: nurse practitioner (NP) , certified nurse midwife (CNM), and certified registered nurse anesthetist (CRNA). An ARNP must maintain certification by an accredited certifying body. Nurse practitioners may be certified by the American Academy of Nurse Practitioners, the American Nurses Credentialing Center, the National Certification Corporation for Obstetric, Gynecological, and Neonatal Nursing, or the Pediatric Nursing Certification Board. Certified nurse midwives must be certified by the American Midwifery Certification Board. Certified registered nurse anesthetists must be certified by the Council on Certification of Nurse Anesthetists.

Since 2009, the NCQAC no longer accepts initial ARNP licensure applications from nurses certified as a community health nurse, maternal/GYN/neonatal nurse, medical/surgical nurse, occupational health nurse, neurosurgical nurse, enterostomal therapist, or psychiatric mental health clinical nurse specialist.

**May an ARNP prescribe legend drugs and controlled substances?**

Upon approval by the NCQAC, an ARNP may prescribe legend drugs and controlled substances contained in Schedule V of the Uniform Controlled Substances Act. An ARNP may prescribe Schedule II – IV drugs provided that the ARNP has applied for, and has been granted prescriptive authority from the NCQAC, And be registered with the U.S. Drug Enforcement Administration.

**What is a Registered Nurse?**

A registered nurse (RN) performs acts requiring substantial knowledge, judgment and skill at or under the direction of a physician, ARNP or certain other health care providers. With direction from an appropriate health care provider, an RN may administer drugs, injections, medications, treatments, tests, and inoculations to a patient.

**What is a Licensed Practical Nurse?**

An LPN is able to recognize and meet the basic needs of a patient and gives routine nursing care under the direction and supervision of a physician, an ARNP, an RN or some other health care providers. Routine nursing care is care that is relatively free of scientific complexity, and the clinical and behavioral state of the patient is relatively stable.

In complex situations, the LPN facilitates patient care by carrying out selected aspects of nursing care to assist the ARNP or RN in their duties.

An LPN may also administer drugs, medications, treatments, tests, injections, and inoculations under the direction of a physician, ARNP, RN, or certain other health care providers if the order to so act is put in writing within a reasonable time and made a part of the patient’s record.

**What is a Nursing Technician?**

A Nursing Technician is a nursing student, or a recent graduate from a nursing school employed in a hospital or nursing home. Nursing technicians may function only under the direct supervision of a Registered Nurse who agrees to act as a supervisor, and who is immediately available to the nursing technician. A Nursing Technician may perform specific nursing functions based upon their ability and level of education. Nursing Technicians may not administer chemotherapy, blood or blood products, intravenous medications or scheduled drugs, and may not care for central lines.

**What is a physician’s role in relation to nurses?**

A physician must adequately supervise auxiliary staff that works in the physician’s practice. Failure to do so may result in disciplinary action. A physician must exercise care not to permit or request a nurse working under the physician’s direction or supervision to exceed the scope of practice for which the nurse is licensed or approved, as a physician can be disciplined for aiding and abetting an unlicensed person to practice medicine.

## Acupuncture

**What is acupuncture?**

Acupuncture is defined under Washington law as a “health care service based on an Oriental system of medical theory utilizing Oriental diagnosis and treatment to promote health and treat organic or functional disorders by treating specific acupuncture points or meridians.”

**Are acupuncturists regulated in Washington?**

Yes. East Asian medicine practitioners (formerly termed acupuncturists) must be licensed by the state and are subject to state regulation.

**Who can be an East Asian medicine practitioner?**

To be licensed as an East Asian medicine practitioner in Washington, a person must be fluent in English, must successfully complete an approved course of East Asian medicine study, must pass a written examination, which may include a practical examination, and must pay an annual registration fee.

**Are East Asian medicine practitioners required to make any special disclosures to patients?**

Yes. An East Asian medicine practitioner must inform the patient in writing, before or at the time of the initial visit, of the East Asian medicine practitioner’s qualifications, scope of practice, and the possible side effects of proposed treatments. The form must also specifically include the East Asian medicine practitioner’s license information, and a description of what is included in the practice of East Asian medicine in Washington.

**What is the physician’s role with regard to East Asian medicine practitioners?**

An East Asian medicine practitioner must have a written plan for consultation, emergency transfer, and referral to other health care practitioners.

For patients with potentially serious conditions, the acupuncturist must immediately obtain a consultation or recent written diagnosis from a physician before initiating or continuing treatment. “Potentially serious conditions” include:

* Cardiac conditions, including uncontrolled hypertension.
* Acute abdominal symptoms.
* Acute undiagnosed neurological changes.
* Unexplained weight loss or gain in excess of 15 percent body weight within a three-month period.
* Suspected fracture or dislocation.
* Suspected systemic infection.
* Any serious undiagnosed hemorrhagic disorder.
* Acute respiratory distress without previous history or diagnosis.

## Assistive Personel

### Health Care Assistants

**NOTE**: Effective July 1, 2013, the Department of Health no longer certifies Health Care Assistants. Legislation passed in 2012 allows practice by Medical Assistants in Washington, does away with Health Care Assistants, provides for scopes of practice for four types of Medical Assistants and calls for the Department of Health to develop rules regarding the training and credentialing of Medical Assistants. See [Medical Assistants](http://legalguide.wsma.org.onexcale.net/other-health-care-professionals/assistive-personel/medical-assistants) for information regarding Medical Assistants. Additional information about Medical Assistants can be found in [Regulatory Issues](http://www.wsma.org/rules-and-other-regulatory-information#asst) on the WSMA website.

### Surgical Technologists

**What is a surgical technologist?**

A surgical technologist is a person, regardless of title, who performs tasks in a surgical setting under the supervision and delegation of authority of a physician, physician’s assistant, osteopathic physician, osteopathic physician’s assistant, advanced registered nurse practitioner, podiatrist, dentist, physician’s assistant surgical assistant, or naturopathic physician acting within the scope of his or her license.

**Must surgical technologists be registered?**

Yes. Anyone representing himself or herself as a surgical technologist by title or by description as a person who performs tasks in the surgical setting under the delegation of authority of a licensed health care practitioner must register with the Department of Health as a surgical technologist. Registered nurses, practical nurses, and other credentialed providers acting within the scope of their license or credential do not need to register as surgical technologists.

**Can appropriate military training or experience be used to satisfy the requirements to be a surgical technologist?**

Yes. Military training or experience which is substantially equivalent to state standards satisfies the requirements to be a surgical technologist.

**What tasks do surgical technologists typically perform?**

Surgical technologists perform tasks that typically consist of, but are not limited to, the following tasks in a surgical setting:

* Prepare basic sterile packs and trays.
* Assist with physical preparation of the operating room, creating the sterile field, and maintaining sterile technique.
* Identify and select appropriate packs, trays and accessory/specialty equipment for each surgery.
* Prepare supplies and instruments for a sterile field.
* Assist with the count of instruments, sponges, needles, and other surgical items.
* Pass correct instruments, supplies and sutures as needed by the surgeon.
* Sponge or suction the operative site, retract tissue for exposure, and assist with irrigation of the operative site under direct supervision.
* Cut sutures placed by a licensed health care provider.
* Prepare specimens for submission to pathology.
* Fire an automatic staple gun as directed by a licensed health care provider for skin stapling. Deep tissue stapling is not permitted.
* Move drugs to the sterile field.

**Are there tasks that a surgical technologist is not allowed to do?**

Yes. A surgical technologist is not allowed to dispense medications or to do activities that constitute the practice of medicine including:

* Prescribing or administering.
* Penetrating or severing tissue, including but not limited to, suturing, cutting and incisions, regardless of instrumentality.
* Dispensing medications.

### Medical Assistants

**What are Medical Assistants?**

Medical assistants (MAs) are health care professionals who have been specifically trained to work in settings such as physicians' offices, medical clinics, medical group practices, and other health care facilities. MAs are individuals who have been trained to perform administrative and clinically-related procedures under the supervision of health care providers.

**How are Medical Assistants different from Health Care Assistants?**

Health care assistants (HCAs) were only recognized in Washington State, and had a very limited scope of practice set forth in statute and administrative rules. HCAs were not permitted to perform any task which was within the scope of practice of a licensed health care provider except as provided in law. Under the law prior to July 1, 2013, HCAs were not permitted to perform tasks such as taking vital signs and performing simple tests (dipstick urinalysis, urine pregnancy test, etc.) because they were not included in the HCA scope of practice, but are included in the scope of practice of licensed health care providers.

Medical assistants (MAs) are much more widely recognized across the United States, and generally have a broader scope of practice. This allows MAs to assist medical practices in a wider variety of tasks associated with patient care. There are also a number of medical specialties which use certain assistive personnel who may or may not be trained as MAs, who nonetheless perform vital specialty-specific tasks.

**What is new in Washington State regarding Medical Assistants?**

The Department of Health (DOH) has new statutes and rules which went into effect July 1, 2013 which establish credentials for Medical Assistants in Washington. The laws created four categories of Medical Assistant which will be discussed in greater detail below:

* MA-Certified (MA-C);
* MA-Registered (MA-R);
* MA-Phlebotomist (MA-P); and
* MA-Hemodialysis Technician (MA-HT).

**What happened to individuals who were Health Care Assistants July 1, 2013?**

Health care assistants who were credentialed and in good standing as of July 1, 2013 transitioned into one or more of the categories of MAs. Health care assistants in Category C, B, D, or F became Medical Assistants-Certified (MA-C). Health care assistants in Category A or B became Medical Assistants-Phlebotomist (MA-P). Health care assistants in Category G became Medical Assistants-Hemodialysis Technician (MA-HT). Multiple certifications as MAs were possible depending on the health care assistant certifications held by an individual. No health care assistant automatically transitioned into the Medical Assistant-Registered category.

**Does every employee who interacts with patients or works in a physician's office need to be a Medical Assistant?**

No. A person employed by a physician or health care facility is not considered to be practicing as a MA if he/she performs only the following tasks:

* Accounting;
* Insurance reimbursement;
* Maintaining medication and immunization records;
* Preparing and maintaining examination and treatment areas;
* Reception;
* Scheduling;
* Telephone and in-person screening limited to intake and gathering of information; or
* Similar administrative tasks.

**What are the general requirements for Medical Assistants?**

Medical assistants must:

* Have the ability to read, write, and converse in English;
* Have knowledge and understanding of the laws and rules which regulate MAs;
* Function within his or her scope of practice;
* Obtain their instruction from the appropriate delegating health care practitioner and demonstrate competency before performing new or unfamiliar duties which are in his or her scope of practice;
* Demonstrate a basic understanding of patients' rights and responsibilities;
* Respect patients' privacy by protecting their confidential information, and not using confidential information for any purpose other than legitimate patient care, or otherwise permitted by law; and
* Comply with all federal and state laws and regulations regarding patient rights and privacy. Which healthcare practitioners are authorized to delegate tasks to Medical Assistants? Healthcare practitioners who may delegate tasks to medical assistants include:
* Physicians and osteopathic physicians; and
* Other healthcare practitioners acting within the scope of their respective licensure including:
  + Podiatric physicians and surgeons;
  + Registered nurses and advanced registered nurse practitioners;
  + Naturopaths;
  + Physician assistants and osteopathic physician assistants; and
  + Optometrists.

**What are the general requirements for delegation by a health care provider?**

The term delegation means the direct authorization granted by a physician or other authorized health care provider to a MA to perform functions within the MA's scope of practice. Prior to delegating any of the functions within the scope of practice of a MA, a health care practitioner must, to the at best of his or her ability, determine that:

* The task is within that health care practitioner's scope of licensure or authority;
* The task is indicated for the patient;
* There is an appropriate level of supervision;
* No law prohibits the delegation;
* The person to whom the task would be delegated is competent to perform that task; and
* The task itself is one that should be appropriately delegated when considering that:
* The task can be performed without requiring the exercise of judgment based on clinical knowledge;
* Results of the task are reasonably predictable;
* The task can be performed without the need for complex observations or critical decisions;
* The task can be performed without repeated clinical assessments; and
* For a MA other than a MA-HT, that the task, if performed improperly, would not present life-threatening consequences or the danger of immediate and serious harm to the patient. (For a MA-HT, that the task if performed improperly, is not likely to present life-threatening consequences or the danger of immediate and serious harm to the patient.)

Note: The use of protocols that do not involve clinical judgment, and do not involve the administration of medications, other than vaccines, are not prohibited.

**What are the general requirements for a Medical Assistant to accept a delegated task?**

A MA also has a responsibility regarding the performance of delegated functions. A MA may only accept delegated tasks when:

* The physician or other health care practitioner follows their requirements for delegation (see Physician Delegation);
* The task can be performed without requiring the exercise of judgment based on clinical knowledge;
* The results of the task are reasonably predictable;
* The task can be performed without the need for complex observations or critical decisions;
* The task can be performed without repeated clinical assessments; and
* For a MA other than a MA-HT, that the task, if performed improperly, would not present life-threatening consequences or the danger of immediate and serious harm to the patient. (For a MA-HT, that the task if performed improperly, is not likely to present life-threatening consequences or the danger of immediate and serious harm to the patient.)

**Are there other rules related to a Medical Assistant accepting delegation of a particular function?**

Yes. In addition to the general requirements listed above, a Medical Assistant:

* May not accept delegation of acts that are not within his or her scope of practice;
* Is responsible and accountable for his or her practice based on, and limited to:
* The scope of his or her education or training;
* The scope of practice set forth in law and regulations;
* The demonstration of competency to the delegating health care practitioner; and
* Written documentation of competency as required by state law and the policies and procedures of the employer of the MA.

Note: A MA who has transitioned from a health care assistant credential as of July 1, 2013, may not accept delegated tasks unless he or she has received the necessary education or training to safely and confidently perform that task.

**Are there requirements for supervision of Medical Assistants while they are performing their duties?**

Yes. A MA functions in a dependent role in providing direct patient care under the supervision and delegation of a health care practitioner.

Supervision in regard to MAs means the supervision by a physician or other health care practitioner who is physically present and immediately available in the facility. (Note: A health care practitioner does not need to be present during procedures to withdraw blood, but must be immediately available.)

Some procedures, identified below, require a greater degree of supervision:

* Direct visual supervision means that the supervising physician or health care practitioner is physically present and within the visual range of the MA.
* Immediate supervision means that the supervising physician or other health-care practitioner is on the premises and available for immediate response as needed.

#### Medical Assistant - Certified

**What information must an applicant for the Medical Assistant-Certified credential submit to the Department of Health?**

Applicants for a MA-C credential must submit the following to the DOH:

* A completed application form;
* Proof of completion of high school education or its equivalent;
* Proof of successful completion of a MA training program approved by the DOH;
* Proof of successful completion of an approved examination, completed within five years prior to submission of an initial application for the MA credential;
* Proof of completion of seven clock hours of AIDS education;
* Payment of any fee required by DOH; and
* Fingerprint cards for national fingerprint-based background checks, if requested by DOH.

**What are the requirements for an individual to become a Medical Assistant-Certified?**

An applicant for the MA-C credential must meet the following requirements:

* Successful completion of a MA training program approved by the DOH; and
* Pass one of the examinations approved by the DOH within five years prior to submitting an initial application for the MA-C credential:
  + Certified Medical Assistant examination through the American Association of Medical Assistants (AAMA);
  + Registered Medical Assistant certification examination through the American Medical Technologists (AMT);
  + Clinical Medical Assistant certification examination through the National Healthcareer Association (NHA); or
  + National certified Medical Assistant examination through the National Center for Competency Testing (NCCT).

**What is an interim certification for a Medical Assistant-Certified, and what are the requirements for it?**

An individual who has met all of the requirements listed above, except for the passage of one of the examinations approved by the DOH, may practice as a MA-C under an interim certification for a period of up to one year. An individual cannot renew an interim certification, and is only eligible for interim certification upon initial application.

**Is there an exception to the training or experience requirements for an individual with military training or experience?**

Yes. The MA statutes and rules provide for an exception to the training or experience requirements for an individual who demonstrates equivalency from his or her background in the U. S. Armed Forces. An applicant with military training or experience will satisfy the training or experience requirements to become a Medical Assistant unless the DOH determines that the military training or experience is not substantially equivalent to the standards established in Washington State.

**What duties may a Medical Assistant-Certified perform?**

A MA-C may perform the following duties provided that the requirements for delegation and supervision (see Delegation and Supervision Requirements) are followed:

* Fundamental Procedures:
  + Wrapping items for autoclaving;
  + Procedures for sterilizing equipment and instruments;
  + Disposing of biohazardous material; and
  + Practicing standard precautions.
* Clinical Procedures:
  + Performing aseptic procedures in a setting other than a hospital;
  + Preparing for, and assisting in, sterile procedures in a setting other than a hospital;
  + Taking vital signs;
  + Preparing patients for examination;
  + Capillary blood withdrawal, venipuncture, and intradermal, subcutaneous, intramuscular injections; and
  + Observing and reporting patients' signs or symptoms.
* Specimen Collection:
  + Capillary puncture and venipuncture;
  + Obtaining specimens for microbiological testing; and
  + Instructing patients in proper technique to collect urine and fecal specimens.
* Diagnostic Testing:
  + Electrocardiography;
  + Respiratory testing;
  + CLIA-waived tests; and
  + Moderate complexity tests if the MA-C meets standards for personnel qualifications and responsibilities in compliance with federal regulations for non-waived testing.
* Patient Care:
  + Telephone and in-person screening limited to the intake and gathering of information without requiring the exercise of judgment based on clinical knowledge;
  + Obtaining vital signs;
  + Obtaining and recording patient history;
  + Preparing and maintaining examination and treatment areas;
  + Preparing patients for, and assisting with, routine and specialty examinations, procedures, treatments, and minor office surgeries;
  + Maintaining medication and immunization records; and
  + Screening and following up on test results as directed by a health care practitioner.
* Administering Medications MAs may only administer medications if the drugs are:
  + Administered only by unit or single dosage, or by a dosage calculated and verified by health care practitioner; (Note that a combination or multidose vaccine is considered a unit dose.)
  + Limited to legend drugs, vaccines, and the schedule III-V controlled substances as authorized by a health care practitioner under the scope of her/his license; and
  + Administered pursuant to a written order from a health care practitioner.

Note: A MA-C may not administer experimental drugs or chemotherapy agents.

* Intravenous Injections:
  + A MA-C may administer intravenous injections for diagnostic or therapeutic agents under the direct visual supervision (defined above) of a health care practitioner if the MA-C meets minimum standards set by the Department of Health (see Medication Injection Requirements).
* Urethral catheterization (provided that the MA-C is appropriately trained)

**What other requirements apply to the administration of medication and injections by a Medical Assistant-Certified?**

A MA-C must:

* Be deemed competent by the delegating physician or health care practitioner before administering any drug (see Physician Delegation); and
* Must act pursuant to a valid order from the delegating health care practitioner (which is written or contained in the patient's electronic health record), and within the health care practitioner's scope of practice.

The delegating physician or other health care practitioner must ensure that a MA-C is competent to administer the medication, and that the MA-C receives training regarding:

* Dosage;
* Technique;
* Acceptable route (s) of administration;
* Appropriate anatomic sites;
* Expected reactions;
* Possible adverse reactions;
* Appropriate intervention for adverse reactions; and
* Risk to the patient.

**Are there circumstances in which a physician may not delegate drug administration?**

A physician or other health care practitioner may not delegate drug administration when:

* The drug may cause life-threatening consequences or a danger of immediate and serious harm to the patient;
* Complex observations or critical decisions are required;
* A patient is unable to physically ingest or safely apply a medication independently or with assistance; or
* A patient is unable to indicate awareness that he or she is taking medication.

**Are there medications which a Medical Assistant-Certified is prohibited from administering?**

Yes. A MA-C is prohibited from administering:

* Schedule II controlled substances;
* Chemotherapy agents or experimental drugs; and
* Medications through a central intravenous line.

**What are the routes of administration and general supervision requirements for drug administration by a Medical Assistant-Certified?**

The following table outlines the permitted routes of administration and the supervision requirements for drug administration by a MA-C:

|  |  |  |
| --- | --- | --- |
| **Drug Category** | **Routes Permitted** | **Level of Supervision Required** |
| Controlled substances, schedule III, IV, and V | Oral, topical, rectal, otic, ophthalmic, or inhaled routes  Subcutaneous, intradermal, intramuscular, or peripheral intravenous routes | Immediate supervision  Direct visual supervision |
| Other legend drugs | All other routes  Peripheral intravenous injections | Immediate supervision  Direct visual supervision |

**What rules apply to a Medical Assistant-Certified regarding intravenous lines?**

A MA-C may not start an intravenous line. A MA-C may interrupt an intravenous line, administer an injection, and restart the line at the same rate.

Medical Assistant Registered

**What information must an applicant for the Medical Assistant-Certified credential submit to the Department of Health?**

An applicant for the MA-R credential must submit the following to the DOH:

* A completed application form;
* Proof of completion of high school education or its equivalent;
* An endorsement signed by a health care practitioner;
* Proof of completion of seven clock hours of AIDS education;
* Payment of any fees required by the DOH; and
* Fingerprint cards for national fingerprint-based background checks, if requested by DOH.

**What are the rules related to endorsement of a Medical Assistant-Registered?**

Each MA-R must have a current attestation filed with the DOH and signed by a physician or other authorized health care practitioner endorsing the individual to perform specific tasks under the MA-R scope of practice (see MA-R Scope of Practice). A MA-R may perform only those tasks listed in his/her current attestation of endorsement on file with the DOH. If the tasks for which a MA-R has been endorsed changes, the MA-R must submit a new attestation of endorsement to the DOH within 30 days.

**Is an attestation of endorsement for a Medical Assistant-Registered transferable from one practice to another?**

No. An endorsement for a MA-R is only valid as long as the MA-R is continuously employed by the same physician or other authorized health care practitioner. The MA-R credential terminates when the MA-R ceases employment with the endorsing health care practitioner, clinic, or group practice. A MA-R must notify the DOH within 30 days of separation of employment. A new application for the MA-R credential must be submitted upon new or additional employment.

**What duties may a Medical Assistant-Registered perform?**

A MA-R may perform the following duties provided that the requirements for delegation and supervision (see Delegation and Supervision Requirements) are followed:

* Fundamental Procedures:
  + Wrapping items for autoclaving;
  + Procedures for sterilizing equipment and instruments;
  + Disposing of biohazardous material; and
  + Practicing standard precautions.
* Clinical Procedures:
  + Preparing for sterile procedures;
  + Taking vital signs;
  + Preparing patients for examination; and
  + Observing and reporting patients' signs or symptoms.
* Specimen Collection:
  + Capillary puncture and venipuncture (including performing finger or heel sticks in order to collect a blood specimen);
  + Obtaining specimens for microbiological testing; and
  + Instructing patients in proper technique to collect urine and fecal specimens.
* Patient Care:
  + Telephone and in-person screening limited to the intake and gathering of information without requiring the exercise of judgment based on clinical knowledge;
  + Obtaining vital signs;
  + Obtaining and recording patient history;
  + Preparing and maintaining examination and treatment areas;
  + Preparing patients for, and assisting with, routine and specialty examinations, procedures, treatments, and minor office surgeries utilizing no more than local anesthetic;
  + Maintaining medication and immunization records; and
  + Screening and following up on test results as directed by a health care practitioner.
* Moderate complexity tests if the MA-R meets standards for personnel qualifications and responsibilities in compliance with federal regulations for non-waived testing.
* Administration of eye drops, topical ointments, and vaccines, including combination or multidose vaccines.
* Urethral catheterization (provided that the MA-R is appropriately trained).

#### Medical Assistant-Phlebotomist

**What information must an applicant for the Medical Assistant-Phlebotomist credential submit to the Department of Health?**

An applicant for a MA-P credential must submit the following information to the DOH:

* A completed application form;
* Proof of completion of high school education or its equivalent;
* Proof of successful completion of a phlebotomy program through a post-secondary school or college accredited by a national or regional accrediting organization recognized by the U. S. Department of Education, or successful completion of a phlebotomy training program as attested by the phlebotomy training program's supervising health care practitioner;
* Proof of completion of seven clock hours of AIDS education;
* Payment of any fees required by DOH; and
* Fingerprint cards for national fingerprint-based background checks, if requested by DOH.

**What are the requirements for the Medical Assistant-Phlebotomist credential?**

Applicants for a MA-P credential must meet the following requirements:

* Successful completion of a phlebotomy program at an institution accredited by a regional or national accrediting organization recognized by the U.S. Department of Education; or
* Successful completion of a phlebotomy training program approved by a physician or other health care practitioner who is responsible for determining the content of the training and for ascertaining the proficiency of the trainee. Details of the requirements for the curriculum are set forth in WAC 246-827-044, which may be found on the DOH website at: <http://www.doh.wa.gov/Portals/1/Documents/2600/WAC246-827.pdf> .

**Must a health care practitioner be present when a phlebotomist performs capillary or venous procedures to withdraw blood?**

The delegating physician or other health care practitioner does not have to be present when a medical assistant withdraws blood through capillary or venous procedures. However, the delegating physician or health care practitioner must be immediately available for consultation by phone or in person within a reasonable period of time.

**Are there special requirements for arterial invasive procedures and line draws by a Medical Assistant-Phlebotomist?**

Yes. A MA-P may only perform arterial invasive procedures or line draws after completing a program of education and training set forth in rules by the DOH. The details of this education program are set forth in WAC 246-827-0420, and are available on the DOH website at: http://www.doh.wa.gov/Portals/1/Documents/2600/WAC246-827.pdf.

#### Medical Assistant-Hemodialysis Technician

**What information must an applicant for the Medical Assistant-Hemodialysis Technician credential submit to the Department of Health?**

An applicant for the MA-HT credential must submit the following information to the DOH:

* A completed application form;
* Proof of high school education or equivalent;
* Proof of successful completion of an approved training program or proof of national credential as a hemodialysis technician (see Training Requirements for MA-HT);
* Proof of completion of seven clock hours of AIDS education;
* Proof of current cardiopulmonary resuscitation certification;
* Payment of any fees required by DOH; and
* Fingerprint cards for national fingerprint-based background checks, if requested by DOH.

**What are the requirements for qualifications and training of a Medical Assistant-Hemodialysis Technician?**

A MA-HT must complete the following requirements:

* Proof of a high school diploma or equivalent;
* Basic math skills, including the use of fractions and decimal points;
* Demonstrate one of the following:
  + Completion of a hemodialysis training program which meets the requirements set forth in WAC 246-827-0500 (2), which may be found on the DOH website at: <http://www.doh.wa.gov/Portals/1/Documents/2600/WAC246-827.pdf> ; or
  + Possess a national credential as a hemodialysis technician which is substantially equivalent to the training requirements discussed immediately above.

**What dialysis tasks may a Medical Assistant-Hemodialysis Technician trained by a federally approved end-stage renal disease facility perform?**

A MA-HT trained by a federally approved ESRD facility may perform the following tasks:

* Venipuncture for blood withdrawal;
* Administration of oxygen as necessary by cannula or mask;
* Venipuncture for placement of fistula needles;
* Connection to vascular catheters for hemodialysis; intravenous administration of heparin and sodium chloride solutions as an integral part of dialysis treatments; intradermal, subcutaneous, or topical administration of local anesthetics in conjunction with placement of fistula needles; and
* Intraperitoneal administration of a sterile electrolyte solutions and heparin for peritoneal dialysis.

Note: The tasks listed above may only be performed in a renal dialysis center under immediate supervision of a registered nurse, or in a patient's home if a physician and a registered nurse are available for consultation during the dialysis.

**Where can physicians obtain more information about Medical Assistants?**

The Department of Health has a web page dedicated to Medical Assistants which can be found at: <http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/MedicalAssistant.aspx>.

## Chiropractors

**Are chiropractors regulated in Washington?**

Yes. Chiropractors must be licensed by the state and are subject to state regulation.

**What is “chiropractic”?**

“Chiropractic” is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.

**What does chiropractic treatment or care include?**

Chiropractic treatment or care includes:

* The use of procedures involving spinal adjustments and extremity manipulation.
* The use of heat, cold, water, exercise, massage, and trigger point therapy.
* Dietary advice and recommendation of nutritional supplementation.
* The normal regimen and rehabilitation of the patient.
* First aid.
* Counseling on hygiene, sanitation, and preventative measures.
* Physiological therapeutic procedures such as traction and light.

Chiropractic care does not include physiological therapeutic procedures involving application of sound, diathermy, or electricity; the prescription or dispensing of any medicine or drug; the practice of obstetrics or surgery; the use of x‑rays or any other form of radiation for therapeutic purposes; colonic irrigation; and any form of venipuncture.

**May a physician perform a chiropractic spinal adjustment?**

No. A physician who is not also a licensed chiropractor is prohibited by law from performing an adjustment by hand of any articulation of the spine. To do so constitutes the unauthorized practice of chiropractic and could subject a physician to disciplinary action and even criminal charges. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct); and [Unauthorized Practice of Medicine](http://legalguide.wsma.org.onexcale.net/physicians/allopathic-physicians/unauthorized-practice-of-medicine).

## Midwives

**Does Washington state allow the practice of midwifery?**

Yes. Individuals practicing midwifery, however, must be licensed by the state. Registered nurses and certified nurse midwives are exempt from the statutes and regulations regarding licensed midwifery.

**What constitutes the practice of midwifery?**

The rendering of aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages of pregnancy or the advertisement as a midwife constitutes the practice of midwifery. A person who provides gratuitous services to pregnant women is not practicing midwifery.

**Are there any circumstances under which a licensed midwife must consult with a physician?**

Yes. Under Washington law, a midwife has a duty to consult with a physician whenever there are significant deviations from normal in either the mother or the infant. Every licensed midwife must develop a written plan for consultation with other health care practitioners, emergency transfer, transport of an infant to a newborn nursery or neonatal intensive care nursery, and transport of a woman to an appropriate obstetrical department or patient care area. The written plan must be submitted annually to the Department of Health with the midwife’s license renewal fee.

**May a licensed midwife administer drugs or medications?**

Yes. A licensed midwife may obtain and administer certain drugs, including:

* Prophylactic ophthalmic medications.
* Postpartum oxytocic.
* Vitamin K.
* Rho immunoglobulin (human).
* Local anesthetics.
* Intravenous fluid limited to Lactated Ringers and 5% Dextrose with Lactated Ringers.
* Heparin and 0.9% sodium chloride for use in intravenous locks.
* Sterile water for intradermal injections for pain relief.
* Magnesium sulphate for prevention of maternal seizures pending transport.
* Epinephrine for use in maternal anaphylaxis pending transport.
* Measles, Mumps and Rubella vaccine to nonimmune postpartum women.
* HBIG and HBV for neonates born to hepatitis B+ mothers.
* Tertbutaline for nonreassuring fetal heart tones and/or cord prolapse pending transport.
* Antibiotics for intrapartum prophylaxis of Group B Beta hemolytic Streptococcus (GBS) per current CDC guidelines.

Antihemorrhagic drugs to control postpartum hemorrhage, such as misoprostel per rectum (for use only in postpartum hemorrhage), methylergonovine maleate in the absence of hypertension, oral or intramuscular, prostaglandin F2 alpha (hemobate), intramuscular.

A licensed midwife may also administer other drugs or medications prescribed by a physician. The client’s record must contain documentation of all medications administered. The licensed midwife must have a procedure, policy or guideline for the use of each drug.

## Naturopathy

**What is naturopathy?**

Naturopathy, sometimes called naturopathic medicine, is based on the belief of vitalism – an idea that special energy (what naturopaths call “vital energy” or “vital force”) is a guiding force that is “different from all the other forces recognized by physics and chemistry,” which “accounts not only for the maintenance of life, but for the development and activities of living organisms such as… the development of an embryo to a living being.” Naturopaths try to encourage natural healing by using naturally occurring substances and minimally invasive methods. Naturopaths often reject biomedicine and modern science, and instead use nutrition, herbs, manipulation of the body, exercise, stress reduction, and acupuncture to heal.

**Are naturopaths regulated in Washington?**

Yes. In Washington, the Board of Naturopathy licenses and regulates the practice of naturopaths.

**Who can be a naturopath?**

Individuals must meet certain education and experience requirements. Generally, they must have a degree/diploma from a board-approved college of naturopathic medicine, and must pass an exam to be licensed. Additionally, to maintain their license, naturopaths must complete ongoing education every year. The Board, however, has the ability to waive some of these requirements in certain situations.

**Can naturopaths prescribe medications?**

Naturopaths are generally not allowed to prescribe controlled substances, with the exception of testosterone and codeine-containing substances categorized as schedules III, IV, and V.

**How does a physician’s role relate to naturopaths?**

A physician may recommend parts of naturopathy alongside conventional medicine; for example, a physician may suggest his patients eat a healthy diet to lower the risk of heart disease. Other naturopathic practices, such as homeopathy, have not been shown by evidence-based studies to effectively treat or cure illness, and in some situations, could actually be harmful to patients.

# Beginning of Life and Childhood Issues

## Pregnancy Care

**May a minor receive pregnancy care without parental consent?**

Generally, yes. See [Minors, Treatment of](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/treatment-of-minors/minors-treatment-of).

**Must a physician provide information about prenatal tests and cord blood banking to pregnant women?**

Yes. Every physician must provide information regarding the use and availability of prenatal tests to pregnant women in their care.

A physician must also provide objective and standardized information to pregnant women about:

* The differences between, and potential risks and benefits of, public and private cord blood banking which is sufficient to allow a pregnant woman to make an informed decision before the third trimester of pregnancy regarding participation in a cord blood banking program; and
* The opportunity to donate blood and tissue extracted from the placenta and umbilical cord following delivery of a newborn child to a public cord blood bank.

**Must a test for syphilis be done for pregnant women?**

Yes. Every physician attending a pregnant woman must take a sample of blood during the woman’s first examination and submit the sample to an approved laboratory for a standard serological test for syphilis. The test will be performed free of charge at the physician’s request. See Communicable Diseases for reporting requirements of a positive syphilis test.

In addition, if a pregnant woman first presents herself for examination after the fifth month of gestation the physician must advise and urge the patient to secure a medical examination and blood test before the fifth month of any subsequent pregnancies.

**Must AIDS counseling be provided for pregnant women?**

Yes. Every physician attending a pregnant woman must provide or ensure AIDS counseling of the patient. See AIDS/HIV/STD for description of AIDS counseling.

**May a health carrier that provides coverage for maternity services dictate through managed care contracts the length of inpatient stay, or the type and location of follow-up care the mother and the newborn may receive?**

No. All health carriers (including disability insurers, health care services contractors, HMOs, plans operating under the Health Care Authority, the state health insurance pool, and insuring entities) that provide coverage for maternity services must permit the attending physician or other provider, in consultation with the mother, to make decisions on length of inpatient stay and the type and location of follow-up care, rather than make such decisions through contracts or agreements between providers, hospitals and insurers. Such decisions must be based on accepted medical practice.

Further, no health carrier that provides coverage for maternity services may deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending physician or other provider ordering care consistent with these provisions.

**Must health care carriers allow maternity patients direct access to certain types of health care providers of their choice for maternity care services?**

Yes. See [Women's Direct Access](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/womens-care/womens-direct-access).

**Are there any special requirements when providing opiate substitution treatment to pregnant women?**

Yes. All approved opiate substitution treatment programs must inform pregnant clients, verbally and in writing, of up to date and accurate health education information regarding the possibility of addiction and the health risks and benefits that opiate substitution treatment may have on the baby. In addition, all pregnant clients must be advised of the risks to them and their baby associated with not initiating or remaining on the opiate substitution program. Educational information must also include referral options to address neonatal abstinence syndrome for the addicted baby.

**What are the requirements for opiate substitution treatment counseling for a pregnant woman?**

A pregnant woman must receive at least one-half hour of counseling and education each month on:

* Matters relating to pregnancy and street drugs;
* Pregnancy spacing and planning; and
* The effects of opiate substitution on the woman and fetus, when opiate substitution treatment occurs during pregnancy.

## Abortion

**When may an abortion be performed?**

Under Washington law, every woman has the fundamental right to choose or refuse to have an abortion.

An abortion may only be performed prior to the viability of the fetus or to protect the woman’s life or health. “Viability” means the point in the pregnancy when there is a reasonable likelihood that the fetus would survive outside the uterus without the application of extraordinary medical measures.

The good faith judgment of a physician as to the viability of the fetus, as to the risk to the life or health of the woman, or as to the duration of a pregnancy, is a defense in any proceeding against the physician in which violation of Washington’s abortion law is in issue.

**Who may perform an abortion?**

Only a physician may perform an abortion, but any health care provider may assist the physician. For anyone else to do so or for a doctor to do so contrary to the provisions of the law is a felony, punishable by up to five years in jail.

**May a physician refuse to participate in the performance of an abortion?**

Yes. No person, including a physician, can be required to participate in the performance of an abortion. State law gives health providers the right to refuse to perform abortions on moral and ethical grounds. No person may be discriminated against in employment or professional privilege for participating or refusing to participate in performing an abortion.

**Are there waiting periods before an abortion may be performed?**

No. There are no set waiting periods in Washington law.

**Must care be given to an infant born alive?**

Yes. A physician must treat an infant born alive in the course of an abortion procedure.

**May an abortion be performed on a minor?**

Yes. An abortion may be performed on a pregnant woman under the age of 18.

**Is parental notification or parental consent required for an abortion on a minor?**

Generally, no. Washington law does not specifically impose a requirement of parental notification or parental consent before an abortion may be performed on a competent or emancipated minor. A Washington statute which conditioned the right of an unmarried minor to obtain an abortion on parental consent was held unconstitutional. Before performing an abortion on a minor without parental notification or parental consent, however, care should be taken to assure that the minor is competent to provide meaningful and informed consent. Among the factors to be considered in determining a minor’s competence are the minor’s age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult, and freedom from parental control.

**May an abortion be performed on a minor against the minor’s will?**

Generally, no. An abortion cannot be performed on a minor against the minor’s will unless it is pursuant to a court order to preserve the life or health of the minor.

**May a husband or spouse prevent a woman from receiving an abortion?**

No. A husband cannot prevent a wife from having an abortion in Washington.

**Are there any reporting requirements for abortions?**

Yes. Each hospital and facility where lawfully induced abortions are performed must complete a report form each month for the Department of Health which specifies the number and dates of abortions performed during the previous month. For each such abortion, the following information must also be reported:

* The age of the patient.
* The geographic location of the patient’s residence.
* The patient’s previous pregnancy history.
* The duration of the pregnancy.
* The method of abortion.
* Any complications, such as perforations, infections, and incomplete evacuations.
* The name of physician(s) performing or participating in the abortion.
* Such other information as may be required by the department.

A physician who performs an abortion in a nonapproved facility based on a determination that an abortion was immediately necessary to meet a medical emergency must report the information listed above and must also provide a clear and detailed statement of the facts which led to the conclusion that a medical emergency existed.

**Does the state provide benefits for abortion?**

Yes. If the state provides maternity care benefits, services or information to women through any program funded to some degree by the state, then the state will provide equivalent benefits, information or services related to voluntary termination of pregnancy to those women that would have otherwise been eligible for the maternity care programs.

## Adoption

**Who may adopt or be adopted?**

Any person may be adopted regardless of age or residence. Any person who is legally competent and age 18 or older may be an adoptive parent.

**Whose consent is required for an adoption?**

Consent to an adoption is required of the following persons if applicable:

* The adoptee, if age 14 or older.
* The parents and any alleged father of an adoptee under age 18.
* The agency, or the department to which the adoptee has been relinquished.
* DSHS, if the adoptee has been relinquished to DSHS.
* The legal guardian, if any, of the adoptee.

Consent to an adoption by an agency, DSHS or a legal guardian may be dispensed with if a court determines that the proposed adoption is in the best interests of the adoptee.

**Once consent is given to an adoption, may it be revoked?**

Yes. A consenting party may revoke consent at any time before the adoption is approved by the court.

**May a birth parent or alleged father who is a minor consent to adoption of his or her child?**

Generally, the court will appoint a guardian ad litem for any birth parent or alleged father who is under age 18 or is otherwise legally incompetent. The guardian ad litem will determine what is in the minor or incompetent parent’s best interest and whether the minor or incompetent, voluntarily and with knowledge of the consequences of the action, signed any written consent to the adoption or any petition for relinquishment of a child.

**What is a physician’s role in an adoption?**

The adoption statutes do not specifically address the role or responsibilities of a physician in the adoption process.

A physician may be asked to provide information for a medical report which the person or entity receiving, securing a home for, or otherwise caring for a minor child must make available to adoptive, or prospective adoptive, parents of the child. Such reports are to contain all known and available information concerning the child’s mental, physical, and sensory handicaps, as well as all known and available mental or physical health history of the birth parents that the adoptive parent may need to facilitate proper care for, and to maximize the developmental potential of the child.

Such reports should include a review of the birth family’s and the child’s past medical history, including the child’s x-rays, examinations, hospitalizations, and immunizations; a physical exam of the child, with appropriate laboratory tests and x-rays; any indicated referrals to specialists; and any recommendations to the adoptive parents.

Generally, the reports should not, however, reveal the identities of the child’s birth parents. Medical histories should be given on a standardized reporting form developed by DSHS. The entities or persons providing the information in the medical report has no duty, beyond providing the information, to explain or interpret the records or information regarding the child's present or future health.

**Should a physician obtain written consent before providing information for an adoption medical report?**

Generally, yes. A child or birth parent’s involvement in an adoption proceeding does not waive the physician-patient privilege. The physician should obtain the written consent of a minor child’s birth parent or legal guardian before releasing confidential information about the child and should obtain the written consent of the birth parent before releasing confidential information about the birth parent.

**May a physician introduce a birth mother to prospective adoptive parents?**

Yes, but only after obtaining the birth mother’s consent to do so. The law otherwise requires the identity of the birth parents to remain confidential. The physician should then refer the birth mother and the prospective adoptive parents to their respective attorneys to complete the process. DSHS publishes a list of adoption resources that might be helpful, as well.

## Assisted Reproduction

**What is assisted reproduction?**

"Assisted reproduction" means a method of causing pregnancy other than sexual intercourse. The term includes:

* Artificial insemination.
* Donation of eggs.
* Donation of embryos.
* In vitro fertilization and transfer of embryos.
* Intracytoplasmic sperm injection.

**What rules apply to consent for assisted reproduction?**

Consent by a couple who intend to be parents of a child conceived by assisted reproduction must be in a record signed by both persons. This requirement does not apply to a donor.

Failure of the person to sign a consent required by the parties above, before or after birth of the child, does not preclude a finding of parentage if the persons resided together in the same household with the child and openly held out the child as their own.

**What is the parental status of the various parties where a child results from assisted reproduction?**

A donor is not the parent of a child conceived by means of assisted reproduction. A woman who donates eggs for assisted reproduction by another woman is not considered by law to be the natural mother of the child so conceived, unless the donor and the woman who gives birth to the child as the result of assisted reproduction have agreed in writing that the donor is to be a parent. Such an agreement must be in writing and signed by the egg donor and the woman who gives birth to the child and any other intended parent of the child. The physician shall certify the parties' signatures and the date of the egg harvest, identify the subsequent medical procedures undertaken, and identify the intended parents. The agreement, including the affidavit and certification, must be filed with the registrar of vital statistics, where it must be kept confidential and in a sealed file.

**How is the parent-child relationship established between a child and a man or woman?**

The parent-child relationship is established between a child and a man or woman by:

* The woman's having given birth to the child, except as otherwise provided by the laws regarding surrogate parenting.
* An adjudication of the person's parentage;
* Adoption of the child by the person.
* An affidavit and physician's certificate in a form prescribed by the department of health wherein the donor of eggs or surrogate gestation carrier sets forth her intent to be legally bound as the parent of a child or children born through assisted reproduction by filing the affidavit and physician's certificate with the registrar of vital statistics within ten days after the date of the child's birth according to law.
* An unrebutted presumption of the person's parentage of the child.
* The man's having signed an acknowledgment of paternity, unless the acknowledgment has been rescinded or successfully challenged.
* The person's having consented to assisted reproduction by his or her spouse or domestic partner that resulted in the birth of the child.
* A valid surrogate parentage contract, under which the person asserting parentage is an intended parent of the child.

**What must a physician who uses eggs harvested from a donor for an assisted reproduction certify?**

The physician must certify the signature of the parties and the date of the ovum harvest, identify the subsequent medical procedure undertaken, and identify the intended parents. This agreement, including the affidavit and certificate of intent to be bound as a legal parent, must be filed with the registrar of vital statistics. This information will be kept confidential and in a sealed file.

**May HIV or STD testing of a sperm donor be disclosed?**

Under limited circumstances, yes. HIV or STD testing of a sperm donor may be disclosed to a health care facility or health care provider that processes, procures, distributes or uses sperm for purposes of artificial insemination. See AIDS/HIV/STD.

## Birth Certificates

**Is a physician responsible for filling out and filing a newborn’s birth certificate?**

Yes. Washington requires that all births within the state be registered immediately. So, within 10 days after a child’s birth, the attending physician (or the physician’s agent) must fill out a birth certificate and file it with the state registrar of vital statistics. Along with the certificate, the physician must also provide the registrar with the mother’s social security number. If the mother is married, or if there is a signed acknowledgement of paternity, or one has been filed with the state registrar of vital statistics, the birth certificate needs to include the father’s name and date of birth, and the father’s social security number.

**Are there certain birth certificate forms that physicians should fill out?**

Yes. The Washington State Department of Health (DOH) has standard forms for use as birth certificates. These forms can be found on DOH’s website, <http://www.doh.wa.gov/LicensesPermitsandCertificates/BirthDeathMarriageandDivorce/Forms.aspx> .

**Are there penalties for failing to comply with birth certificate requirements?**

Yes. Failure to comply with birth certificate requirements is a misdemeanor; repeated violations may subject a physician to a fine of up to $250, imprisonment for up to 90 days, or both. Also, willfully providing false information for or making any false statement on a birth certificate is a gross misdemeanor.

**When a child is born to an unmarried mother, what must the attending physician do?**

The attending physician (or the physician’s agent) must provide the mother and natural father with written and oral information furnished by the Washington State Department of Social and Health Services (DSHS) regarding the benefits, responsibilities, and legal consequences of having the child’s paternity established. The information the attending physician must provide can be found at: <http://www.dshs.wa.gov/dcs/services/providers.asp> .

The attending physician (or the physician’s agent) must also provide an opportunity for the child’s mother and the man claiming to be the father to complete an acknowledgement of paternity. The acknowledgement must:

* Be signed under penalty of perjury by the mother and the man seeking to establish his paternity.
* State that the child does not have a presumed father, or has a presumed father whose full name is stated, and that the child does not have any other acknowledged or legally determined father.
* State whether genetic testing has been performed, and, if so, that the acknowledging man’s claim of paternity is consistent with the results of that testing.
* State that the woman and man signing the acknowledgement understand that it is the legal equivalent of a judicial determination of paternity, and that a challenge to that acknowledgement is permitted only under limited circumstances and, with few exceptions, is barred after 2 years.

The completed acknowledgment must be filed with the state registrar of vital statistics. Once the acknowledgment is filed, the physician is entitled to reimbursement for reasonable costs.

## Birth Control

**Who may receive birth control?**

Under Washington law, every individual has the fundamental right to choose or refuse birth control.

**May contraceptives be prescribed for minors?**

Yes. Contraceptives may be prescribed for minors.

**Is parental notification or parental consent required before contraceptives may be prescribed for minors?**

Generally, no. Washington law does not specifically impose a requirement of parental notification or parental consent before contraceptives may be prescribed for an otherwise competent minor. Before prescribing contraceptives for a minor without parental notification or consent, however, care should be taken to assure that the minor is competent to provide informed consent. Among the factors to be considered in determining a minor’s competence are the minor’s age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult, and freedom from parental control.

**Is parental notification or parental consent required for a sterilization procedure on a minor?**

Generally, yes. As a general rule, parental consent is required for the performance of sterilization procedures on minors. If, however, the minor is emancipated (i.e., married or independent of parental control and financial support) and sufficiently intelligent, educated and knowledgeable to provide informed consent to a sterilization procedure, parental consent may not be necessary.

**May a sterilization procedure be performed on a minor or incompetent against the minor or incompetent’s will?**

Generally, no. A sterilization procedure cannot be performed on a minor or incompetent against the minor or incompetent’s will absent a court order.

## Neonatal or Pediatric Conditions

### Birth Defects

**What birth defects must physicians report to public health authorities?**

Under Washington law, physicians, as health care providers, must notify the Washington State Department of Health of these birth defects within one month of diagnosis:

* Alcohol-related birth defects.
* Autism spectrum disorders.
* Cerebral Palsy.

In addition to the three defects listed above, health care facilities must also notify the Washington State Department of Health of the following birth defects within one month of diagnosis:

* Abdominal wall defects (including gastroschisis and omphalocele.)
* Autism.
* Cerebral Palsy.
* Down Syndrome.
* Alcohol-related birth defects.
* Hypospadias
* Limb reductions.
* Neural tube defects (including anencephaly and spina bifida.)
* Oral clefts (including cleft lip with or without cleft palate.).

**May a health care facility choose to assume the responsibility for such notification for its physicians?**

Yes, as long as more than one health care provider is in attendance for a patient with a notifiable condition.

**What information concerning these birth defects must be reported and how?**

The principal health care provider and/or health care facility must notify the Washington State Department of Health of each case of a birth defect listed above within one month of the diagnosis. (Health care providers other than the principal provider that have been in attendance must also make this notification unless it has already been made.) The provider and/or facility may send this notice by written case report, secure electronic transmission, telephone, or secure facsimile copy of a case report. The notice must provide the following information:

* ﻿Patient’s name.
* Patient’s address, including the zip code.
* Patient’s telephone number.
* Patient’s date of birth.﻿﻿
* Patient’s sex.
* Diagnosis or suspected diagnosis of disease or condition.
* Pertinent laboratory data, if available.
* Name and telephone number of the person providing the report.
* Name, address, and telephone number of the principal health care provider.
* Any other information the department may require on forms it generates.

The department may also require other information of epidemiological or public health value.

### Newborns: Testing and Reporting

**Are screening tests for newborns required?**

Yes. Except where a newborn’s parent or guardian objects on religious grounds, screening tests of all newborn infants before discharge from the hospital are required for the detection of phenylketonuria and other heritable or metabolic disorders leading to intellectual disabilities or physical defects.

The hospital performing the birth services must provide information to the parents or responsible parties regarding:

* The purpose of screening newborns for congenital disorders.
* The list of disorders for which screening is performed.
* The requirement for newborn screening.
* The parent’s legal right to refuse testing because of religious tenets or practices.
* The specimen storage, retention and access procedures required by the State.

The information above may be provided by a pamphlet from the Department of Health, or by other means.

A blood specimen must be obtained from each newborn prior to discharge from the hospital, or if not yet discharged, no later than five days after birth. If a parent or guardian refuses to allow newborn metabolic screening, the parent or guardian’s signature must be obtained on a refusal form specified by the Department of Health. The specimen or signed refusal must be forwarded to the state public health laboratory no later than one day after the specimen is collected or the refusal form is signed.

Upon receipt of the specimen, the state public health laboratory will perform screening tests for the following:

* Biotinidase deficiency.
* Congenital hypothyroidism.
* Congenital adrenal hyperplasia.
* Galactosemia.
* Homocystinuria.
* Hemoglobinopathies.
* Maple syrup urine disease.
* Medium chain acyl-coA dehydrogenase deficiency.
* Phenylketonuria.
* Cystic fibrosis.
* The amino acid disorders: Argininosuccinic acidemia (ASA), citrullinemia (CIT), and tyrosinemia type I (TYR 1).
* The fatty acid oxidation disorders: Carnitine uptake defect (CUD), long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHADD), trifunctional protein deficiency (TFP), and very long-chain acyl-CoA dehydrogenase deficiency (VLCADD).
* The organic acid disorders: 3-OH 3-CH3 glutaric aciduria (HMG), beta-ketothiolase deficiency (BKT), glutaric acidemia type I (GA 1), isovaleric acidemia (IVA), methylmalonic acidemia (CblA,B), methylmalonic acidemia (mutase deficiency) (MUT), multiple carboxylase deficiency (MCD), propionic acidemia (PROP).

The laboratory will report significant test results to the newborn’s attending physician or the newborn’s family if the attending physician cannot be identified. The Department of Health will offer the diagnostic and treatment resources of the department to physicians attending affected infants.

**May screening tests be given to a newborn whose parent or guardian objects on religious grounds?**

No. No screening tests may be given to any newborn whose parent or guardian objects on religious grounds.

**When may a newborn be tested for AIDS/HIV?**

Testing for AIDS/HIV may be performed on newborn infants with the consent of the newborn’s parent or legal representative. See AIDS/HIV/STD.

**Must phenylketonuria testing results be reported?**

Yes. Laboratories, attending physicians, hospital administrators, or other persons performing or requesting any test for phenylketonuria must report all positive results to the Department of Health.

## Child Abuse

**Must a physician report suspected child abuse?**

Yes. When a physician has reasonable cause to believe that a child has suffered abuse or neglect, the physician must report the incident to the proper law enforcement agency or to the Washington State Department of Social and Health Services (DSHS).

A “child” for purposes of the requirement to report child abuse is any person under age 18.

“Abuse or neglect” means sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child’s health, welfare or safety; or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. “Abuse or neglect” does not, however, include physical discipline, for purposes of restraining or correcting the child, which is reasonable and moderate and is inflicted by a parent, teacher, guardian, or any other person who has the parent or guardian’s advance authorization.

**Is there any exception to the requirement to report child abuse?**

Yes. The requirement to report child abuse does not apply to child abuse or neglect that was discovered after the child became an adult, unless the physician has reasonable cause to believe that other children are or may be at risk of abuse or neglect by the accused.

**When must the report of child abuse be made?**

The report must be made at the earliest opportunity, but no later than 48 hours after the physician has reasonable cause to believe that the child has suffered abuse or neglect. If known, the report must include the identity of the suspected abuser.

**How must the report of child abuse be made?**

The physician must make an immediate oral report, by telephone or otherwise, to the proper law enforcement agency or to DSHS. Upon request, the physician must follow up the oral report with one in writing.

Such reports must contain the following information, if known:

* The name, address, and age of the child.
* The name and address of the child’s parents, stepparents, guardians, or other persons who have custody of the child.
* The nature and extent of the alleged injury or injuries.
* The nature and extent of the alleged neglect.
* The nature and extent of the alleged sexual abuse.
* Any evidence of previous injuries, including their nature and extent.
* Any other information that may be helpful in establishing the cause of the child’s death or injury and the identity of the alleged abuser(s).

**May a physician detain an abused child?**

Yes. A physician may detain a child without consent of a person legally responsible for the child, whether or not medical treatment is required, if the physician has reasonable cause to believe that, based on the child’s condition or circumstances, allowing the child to return home would present an imminent danger to the child’s safety. If a child is detained, the physician must notify, or cause to be notified, the appropriate law enforcement agency or child protective services as soon as possible and within no more than 72 hours.

**Can a physician be held liable for detaining a child where child abuse is suspected?**

Generally, no. If done in good faith, a physician cannot be held civilly or criminally liable for detaining a child.

**Can a physician be held liable for reporting suspected child abuse?**

Generally, no. A physician who in good faith makes a report of suspected child abuse is immune from any liability resulting therefrom. If, however, a physician intentionally and in bad faith makes a false report of child abuse, the physician is guilty of a misdemeanor. Making a false report is also unprofessional conduct, which may subject a physician to disciplinary action.

**Are there penalties for failing to make a report of suspected child abuse?**

Yes. Failure to make a required report of child abuse is punishable as a gross misdemeanor. Failure to make a required report may subject a physician to civil liability as well if the failure to file a report is a proximate cause of an actionable injury. Failure to make a required report can also constitute unprofessional conduct, which may result in disciplinary action. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct).

## Immunizations

**What are the immunization requirements for children enrolled in child care centers, preschools, kindergartens, or grade schools?**

Child care centers, public and private preschools, kindergartens, grade schools (grades 112) and licensed child care facilities that regularly provide care to a group of 13 or more children must establish, in accordance with Washington law, requirements for full immunization of attending children.

Full immunization requires vaccination in accordance with schedules and immunizing agents approved by the Department of Health for:

* Diphtheria.
* Tetanus.
* Pertussis ( whooping cough).
* Poliomyelitis
* Measles (rubeola).
* Mumps.
* Rubella.
* Hepatitis B.
* Hemophilus influenzae type B disease.
* Varicella.
* Pneumococcus.

**What are the exemptions to the full immunization requirements?**

A child may attend child care, preschool, kindergarten, or grade school without proof of full immunization only if proof of one of the following is provided:

* Proof of conditional immunization status (CIS), which must include all of the following:
  + Name of child or student.
  + Birth date.
  + Type of vaccine(s) administered.
  + Month, day, and year of each dose of vaccine received.
  + A section to indicate whether an accompanying Certificate of Exemption (COE) form has been provided.
  + A section to document serologic proof of immunity which must be signed by a licensed health care provider and include a copy of a lab report.
  + Parent signature and date.
* Proof of a medical exemption which requires the signature of a licensed physician, physician assistant or nurse practitioner on a Certificate of Exemption (COE) certifying the medical reasons to defer one or more immunizations on a Certificate of Immunization Status (CIS) form;
* Proof of a parental exemption, which requires the child’s parent, guardian, or adult in loco parentis to sign and note on the CIS form that the child is exempt from the required immunization for religious, philosophical, or personal objections.

The form signed by the physician (or PA, ARNP, or ND) must be signed prior to enrollment in a school or licensed day care, and must include a statement that he or she provided the parent or guardian with information about the benefits and risks of immunization to the child. A parent or legal guardian who exempts the child due to religious beliefs is not required to have the exemption form signed by a physician if the parent or guardian demonstrates membership in a religious body or a church in which the religious beliefs or teachings of the church preclude a health care practitioner from providing medical treatment to the child.

**Are physicians who sign an exemption from immunization form protected from being sued?**

A physician, PA, ARNP, or ND who, signs an exemption form for immunizations in good faith are immune from civil liability for providing the signature.

**What must be included in a Certificate of Exemption (COE)?**

A COE form must be approved by the Department of Health and signed and dated by a parent. A COE form must include:

* Name of child or student.
* Birth date.
* A section to indicate a medical exemption for one or more vaccines which must be signed by a licensed health care provider.
* A section to indicate a religious exemption for one or more vaccines.
* A section to indicate a personal or philosophical exemption for one or more vaccines.
* Notice to parents that if an outbreak of vaccine-preventable disease for which the child is exempted occurs, the child may be excluded from the school or child care center for the duration of the outbreak.

**Is a physician required to provide a record of immunization?**

Yes. Persons or organizations administering immunizations must furnish each person immunized, or his or her parent, with a written record of immunization containing the information required by the Department of Health.

**Are there diseases about which schools are required to provide information to parents and guardians?**

Yes. Beginning with entry into 6th grade, all schools, at the beginning of every school year, must provide parents and guardians with information about meningococcal disease and its vaccine including information about the causes and symptoms of meningococcal disease, the manner in which it spreads, current CDC recommendations for receipt of the vaccine, where it can be obtained, and where parents can obtain additional information. Vaccination for meningococcal disease is not required by law.

Beginning with entry into 6th grade, all schools, at the beginning of every school year, must provide parents and guardians with information about human papilloma virus (HPV) and its vaccine at the beginning of every school year. This information must include its causes and symptoms, how HPV is spread, places where parents and guardians can obtain more information, the current CDC recommendations for receipt of the vaccine, and where it can be received. Vaccination for HPV is not required by law.

## Treatment of Minors

**Can minors legally consent to their own health care?**

In some cases, yes. A minor can legally provide consent in the following circumstances:

* If the minor is emancipated (legally independent) or married to someone over age 18.
* If emergency care is being given, and the parent or legal guardian is unable to provide consent.
* For birth control and pregnancy-related care. See Birth Control; and Pregnancy Care.
* For sexually transmitted diseases, including HIV if the minor is age 14 or older.See AIDS/HIV/STD.
* For outpatient drug and alcohol abuse treatment if the minor is age 13 or older.
* For outpatient mental health treatment, if the minor is age 13 or older.

For any other care and treatment of a minor, consent of a parent or guardian is usually necessary.

**Can a minor’s parent obtain copies of a minor’s medical record?**

Yes and no. A minor’s parent can obtain copies of most of a minor’s record by signing an authorization as the parent. Absent the minor’s consent, however, a minor’s parent cannot obtain copies of records for care and treatment as to which the minor had the right to consent. See Disclosure of Health Care Information.

**Can a minor 14 years old or older receive testing and treatment for HIV or other STD without parental notification or parental consent?**

Yes. See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd).

**May birth control be prescribed for minors without parental notification or parental consent?**

Generally, yes. See [Birth Control.](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/birth-control/birth-control)

**May a minor receive pregnancy care without parental consent?**

Generally, yes. An otherwise competent minor may receive pregnancy care without parental consent.

**May an abortion be performed on a minor without parental notification or parental consent?**

Generally, yes. See [Abortion](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/abortion/abortion).

**May an abortion be performed on a minor against the minor’s will?**

Generally, no. See [Abortion](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/abortion/abortion).

**May a sterilization procedure be performed on a minor without parental notification or parental consent?**

Generally, no. See [Birth Control](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/birth-control/birth-control).

**May a sterilization procedure be performed on a minor against the minor’s will?**

Generally, no. See [Birth Control](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/birth-control/birth-control).

**May a minor be involuntarily committed?**

Yes. See [Involuntary Commitment – Chemical Dependency](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/involuntary-commitment/involuntary-commitment-chemical-dependency); and [Involuntary Commitment – Mental Disorders](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/involuntary-commitment/involuntary-commitment-mental-disorders) for circumstances under which involuntary commitment of a minor is permissible.

**May a minor request and receive outpatient drug or alcohol abuse treatment without consent of the minor’s parents?**

Yes. An otherwise competent minor, age 13 or older, may consent to and receive outpatient drug or alcohol treatment by a chemical dependency treatment program. Parental consent, however, is required for treatment of a minor under age 13.

**When must a physician provide notice of outpatient drug or alcohol abuse treatment of a minor to the minor’s parents?**

Any provider of outpatient drug or alcohol abuse treatment to a minor age 13 or older must provide notice of the minor’s request for treatment to the minor’s parents if:

* The minor consents to disclosure in writing; or
* The treatment program director determines that the minor lacks capacity to make a rational choice regarding consenting to disclosure.

Notice, when required, must be provided within seven days of the request for treatment, excluding Saturdays, Sundays, and holidays. The notice must specify the location of the treatment facility and the name of a treatment professional on the staff of the facility providing treatment designated to discuss the minor’s need for treatment with the parent.

**May a minor request and receive inpatient drug or alcohol abuse treatment without parental consent?**

Except in limited circumstances, no. Consent of a parent is required for inpatient chemical dependency treatment of a minor, unless DSHS determines that the child is in need of necessary services, including food, clothes, shelter, and health care, and the parents have evidenced unsuccessful efforts to maintain the family structure.

**Is a parent of a minor who receives chemical dependency treatment without the parent’s consent liable for payment for the care?**

No. A parent of a minor is not liable for payment for the chemical dependency treatment of the minor unless the parent has consented to the treatment. See Billing.

**May the parent of a minor child initiate outpatient chemical dependency treatment of the minor without the minor’s consent?**

Yes. A parent may bring, or authorize the bringing of, his or her minor child, even one who is age 13 or older, to a provider of outpatient chemical dependency treatment and request that an appropriately trained professional person examine the minor to determine whether the minor has a chemical dependency and is in need of outpatient treatment. The consent of the minor is not required for evaluation if the parent brings the minor to the provider.

**May the parent of a minor initiate inpatient chemical dependency of the minor without the minor’s consent?**

Yes. See [Involuntary Commitment – Chemical Dependency](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/involuntary-commitment/involuntary-commitment-chemical-dependency).

**May a minor request and receive outpatient mental health treatment without parental consent?**

Yes, if the minor is age 13 or older. Parental authorization, or authorization from a person who may consent on behalf of the minor, however, is required for outpatient mental health treatment of a minor under age 13.

**May a minor request and receive inpatient mental health treatment without parental consent?**

Under certain circumstances for minors age 13 or older, yes. A minor, age 13 or older, may, with the concurrence of the professional person in charge of an evaluation and treatment facility, admit himself or herself without parental consent, or authorization from a person who may consent on behalf of the minor, provided that:

* Notice of the minor’s admission to inpatient treatment, including the location and telephone number of the inpatient facility, the name of the professional person providing treatment to the minor, and the medical necessity for the admission is given to the minor’s parent by the facility in the form most likely to reach the parent within 24 hours.
* Unless the facility files a petition for continued detention of the minor, the minor must be released to the parent at the parent’s request.

A minor under age 13 may be admitted for inpatient mental health evaluation and treatment only by application of the minor’s parent, or with authorization from a person who may consent on behalf of the minor.

**May the parent of a minor child initiate outpatient mental health treatment of the minor without the minor’s consent?**

Yes. A parent may bring, or authorize the bringing of, his or her minor child, even one who is age 13 or older, to a provider of outpatient mental health treatment and request that an appropriately trained professional person examine the minor to determine whether the minor has a mental disorder and is in need of outpatient treatment. The consent of the minor is not required for evaluation if the parent brings the minor to the provider. Parental authorization, or the authorization of a person who may otherwise legally consent on behalf of a child, is required for inpatient treatment of a minor under 13 years of age.

**May the parent of a minor child initiate inpatient mental health treatment of the minor without the minor’s consent?**

Yes. See [Involuntary Commitment – Mental Disorders](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/involuntary-commitment/involuntary-commitment-mental-disorders).

**Must child abuse be reported?**

Yes. See [Child Abuse](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/child-abuse/child-abuse) for reporting circumstances and requirements.

# End of Life Issues

## Advance Directives/POLST

[LIVING WILLS](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/advance-directivespolst/end-of-life-care-document#living_wills), [POWER OF ATTORNEY](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/advance-directivespolst/end-of-life-care-document#attorney) and [POLST](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/advance-directivespolst/end-of-life-care-document#polst) (PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

**May an adult person decide to have life-sustaining treatment withheld or withdrawn in case of a terminal or permanent unconscious condition?**

Yes. Adult persons have the fundamental right to control decisions related to the rendering of their own health care including the decision to have life-sustaining treatment withheld or withdrawn in cases of terminal or permanent unconscious conditions.

**What is a “terminal condition” or a “permanent unconscious condition”?**

Washington’s Natural Death Act defines a “terminal condition” is definedas “an incurable and irreversible condition caused by injury, disease, or illness that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.”

“Permanent unconscious condition” is defined as “an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.”

**What is considered “life-sustaining treatment”?**

Washington law defines “life-sustaining treatment” as “any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which, when applied to a qualified patient, would serve only to prolong the process of dying.” It does not include, however, “the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.”

**What documents commonly apply at the end of life?**

In Washington State, there are three types of documents that pertain to the end of life care: the Health Care Directive (also known as a Living Will or Directive to Physician), the Durable Power of Attorney for Health Care, and the Physician Orders for Life-Sustaining Treatment (POLST) which applies in emergency situations and translates your end-of-life wishes into medical orders.

#### LIVING WILLS

**What is a living will?**

A living will, sometimes referred to as a Health Care Directive, or an Advance Directive is a document in which an adult person directs, in advance, that life-sustaining treatment be withheld or withdrawn when the person is diagnosed with a terminal or a permanent unconscious condition and that person is otherwise unable to communicate to the physician his or her own decisions as to treatment.

**How does a person make a valid living will?**

A living will must be signed by a mentally competent patient in the presence of two witnesses. The witnesses must not be:

* Related to the patient by blood or marriage.
* Entitled to, or claiming, any portion of the patient’s estate.
* The attending physician of the patient.
* An employee of either the attending physician or the health care facility providing treatment to the patient.

A living will or a copy thereof must be made a part of the patient’s medical records maintained by the attending physician. A copy must be sent to the health care facility when the withholding or withdrawal of life support is contemplated.

**What is the Health Care Declarations Registry?**

The Washington State Living Will Registry in the Department of Health was eliminated due to budget constraints in 2012. If you registered and provided health declaration documents before July 1, 2011, information should be available using the following steps below as provided on the DOH Living Will Registry web page. That information may be found at: <http://www.doh.wa.gov/AboutUs/ProgramsandServices/DiseaseControlandHealthStatistics/CenterforHealthStatistics/LivingWillRegistry.aspx> . If you have problems accessing documents please call 1-800-548-9455.

* Go to <http://www.uslivingwillregistry.com> .
* At the very top of screen in the black bar click on “Access to Document using Wallet Card ID.”
* Next in the Source drop down select “Washington” which is at the very bottom of the list.
* In the registrant’s ID number use your wallet ID card and type in your registration ID #.
* Click on “Look Up”.

**How and when may a living will be revoked?**

A living will may be revoked at any time by the patient, without regard to the patient’s mental state or competency. If the patient becomes comatose or is rendered incapable of communicating with the attending physician, the living will remains in effect for the duration of such condition.

Acceptable means of revocation include:

* Cancellation, defacement, obliteration, burning, tearing, or other destruction of the document either by the patient or by some person in the patient’s presence and at the patient’s direction.
* Any written revocation expressing the patient’s intent to revoke, signed and dated by the patient.
* Any verbal expression by the patient of the patient’s intent to revoke the living will.
* An online method established by the Department of Health in the case of a directive that is stored in the Health Care Declarations Registry (see above for information on the Registry)

A written or verbal revocation is not effective until communicated to the attending physician who must then record such revocation in the patient’s medical records.

**What procedures must a physician follow to give effect to a living will?**

A physician must follow the following procedures to give effect to a living will:

* The attending physician must make a reasonable effort to determine that the living will complies with the requirements of the Natural Death Act and, if the patient is capable of making health care decisions, the living will and all steps proposed by the attending physician to be undertaken are currently in accord with the desires of the patient.
* Prior to withholding or withdrawing treatment, a diagnosis of “terminal condition” by the attending physician, or a diagnosis of a “permanent unconscious condition” by two physicians must be entered in writing and recorded in the patient’s permanent medical records.
* If the patient is unable to communicate or make health care decisions, and another person has been appointed to make health care decisions for the patient through a durable power of attorney or otherwise, that other person must be notified to ensure continued validity of the living will and the health facility must be notified of the situation.

**May a physician refuse to comply with a patient’s living will?**

Yes. No health care practitioner may be required to participate in the withholding or withdrawal of life-sustaining treatment.

**Must a physician or facility notify the patient or the patient’s legal representative of any policy or practice which would preclude honoring a living will?**

Yes. At the time the physician or health facility becomes aware of the existence of a living will, the physician or facility must inform the patient or the patient’s authorized representative of the existence of any policy or practice that would preclude the honoring of the living will. If the patient, after being informed of such policy or practice, chooses to continue to retain the physician or facility, the physician or facility along with the patient or patient’s representative must prepare a written plan to be filed with the patient’s living will that sets forth the physician or facility’s intended actions. The physician or facility has no obligation to honor the patient’s living will if they comply with these procedures and the written plan.

**What are the legal effects of carrying out a patient’s living will?**

Any physician or health care provider acting under the direction of a physician who participates in good faith in the withholding or withdrawal of life-sustaining treatment from a patient in accordance with the requirements of the Natural Death Act is immune from legal liability, including civil, criminal, or professional conduct sanctions, unless otherwise negligent.

Carrying out a living will in compliance with the Natural Death Act will not be treated as an intervening force or affect the chain of causation between the conduct of anyone that placed the patient in a terminal or a permanent unconscious condition and the death.

Carrying out a living will in compliance with the Natural Death Act does not, for any purpose, constitute a suicide or a homicide.

**Is it unlawful to discriminate against a physician based upon the physician’s willingness or refusal to participate in the withholding or withdrawal of life support?**

Yes. It is unlawful to discriminate in employment or professional privileges because of a person’s participation or refusal to participate in the withholding or withdrawal of life-sustaining treatment.

**What is treated as criminal conduct under the Natural Death Act?**

Under the Natural Death Act:

* Any person who willfully conceals, cancels, defaces, obliterates, or damages a living will of a patient without the patient’s consent, is guilty of a gross misdemeanor.
* Any person who falsifies or forges the living will of another, or willfully conceals or withholds personal knowledge of a revocation with the intent to cause a withholding or withdrawal of life-sustaining treatment contrary to the wishes of the patient, and thereby causes such life-sustaining treatment to be withheld or withdrawn and death to be hastened, is subject to prosecution for murder in the first degree.

**May a physician, health facility, or other health care provider require a person to execute a living will as a condition for receiving health care services?**

No.

**May the carrying out of a living will invalidate or impair any life insurance policy of the patient?**

No.

**May a patient, upon request, be released to die at home?**

Yes. The Natural Death Act specifically allows a qualified patient capable of making health care decisions to indicate that they wish to die at home. The health care provider or facility has an obligation to explain the medical risks of an immediate discharge to the qualified patient and to discharge the patient as soon as reasonably possible following the patient’s decision.

**Is a physician liable for adverse consequences if the patient, upon request, is released to die at home?**

If the physician complies with the obligation to explain the medical risks of an immediate discharge to a qualified patient, there shall be no civil or criminal liability for claims arising from such discharge.

**Absent a directive, under what circumstances may a physician withhold or withdraw life-sustaining treatment?**

Judicial intervention, including the appointment of a guardian, is not routinely required even if the treatment decision is to discontinue life-sustaining treatment for a terminally ill or permanently unconscious individual, but may be necessary in some circumstances.

Additional safeguards should be present before a decision is made to withdraw treatment in circumstances where the incompetent individual did not execute, while competent, an advance directive and/or durable power of attorney for health care.

Life-sustaining treatment may be withheld or withdrawn when all of the following circumstances are met:

* An incompetent patient’s attending physician, together with at least two other disinterested physicians qualified to assess the patient’s condition and/or a unanimous prognosis committee, determine with reasonable medical judgment that the patient is either in a persistent vegetative state with no reasonable chance of recovery or in an advanced stage of a terminal and incurable illness and is suffering severe and permanent mental and physical deterioration.
* The incompetent patient’s attorney in fact or guardian, if one has been appointed, determines that either (a) the patient, if competent, would choose to refuse life sustaining treatment; or, (b) if such a determination cannot be made, the attorney in fact or guardian determines that the withholding of life sustaining treatment would be in the best interests of the patient. If no attorney-in-fact or guardian has been appointed, the incompetent patient’s immediate family must make these determinations.
* All members of the incompetent patient’s immediate family concur in the decision.
* Neither the patient’s physicians nor the health care facility responsible for the care of the patient objects to the decision.

**Where can a physician obtain more information about living wills?**

The WSMA has provides information for physicians and patients, and sample health care directive and durable power of attorney for health care forms. This information can be found online at: <http://www.wsma.org/advance-directives> .

#### DURABLE POWER OF ATTORNEY FOR HEALTH CARE

**What is a durable power of attorney for health care?**

A durable power of attorney for health care is a legal document allowing you to name a person as your health care agent - someone who is authorized to consent to, stop or refuse most medical treatment for you if a physician determines you cannot make these decisions yourself. Once appointed, your health care agent can speak on your behalf anytime you are unable to make your own medical decisions, not only at the end of life.

This type of advance directive is also referred to as a health care proxy, appointment of health care agent or a medical power of attorney.

A durable power of attorney for health care form can be downloaded on the WSMA website, located here: <http://www.wsma.org/Media/Patients-pdfs/advance-directive-forms.pdf> .

**What rules apply to surrogate decision-making for persons who are incompetent?**

In the absence of an advance directive executed under the Natural Death Act, medical decisions for an incompetent person are made by a surrogate decision-maker. In Washington, the persons authorized to make medical decisions on behalf of an incompetent individual are as follows, in order of priority:

* The appointed guardian of the patient, if any.
* The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
* The patient's spouse or state registered domestic partner.
* Children of the patient who are at least eighteen years of age.
* Parents of the patient.
* Adult brothers and sisters of the patient.

As indicated by the class of persons listed above, an individual patient may execute, while competent, a durable power of attorney for health care. The effect of this instrument is to authorize the attorney-in-fact to provide informed consent for health care decisions on the principal's (incompetent individual's) behalf. The attorney-in-fact is second only to a court-appointed guardian in decision-making priority under Washington's informed consent statute.

The surrogate decision-making statute specifies that a physician who is seeking informed consent for an incompetent patient, and who has been unsuccessful in locating and obtaining authorization from a competent person in the first or succeeding class, may seek consent from any person in the next class in the order of descending priority. However, a person who has lower priority may not consent if a person of higher priority has refused, and a person in the same class with two or more individuals may not give informed consent unless the decision is unanimous.

#### POLST

**What is the Physician Orders for Life-Sustaining Treatment (POLST) Form?**

The POLST form represents a way of summarizing wishes of an individual regarding life-sustaining treatment. These wishes may have already been expressed in another document, such as a Healthcare Directive or Durable Power of Attorney for Health Care. The form accomplishes two major purposes:

* It is portable from one care setting to another.
* It translates wishes of an individual into actual physician orders.

The POLST form takes the previously expressed wishes of an individual and translates them into a set of physician orders for medical treatment that should be followed by health care providers in a variety of care settings. These include the site of an emergency, an emergency room, an acute care hospital, or a long-term facility. Moreover, the form represents a means of transferring the known wishes of an individual from one care setting to another, using a uniform document in each setting. The form reduces the need for repetitive end-of-life discussions, facilitates the process, and provides security for the individual and the physician that the expressed wishes will be carried out. There is no other form that streamlines the process in this way.

**Who should complete the POLST form?**

The POLST form should be completed by the attending physician after discussion with the patient or surrogate decision-maker regarding the preferences of the patient. The document may be completed by other health care professionals under the direction of the attending physician. The attending physician must sign the form and assume full responsibility for its accuracy. The form may also be signed by an ARNP or a certified physician assistant.

**How is the POLST form used?**

In a health care facility, the form should be the first document in the clinical record. It should be recognized as a set of physician orders to be implemented as any physician orders would. In a non-institutionalized setting (such as a home), the form should be located in a prominent location. It will be recognized by emergency personnel as orders to be followed, in the same way the current EMS/No CPR form is used.

**How is the POLST form transferred from one setting to another?**

The completed POLST form is a physician order form that should remain with the patient when the patient is transported between care settings, regardless of whether the patient is in a hospital, at home, or in a long-term care facility. The institution may wish to keep a duplicated copy in the permanent medical record upon discharge. Photocopies and electronic facsimiles of signed POLST forms are legal and valid. The institution may wish to keep a duplicate copy in the permanent medical record upon discharge.

**If a patient has a POLST form, do they need an advance directive, too?**

Patients should be encouraged to have an advance directive, such as a durable power of attorney for health care and/or living will. While advance directives are often very helpful in determining end-of-life decisions, they are not required or necessary for having a POLST form.

**How may a POLST form be obtained?**

Individuals are encouraged to contact their physician to request a POLST form. Patients may, however, obtain the POLST form (and/or the WSMA POLST brochure) by sending a self-addressed, stamped envelope to WSMA, Attn: POLST, 2033 Sixth Avenue, Suite 1100, Seattle, WA 98121. Physicians may order free copies of the POLST form and patient information brochures from the Washington State Medical Association at: <http://www.wsma.org/POLST> , or by calling WSMA at 1 (800) 237-3329, or (206) 956-3649.

Information regarding POLST is also available at the Department of Health, <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/PhysiciansOrdersforLifeSustainingTreatment.aspx>.

## Organ and Tissue Donation

**What is an “anatomical gift”?**

An “anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

**Who may make an anatomical gift during the life of the donor?**

Anyone over the age of 18 may make an anatomical gift, limit an anatomical gift, or refuse to make an anatomical gift.

A minor who is authorized to apply for a driver’s license because he/she is at least age 15 and half years old may make an anatomical gift. However, until the minor is 18 years of age or emancipated, the parent or guardian of the minor has the right to revoke the minors consent at the time of donation. Also, a minor who is emancipated may also make an anatomical gift.

**If a person has not documented a preference with respect to donation of organs or body parts, who may make an anatomical gift after the donor’s death?**

The following people, in order of priority, have authority to make an anatomical gift of all or part of a decedent’s body (absent contrary instructions or an unrevoked refusal to make that anatomical gift from the decedent):

* An agent of the decedent at the time of death who could have made an anatomical gift during the life of the donor immediately before the decedent's death;
* An individual to whom the decedent gave a durable power of attorney encompassing the power to make health care decisions. See [Guardians and Attorneys-in-Fact](http://legalguide.wsma.org.onexcale.net/practice-management-issues/health-care-representatives/guardians-and-attorneys-in-fact).
* The spouse or registered domestic partner of the decedent.
* A child of the decedent who is over age 18.
* Either parent of the decedent.
* A sibling of the decedent who is at least age 18.
* A grandparent of the decedent.
* The appointed guardian at the time of the decedent’s death. See Guardians and Attorneys-in-Fact.

An anatomical gift may not, however, be made by one of the above persons for a decedent, if:

* A person of a higher priority is available at the time of death to make an anatomical gift.
* The person proposing to make the anatomical gift knows of an objection by a person of the same or higher priority.
* The person proposing to make the anatomical gift knows of a refusal or contrary indication by the decedent.

**How is an anatomical gift made?**

There are several ways an anatomical gift may be made:

* By authorizing a statement or symbol imprinted on the donor’s driver’s license or identification card indicating that the donor has made an anatomical gift.
* In a will.
* By any form of communication during a terminal illness or injury of the donor which is addressed to at least two adults, at least one of which must be a disinterested witness.
* By a donor card or other record signed by the donor, or other person authorized to make the gift, or by authorizing that a statement indicating the donor has made an anatomical gift be included in the donor registry. If the donor is unable to sign, the document of gift must be signed by another individual and by two witnesses, all of whom must sign and state that they signed the document at the request of the donor or other person authorized to make the anatomical donation.

After a donor’s death, a person authorized to make an anatomical gift (see above) may make an anatomical gift by a document of gift signed by that individual, communicated orally by the individual and contemporaneously made into a record and signed by the individual receiving the oral communication.

Note that when English is not the first language of the person making, amending, revoking or refusing anatomical gifts, organ procurement organizations (see below) are responsible for providing, at no cost, appropriate interpreter/translation services for the purpose of making decisions around anatomical gifts.

**Must the physician make the arrangements for donation personally?**

No. State law requires hospitals to develop procedures for identifying potential anatomical parts donors and, after consulting with other hospitals and organ procurement associations, to establish agreements or affiliations for coordination of procurement and use of human bodies and body parts. Specifically, each hospital in this state must enter into agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.

Representatives of the organ procurement organization for Washington State are available to discuss the details of organ donation with the families of the potential donor and to take care of the required paperwork and consent. The organ procurement organization for Washington State is:

LifeCenter Northwest

1407 116th Ave. NE Suite 210

Bellevue, WA 98004

(425) 201-6563 (phone)

Toll-free 1-877-275-5269

(425) 688-7641 (fax)

[info@lcnw.org](mailto:info@lcnw.org)

<http://www.lcnw.org>

**How is an anatomical gift amended or revoked?**

A donor or other person authorized to make an anatomical gift may amend or revoke an anatomical gift by a record signed by:

* The donor.
* The other person authorized to make the anatomical gift.
* Another individual acting at the directions of the donor or authorized individual if the donor or other individual is unable to sign

The record made to amend or revoke an anatomical gift must be witnessed by two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or other authorized individual, and must state that the record has been signed and witnessed as described above.

If the donor made the anatomical gift by will, the donor may amend or revoke the gift in the same manner by which a will may be amended or revoked as described above.

A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury which is addressed to two adults, at least one of which is disinterested.

An anatomical gift that is not revoked by the donor before death is irrevocable and does not require anyone else’s consent or concurrence after the donor’s death.

An anatomical gift made by an authorized person for a decedent may be revoked by a person of the same or a higher priority as the person authorizing the gift, only if the procurement organization, transplant hospital, the physician, or technician knows of the revocation. If more than one member of the priority class is reasonably available, the anatomical gift may be amended only if a majority of the reasonably available members agree to amending the gift, or be revoked only if a majority of the reasonably available members agrees to the revocation, or if they are equally divided as to whether to amend the gift.

**Can a revocation be made after an incision to remove the organ or body part?**

Generally, no. A revocation is only effective if the procurement organization, transplant hospital, physician, or technician knows of the revocation before an incision is made to remove the donated body part or before the transplant procedures have begun on the recipient. Once these procedures have begun, any revocation is moot.

**Who may receive an anatomical gift, and for what purpose?**

An anatomical gift may be made to the following persons or entities named in the document of gift:

* A hospital, accredited medical school, dental school, college, or university, or an organ procurement organization for research or education.
* An individual designated by the person making the anatomical gift. If the anatomical gift cannot be transplanted into the designated individual, the gift will pass to the appropriate eye or tissue bank, and/or organ procurement organization so long as there is not an expressed, contrary indication by the individual making the gift.
* An eye or tissue bank.
* An organ procurement organization.

If an anatomical gift of one or more specific parts does not name a person to donate but identifies the purpose for which an anatomical gift may be used, the following rules apply:

* If the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank.
* If the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank.
* If the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.
* If the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

If the donee knows of the decedent’s refusal or contrary indication to make an anatomical gift, or that an anatomical gift made by an authorized person for the decedent is opposed by a person of the same or a higher priority, the donee may not accept the anatomical gift.

**When is a physician prohibited from removing or transplanting an anatomical gift?**

A physician may not participate in removing or transplanting a part if:

* The physician attended the donor at death.
* The physician determined the time of death.

A physician or technician may remove a donated part from the body of a donor that the physician or technician is qualified to remove.

**How does a person refuse to make an anatomical gift?**

A person may refuse to make an anatomical gift of any part of his or her body by:

* A writing signed in the same manner as a document of gift by the individual or another individual acting at he direction of the refusing individual if that individual is physically unable to sign.
* A statement attached to or imprinted on the person’s driver’s license.
* The individual’s will.
* During terminal illness or injury, an oral statement or any other form of communication.

In the absence of contrary indications by a donor, an anatomical gift of one part is not a refusal to give other parts and is not a limitation on an anatomical gift. In the absence of contrary indications by a donor, a revocation of an anatomical gift is not a refusal to make another anatomical gift.

An individual's unrevoked refusal to donate bars any donation by any other persons.

Note that the revised law makes it clear that absent express action by the donor, organ donation should be encouraged and facilitated. Thus, under this part of the code, revocation by a donor of an anatomical gift is not a refusal and does not bar an authorized person from making an anatomical gift.

**What if there is a conflict between an advance directive and the anatomical gift?**

If there is a conflict between an advance directive and the measures necessary to ensure suitability to donate under the terms of an anatomical gift donation, measures must be taken to ensure the medical suitability of the prospective donor while the conflict is resolved. Measures may only be withheld if they are contraindicated by appropriate end-of-life care.

**May HIV or STD testing done on a donor be disclosed?**

Under limited circumstances, yes. HIV or STD testing of a donor may be disclosed to a health facility or health care provider that processes, procures, distributes or uses human body parts, tissues, or blood from a deceased person. See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd).

**May a physician be held civilly or criminally liable in connection with organ donation procedures?**

No, as long as the physician acts, or attempts in good faith to act, in accordance with the provisions of Washington’s Uniform Anatomical Gift Act or the applicable anatomical gift law of another state or foreign country.

## Death With Dignity Act

**May an adult person who has a terminal disease and less than six months to live request medication to self-administer to end his or her life?**

Yes. The Washington Death with Dignity Act, Initiative Measure no. 1000, was approved by voters in November, 2008. The Act became effective on March 4, 2009 after the Department of Health finalized administrative rules implementing the Act.

**What are the requirements for the patient?**

The patient must:

* Be an adult (over 18 years of age);
* Be a resident of Washington State;
* Be suffering from a terminal disease;
* Be mentally competent;
* Make a written request for medication that the patient may self-administer to end his or her life;
* Make an oral request to the attending physician for medication that the patient may self-administer to end his or her life; and
* Make a second oral request to the attending physician for medication that the patient may self-administer to end his or her life 15 days or more after the first oral request.

**Is there a standard form for the patient to make a written request for medication to self-administer to end his or her life?**

Yes. The Department of Health Form DOH 422-063, “Request for Medication to End My Life in a Humane and Dignified Manner” is the form a patient must use under the Death with Dignity Act. The form is available at: <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-063-RequestMedicationEndMyLifeHumaneDignifiedManner.pdf> . The form must be signed by the patient and the patient must acknowledge the following:

* The patient is of sound mind
* The patient is suffering from a known diagnosis which the patient’s attending physician has determined is an “incurable, irreversible terminal disease that will result in death within six months” and that the diagnosis and prognosis have been confirmed by a consulting physician;
* The patient has been fully informed of the diagnosis, prognosis, medications to be prescribed, associated risks, likely outcome, and feasible alternatives;
* The patient requests the attending physician to prescribe, and a pharmacist to dispense, medication the patient may self-administer to end his or her life;
* Whether or not the patient has informed his or her family of the decision, or has no family to inform;
* The patient has the right to rescind the request at any time
* The patient understands that death will occur, that death usually occurs within three hours, but may take longer;
* That the requests is made voluntarily, and without reservation; and
* That he or she accepts full moral responsibility for his or her actions;

The form must be witnessed by two persons, one of which shall not be a relative by blood, marriage, or adoption, shall not be entitled to any portion of the patient’s estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or a resident. The witnesses must acknowledge that the person requesting the medications under the Act:

* Is personally known to the witness or has provided proof of identity;
* Has signed the request in the witness’ presence
* Appeared to be of sound mind, and not under duress, fraud, or undue influence; and
* Is not a patient for whom either of the witnesses is the attending physician

**Is the patient who requested medication to end his or her life under the Death with Dignity Act the only person who may administer the prescribed medication?**

Yes. Once all of the requirements of the Death with Dignity Act have been met, only the patient may self-administer the medication(s) to end his or her life. The Death with Dignity Act does not authorize or permit a physician or any other person to end a patient’s life. The Act prohibits active euthanasia, lethal injection, or mercy killing.

**Who may prescribe the medication(s) to end a person’s life under the Death with Dignity Act?**

Only the requesting patient’s attending physician may prescribe under the Act. When a patient has more than one physician, the physician who acts as the attending physician must be clearly documented.

**What are the responsibilities of the attending physician?**

The attending physician must complete the “Attending Physician’s Compliance Form,” DOH 422-064. The form is available at: <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-064-AttendingPhysicianComplianceForm.pdf> . This form requires that the attending physician must document the patient’s first oral request for medication(s) to end life and determine that the patient:

* Has a terminal disease;
* Has six months or less to live;
* Is competent;
* Is a Washington resident – which may be proven by the patient:
* Possessing a Washington state driver’s license;
* Being registered to vote in Washington; or
* Produce evidence that the person owns or leases property in Washington;
* Is acting voluntarily;
* Has made his or her decision after being fully informed of:
* His or her medical diagnosis;
* His or her prognosis;
* The potential risks associated with taking the medications prescribed;
* The potential result of taking the medications prescribed; and
* The feasible alternatives, including (but not limited to) comfort care, hospice, and pain control.

In addition, the attending physician must indicate that the patient:

* Was informed of his or her right to rescind the request at any time (permitted at any time, but is required at the time of the patient’s second oral request);
* Was recommended to inform the next of kin;
* Was counseled about the importance of having another person present when the patient takes the medications(s); and
* Was counseled about the importance of not taking the medication(s) in a public place.

The attending physician must also:

* Refer the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is competent and acting voluntarily;
* Refer the patient for counseling if the attending physician or the consulting physician believes the patient may be suffering from a psychiatric disorder or depression causing impairment;
* Document the patient’s written and oral requests for medication to end his or her life, the attending physician’s diagnosis and prognosis and that of the consulting physician;
* Document the outcomes and determinations from counseling, if performed; and
* Document that all requirements under the DWDA have been met, and indicate the steps taken to carry out the patient’s request, including a notation of the medication prescribed.

Only after all the required steps have been taken may the attending physician write a prescription for medication which would enable the qualified person to self-administer in order to end his or her life.

**What are the requirements for the attending physician regarding the mental status of the patient?**

If the attending physician is comfortable making the determination that the patient is not suffering from a psychiatric or psychological disorder, or depression that would cause impaired judgment, the attending can so attest on the “Attending Physician’s Compliance Form.” However, if the attending physician is not able to comfortably and confidently make that determination, then the attending physician must refer the patient for evaluation and counseling for a possible psychiatric or psychological disorder, or depression. The attending physician must attach the completed “Psychiatric/Psychological Consultant’s Compliance Form” to the “Attending Physician’s Compliance Form.”

**What are the attending physician’s responsibilities regarding the death certificate?**

The attending physician may sign the death certificate. The death certificate must list the underlying terminal disease as the cause of death. Death resulting from participation in the Act is not suicide.

**What are the reporting requirements for the attending physician?**

Within 30 calendar days of writing a prescription for medication to end the life of a qualified patient, the attending physician must send the following documentation, completed, signed, and dated to the State Registrar, Center for Health Statistics, P.O. Box 47814, Olympia, WA 98504:

* The patient’s completed written request for medication to end life, either on the “Request for Medication to End My Life in a Humane and Dignified Manner” form, DOH 422-063, or in a substantially same form;
* The “Attending Physician’s Compliance Form,” DOH 422-064;
* The “Consulting Physician’s Compliance Form,” DOH 422-065; and
* The “Psychiatric/Psychological Consultant’s Compliance Form,” DOH 422-066, if such an evaluation was performed.

Within 30 calendar days of a qualified patient’s ingestion of a lethal dose of medication prescribed under the Act, or death from any cause, whichever comes first, the attending physician must complete the “Attending Physician’s After Death Reporting Form,” DOH 422-068. The form is available at: <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-068-AttendingPhysicianAfterDeathReportingForm.pdf> . This form requires that the attending physician answer questions regarding the patient and the attending physician’s care of the patient. In addition, the attending physician must provide information regarding the circumstances of the patient’s death, if known, including whether there were any complications from ingestion of the medication(s).

In addition, within 30 calendar days of a qualified patient’s ingestion of a lethal dose of medication prescribed under the Act, or death from any cause, whichever comes first, the dispensing health care provider must complete the “Pharmacy Dispensing Record Form,” DOH 422-067. This form is available at: <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-067-PharmacyDispensingRecord.pdf> . Information reported to the Department of Health must include:

* Patient’s name and date of birth;
* Patient’s address;
* Prescribing physician’s name and phone number;
* Dispensing health care provider’s name, address and phone number;
* Medication dispensed and quantity;
* Date the prescription was written; and
* Date the medication was dispensed.

**What happens to the information gathered by the Department of Health?**

The Department of Health must generate and make available to the public an annual statistical report of information collected under the Act. All information collection by the Department of Health under the Act shall not be a public record and may not be available for inspection by the public under the Washington Public Records Act. The protected information includes, but is not limited to, the identity of patients, health care providers, and health care facilities.

**What are the responsibilities of the consulting physician?**

The consulting physician must examine the patient and his or her relevant medical records. The consulting physician must complete the “Consulting Physician’s Compliance Form,” DOH 422-065. The form is available at <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-065-ConsultingPhysicianComplianceForm.pdf>. This form requires the consulting physician to confirm the determinations:

* That the patient has a terminal disease;
* That the patient has six months or less to live;
* That the patient is competent;
* That the patient is acting voluntarily;
* That the patient has made his or her decision after being fully informed of:
* His or her medical diagnosis;
* His or her prognosis;
* The potential risks associated with taking the medication(s) to be prescribed; and
* The feasible alternatives, including (but not limited to) comfort care, hospice care, and pain control.

The consulting physician must make a determination concerning the patient’s mental state. The consulting physician either determines that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, or refers the patient for evaluation and counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment.

**What are the responsibilities of the psychiatric/psychological consultant?**

The psychiatric/psychological consultant must examine the patient in order to determine if the patient suffers from a psychiatric or psychological disorder, or depression causing impaired judgment. The consultant must document the results of the examination on the “Psychiatric/Psychological Consultant’s Compliance Form,” DOH 422-066. This form is available at: <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-066-PsychiatricPsychologicalConsultantComplianceForm.pdf> . The completed form must include:

* The patient’s medical diagnosis;
* The psychiatric/psychological evaluation; and
* The consultant’s signature attesting that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

The form does not provide a clear mechanism to indicate that the patient does indeed have a condition that may cause impaired judgment. If the consultant makes such a determination, the consultant may consider writing the conclusion prominently, and signing the document outside of the section which indicates the patient does not have impaired judgment.

**Are physicians who comply with a patient’s request under the Death with Dignity Act protected from criminal and civil liability or other forms of retribution?**

Yes. A person participating in good faith under the Act is not subject to civil or criminal liability or professional disciplinary action. In addition, any professional organization or association, or a health care provider, may not subject a physician who participates in good faith under the Act to censure, discipline, suspension, loss of license, loss of privileges, or other penalty.

**May a physician or a health care facility refuse to participate in a patient’s request for medication(s) to end his or her life under the Death with Dignity Act?**

Yes. Only willing health care providers shall participate in the provision of medication(s) to end the life of a qualified patient under the Act.

**If a physician does not want to participate, does the act require a referral to a physician who will?**

No. But if the patient transfers his or her care to another attending physician, then the non-participating physician must transfer, upon request, a copy of the patient’s relevant medical records to the new health care provider.

**May a health care facility prohibit a physician from participating under the Death with Dignity Act?**

Yes. A health care facility may prohibit a physician from participating under the Act on the premises of the facility if the facility has given notice to all physicians and health care providers with privileges to practice on the premises of the facility and to the general public of the facility’s policy regarding participation under the Act.

**May a health care facility, or another health care provider, which prohibits participation under the Death with Dignity Act impose sanctions on physicians who violate the policy of the health care facility?**

Yes. A health care facility or other health care provider may subject a physician to certain sanctions if the facility or health care provider notified the sanctioned physician before participation under the Act that it prohibits participation under the Act. A health care facility or other health care provider that imposes sanctions for participation under the Act must follow all due process and other procedures in the sanction process. If a physician participates under the Act on the premises of a health care facility which has given notice that it prohibits such participation, sanctions may include:

* Loss of privileges, loss of medical staff membership, or other sanctions provided under the applicable medical staff bylaws, policies, and procedures of the health care facility;
* Termination of a lease or other property contract; or
* Termination of a contract under which the sanctioned physician is an employee or independent contractor.
  + But a participating physician is protected from sanctions if the physician participates under the Act outside the scope of the physician’s capacity as an employee or independent contractor.

**Are the attending and consulting physicians eligible for reimbursement for services provided under the Death with Dignity Act?**

The Death with Dignity Act does not address payment for physicians’ services or the medications prescribed.

As the Act states that the “terminal disease” shall be listed as the cause of death rather than “suicide” on the death certificate, insurance benefits may be available under that definition.However, while reimbursement is possible, a health insurer may invoke a “not medically necessary” exclusion, denying payment for these services. Physicians are encouraged to contact the relevant health insurer for the patient in question to ascertain the specific policy regarding reimbursement for services rendered under this Act.

Federal funds may not be used to reimburse for services or items rendered under this Act, which likely will affect Medicaid, TRICARE, and other federal programs. For Medicare, the Medicare Benefit Policy Manual specifically states “[a] health care item or service for the purpose of causing, or assisting to cause, the death of any individual (assisted suicide) is not covered.”

For non-governmental programs, a health insurer would make the determination whether the service is covered under its policies.

**Does the State of Washington provide information regarding the Death with Dignity Act which is available to the public?**

Yes. The Department of Health has a detailed website devoted to the Death with Dignity Act. The website contains information regarding the Act, a link to all required forms, and the yearly reports of data gathered by the department. The website is located at: <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct.aspx>.

## Death Certificates

**When is an individual legally considered “dead”?**

Under Washington law, an individual is “dead” when it is determined according to accepted medical standards that the individual has sustained either:

* Irreversible cessation of circulatory and respiratory functions; or
* Irreversible cessation of all functions of the entire brain, including the brain stem.

**What is the legal definition of a “fetal death”?**

Under Washington law, a “fetal death” occurs when any product of conception, after complete expulsion or extraction from its mother, shows no evidence of life such as breathing, beating of the heart, pulsating of the umbilical cord, or definite movement of voluntary muscles.

**Must a death certificate be prepared and filed for all deaths?**

Yes, with one exception—no certificate is required for fetal deaths if the period of gestation is less than 20 weeks.

**Who must prepare and file the death certificate?**

The funeral director or the person with the right to dispose of the deceased’s remains must prepare and file the death certificate. In preparing the certificate, he or she must present the death certificate to the physician, physician’s assistant, or advanced registered nurse practitioner who last attended the deceased or who was in attendance at the fetal death. Within two business days, the physician, physician’s assistant, or advanced registered nurse practitioner must certify the cause of death according to her or his best knowledge and then sign or electronically approve the certificate unless good cause for not doing so within this timeframe can be established.

If the deceased died without medical attendance, the health officer, medical examiner, coroner, or prosecuting attorney having jurisdiction must similarly certify the cause of death and sign or electronically approve the certification. If the circumstances suggest the cause of death (or fetal death) was caused by unlawful or unnatural causes the individual completing or signing the death certificate noting only that no physician, PA, or ARNP was in attendance at the time of death. If there is no suspicion of death from unlawful or unnatural causes, the death certificate should note that no physician, PA, or ARNP was in attendance at the time of death, and also note the cause of death without the holding of an inquest or performing an autopsy, but from statements of family or persons in attendance at the time of death or during the deceased individual’s last illness, or others who have an adequate knowledge of the facts.

**Can a county coroner or medical examiner be liable for erroneously determining the cause of death?**

No. A physician acting as a county coroner or medical examiner is immune from civil liability for determining the cause and manner of death.

**When and where must a death certificate be filed?**

If the place of death is known, a death certificate must be filed with the local registrar of the district where the death occurred within three business days after the death becomes known. .

If the place of death is not known, the death certificate must be filed with the local registrar of the district where the body’s remains are discovered within one business day of the discovery.

The death certificate must be filed before the body’s interment or other disposition. If after three business days, however, the cause of death still cannot be determined—and thus the certificate cannot yet be certified and filed—the deceased’s attending physician must give a written explanation for the delay to the local registrar of the district where the death occurred so that a permit for the body’s disposition can be issued.

**Are there penalties for failing to comply with death certificate requirements?**

Yes. Failure to comply with death certificate requirements is a misdemeanor; repeated violations may subject a physician to a fine of up to $250, imprisonment for up to 90 days, or both. Also, willfully providing false information for or making any false statement on a death certificate is a gross misdemeanor.

## Autopsies/Human Remains

### Autopsies

**Who may authorize an autopsy?**

While an autopsy does not necessarily need to be performed on every dead human body, certain individuals and agencies may authorize an autopsy.

A coroner may, in his or her discretion, order an autopsy of any dead body over which the coroner has jurisdiction. See [Human Remains](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/autopsieshuman-remains/human-remains).

If a death occurs on the job and the cause of death is unknown, the Washington State Department of Labor and Industries may request in writing that the coroner perform an autopsy. Upon receiving the request, the coroner must promptly perform the autopsy to determine the cause of death.

The following persons, in order of priority, may also authorize an autopsy, as long as a person of higher priority has not refused such authorization:

* The decedent’s surviving spouse or state registered domestic partner.
* Any child of the decedent who is age 18 or older.
* A parent of the decedent.
* Any adult sibling of the decedent.
* A guardian of the decedent at the time of death.
* Any other person or agency authorized or under an obligation to dispose of the decedent’s remains.

If the person seeking authority to have an autopsy performed makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class of priority and finds that no such person is available, the authorization may be given by any person in the next class in the order of descending priority.

Any other party, by showing just cause, may petition the court to have an autopsy performed and the results made known to the party at that party’s expense.

**Is an unauthorized autopsy a crime?**

Yes. Making any unauthorized dissection of a dead body is a gross misdemeanor.

**Who has access to autopsy results?**

Reports and records of all autopsies are confidential, but the following persons may examine and obtain copies of any of these reports and records:

* The personal representative of the decedent.
* Any family member of the decedent.
* The attending physician or advanced registered nurse practitioner.
* A prosecutor or law enforcement agency with jurisdiction.
* A public health official.
* The Washington State Department of Labor and Industries when it has an interest in an industrial death.
* The Secretary of the Washington State Department of Social and Health Services in certain child-fatality cases under review.

**If requested, must a physician meet with the decedent’s family members to discuss the findings of the autopsy?**

Yes. The coroner, medical examiner, or attending physician must, upon request, meet with the decedent’s family to discuss the findings of the autopsy. “Family” includes the surviving spouse, the state registered domestic partner, any child, parent, grandparent, grandchild, brother or sister of the decedent, or any guardian of the decedent at the time of death.

**Can a physician be held liable to a decedent’s relatives for improper disclosure of autopsy records or photographs?**

Yes. A decedent’s immediate relatives can sue a physician (or other person) who makes such improper disclosure for invasion of privacy.

### Human Remains

**May a physician obtain or have in his or her possession dead human bodies or body parts?**

Yes. Any state-licensed physician or surgeon, or any medical student under the authority of any such physician or surgeon, may obtain or have in his or her possession human dead bodies, or parts of human dead bodies, for the purposes of anatomical inquiry or instruction.

**Where does a physician obtain a dead human body or body parts?**

Generally, a public agency required to dispose of a body at public expense will give the body to a physician to use for the advancement of anatomical science. Preference will be given to Washington medical schools.

A person may make an anatomical gift of his or her body for research or education to a hospital; an accredited medical school, dental school, college, or university; or an organ procurement organization. See [Anatomical Gifts](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/organ-and-tissue-donation/anatomical-gifts).

**Are there any procedures which must be followed in obtaining a body for anatomical study?**

Yes. In order to receive a body, a physician must provide to the board or officer surrendering the body certification from the county medical society or the county board of supervisors, stating that the physician is fit to receive the body. The physician must also provide a bond, with two sureties, that any body received will be used only for the promotion of anatomical science within the state of Washington and in a way that will not outrage the public feeling.

Failure to follow these procedures may result in a fine of up to $500.

**Is the improper disposition of human remains a crime?**

Yes. It is a crime to:

* Fail to notify the coroner of the existence and location of a dead body coming within the jurisdiction of the coroner, unless there is good reason to believe that the coroner has already been given notice.
* Remove or conceal a body without the approval of the deceased’s next of kin and/or the coroner.
* Detain or threaten to detain a body for any debt or lien.
* Dissect a body without appropriate authorization.
* Unlawfully dispose of human remains.
* Unlawfully disturb, remove, or sell human remains.

**When does the coroner have jurisdiction over a body?**

A coroner has jurisdiction over a body:

* When the deceased person came to death suddenly while in apparent good health without medical attendance within the 36 hours preceding death.
* When the circumstances of death indicate that death was caused by unnatural or unlawful means.
* When death occurs under suspicious circumstances.
* When a coroner’s autopsy, inquest or postmortem is to be held.
* When death results from unknown or obscure causes.
* When death occurs within one year following an accident.
* When death is caused by any violence whatsoever.
* When death results from a known or suspected abortion, whether self‑induced or otherwise.
* When death apparently results from drowning, hanging, burns, electrocution, gunshot wounds, stabs or cuts, lightning, starvation, radiation, exposure, alcoholism, narcotics or other addictions, tetanus, strangulation, suffocation or smothering.
* When death is due to still birth or premature birth.
* When death is due to a violent contagious disease or suspected contagious disease which may be a public health hazard.
* When, in jail or prison, death results from alleged rape, carnal knowledge or sodomy.
* When a body is found dead and not claimed by relatives or friends.

**Is an autopsy required for every dead human body?**

No. See [Autopsies.](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/autopsieshuman-remains/autopsies)

## Elder Abuse

Vulnerable Adult Abuse

**Must a physician report suspected abuse of a vulnerable adult?**

Yes, when a physician has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, the physician must immediately report the incident to DSHS. If there is reason to suspect sexual or physical assault of a vulnerable adult, the physician must immediately report the incident to the appropriate law enforcement agency and to DSHS.

**What is a vulnerable adult?**

Vulnerable adults include persons who:

* Are 60 years of age or older and have a functional, mental, or physical inability to care for themselves.
* Have been found legally incapacitated.
* Have a developmental disability (i.e. a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition closely related to intellectual disability which developed before age 18 and has continued, or can be expected to continue indefinitely, or to require treatment similar to that required for intellectual disabilities, and which constitutes a substantial limitation to the individual.
* Is admitted to any facility.
* Is receiving services from home health, hospice, or a licensed home care agency.
* Is receiving services from an individual provider
* Who self-directs his or her own care, and receives services for compensation from a personal aide registered with DSHS.

**How must the report of vulnerable adult abuse be made?**

An immediate oral or written report must be made to DSHS. The report should include as much of the following information as possible:

* The name and address of the person making the report.
* The name and address of the vulnerable adult.
* The name and address of the facility or agency providing care for the vulnerable adult.
* The name and address of the legal guardian or alternate decision maker.
* The nature and extent of the abandonment, abuse, financial exploitation, neglect, or self-neglect.
* Any history of previous abandonment, abuse, financial exploitation, neglect, or self-neglect.
* The identity of the alleged perpetrator, if known.
* Other information that may be helpful in establishing the extent of abandonment, abuse, financial exploitation, neglect, or the cause of death of the deceased vulnerable adult.

**Can a physician be held liable for reporting suspected vulnerable adult abuse?**

Generally, no. A physician who in good faith makes a report or testifies about suspected abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult is immune from liability resulting from the report or testimony.

**Are there any penalties for failing to report suspected vulnerable adult abuse?**

Yes. Knowing failure to make a report constitutes a gross misdemeanor. Failure to file a required report may also subject the physician to civil liability if the failure to file a report is a proximate cause of an actionable injury. Failure to file a required report may also constitute unprofessional conduct which could result in disciplinary action. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct).

**Are there any penalties for filing a false report of vulnerable adult abuse?**

Yes. A person who intentionally, maliciously, or in bad faith makes a false report of alleged abandonment, abuse, financial exploitation, or neglect of a vulnerable adult is guilty of a misdemeanor.

# Liability and Litigation Issues

## Medical Malpractice

### Informed Consent

**What is informed consent?**

Informed consent is consent to treatment given by a patient or a patient’s legal representative, after being fully informed in language the patient or patient’s legal representative can reasonably be expected to understand, of all material facts relating to the treatment, including:

* The nature and character of the treatment proposed and administered.
* The anticipated results of the treatment proposed and administered.
* The recognized possible alternative forms of treatment.
* The recognized serious possible risks, complications, and anticipated benefits involved in the treatment proposed and the recognized possible alternative forms of treatment, including non-treatment.

**When is informed consent required?**

Generally, except in certain emergency cases or when the patient requests not to be fully informed, informed consent is required before any treatment may be rendered to a patient. A physician’s failure to obtain informed consent prior to treatment may subject the physician to liability in a medical malpractice action for any injuries caused by treatment to which the patient or the patient’s legal representative did not consent.

Special informed consent is required in some instances. See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd).

**Who may give consent to treatment?**

An otherwise competent adult patient may give informed consent to treatment.

If a patient is not competent to give informed consent, informed consent may be obtained from one of the following persons in order of priority:

* The appointed guardian of the patient, if any.
* A person to whom the patient has given a durable power of attorney encompassing the authority to make health care decisions.
* The patient’s spouse or state registered domestic partner.
* Children of the patient who are age 18 or older.
* Parents of the patient.
* Adult siblings of the patient.

If the physician seeking informed consent for an incompetent patient makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class of priority and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. No person may provide informed consent if a person in a higher class of priority has refused to give such authorization. If there are two or more persons in the same class of priority, the decision must be unanimous among all available members of that class.

**Is a minor competent to give informed consent?**

A minor is competent to provide informed consent in certain specific situations. See Minors, Treatment Of for when minors can provide informed consent.

**Who may provide informed consent on behalf of minors who are not authorized to provide consent on their own behalf?**

If a minor is not otherwise authorized to provide informed consent for health care, including mental health care, such consent may be obtained from one of the following persons in order of priority:

* The appointed guardian, or legal custodian of the minor patient, if any.
* A person authorized by the court to consent for medical care for a child in an out-of-home placement.
* Parents of the minor child.
* A person to whom the parents have given a signed authorization to make health care decisions.
* A competent adult representing himself or herself to be a relative responsible for the healthcare of the child, provided that the person sign a sworn statement to that effect.

A physician may rely on the representation of a person who claims to be responsible for the healthcare decisions of a child, but is not required to do so. A physician who renders care to a minor, relying on consent obtained from a person who has signed such a sworn declaration is protected from legal action related to the consent.

**Must informed consent be obtained in an emergency?**

Not necessarily. Consent of the patient will usually be implied if an emergency situation exists requiring prompt treatment to avoid the possibility of injury or death and if the patient is unable to consent for any reason and no other person legally authorized to provide consent is reasonably available.

**How should informed consent be documented?**

Signed consent forms may be used, but not in lieu of, or as a substitute for, a discussion with the patient. Signed consent forms should be kept in the patient’s chart.

If the patient requests not to be informed or to receive only limited information, the patient’s request should be put in writing, signed by the patient, and placed in the patient’s chart.

Discussions with the patient about risks, benefits and alternatives should be documented with specificity in the patient’s chart. The absence of specific contemporaneous documentation of informed consent discussions in medical malpractice actions alleging failure to obtain informed consent brought on behalf of patients who have died or become incompetent may prove difficult to defend. In such cases, absent such documentation, the physician may be barred by the deadman’s statute from presenting evidence as to the details of what the physician told the patient, or as to the physician’s habit and routine in informing similarly situated patients, about risks, benefits, and alternatives to the treatment proposed and administered.

**Must informed consent be given to involuntarily committed patients?**

Generally, yes. But see [Involuntary Commitment – Chemical Dependency](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/involuntary-commitment/involuntary-commitment-chemical-dependency) and [Involuntary Commitment – Mental Disorders](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/involuntary-commitment/involuntary-commitment-mental-disorders) for circumstances where informed consent is not required. Informed consent may be contained in a validly executed mental health advance directive.

**Should a physician ever promise a patient a particular result from treatment or a cure?**

No. Generally, the law presumes that a physician does not guarantee a particular result or cure. If, however, the physician promises the patient or the patient’s legal representative that a particular injury will not occur, the physician may be liable for medical malpractice if the injury does occur.

### Medical Malpractice

**Under what circumstances may a physician be liable for medical malpractice?**

Under Washington law, a physician may be liable for medical malpractice if a plaintiff proves by a preponderance of the evidence one of the following:

* That injury resulted from the failure of the physician to follow the accepted standard of care.
* That the physician promised the patient or his representative that the injury suffered would not occur.
* That injury resulted from health care to which the patient or the patient’s representative did not consent.

**What is the standard of care?**

The standard of care is that degree of care, skill, and learning expected, at the time the patient was being treated, of a reasonably prudent physician in the profession or class to which the physician belongs, in the state of Washington, acting in the same or similar circumstances.

**Generally, what must be proven to show that injury resulted because a physician failed to follow the accepted standard of care?**

In order to prove that injury resulted from a physician’s failure to follow the accepted standard of care, the plaintiff must prove that:

* The physician failed to exercise that degree of care, skill, and learning expected, at the time the patient was being treated, of a reasonably prudent physician in the profession or class to which the physician belongs, in the state of Washington, acting in the same or similar circumstances.
* The physician’s failure to do so was a proximate cause of the plaintiff’s injury.

**What must be proven to show that injury resulted from health care to which the patient did not consent?**

In order to prove that an injury resulted from a physician’s failure to secure the patient’s informed consent, the plaintiff must prove that:

* The physician failed to inform the patient or the patient’s representative of a material fact or facts relating to the treatment.
* The patient consented to the treatment without being aware of or fully informed of such material fact or facts.
* A reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts.
* The treatment in question proximately caused injury to the patient.

A fact is considered “material” if a reasonably prudent person in the position of the patient would attach significance to it in deciding whether or not to submit to the proposed treatment. Material facts include, but are not necessarily limited to:

* The nature and character of the treatment proposed and administered.
* The anticipated results of the treatment proposed and administered.
* The recognized possible alternative forms of treatment.
* The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

See [Informed Consent](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-malpractice/informed-consent).

**How is a medical malpractice lawsuit initiated against a physician?**

The patient or the patient’s legal representative commences a medical malpractice lawsuit against a physician by filing with the court and serving upon the defendant a summons and complaint. The summons is the document which tells the physician that a lawsuit has been started, that the physician must appear and defend within a certain period of time, and that the physician’s failure to do so will result in a default judgment. The complaint is the document which sets forth the factual and legal basis for the patient’s claim against the physician.

The law requires mandatory mediation of malpractice claims, except those claims that are subject to mandatory arbitration, or when the parties have agreed to voluntary binding arbitration.

**What should a physician do when the physician receives a summons and complaint?**

Upon receiving a summons and/or complaint, a physician should immediately call his or her professional liability insurance company. Failure to act promptly could result in a default judgment being entered against the physician.

**May a physician offer an apology or express sympathy for a treatment outcome that is the basis of a malpractice action without it being admissible in evidence?**

Yes. In a medical malpractice lawsuit, a statement, affirmation, gesture or conduct expressing fault, apology, sympathy, condolence or another general sense of benevolence, or a statement or affirmation regarding remedial actions that may be taken, is not admissible as evidence if the statement was conveyed by the physician to the injured person or certain family members within 30 days of the act or within 30 days of the time the act was discovered by the physician, whichever period expires later.

**What is the discovery phase of a medical malpractice lawsuit?**

The “discovery” phase, which usually does not begin for at least 20 days after the summons and complaint are served, is the phase of a lawsuit in which the parties “discover” the facts, the opinions to be expressed by experts, the existence of relevant documents, such as medical and employment records of the plaintiff, and other details. The most frequently used methods of discovery include:

* Requests for production (a way to obtain documents from the other party).
* Interrogatories (written questions which must be answered under oath).
* Depositions (oral questions posed to parties and other witnesses who are under oath).
* Requests for admission (written requests for a party to admit certain statements or opinions of fact or to admit the genuineness of certain documents).
* Independent medical examinations.

It is extremely important for a physician who is sued in a medical malpractice case to work closely with his or her attorney in responding to discovery requests.

**What is a deposition?**

A deposition is oral testimony given under oath before a court reporter. A deposition of a party to the lawsuit or of a witness who is unavailable at the time of trial can be read to the jury at trial as if it were live testimony. A deposition also can be used to “impeach” a witness if the witness’ testimony at trial differs from the witness’ deposition testimony.

Because depositions can be used against a physician at trial, it is extremely important for a physician to be well prepared for his or her deposition.

**When is the trial phase of lawsuit?**

It usually takes a year or more from the filing of the lawsuit until a medical malpractice case actually goes to trial.

Only a small percentage of medical malpractice cases actually go to trial. Many cases are disposed of by way of a compromise settlement. Some are voluntarily dismissed. Some are dismissed on summary judgment motions.

The medical malpractice cases that do go to trial usually are tried to a jury, but occasionally are tried to a judge. In a jury trial case, the jury determines whether there was malpractice, whether the malpractice caused the injury, and how much money, if any, should be awarded to the plaintiff.

Malpractice trials usually last anywhere from one to three weeks, but can take longer. Except for emergencies, it is extremely important that the defendant physician be in attendance for the entire trial.

**When a physician is sued in a medical malpractice action, should the physician discuss the details or merits of the case with anyone other than representatives of the physician’s insurance carrier, employer or attorney?**

No. A physician should not discuss the lawsuit with anyone except representatives of the physician’s professional liability insurance company, the employer or attorney without first obtaining approval from his or her attorney. In particular, a defendant physician should not discuss the details and merits of the case with colleagues or with persons who potentially may be witnesses in the case.

**Must the patient’s attorney certify that the filing of a malpractice claim is not frivolous?**

Yes. When a malpractice claim is filed, the patient’s attorney must certify that the claim is not frivolous, that it is grounded in fact, is warranted by existing laws or a good faith extension, modification, or reversal of an existing law, and that the claim is not filed for the purpose of harassment. If the court finds that the attorney has violated these rules, the court may impose sanctions, including legal fees and the physician’s attorney’s fees.

**May a physician who is sued for malpractice make a counterclaim against a plaintiff for malicious prosecution?**

In rare cases, a physician who is sued for malpractice may have a valid basis for asserting a counterclaim for malicious prosecution against the plaintiff. The physician’s burden of proof in a malicious prosecution counterclaim is very high. The physician must prove that the plaintiff initiated the medical malpractice action against the physician with knowledge that the claim was false, unfounded, malicious, and without probable cause. The success rate on malicious prosecution counterclaims is very low.

If the court finds that the malicious prosecution counterclaim was frivolous and advanced without reasonable cause, the physician may be liable for the plaintiff’s reasonable expenses, including attorneys’ fees, incurred in defending against the counterclaim.

A physician’s attorneys’ fees incurred in pursuing a malicious prosecution counterclaim are generally not covered by insurance.

**Are there requirements for health care liability risk management training?**

Yes. Washington law requires that once every 3 years physicians must complete a health care liability risk management training program provided by the physician’s professional liability insurance carrier. The risk management training provides information related to avoiding adverse health outcomes resulting from substandard practice and minimizing damages associated with the adverse health outcomes that do occur.Completion of such a training program is mandatory for renewal of a physician’s professional liability insurance.

**Must an insurer report payments in connection with the settlement or judgment of a malpractice insurance claim to the Medical Quality Assurance Commission or the National Practitioner Data Bank?**

Under state law, a professional liability insurer is required to report to the MQAC all malpractice payments in excess of $20,000, and the payment of three or more malpractice claims during a five-year period, made on behalf of a physician. Under federal law, any entity which makes any payment under a policy of insurance, self-insurance, or otherwise in settlement, partial settlement, or satisfaction of a judgment in a medical malpractice action or claim on behalf of a physician, must report the payment to the National Practitioner Data Bank and the MQAC. See [National Practitioner Data Bank](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/national-practitioner-data-bank).

### Statute of Limitations

**What is a statute of limitations?**

It is a time limit beyond which a person may not bring a lawsuit.

**What is the medical malpractice statute of limitations in Washington?**

A medical malpractice action in Washington must be brought within the later of:

* Three years of the act or omission alleged to have caused the injury or condition.
* One year of the time the patient or his representative discovered or reasonably should have discovered that the injury or condition was caused by the act or omission.

In 2006, the Washington Legislature re-enacted the eight-year statute of repose for medical malpractice actions, providing that “in no event shall an action be commenced more than eight years after said act or omission”. An earlier enactment of this statute of repose was declared unconstitutional by the Washington Supreme Court. Whether the 2006 reenactment of the statute repose will survive constitutional challenge remains to be seen.

For purposes of a claim of continuing negligent medical treatment, the statute of limitations begins to run on the date of the last act or omission alleged to have caused the harm.

**When is the medical malpractice statute of limitations tolled?**

The medical malpractice statute of limitations is tolled (does not run) in the following circumstances:

* Upon proof of fraud.
* Upon proof of intentional concealment.
* Upon proof of the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect.
* During the incompetency of a patient.
* For one year following a written, good faith request for mediation before filing a lawsuit.

**Does the medical malpractice statute of limitations apply to every medical malpractice action against a physician?**

No. The medical malpractice statute of limitations does not apply in a civil action based on intentional conduct brought against a physician for recovery of damages for injury as a result of childhood sexual abuse.

It also does not apply to an action for wrongful death against a physician. The patient’s personal representative has three years from the date of the patient’s death to bring a wrongful death, and to medical malpractice resulting in death.

**How does the medical malpractice statute of limitations apply to minors?**

Since 2006, the medical malpractice statute of limitations does not toll for minors in medical malpractice cases. The minor has the later of three years, or one year from the date he or she discovers or reasonably should have discovered that the injury or condition was caused by the alleged professional negligent, to file suit. The statute of repose states that in no case may a medical malpractice action be commenced more than eight years after the alleged negligent act or omission (except for the tolling of the statute of limitations until the patient/representative is aware of proof of fraud, intentional concealment, or a non-therapeutic foreign body).

Once the minor reaches age 18 and is not otherwise incompetent, any knowledge that the custodial parent or guardian has about the minor’s possible medical malpractice claim is imputed to the minor.

If a minor reaches age 18, but is otherwise incompetent, the statute of limitations does not begin to run unless and until the patient becomes competent.

## Medical Discipline and Unprofessional Conduct

### Healthcare Integrity and Protection Data Bank (HIPDB)

NOTE: The U.S. Department of Health and Human Services has merged the Healthcare Integrity and Protections Data Bank (HIPDB) into the National Practitioner Data Bank (NPDB), now called simply the Data Bank. See [National Practitioner Data Bank](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/national-practitioner-data-bank).

### Medical Discipline

**Who has the power to discipline physicians?**

The Medical Quality Assurance Commission (MQAC) is the state agency which has the power to discipline physicians. MQAC members are appointed by the governor. The MQAC is composed of thirteen physicians, two physician assistants, and six members of the public, at least two of which are from outside of the health care industry. Each congressional district has at least one physician member on the MQAC.

**What are the grounds for discipline?**

The Uniform Disciplinary Act identifies 25 kinds of unprofessional conduct for which a physician can be disciplined. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct) for a listing.

**How does an MQAC investigation begin?**

An MQAC investigation usually begins as a result of a patient complaint, a complaint by an impaired practitioner program, or a voluntary substance abuse monitoring program approved by the MQAC, a complaint by another health care provider, or a mandatory report of malpractice payments, adverse professional review actions, findings of unprofessional conduct, or improper billing practices.

The MQAC reviews every complaint it receives, including anonymous complaints. If the MQAC determines it has jurisdiction over the subject of the complaint and receives a waiver of confidentiality from the complainant, if necessary, MQAC conducts an investigation of the complaint. The MQAC will consider any prior complaints, findings of fact, stipulations to informal dispositions and any other comparable actions when it decides whether or not to investigate a complaint.

The MQAC must initiate an investigation when it receives information that a physician has been disqualified from participating in Medicare or the federal Medicaid program, and when there is a pattern of complaints, arrests, or other actions which may not have resulted in a formal judgment against the physician, but when considered together demonstrate a pattern of similar conduct that, without investigation, likely poses a risk to the safety of the physician’s patients.

**When must an entity, organization or institution report unprofessional conduct?**

Under state law, a professional liability insurer is required to report to the MQAC all malpractice payments in excess of $20,000, and the payment of three or more malpractice claims during a five-year period, made on behalf of a physician. This state law, however, effectively has been preempted by federal law which requires the reporting of any payment under a policy of insurance, self-insurance, or otherwise in settlement, partial settlement, or satisfaction of a judgment in a medical malpractice action or claim, on behalf of a physician to the National Practitioner Data Bank and the MQAC.

Health care institutions, including hospitals, ambulatory surgery facilities, childbirth centers, nursing homes, chemical dependency treatment programs, drug treatment agencies, and public and private mental health treatment agencies, must report to the MQAC when a physician’s privileges are restricted or terminated.

Every physician, corporation, organization, health care facility, and state and local governmental agency that employs a physician shall report when the employed physician’s services have been terminated or restricted based on a final determination that the physician has committed an act that may constitute unprofessional conduct, or may not be able to practice medicine with reasonable skill and safety due to a mental or physical condition.

Professional review organizations, including every peer review committee, quality improvement committee, or other similarly designated professional review organization, must report when it makes a determination that a physician has caused harm to a patient or placed a patient at unreasonable risk of harm, and when it has actual knowledge that the physician poses an unreasonable risk of harm due to a mental or physical condition – provided that such a report is not prohibited by state or federal law. Professional review organizations and individual physicians who are participating in such an organization, do not need to report during an investigation so long as the investigation is conducted in a timely manner.

Medical associations and societies are required to report to the MQAC any findings of unprofessional conduct or inability to practice medicine with reasonable skill and safety made against a physician.

Health care services contractors and disability insurers must report any billing impropriety and overutilization of medical services by a physician.

**Does a physician have to self-report?**

A physician must self-report any conviction, determination, or finding that the physician has committed unprofessional conduct, information that the physician is unable to practice medicine with reasonable skill and safety due to a mental or physical condition, or any disqualification from the federal Medicare or Medicaid program.

**Does a physician have a duty to report unprofessional conduct of another physician?**

In some circumstances, yes. A physician must report another physician (or other licensed health care professional) when the physician has actual knowledge of any conviction, determination, or finding that another physician (or license holder) has committed an act that constitutes unprofessional conduct, or that the other physician (or license holder) may not be able to practice medicine (or relevant profession) with reasonable skill and safety due to a mental or physical condition.

Physicians who are treating physicians currently enrolled in a drug or alcohol abuse treatment program through the Washington Physicians Health Program or other approved impaired practitioner program are not required to report their physician patient so as long as the physician patient actively participates in the treatment program and so as long as the physician patient’s impairment does not constitute a clear and present danger to the public health, safety or welfare.

Physicians who provide health care to another physician (or license holder) do not have to report the physician (or license holder) patient if the patient does not pose a clear and present danger to patients or clients.

Physicians who are member of a professional review organization (which includes peer review committees, quality improvement committees, or other similarly designated professional review organizations) also are not obligated to report.

**How does a physician know if a complaint has been filed with the MQAC against the physician?**

Usually the physician will be notified the MQAC receives a complaint, and MQAC has completed an initial assessment and determined it has jurisdiction over the matter and the matter warrants an investigation, except where such notification would impede an effective investigation. During the initial investigatory phase, a physician is not entitled to the written or oral complaint or to information gathered during the investigation.

**When does an MQAC complaint become public knowledge?**

Once the MQAC has assessed the complaint and determined that it is warranted, the existence of the complaint becomes a matter of public record. The contents of the complaint, however, are not public until the Commission takes action or the case is closed, whichever occurs first.

**Must a physician cooperate with a Department of Health investigator who calls for an interview?**

The law requires a physician to cooperate with an investigation by submitting records requested by the investigator, submitting a written statement explaining the matter in the complaint, complying with subpoenas, and providing reasonable and timely access for the investigator to conduct a practice review at the facility where the physician practices. . Failure to cooperate with an investigation is itself grounds for discipline. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct). There is no legal obligation to submit to an interview. If the physician decides to submit to an interview, the physician has a right to have an attorney present during an interview by the investigator. It is advisable to seek legal advice from an attorney experienced in handling disciplinary matters as soon as a physician becomes aware of an investigation.

**How should a physician respond to a written request to provide information to a Department of Health investigator?**

A physician must respond to the request from the investigator. It is advisable to seek legal advice before speaking to the investigator or sending any response to the investigator. Everything a physician says or writes to an investigator may be used against that physician.

**Must a physician release patient records to the investigator?**

Yes. Failure to respond to a records subpoena is grounds for discipline. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct). It is advisable to seek legal advice, however, before releasing patient records.

**What should a physician do if the physician receives an order to undergo a mental or physical examination?**

Under certain circumstances, the MQAC has the authority to order a physician to undergo a mental and/or physical examination to determine if the physician is able to practice with reasonable skill and safety. A physician must comply with the order or risk discipline. A physician receiving such an order should seek legal advice immediately.

**What happens after an investigation is complete?**

After an investigation is complete, the file is sent to a member of the MQAC, called the reviewing commission member.

The reviewing commission member presents the case to the MQAC and the MQAC will vote on whether charges should be filed. At the time the MQAC votes, the name of the physician involved is known only to the reviewing commission member, who is not permitted to vote on whether to bring charges.

If the MQAC votes to bring charges against a physician, charges are issued and served on the physician and the formal disciplinary process begins.

**What types of actions does the MQAC take against a physician?**

The MQAC issues three different types of charges:

* A Statement of Allegations.
* A Statement of Charges.
* An Order of Summary Suspension.

The least serious action the MQAC may take is issuing a Statement of Allegations. In these cases, the Commission issues a Statement of Allegations along with a Stipulation to Informal Disposition (STID). These documents are not public at this point of the process. If the physician agrees to the terms of the STID, the Statement of Allegations and the STID become public. Even though a Statement of Allegations and a STID are not formal disciplinary actions, they are subject to public disclosure, placed on the Department’s web site, and reportable to the National Practitioner Data Bank (NPDB), the Healthcare Integrity and Protection Data Bank (HIPDB), and to the Physician Data Center of the Federation of State Medical Boards. See [National Practitioner Data Bank](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/national-practitioner-data-bank).

Often, the MQAC issues a Statement of Charges. A Statement of Charges is a matter of public record and an adverse outcome is reportable.

Where serious concerns about public safety exist, the MQAC may issue an Order of Summary Suspension which automatically suspends the physician’s license and prohibits him or her from practicing medicine. The Commission may also issue an Order of Summary Limitation which immediately limits or restricts a physician’s practice.

**What should a physician do if he or she is served with formal charges issued by the MQAC?**

A physician has 20 days to respond to charges after being served with them. It is critical to respond promptly to such charges. Failure to do so may constitute a waiver of all rights to contest the charges and may result in a default. It is advisable to seek legal advice regarding an appropriate response.

**May a physician review the MQAC investigatory file when defending against formal charges?**

Yes. Once there are formal charges, a physician has the right to see most of the investigatory file and conduct discovery similar to discovery conducted in a civil lawsuit.

**How are disciplinary cases resolved?**

Disciplinary cases may be resolved in several different ways:

* A physician may agree to the charges and submit to discipline.
* A physician may dispute the charges, but resolve the matter prior to hearing by a settlement.
* A physician may dispute the charges and the MQAC may decide to withdraw the charges.
* A physician may dispute the charges and the case may go to hearing.

**What type of disciplinary actions may the MQAC take against a physician?**

The types of disciplinary action the MQAC may take against a physician include:

* Revocation of the license.
* Suspension of the license for a fixed or indefinite term.
* Restriction or limitation of the practice.
* Requiring the satisfactory completion of a specific program of remedial education or treatment.
* Monitoring of the practice by a supervisor approved by the disciplining authority.
* Censure or reprimand.
* Requiring compliance with conditions of probation for a designated period of time.
* Requiring payment of a fine for up to $5000 each violation.
* Denial of a license request.
* Corrective action.
* Requiring refund of fees billed to and collected from the patient.
* Surrender of the physician’s license in lieu of other sanctions, which must be reported to the National Practitioners’ Data Bank.

The MQAC can consider prior findings of fact, stipulations to informal disposition, and any other actions taken by in-state or out-of-state disciplinary authorities in determining imposition of sanctions for unprofessional conduct.

**How does MQAC determine which sanctions to take against a physician?**

Sanctions are selected to protect the public and, if possible, rehabilitate the physician. The MQAC determines sanctions according to a table based on the nature of the unprofessional conduct and the severity of the unprofessional conduct. There are sanction schedules which provide a range of sanction for practice below the standard of care, sexual misconduct or contact, physical and emotional abuse, diversion of controlled substances or legend drugs, substance abuse, and criminal convictions. If different acts of unprofessional conduct fall under more than one sanction schedule, or if there are multiple acts of unprofessional conduct under one schedule, the greater sanction is imposed. More than one act of unprofessional conduct within one sanction schedule is considered an aggravating factor.

**Does the MQAC take into account any other factors in determining disciplinary action?**

Yes. The MQAC must determine any aggravating or mitigating factors before determining a sanction. When determining a sanction the MQAC starts in the middle of the range of disciplinary actions within a tier of the sanction schedule. Aggravating factors move the appropriate sanction toward the maximum end of the range, while mitigating factors move the appropriate sanction toward the minimum end of the range. The MQAC relies on a list of aggravating and mitigating factors related to the nature of the unprofessional conduct, the physician, conduct during the disciplinary process, and a number of general factors.

**When is suspension or revocation of a physician’s license imposed?**

A physician’s license may be suspended or revoked if the MQAC determines that the physician cannot practice medicine with reasonable skill or safety. A physician’s license may be permanently revoked when the MQAC determines that the physician can never be rehabilitated or can never regain the ability to practice safely.

**Who learns of disciplinary actions taken against a physician?**

Actions taken by the MQAC against a physician are public record. Any person who inquires will receive information about disciplinary actions taken against a physician.

The MQAC sends out a Hospital/Public Disclosure Listing twice per month to all hospitals and persons requesting such information which summarizes actions taken against physicians in the previous two weeks.

In addition, the MQAC is required to report most adverse disciplinary actions to the National Practitioner Data Bank. The Commission also reports disciplinary actions and other state licensing boards. See [National Practitioner Data Bank](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/national-practitioner-data-bank).

**May a physician appeal actions taken by MQAC?**

Yes. MQAC decisions may be appealed to Superior Court. However, decisions of the MQAC carry a presumption of correctness and are difficult to overturn.

**Is a physician immune from civil liability for a complaint made or information provided to the MQAC?**

Generally, yes. A physician is immune from civil liability for reporting or providing information to the MQAC, provided the physician does so in good faith.

**Must a physician self-report any information to the MQAC?**

Yes. A physician must self-report to the MQAC any conviction, and any determination or finding that the physician has committed unprofessional conduct or is unable to practice with reasonable skill or safety. A physician must also report any disqualification from federal Medicare or Medicaid programs.

**Has the MQAC issued guidelines for pain management and how it will evaluate physicians’ prescribing practices for pain?**

Yes. See [Pain Management.](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/pain-management-and-controlled-substances/pain-management)

### National Practitioner Data Bank (NPDB)

NOTE: **The U.S. Department of Health and Human Services has merged the Healthcare Integrity and Protections Data Bank (HIPDB) into the National Practitioner Data Bank (NPDB), now called simply the Data Bank.**

**What is the Data Bank?**

The Data Bank is a national, computerized information source which tracks the following information:

* Payments made as a result of medical malpractice actions or claims.
* Adverse licensure actions taken by state licensing boards.
* Adverse actions on clinical privileges taken by hospitals, other health care entities and professional society membership actions.

The U.S. Department of Health and Human Services announced in April, 2013 that two previously maintained data banks – the Healthcare Integrity and Protections Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB) – would merge together. Now HIPBD and NIPDB have been combined into a single entity called “the Data Bank.” Under certain circumstances, various private and public entities are required to report health care related information to this new combined Data Bank.

**What is new now that the NPDB has merged with the HIPDB?**

Now that the NPDB and HIPDB are one data bank, users’ query results will be more inclusive than before, but there has been no change to the reporting requirements. The statutes that require reporting have all remained in effect, though slightly modified, and the merger simply combines all the reported information into a single data bank.

Database queriers may notice some differences. The Data Bank’s website lists the changes that each user group may experience (<http://www.npdb-hipdb.hrsa.gov/resources/npdbMerge.jsp> ):

**What entities are subject to the reporting requirements for the Data Bank?**

The reporting requirements for the Data Bank apply to:

* Hospitals and other health care entities;
* Entities (including insurance companies) that make payments as a result of medical malpractice actions or claims;
* Professional societies that follow a formal peer review process;
* State Licensing and Certification Authorities (including State Medical and Dental Boards);
* Private accreditation organizations;
* Peer review organizations;
* State law enforcement agencies;
* State Medicaid Fraud Control Units;
* State agencies administering or supervising the administration of a state health care program;
* Federal government agencies (including the Drug Enforcement Administration and the HHS Office of Inspector General); and
* Health plans.

**What actions trigger the need to report to the Data Bank?**

The Data Bank website maintained by HHS briefly summarizes the major categories of actions that trigger the need for the appropriate entity to report to the Data Bank and the format for such a report (<http://www.npdb-hipdb.hrsa.gov/hcorg/aboutReporting.jsp> ):

|  |  |
| --- | --- |
| **Reportable Action** | **Data Bank Report Format** |
| Medical malpractice payments | Medical Malpractice Payment Report (MMPR) format |
| Adverse clinical privilege(including but not limited to network participation and panel membership) actions | Clinical Privileges Action category on the Adverse Action Report (AAR) format |
| Adverse professional society membership actions | Professional Society Action category on the AAR format |
| State licensure and certification actions:   * Actions related to licensure, certification, registration, or other authorization by the state to provide health care services * Actions related to certification agreements or contracts for participation in a government health care program | * State Licensure Action category on the AAR format * Government Administrative Action category on the AAR format |
| Federal licensure and certification actions:   * Actions related to licensure, certification, registration or other authorization to provide health care services * Actions related to certification agreements or contracts for participation in a government health care program | * Federal Licensure Action category on the AAR format * Government Administrative Action category on the AAR format |
| Negative actions or findings by a peer review organization | Peer Review Organization Action category on the AAR format |
| Negative actions or findings by a private accreditation organization | Accreditation Action category on the AAR format |
| Exclusions from participation in a Federal or state health care program (including Medicare and Medicaid) | Exclusion or Debarment Action category on the AAR format |
| Other adjudicated actions or decisions:   * Other adjudicated actions taken by a government agency * Other adjudicated actions taken by a health plan | * Government Administrative Action category on the AAR format * Health Plan Action category on the AAR format |
| Health care-related civil judgments and criminal convictions in Federal or state court\*  (Federal, state, and local prosecutors must report criminal convictions) | Judgment or Conviction Reports (JOCR)   * Criminal Conviction * Deferred Conviction * Nolo Contendere/No Contest Plea * Injunction * Civil Judgment |

**What information regarding malpractice payments for physicians must be reported to the Data Bank?**

Medical malpractice payers must report to the Data Bank any payment made on behalf of a physician in full or partial settlement or satisfaction of a written medical malpractice claim or judgment against a physician. The report must be made by the payer within 30 days of the payment and the report must include, among other things:

* The name, address (work, and home if known), social security number, date of birth, each professional school attended (and year of graduation), and license number of the physician for whose benefit the payment was made (including the field of licensure and state of issue);
* DEA number;
* The name of any hospital with which the physician is associated;
* The name of the entity making the payment and the name and contact information for the individual submitting the report;
* Relationship of the reporting entity to the physician on whose behalf the payment was made;
* Where a legal action or claim has been filed with a court, the identification of the court, and the case number;
* Date(s) on which the action(s) or omission(s) that were the basis of the action or claim occurred;
* The date of judgment or settlement;
* The amount of the payment;
* A description of the acts or omissions and injuries or illnesses upon which the claim was based;
* Classification of the acts or omissions according to codes required by the Data Bank; and
* Any other information that may be required in the future after the requirements have been published and adopted.

There may be some exceptions to the reporting requirements if a physician’s circumstances differ from those described above. In that case physicians are advised to seek legal counsel regarding reporting. Note also that the waiver of an outstanding debt is not considered a “payment” and is not reportable.

**What information regarding licensure actions against a physician must be reported to the Data Bank?**

The following information must be reported to the Data Bank by the Medical Quality Assurance Commission (MQAC) within 30 days of the action based on reasons related to a physician’s professional competence or professional conduct:

* Any surrender of a physician’s license.
* Any revocation, suspension, or restriction of a physician’s license.
* Any censure, reprimand, or probation of a physician, for reasons relating to the physician’s professional competence or conduct as the result of a formal proceeding. Matters resolved by a stipulation to informal disposition (STID), which are not formal disciplinary actions, are nonetheless subject to public disclosure, and must also be reported. See Medical Discipline.
* The MQAC must include the physician’s name, work address, home address if known, social security number if known, date of birth, each professional school attended, date of graduation, and license number, DEA number, a description of the acts or omissions for which the discipline was imposed, a description of the action taken by the MQAC, and the classification of the action under the Data Bank reporting codes.

In addition, the following licensure actions taken by a state as the result of a formal proceeding must be reported:

* Any dismissal or closure of a formal proceeding by reason of the physician surrendering his/her license, or leaving the state or jurisdiction.
* Any other loss of the physician’s license whether by operation of law, voluntary surrender (excluding those due to non-payment of licensure renewal fees, retirement, or change to inactive status), or otherwise.
* Any negative action or finding by such authority, organization, or entity regarding the physician.

What information regarding adverse professional review actions on clinical privileges taken against a physician must be reported to the Data Bank?

Each health care entity must report information concerning an adverse professional review action whenever:

* The entity takes a professional review action that adversely affects a physician’s clinical privileges for more than 30 days.
* The entity accepts the surrender of clinical privileges of a physician in either of the following circumstances:
  + While the physician is under an investigation relating to possible incompetence or improper professional conduct.
  + In return for not conducting such an investigation or proceeding.
* A professional society takes a professional review action, based on reasons relating to professional competence or conduct, which adversely affects the membership of a physician in the society.

The entity must report such adverse professional review actions to the MQAC within 15 days of reviewing the entity’s report. The MQAC must then report the action to the Data Bank.

**Can a physician dispute a Data Bank report?**

Yes. A physician may dispute either of the following, within 60 days of the date the report is mailed:

* The factual accuracy of a report.
* Whether a report was submitted in accordance with the Data Bank requirements, including the eligibility of the entity to make the report.

When disputing the accuracy of a report, the physician must:

* Inform the Secretary of the Department of Health and Human Services and the reporting entity, in writing, of the disagreement, and the basis for it.
* Request that the disputed information be entered into a “disputed” status, and be so related to inquirers.
* Attempt to enter into a discussion with the reporting entity to resolve the dispute.

The physician may not, however, dispute a report in order to do any of the following:

* Protest an insurer’s decision to settle a claim.
* Appeal the underlying reasons for an adverse action.

**How does a physician dispute a report to the Data Bank?**

When the Data Bank processes a report, the Data Bank sends a Notification of a Report in the Data Bank(s) to the physician who has been reported. The physician should review the report for accuracy and, if any information in the report is inaccurate, contact the reporting entity to correct the information.

A physician who disagrees with the factual accuracy of a report has three options if the reporting entity will not correct the information:

* Add a statement to the report.
* Initiate a dispute of the report (must be done within 60 days from the date the report was mailed).
* Add a statement and initiate a dispute.

To add a statement or to dispute the report, the physician should follow the applicable instructions on the Notification of a Report in the Data Bank(s). If the physician does not have the original Notification of a Report in the Data Bank(s), the physician may follow the steps outlined on the Databank’s website and use the Report Response Service offered online to submit a statement or dispute a report. More information about how dispute a report and/or file a statement can be found at: <http://www.npdb-hipdb.hrsa.gov/pract/howToDisputeAReport.jsp> .

**Who must query the Data Bank for information concerning a physician?**

A hospital must request information from the Data Bank whenever a physician applies to the hospital for admission to the medical staff or for clinical privileges, and at least every two years for all physicians who are on the medical staff or have clinical privileges.

**Who else may query the Data Bank for information concerning a physician?**

The following persons or entities may query the Data Bank for information concerning medical malpractice payments, adverse licensure actions by Boards of Medical Examiners, and adverse actions against clinical privileges:

* A hospital that requests information concerning a physician who is on its Medical Staff (courtesy or otherwise) or has clinical privileges at the hospital.
* Health care entities when entering an employment relationship or other affiliation with a physician or in conjunction with professional review activities.State licensing boards.
* Physicians, but only for information about themselves.
* Plaintiff attorneys, or individuals representing themselves, who have filed a medical malpractice action or claim against a hospital, who have named the physician on whom information requested in the action or claim, and who have demonstrated that the hospital failed to make a mandatory query to the Data Bank regarding the physician. Plaintiff attorneys or individuals representing themselves may only use the information with respect to litigation resulting from the action or claim against the hospital.
* A health care entity with respect to professional peer review activities.
* A person requesting statistical information, in a form which does not permit the identification of the affected individual or entity.

The following persons or entities may query the Data Bank for adverse state licensure actions, adverse Federal licensure actions, negative actions or findings by peer review organizations or private accreditation entities, state or Federal convictions related to delivery of health care services or items, exclusion from participation in state or Federal health care programs, or other reported adjudicated actions or decisions:

* Agencies administrating Federal health care programs, including private entities administering such programs under contract.
* State or Federal agencies responsible for licensing or certification of health care practitioners, providers, or suppliers.
* State agencies administering or supervising administration of state health care programs.

State law or fraud enforcement agencies such as:

* United States Attorney General.
* United States Inspector General.
* United States Attorneys.
* United States Comptroller General.
* United States Drug Enforcement Administration.
* United States Nuclear Regulatory Commission.
* Federal Bureau of Investigation.
* Federally contracted utilization and peer review organizations.
* Health care entities when entering an employment relationship or other affiliation with a physician, including physicians who have applied for clinical privileges or appointment to the Medical Staff.
* Health plans.
* A physician, health care entity, provider, or supplier who is requesting information concerning himself, herself, or itself.
* A person or entity requesting statistical information which does not permit identification of any individual or entity.

Medical malpractice payors may not query the Data Bank at any time.

### Peer Review, Quality Improvement, and Immunity

**What is peer review?**

Peer review is the process by which a committee of health care professionals reviews and evaluates the credentials, competence, physical and mental capacity and other qualifications of health care professionals or reviews, evaluates, monitors and assures the quality of patient care.

**Is a physician who serves on a peer review committee immune from liability?**

Generally, yes. A physician who serves on a peer review committee and performs his or her duties in good faith is immune from liability for damages in any civil action brought by or on behalf of persons who were being evaluated. No member of a peer review committee shall be liable in a civil action as a result of acts or omissions made in good faith on behalf of the committee.

**Is a physician immune from liability for filing charges or presenting evidence in a peer review proceeding?**

Generally, yes. A physician who, in good faith, files charges or supplies information or testimony to a peer review committee is immune from civil liability for damages arising out of such actions.

**What is a coordinated quality improvement program (CQIP)?**

Every hospital is required to maintain a coordinated quality improvement program (CQIP). The purpose of a CQIP is to improve the quality of health care services provided to patients by identifying and preventing medical malpractice. A CQIP must include at least:

* Establishment of a quality improvement committee with responsibility to review services rendered in the hospital, both retrospectively and prospectively, to improve quality of patient care and prevent medical malpractice. Such committee should oversee and coordinate the quality improvement and malpractice prevention program and ensure that information gathered is used to review and revise policies and procedures.
* A procedure to periodically review the credentials, physical and mental capacity, and competence in delivering health care services by members of the hospital Medical Staff as part of its evaluation of Medical Staff privileges.
* Periodic review of the credentials, physical and mental capacity, and competence of all persons employed or associated with the hospital.
* A procedure for prompt resolution of patient grievances related to accidents, injuries, treatment, and other events that may result in medical malpractice claims.
* The maintenance and continuous collection of information about the hospital’s experience with negative outcomes, incidents injurious to patients including health care-related infections, patient grievances, professional liability premiums, settlements, awards, and costs incurred for patient injury prevention and safety improvement activities.
* The maintenance in physicians’ personnel files of relevant and appropriate information gathered concerning individual physicians in the hospital.
* Education programs dealing with quality improvement, patient safety, medication errors, infection control, injury prevention, staff responsibility to report professional misconduct, the legal aspects of patient care, improved patient communications, and causes of malpractice claims.
* Policies to ensure compliance with reporting requirements.

**May physician groups maintain a coordinated quality improvement program (CQIP) which is subject to the same immunities and protection from discovery as hospital-based CQIP’s?**

With certain limitations, yes. Physician or other health care provider groups of five or more physicians or providers, health care professional societies or organizations, and health carriers, contractors or HMOs may maintain a coordinated quality improvement program (CQIP) for the improvement of quality of health care services rendered to patients and the identification and prevention of medical malpractice similar to the programs hospitals must maintain. Such programs, as modified to reflect the structural organization of the group, must include the following:

* Establishment of a quality improvement committee with responsibility to review services rendered in the group, both retrospectively and prospectively, to improve quality of patient care and prevent medical malpractice. Such committee should oversee and coordinate the quality improvement and malpractice prevention program and ensure that information gathered is used to review and revise policies and procedures.
* Periodic review of the credentials, physical and mental capacity, and competence of all persons employed or associated with the group.
* A procedure for prompt resolution of patient grievances related to events that may result in medical malpractice claims.
* The maintenance and continuous collection of information about the group’s experience with negative outcomes, incidents injurious to patients including health care-related infections, patient grievances, professional liability premiums, settlements, awards, and costs incurred for patient injury prevention and safety improvement activities.
* The maintenance in physicians’ personnel files of relevant and appropriate information gathered concerning individual physicians in the group.
* Education programs dealing with quality improvement, patient safety, medication errors, infection control, injury prevention, staff responsibility to report professional misconduct, the legal aspects of patient care, improved patient communications, and causes of malpractice claims.
* Policies to ensure compliance with reporting requirements.

Any such program must be approved by the Department of Health before the immunity and discovery protections will apply. The Department of Health has established eligibility requirements, structural criteria, and the process for approval of a CQIP.

**If such a program is approved by the Department of Health, what immunity protections will apply?**

If the program is approved, any person who, in substantial good faith, provides information, or shares information or documents, to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity.

**If such a program is approved by the Department of Health, what discovery protections will apply?**

If the program is approved, then, with limited exceptions, information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by the quality improvement committee will not be subject to review or disclosure, discovery, or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee.

**May the results of a Medicare Peer Review Organization be disclosed?**

Yes, under certain circumstances. Federal law requires that a Medicare Peer Review Organization (PRO) shall inform the individual who has made a complaint regarding a provider for not meeting professionally recognized standards of the organization’s final disposition of the complaint. Before that organization concludes that the service in question did not meet professional standards, it must provide the practitioner with reasonable notice and an opportunity to discuss the complaint.

### Sexual Misconduct, Harassment, Sexual Abuse

**Can a physician be disciplined for sexual contact with a current patient?**

Yes. Sexual contact with a patient is considered unprofessional conduct. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct)v.

**Can a physician be disciplined for sexual contact with a former patient or a person in a close personal relationship with the patient?**

Yes. A physician shall not engage in sexual conduct with a former patient or a key third party (a person in a close personal relationship with the patient – including spouses, partners, parents, siblings, children and guardians) if the physician:

* Uses or exploits the trust, knowledge, influences, or emotions derived from the professional relationship.
* Uses or exploits privileged information or access to privileged information to meet the physician’s personal or sexual needs.

See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct).

**What activities comprise sexual misconduct?**

A physician engages in sexual misconduct when he or she engages in the following behaviors with a patient or key third party:

* Sexual intercourse or genital to genital contact.
* Oral to genital contact.
* Genital to anal contact, or oral to anal contact.
* Kissing in a romantic or sexual manner.
* Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment.
* Examination or touching of genitals without using gloves.
* Not allowing a patient the privacy to dress or undress.
* Encouraging the patient to masturbate in the presence of the physician, or masturbation by the physician while the patient is present.
* Offering to provide practice-related services, such as medications, in exchange for sexual favors.
* Soliciting a date.
* Engaging in a conversation regarding sexual history, preferences, or fantasies of the physician.

A physician may be found to have engaged in sexual misconduct even if the contact was initiated by the patient, former patient, or key third party, or if the party consented to the contact, or if the contact occurred outside the professional setting.

**Can a physician be disciplined for inappropriate examinations?**

Yes, if sexually explicit questions are asked or sexually explicit comments are made, or if an examination is inappropriate and has no bearing on the patient’s complaints, diagnosis or treatment, the conduct could constitute unprofessional conduct, even without sexual contact. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct).

**How does Washington State handle complaints involving alleged sexual misconduct?**

Unlike other disciplinary matters pertaining to physicians which are handled by the Medical Quality Assurance Commission (See [Medical Discipline](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/medical-discipline)), all complaints which allege a physician has committed unprofessional conduct relating to sexual misconduct are addressed by the Department of Health. The Department of Health initiates investigations, performs investigations, determines the disposition of complaints, holds hearings, and decides the matter.

**Can a physician be disciplined for abuse of a patient?**

Yes, abuse of a patient by a physician is considered unprofessional conduct. A physician abuses a patient when the physician:

* Makes statement regarding the patient’s body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose.
* Removes a patient’s clothing or gown without consent.
* Fails to treat an unconscious or deceased patient’s body or property respectfully.

Engages in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.

**What is sexual harassment?**

Sexual harassment is a form of unlawful sex discrimination under Title VII of the Civil Rights Act. Sexual harassment consists of unwelcome sexual advances, requests for sexual favors and other verbal or physical of a sexual nature when:

* Submission to such conduct is either explicitly or implicitly a term or condition of an individual’s employment;
* Submission to, or rejection of, such conduct by an individual is used as the basis for employment decisions affecting such an individual; or
* Such conduct has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive work environment.

**Under what circumstances may sexual harassment occur?**

Sexual harassment may occur in a variety of circumstances including, but not limited to the following:

* The victim as well as the harasser may be a woman or a man. The victim does not have to be of the opposite sex.
* The harasser can be the victim's supervisor, an agent of the employer, a supervisor in another area, a co-worker, or a non-employee.
* The victim does not have to be the person harassed but could be anyone affected by the offensive conduct.
* Unlawful sexual harassment may occur without economic injury to or discharge of the victim.
* The harasser's conduct must be unwelcome.

**What are some examples of sexual harassment?**

Sexual harassment may take many forms, including:

* Unwelcome sexual advances.
* Requests for sexual favors.
* Unnecessary touching.
* A display of sexually suggestive objects or pictures.
* Sexually explicit objects or pictures.
* Sexually explicit or offensive jokes or remarks.
* Threats or insinuations that refusal to submit to sexual advances will adversely affect that person’s employment, work status, evaluation, wages, advancement, assigned duties, shifts, or any other condition of employment or career development.
* Same-sex harassment regardless of whether the alleged harasser is gay or lesbian.

The federal, state, and local laws governing sexual harassment set minimum standards only. Hospitals, clinics and other businesses may have policies that prohibit less offensive conduct. A physician may violate these policies and be subject to disciplinary action by the hospital, clinic or other business even though the physician may not necessarily have violated any law.

**In what capacities may a physician be accused of sexual harassment?**

The capacities in which a physician could be accused of sexual harassment include:

* The physician as an employer.Title VII of the Civil Rights Act of 1964 prohibits sexual harassment by employers with 15 or more employees.Washington’s Law Against Discrimination prohibits sexual harassment by employers with eight or more employees.The King County Code, the Tacoma Municipal Code, and the Spokane Municipal Code also prohibit sexual harassment by employers with eight or more employees.The Seattle Municipal Code prohibits sexual harassment by employers with one or more employees. See Discrimination.
* The physician as a supervisor.
* The physician as co-worker.
* The physician as an independent contractor.
* The physician as a customer or vendor.
* The physician as a faculty member/instructor.
* The physician as a service provider.

**Does a physician as an employer have a duty to provide a workplace free of harassment by others?**

Yes. A physician who is an employer has a duty not only to avoid engaging in harassment toward employees and third parties, but also to provide a workplace free of harassment from others, including employees and third parties, such as patients, vendors, and other non-employees.

**In what capacities might a physician be sexually harassed?**

The capacities in which a physician could be a victim of sexual harassment include:

* The physician as an employee.
* The physician as a supervisee.
* The physician as a co-worker.
* The physician as a customer or vendee.
* The physician as a student.
* The physician as a service provider.

Note: Under Washington law, independent contractors are not entitled to the protections of the laws prohibiting unfair practices and discrimination in employment, but are still protected against discrimination. There are a number of factors used by the Washington State Human Rights Commission to determine if an individual is an employee or an independent contractor.

**Is a person who, in good faith, reports an incident of sexual harassment protected from retaliation?**

Yes. It is against the law to retaliate against anyone who, in good faith, makes a formal or informal complaint or files a grievance alleging sexual harassment. It is also against the law to retaliate against anyone who participates in the investigation of such a complaint or testifies in any legal proceeding arising from such a complaint.

Most public and private businesses also have internal policies that prohibit retaliation.

**Are there other forms of harassment that constitute unlawful discrimination?**

Yes, various laws against discrimination, in addition to prohibiting sexual harassment, also prohibit harassment on the basis of other protected statuses, such as age, race, creed, religion, color, national origin, sexual orientation, disability, or use of a service animal. Prohibited harassment is conduct that has the purpose or effect of unreasonably interfering with an individual’s work performance or use of service, or that creates an intimidating, hostile, or offensive work or service environment. See [Discrimination](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/americans-with-disabilities-act).

### Unprofessional Conduct

**What conduct is considered to be unprofessional conduct?**

The following acts constitute unprofessional conduct which may serve as the basis for disciplinary action by either the Medical Quality Assurance Commission (MQAC) or the Board of Osteopathic Medicine and Surgery (BOMS):

* The commission of an act involving moral turpitude, dishonesty or corruption relating to the physician’s practice, whether or not the act constitutes a crime.
* Misrepresentation or concealment of a material fact in obtaining a license.
* Advertising which is false, fraudulent or misleading. See [Advertising](http://legalguide.wsma.org.onexcale.net/business-issues/advertising/advertising).
* Incompetence, negligence or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be injured.
* Suspension, revocation or restriction of a physician’s license by a competent authority in any state, federal or foreign jurisdiction.
* The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes; diversion of controlled substances or legend drugs; the violation of any drug law; or prescribing controlled substances for oneself.Note There is an exception to this prohibition related to naloxone which is described below. See [Controlled Substances](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/pain-management-and-controlled-substances/controlled-substances); and [Legend Drugs](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/prescription-drugs/legend-drugs).
* Violation of any state or federal statute or administrative rule regulating the practice of medicine including any statute or rule defining or establishing standards of patient care or professional conduct or practice.
* Failure to cooperate with the MQAC or BOMS (as applicable) by: (1) not furnishing papers, documents, records, or other items; (2) not furnishing a written, full and complete explanation covering a matter contained in a complaint filed with the MQAC or BOMS (as applicable); (3) not responding to subpoena of the MQAC or BOMS (as applicable); or (4) not providing MQAC or BOMS (as applicable) timely access to perform practice reviews at facilities utilized by the practitioner.
* Failure to comply with an order of the MQAC or BOMS (as applicable) or failure to abide by a stipulation for informal disposition (STID) with either disciplining authority.
* Aiding or abetting an unlicensed person to practice when a license is required. See [Unauthorized Practice of Medicine](http://legalguide.wsma.org.onexcale.net/physicians/allopathic-physicians/unauthorized-practice-of-medicine).
* Violation of rules established by any health agency.
* Practice beyond the scope of practice as defined by law or rules. See [Unauthorized Practice of Medicine](http://legalguide.wsma.org.onexcale.net/physicians/allopathic-physicians/unauthorized-practice-of-medicine), and [Chiropractic](http://legalguide.wsma.org.onexcale.net/other-health-care-professionals/chiropractors/chiropractic).
* Misrepresentation or fraud in any aspect of the conduct of the physician’s business or profession.
* Failure to adequately supervise staff to the extent that the patient’s health or safety is at risk.
* Treatment of patients while suffering from a contagious or infectious disease involving serious risk to public health.
* Promotion for personal gain of any unnecessary or inefficacious drugs, devices, treatments, procedures or services.
* Conviction of any gross misdemeanor or felony relating to a physician’s practice. (This includes pleading guilty or nolo contendere, and all proceedings where the sentence has been deferred or suspended.)
* The procuring or aiding or abetting in procuring a criminal abortion. See [Abortion](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/abortion/abortion).
* Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or treating, operating or prescribing for any health condition by any method, means or procedure which the physician refuses to divulge upon demand to the MQAC or BOMS (as applicable).
* Willful betrayal of the physicianpatient privilege. See [Confidential and Privileged Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/medical-records/confidential-and-privileged-information).
* Violation of medical rebating law. See [Rebates](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/civil-andor-criminal-liability-under-selected/rebates).
* Interference with a disciplinary investigation by willful misrepresentation of facts before the MQAC or BOMS (as applicable), or interference with witnesses, including patients, by use of threats or harassment, or use of financial inducements to prevent them from providing evidence in a disciplinary proceeding, or other legal action.
* Current misuse of alcohol, controlled substances or legend drugs.
* Abuse of a client or patient (defined below) or sexual contact with a client or patient. See [Sexual Conduct/Harassment](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/sexual-conductharassmentabuse)).
* Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or healthrelated products or services in contemplation of a sale or for research where a conflict of interest is presented as defined by the MQAC or BOMS (as applicable) based on recognized professional ethical standards.

With respect to individuals practicing medicine without a license, the Department of Health (DOH) may also investigate complaints and take actions including cease and desist orders and civil fines.

**How is naloxone treated in regard to unprofessional conduct?**

The administration, dispensing, prescribing, purchasing, acquisition, or use of naloxone is not considered to be unprofessional conduct so long as the physician’s actions which would otherwise be considered unprofessional conduct are taken in a good faith effort to assist a person experiencing (or likely to experience) an opiate-related overdose, or a family member, friend, or other person in a position to assist a person experiencing (or likely to experience) an opiate-related overdose.

**What actions comprise abuse of a patient by a physician?**

A physician abuses a patient when he or she:

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

**Does a physician have a duty to report unprofessional conduct of another physician?**

Yes. See [Medical Discipline](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/medical-discipline).

**Must a physician self-report any information to the MQAC?**

Yes. See [Medical Discipline](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/medical-discipline).

## Emergency Treatment

### Emergency Medical Services

**What types of non-physician emergency service medical personnel are authorized to provide emergency medical care in Washington?**

The following types of non-physician emergency medical service personnel can be certified by the state to provide emergency medical care under the responsible supervision and control of licensed physicians or approved emergency medical services medical program directors:

* First responders.
* Emergency medical technicians.
* Physician-trained emergency medical service intermediate life support technicians and paramedics. which includes:

Statutes and regulations set forth detailed training, certification, and continuing medical education requirements for such non-physician emergency medical service personnel.

**To what extent may a physician be held liable for acts or omissions of trained mobile emergency medical service personnel under the physician’s supervision and control?**

The general rule is that no act or omission of any physician’s trained emergency medical service intermediate life support technician and paramedic, or of any emergency medical technician or first responder, made in good faith while rendering emergency medical service under the responsible supervision and control of a licensed physician or an approved medical program director, will impose liability on:

* Such emergency medical service personnel.
* The medical program director.
* The supervising physician or physicians.
* Any hospital or its officers, members of the staff, nurses, or other employees.
* Any training agency or training physician or physicians.
* Any licensed ambulance service.
* Any federal, state, county, city, or other local governmental unit or its employees.

The general rule applies to acts or omissions made in good faith in the performance of actual emergency medical procedures, or in rendering services at the request of an approved medical program director in the training of emergency service medical personnel for certification or recertification. It does not apply, however, to:

* The commission or omission of an act not within the field of medical expertise of the particular emergency service personnel.
* Any act or omission that constitutes either gross negligence or willful or wanton misconduct.

**May a physician be held liable for failing to obtain consent to the rendering of emergency medical or surgical or health services?**

Generally, no. A physician is not subject to civil liability for failure to obtain consent in rendering emergency medical or surgical services where the patient is unable to give consent for any reason and no other person legally authorized to provide consent is reasonably available, so long as the physician has acted in good faith and without knowledge of facts negating consent.

**Under what circumstances will the Department of Health defend and hold harmless those involved in training emergency service medical personnel for certification and recertification?**

The Department of Health will defend and hold harmless approved medical program directors, delegates, or agents—including, but not limited to, hospitals and hospital personnel—in their capacity of training emergency service medical personnel for certification or recertification at the request of such directors for any act or omission made in good faith in the performance of their duties.

**May a physician be held liable for voluntarily providing emergency medical services?**

Generally, no. See [Good Samaritan Law](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/emergency-treatment/good-samaritan-law) regarding liability for emergency services rendered without compensation.

**May retired physicians provide medical assistance during an emergency or a disaster?**

Yes. The Washington State Department of Health (DOH) may issue a retired volunteer medical worker license to any person that:

Held an active health care license within 10 years prior to his or her initial application for the retired volunteer medical worker license;

* Does not hold a current health care license, but does not have any restrictions on his or her ability to obtain an active license; and
* Registers as a volunteer emergency worker with a local organization for emergency services or management organization.

Retired volunteer medical workers can only perform the duties assigned, must be supervised, and may only perform the duties that were associated with their previous medical practice. Retired volunteer medical workers will be required to maintain competency requirements that are established by the DOH. A physician who holds a retired volunteer medical license, and is registered as an emergency worker, is immune from liability for his or her actions while providing assistance in an emergency or disaster, or while participating in an approved training exercise or preparation for an emergency or disaster. This immunity does not apply to acts of gross negligence or willful or wanton misconduct.

### EMTALA (Patient Dumping)

**What is the Emergency Medical Treatment and Active Labor Act?**

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal statute which requires hospitals:

* To provide for an appropriate medical screening examination within the capability of the hospital’s emergency department for any person who comes to the hospital’s emergency department in order to determine whether an emergency medical condition exists. The appropriateness of a screening examination is judged by whether it is performed equitably in comparison to other patients with similar symptoms, not by its proficiency in accurately diagnosing the patient’s illness.
* To provide stabilizing treatment to any person who comes to the hospital and has an emergency medical condition.

**What is an “emergency medical condition” under EMTALA?**

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical treatment could reasonably be expected to result in one of the following:

* Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
* Serious impairment to bodily functions.
* Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, an “emergency medical condition” means that:

* There is inadequate time to effect a safe transfer to another hospital before delivery, or
* Transfer may pose a threat to either the health or safety of the woman or the unborn child.

**What does “stabilized” mean under the EMTALA?**

The term “stabilized,” with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during a transfer. In the case of a pregnant woman having contractions, “stabilized” means that the woman has delivered the baby and the placenta. The stabilization requirement is defined in regard to a possible transfer, and without reference to the patient’s long-term care within the hospital system.

**When may a hospital transfer a person with an emergency medical condition that has not been stabilized?**

* Under the EMTALA, a hospital may not transfer to another medical facility a person who has an emergency medical condition which has not been stabilized unless:
* The person or the person’s legal representative, after being informed of the hospital’s obligations and the risks of transfer, in writing requests a transfer.
* A physician has signed a certification stating that, based on the information available at the time of the transfer, the medical benefits expected from appropriate medical treatment at another medical facility outweigh the increased risks to the person, or in the case of active labor, to the unborn child, from the transfer.
* If a physician is not physically present in the emergency department at the time the person is transferred, a qualified medical person, after consulting with a physician who determines that the benefits of transfer outweigh the risks, signs the required certification. The physician consulted must subsequently countersign the certification.

Any such transfer must be an appropriate transfer, meaning that:

* The transferring hospital provides the medical treatment within its capacity which minimizes the risks to the patient’s health and, in an active labor case, the unborn child’s health.
* The receiving facility has available space and qualified personnel to treat the individual and has agreed to accept the transfer and provide appropriate medical treatment.
* The transferring hospital sends all medical records relating to the emergency medical condition, including records regarding the emergency medical condition, observations of signs and symptoms, preliminary diagnosis, treatment provided, test results, if any, and the informed written consent or certification for transfer, to the receiving facility.
* The transfer is effectuated by qualified personnel with the use of any necessary transportation equipment and medically appropriate life support measures.

**Does EMTALA only apply to patients without health insurance?**

No. EMTALA applies to “any individual” who presents to an emergency room regardless of whether the patient has health insurance or not.

**Does EMTALA create a national standard of care?**

No. The aim of EMTALA is to address the problem of disparate treatment of insured and uninsured patients with emergency medical conditions. EMTALA does not create a federal medical malpractice statute, or recognize a separate cause of action for misdiagnosis or failure to recognize the extent of injury or illness and order additional diagnostic studies.

**Does EMTALA provide a private cause of action against an individual physician or a private clinic?**

No. EMTALA provides a private cause of action only against hospitals for any individual who suffers personal harm as a result of the hospital violating EMTALA. Courts which have addressed the issue have confirmed that EMTALA provides a cause of action against hospitals, not against physicians or private clinics.

**Does a physician have any individual liability under EMTALA?**

Yes. Any physician who is responsible for the examination, treatment, or transfer of an individual with an emergency medical condition in a hospital and who negligently violates EMTALA’s provisions, or negligently signs a certification for transfer, or who negligently misrepresents an individual’s condition or other information is subject to a civil money penalty of up to $50,000 for each violation. If the physician engages in gross and flagrant or repeat violations, the physician may be excluded from participation in the Medicare and Medicaid programs. In addition, a physician may be subject to malpractice liability if the physician’s conduct violates the applicable standard of care and proximately causes injury.

**What is the potential liability of an on-call physician at a hospital who fails or refuses to appear within a reasonable amount of time after being notified of the need to see a patient with an emergency medical condition and the patient is transferred because the risk of being without the on-call physician’s services is greater than the risk of transfer?**

A hospital oncall physician who fails or refuses to appear, within a reasonable amount of time, after being notified of the need to see a patient with an emergency medical condition, is subject to a civil money penalty of up to $50,000 and, for gross and flagrant or repeated refusals, exclusion from participation in the Medicare and Medicaid programs. The physician authorizing the transfer is not subject to penalty.

**Must an on-call physician who is called to see a patient in the hospital emergency department assume the ongoing care of the patient after conducting an appropriate medical screening examination and providing any necessary stabilizing treatment?**

Typically, no. A hospital on-call physician who is notified that his or her services are needed to screen and stabilize a patient in the emergency department must come in, screen, and stabilize the patient, but is not required to provide ongoing care to the patient after the patient has been screened and stabilized. If, however, the patient is admitted to the hospital, and the on-call physician is the one who admits the patient, or is designated as the patient’s attending physician, or is asked to provide care and treatment to the patient in the hospital, then the on-call physician would have obligations with respect to the patient’s ongoing care.

**May a hospital on-call physician bill the patient or the patient’s health plan for services the physician provides to screen and stabilize the patient in the emergency department even if the physician does not participate in the patient’s health plan?**

Yes. A nonparticipating hospital on-call physician may bill the patient or the patient’s health plan for the services the physician provides in the emergency department to screen and stabilize the patient. Under Washington law, health plans are required to provide coverage for emergency services necessary to screen and stabilize a covered person even when those services are obtained from a nonparticipating hospital emergency department if a prudent layperson would reasonably have believed that an emergency medical condition existed and that use of a participating hospital emergency department would result in a delay that would worsen the emergency or if a provision of federal, state or local law required the use of a specific provider or facility.

### Good Samaritan Law

**May a physician be held liable for services voluntarily rendered at the scene of an emergency?**

Generally, no. Washington’s Good Samaritan statute provides immunity from civil liability to any person who renders emergency care, including providing or assisting in transportation of a victim, at the scene of an emergency, or participates in transporting an injured person for emergency treatment, provided that such actions were taken without compensation or the expectation of compensation. The “scene of an emergency” is defined as “the scene of an accident or other sudden or unexpected event or combination of circumstances which calls for immediate action.” “Emergency care” means first aid, treatment, or assistance rendered to an injured person in need of immediate medical attention. The immunity does apply when a person’s actions while providing assistance constitute gross negligence or wanton misconduct, or if a person transporting an injured individual operates a motor vehicle negligently.

**Are there other circumstances in which physicians are afforded immunity for medical care?**

Washington law also provides immunity from civil liability to any licensed health care provider who provides uncompensated health care services at a “community health care setting.” These settings include entities that provide health care services and are publically operated, operated by certain non-profit entities, operated by for-profit entities but hold themselves out to the public as providing regular free health care services, or is a contracted participant in a community-based program to provide access to free health care for uninsured individuals. However, a physician will be subject to liability if the physician’s acts or omissions constitute gross negligence or willful or wanton misconduct.

If, however, the physician renders emergency care in the course of regular employment and receives or expects to receive compensation for such care, the “good Samaritan law” does not apply and the physician may be held liable for his or her negligent acts or omissions.

**May a retired physician volunteer be held liable for providing medical assistance during an emergency or a disaster?**

Generally, no. A physician who holds a retired volunteer medical license, and is registered as an emergency worker, is immune from liability for his or her actions while providing assistance in an emergency or disaster, or while participating in an approved training exercise or preparation for an emergency or disaster. This immunity does not apply to acts of gross negligence or willful or wanton misconduct. See [Licensure - Medical Doctors](http://legalguide.wsma.org.onexcale.net/physicians/allopathic-physicians/licensure---medical-).

See also [Emergency Medical Services](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/emergency-treatment/emergency-medical-services).

### Gunshot Wounds

**Must a gunshot wound be reported?**

Yes. Nonfatal gunshot wounds are notifiable conditions which must be reported monthly to the state Department of Health by health care facilities. See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions); and [Reporting Requirements](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/reporting-requirements).

**What must be included in a report to the Department of Health regarding bullet wounds, gunshot wounds or stab wounds?**

The report required must include the following information, if known:

* The patient’s name, address including zip code, telephone number, date of birth, and sex.
* Diagnosis or suspected diagnosis of disease or condition.
* Pertinent laboratory data (if available).
* Name of the principal health care provider.
* Telephone number of the principal health care provider
* Address of the principal health care provider.
* Name and telephone number of the person providing the report.
* Any other information the Department of Health may require on forms generated by the department.

**Are there mandatory reporting requirements for hospitals regarding gunshot wounds?**

Yes. Hospitals are required to report to law enforcement authorities when the hospital provides treatment for a gunshot wound (or stab wound) to a patient who is unconscious as soon as possible, taking into consideration the patient’s emergency care needs. The report required must include the following information, if known:

* The name, residence, sex, and age of the patient.
* Whether the patient has received a bullet wound, gunshot wound, or stab wound.
* The name of the health care provider providing treatment for the bullet wound, gunshot wound, or stab wound.

**Are there any specific requirements if the patient states that her/his injury is the result of domestic violence?**

Yes. A law enacted in the 2013 legislative session imposes a new requirement on hospitals if a patient states that her/his injury is the result of domestic violence. In that situation hospital must follow its established processes to inform the patient of resources which may be helpful to assure the safety of the patient and her/his family.

## Civil and/or Criminal Liability Under Selected Laws

### Antitrust

**What are the antitrust laws and what do they prohibit?**

In general, the antitrust laws are federal and state laws designed to:

* Promote competition.
* Prevent contracts, combinations, and conspiracies in restraint of trade.
* Prohibit attempts to monopolize, conspiracies to monopolize, and actual monopolies.
* Prevent mergers and acquisitions which tend to create a monopoly or substantially lessen competition.
* Prevent unfair trade practices and unfair methods of competition.

**Who enforces the antitrust laws?**

The antitrust laws are enforced by:

* The Antitrust Division of the Department of Justice, which has both civil and criminal jurisdiction to enforce the federal antitrust laws.
* The Federal Trade Commission, which has civil, but not criminal, jurisdiction to enforce the federal antitrust laws.
* The Washington State Attorney General’s office, which has authority to enforce the state antitrust laws.
* Private individuals, who may bring private actions for damages resulting from antitrust violations under state or federal law.

**Are physicians or physician practices bound by the antitrust laws?**

Yes.

**What are some of the kinds of physician activities which might have antitrust implications?**

Because application of the antitrust laws is complex and extremely fact specific, it is not possible to delineate all of the ways physicians might run afoul of the antitrust laws. Some examples, however, of physician activities which would unquestionably be antitrust violations include such things as:

* Conspiracies or agreements among competing physicians or physician groups to fix prices for health care services.
* Conspiracies or agreements among competing physicians or physician groups as to what services will be offered or what patients will be treated.
* Conspiracies or agreements among competing physicians or physician groups not to deal with particular entities, competitors, or managed care plans.

Some other examples of physician activities which may, depending upon the factual circumstances, have antitrust implications include such things as:

* Collective exchange of fee related information to purchasers of health care services by competing physicians or physician practices.
* Collective exchange of non-fee related information to purchasers of health care services by competing physicians or physician practices.
* Collective exchange of price and cost information among competing physicians or physician practices.
* Joint purchasing agreements among competing physicians or physician practices.
* Certain physician network joint ventures such as independent practice arrangements (IPAs), physician-controlled preferred provider organizations (PPOs), and other physician-controlled managed care organizations (MCOs).
* Certain exclusive dealing arrangements or exclusive contracts with hospitals or with managed care plans.
* Certain collective negotiations with health plans by competing physicians or physician practices.
* Exclusion of other physicians by a physician-controlled network joint venture.
* Certain adverse hospital privileging decisions.

Because the determination whether specific conduct violates the antitrust laws requires an extremely complex and fact-specific analysis, physicians engaging in activities which may have antitrust implications are well-advised to seek expert legal advice. A summary of federal and state antitrust laws is available at the Washington State Attorney General’s web site, <http://www.atg.wa.gov/antitrustguide.aspx>.

**Have the Department of Justice (DOJ) and the Federal Trade Commission (FTC) issued any guidelines or policy statements concerning antitrust enforcement in health care?**

Yes. The DOJ and the FTC have issued “Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust” which address the following topics:

* Mergers among hospitals.
* Hospital joint ventures involving high technology or other expensive health care equipment.
* Hospital joint ventures involving specialized clinical or other expensive health care services.
* Providers’ collective provision of non fee related information to purchasers of health care services.
* Providers’ collective provision of fee related information to purchasers of health care services.
* Provider participation in exchanges of price and cost information.
* Joint purchasing arrangements among health care providers.
* Physician network joint ventures.
* Analytical principles relating to multiprovider networks.

You may contact the Antitrust Division regarding business review letters by writing or calling: Legal Procedure Unit; Antitrust Division U.S. Department of Justice, Suite 215, 325 7th St., NW, Washington, D.C. 20530. The phone number is (202) 514-2481. They can also be accessed online from the FTC’s website at [www.ftc.gov](http://www.ftc.gov).

**Can physicians who are considering engaging in an activity addressed in the policy statements obtain an advisory opinion on the legality of their conduct under the antitrust laws from the DOJ or the FTC?**

Yes. Physicians and other providers who are considering doing any of the things addressed in the policy statements and are unsure of the legality of their conduct under the federal antitrust laws can take advantage of the DOJ’s expedited business review procedure for joint ventures and information exchange programs or the FTC’s advisory opinion procedure.

The length of time necessary to respond to a request for an advisory opinion will vary depending on several factors, including the nature and complexity of the issues posed by the proposed conduct, the magnitude and sufficiency of the request and supportive information provided with the initial request, the time it takes for the opinion requester to respond to any requests from staff for additional information, and whether the opinion will be issued by the Commission or the Commission staff, among other things. Some advisory opinions have been issued within a matter of weeks after the request was filed, although it is more typical for opinions to take at least several months before the process is completed and an opinion is issued. Subject to statutory restrictions, FTC rules and the public interest, the FTC may make public its advisory opinions and the requests therefrom. The DOJ’s business review letters and requests therefore are available to the public upon request for one year after issuance of the business review letter. Physicians and other providers who wish to take advantage of the DOJ’s expedited business review procedure or the FTC’s advisory opinion procedure are well-advised to seek the assistance of experienced legal counsel. While Commission and FTC staff advisory opinions may have persuasive value, they are not binding on courts, other governmental entities, or private parties. Consequently, advisory opinions should not be considered to provide immunity from legal challenge by others to the conduct at issue, or from contrary or adverse legal determinations by courts or other decisional bodies.

To formally request an advisory opinion, file the request with the Office of the Secretary, Federal Trade Commission, 600 Pennsylvania Avenue, N.W., Room 135-H, Washington, D.C. 20580, in the manner prescribed by Commission Rule 4.2(d)(1). The request should include one original, plus two paper copies, and an electronic copy on CD or DVD. For a request concerning health-care antitrust and competition issues, also send two additional copies directly to the Assistant Director, Health Care Division, Bureau of Competition, Federal Trade Commission, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580. There is no fee for filing an advisory opinion request or receiving an advisory opinion. Parties also may obtain less formal advice regarding a proposed course of action by contacting FTC staff to discuss issues relating to proposed conduct.

**Is there a topical index of Antitrust Advisory Opinions made by FTC staff?**

Yes. A range of topics are addressed at the following link: <http://www.ftc.gov/bc/adops/indexfin1112.pdf>.

**Has Washington State enacted any laws to provide antitrust exemptions or antitrust immunity to physicians involved in managed care competition?**

Yes. The Washington State Legislature has enacted provisions which exempt from state antitrust laws, and provide immunity from federal antitrust laws through the state action doctrine, certain activities that might otherwise be constrained under those laws. Such exemption from state antitrust laws, and immunity from federal antitrust laws under the state action doctrine, apply only to activities explicitly permitted by rules adopted by the Department of Health or specifically approved by the Department of Health in a written decision on a petition for approval of conduct that could tend to lessen competition in a relevant market.

In granting such exemption from state antitrust laws and immunity from federal antitrust laws, the Washington State Legislature explicitly does not authorize any person or entity to engage in activities that would constitute per se violations of state and federal antitrust laws, which for physicians include, but are not limited to, conspiracies or agreements among competing physicians to fix the price of their services, not to grant discounts, or not to provide services.

Has the state Department of Health adopted rules specifically permitting any cooperative activities among competing health care providers for which there may be antitrust exemption and immunity?

Yes. Although the Department of Health has stated that it would not yet be appropriate to establish with precision specific areas where cooperative activities are entitled to immunity from antitrust laws, as an interim policy, it has adopted the DOJ and FTC’s Statements of Enforcement Policy and Analytical Principles Relating to Antitrust discussed above.

**Has the state Department of Health adopted any rules specifically permitting any collective negotiation by competing health care providers of contracts with health carriers for which there may be antitrust exemption and immunity?**

Yes, but only with respect to specified non-fee-related terms and conditions of contracts with health carriers, only if done through an authorized third-party representative, and only if done in conformance with specified criteria. Given the complexity of the criteria and the limitations placed on collective negotiations, competing physicians contemplating engaging in collective negotiations are well-advised to first seek advice from experienced legal counsel. Physicians, or other health care providers, who exceed the authority granted by the Department of Health with respect to collective negotiations face the prospect of legal action against them for violation of state and federal antitrust laws.

**What terms and conditions of contracts with health care providers are competing physicians permitted by the Department of Health to collectively negotiate if they do so in conformance with the criteria specified by the Department of Health?**

Under the collective negotiation rules adopted by the state Department of Health, competing health care providers within the service area of a health carrier may meet and communicate for purposes of collectively negotiating the following terms and conditions of contracts with health carriers, provided they do so in complete conformance with criteria specified by the Department of Health:

* Respective provider and health carrier liability for the treatment or lack of treatment of health carrier enrollees.
* Administrative procedures including methods and timing of provider payment for services.
* Dispute resolution procedures relating to disputes between health carriers and providers including disputes between providers and health carriers that originate from enrollees.
* Patient referral procedures.
* With specified exceptions, formulation and application of reimbursement methodology, e.g., risk pools, capitation, and capitation between providers and hospitals.
* Quality assurance programs.
* Health service utilization review procedures.
* Carrier provider selection and termination criteria, or whether to engage in selective contracting.

Competing health care providers, however, cannot meet and communicate for the purposes of collectively negotiating any of the following terms and conditions of contracts with health carriers:

* The fees or prices for services, including those arrived at by applying any reimbursement methodology procedures.
* The conversion factor in a resource based relative value scale reimbursement methodology or similar methodologies.
* The amount of any discount on the price of services to be rendered by providers.
* The dollar amount of capitation or fixed payment for health services rendered by providers to health carrier enrollees.
* The inclusion or alteration of terms and conditions to the extent they are the subject of government regulation prohibiting or requiring the particular term or condition in question; however, such restriction does not limit providers’ rights to collectively petition government for a change in such regulation.

**To what criteria must competing health care providers’ permitted collective negotiations with health carriers conform?**

Competing health care providers’ exercise of the collective negotiation rights permitted by Department of Health rules must conform to the following criteria:

* Providers must communicate or negotiate with health carriers through a third party who is authorized by the providers.
* Each competing provider involved in the communication and negotiation with health carriers must make an independent decision to accept or reject a specific offer from a health carrier.
* Health carriers communicating or negotiating with the providers’ representative must remain free to contract with or offer different contract terms and conditions to individual competing providers.
* The providers’ representative must not recommend to providers that providers accept or reject the health carrier’s offer. The representative may only deliver the offer to providers and communicate to providers an evaluation of the positive or negative aspects of the offer.
* The providers’ representative must not represent more than 30% of the market of practicing providers for the provision of services of a particular provider type or specialty in the service area or proposed service areas of a health carrier with less than 5% of the market, as measured by (1) the number of covered lives as reported by the Insurance Commissioner, or (2) the actual number of consumers of prepaid comprehensive health services.
* The providers’ representative must also file specified information with the Department of Health and obtain its approval before engaging in collective negotiations on behalf of competing providers and before reporting the results of its negotiations with a health carrier or giving the providers an evaluation of any offer made by a health carrier.

Under no circumstances are competing providers authorized to act in concert in response to a report issued by the providers’ representative related to the representative’s discussions or negotiations with health carriers.

**Can physicians who are involved in the development, delivery, or marketing of health care or health plans obtain an informal opinion as to whether particular conduct is authorized under the antitrust laws, or otherwise petition the Department of Health for approval of conduct that could tend to lessen competition?**

Yes. A health carrier, health care facility, health care provider, or other person involved in the development, delivery, or marketing of health care or health plans may request, in writing, that the Department of Health obtain an informal opinion from the attorney general as to whether particular conduct is authorized under the antitrust laws, and may file a written petition with the Department of Health requesting approval of conduct that could tend to lessen competition in the relevant market. Generally, the attorney general will issue an informal opinion within 30 days of receipt of a written request for an opinion or within 30 days of receipt of all additional requested information, unless the time period is extended by the attorney general for good cause. Generally, the Department of Health will issue a written decision approving or denying a petition requesting approval of conduct within 90 days of a properly completed written petition unless the time period is extended by the Department of Health for good cause. The requisite contents of a request for an informal opinion or a petition requesting approval of conduct are established by regulation. Physicians or other health care providers wishing to take advantage of the informal opinion or petition process are well-advised to seek the assistance of experienced legal counsel.

**Under Washington law, do “most favored nations clauses” and exclusive dealing clauses in contracts between physicians and managed care organizations pose potential antitrust problems?**

Yes. Department of Health rules prohibit the use of “most favored nation” clauses in contracts between a health care provider or facility and a certified health plan. See [Contracting Issues Related To Managed Care Organizations](http://legalguide.wsma.org.onexcale.net/practice-management-issues/managed-care/contracting-issues-related-to-managed-care-or).

**What types of penalties may be imposed for antitrust violations?**

Violation of the federal antitrust laws is a felony punishable by up to ten years in jail, a fine of up to $100,000,000 for corporations and up to $1,000,000 for individuals, or both in the discretion of the court.

Violation of the state antitrust laws may result in imposition of a civil penalty of up to $500,000 for corporations and $100,000 for individuals.

Successful private plaintiffs in antitrust suits under federal or state law may obtain injunctive relief, treble damages, and attorneys’ fees and costs, although under state law trebling of damages is limited to $25,000.

### Jury Duty

**May a physician be excused from jury duty?**

Yes. A state court may excuse a physician from jury duty upon a showing of undue hardship, extreme inconvenience, public necessity or for any reason deemed sufficient by the court for a period of time that the courts deems necessary.

**What must a physician do to be excused from jury duty?**

Upon receiving a summons for jury duty and prior to the date on which the physician is to appear, a physician should call the court clerk’s office with an explanation of the extreme inconvenience and public necessity. The court may require the physician to provide a written explanation of the reasons for the request to be excused from jury duty. The physician should promptly complete and return any forms sent from the court.

**What is the penalty for failing to appear for jury duty when summoned?**

Intentional failure to appear for jury duty without being excused is a misdemeanor.

**Must physicians provide employees with leaves of absence from employment to serve as jurors when summoned to do so?**

Yes. Employers must provide employees with a sufficient leave of absence from employment to serve as jurors when summoned to do so. Moreover, employers are prohibited from depriving employees of employment, threatening, coercing, or harassing employees, or denying employees promotional opportunities because the employees receive or respond to summons for jury service, serve as jurors, or attend court for prospective jury service.

An employer who intentionally fails to provide an employee a sufficient leave of absence to serve as a juror or who intentionally engages in any prohibited conduct because an employee receives or responds to a summons for jury duty, serves as a juror, or attends court for prospective jury service is guilty of a misdemeanor and may be liable to the affected employee for civil damages, including reasonable attorney fees.

### Medicare – Medicaid Fraud and Abuse and Anti-kickback Provisions

**NOTE:** Analysis of issues related to Medicare and Medicaid fraud and abuse, federal and state anti-kickback laws is generally quite complex and fact-specific. Most of the safe harbors related to the federal anti-kickback law contain multiple enumerated requirements which must be met in order to achieve safe harbor protection. Physicians are well-advised to seek legal advice on these matters.

**What constitutes fraud under the Medicare-Medicaid laws?**

In general terms, for purposes of Medicare and Medicaid laws, “fraud” means an intentional deception or misrepresentation made for the purpose of obtaining payment or other benefit not otherwise due or made with the knowledge that the deception or misrepresentation could result in some unauthorized payment or benefit to oneself or to some other person. Fraud, for purposes of Medicaid law, also includes any act that would constitute fraud under any applicable state or federal law.

Health care fraud may take one of several forms, including among others:

* Submission of false claims for payment of items or services which were not provided.
* Submission of claims for payment for items or services more complicated (or more costly) than those which were actually provided.
* Kickback arrangements between service providers and their suppliers or referral sources.

With respect to fraudulently making false statements regarding a federal health care program, a person does not need to have actual knowledge of the wrongful act or have a specific intent to commit fraud.

**What constitutes abuse under the Medicare-Medicaid laws?**

“Abuse,” for purposes of Medicare and Medicaid laws, means those practices of providers, physicians, and other suppliers of health care items or services which are inconsistent with accepted sound medical, financial, or business practices, such that those practices result, directly or indirectly, in unnecessary costs to the Medicare or Medicaid programs. Specifically, the standards CMS uses to determine abuse in in billing are whether the act was (i) reasonable and necessary, (ii) conformed to professionally recognized standards, and (iii) provided at a fair price. Abuse can involve, among other things, claims for items or services which were not medically necessary or for which there is no legal entitlement to payment. However, to constitute abuse, unlike fraud, no intentional deception or misrepresentation is required.

**What constitutes an illegal kickback under the Medicare and Medicaid programs?**

The Medicare-Medicaid anti-kickback statute makes it a felony to knowingly and willfully offer, pay, solicit or receive any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce or in return for:

* Referring an individual to a person for the furnishing or arranging for the furnishing of any item or service payable in whole or in part under Medicare or Medicaid.
* Purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item payable in whole or in part under Medicare or Medicaid.

Thus, the Medicare-Medicaid anti-kickback statute prohibits a physician from knowingly and willfully soliciting or receiving any kind of remuneration in any form in return for referring a patient for Medicare or Medicaid services. But a physician or other defendant does not have to have actual knowledge or a specific intent to commit a violation of the anti-kickback statute. Further, some courts have held that, even where there are legitimate purposes for a payment, if one purpose of a payment is to induce referrals then the Medicare-Medicaid anti-kickback law has been violated.

**What are the penalties for violating the Medicare-Medicaid anti-kickback law?**

Violation of the Medicare-Medicaid anti-kickback law constitutes a felony punishable, upon conviction, by a fine of up to $25,000 and/or imprisonment for up to five years. Violations of the anti-kickback law may also result in the imposition of substantial civil money penalties and exclusion from participation in the Medicare and Medicaid programs.

**Are there any statutory exceptions to the Medicare-Medicaid anti-kickback law prohibitions?**

Yes. There are several statutory exceptions to the Medicare-Medicaid anti-kickback law prohibitions, which include:

* Discounts or price reductions obtained by a provider of services, if the discount or price reduction is properly disclosed and is passed along to Medicare and Medicaid.
* Amounts paid by an employer to an employee who has a true employment relationship with the employer, for employment in the provision of items or services covered under Medicare or Medicaid.
* Payments to certain group purchasing arrangements.
* Waivers of Part B Medicare coinsurance by a federally qualified health care center with respect to an individual who qualifies for subsidized services under the Public Health Service Act.
* Other payment practices, known as “safe harbors,” which have been specified in regulations promulgated by the Department of Health and Human Services (DHHS).
* Certain remuneration between health maintenance organizations or competitive medical plans and individuals or entities providing items or services pursuant to written agreements, including through a risk-sharing arrangement that places the individual or entity at substantial financial risk for the cost or utilization of the items or services the individual or entity is to provide.
* Certain waivers or deductions by pharmacies of cost-sharing.
* Certain remuneration between certain federally qualified health centers (or entities controlled by such health centers) and a Medicare Advantage (MA) pursuant to a written agreement as described by law.
* Certain remuneration between certain federally qualified health centers and individuals or entities providing goods, items, services, donations, loans, or a combination thereof to such health centers pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center.
* A discount in the price of an applicable drug of a manufacturer that is furnished to an applicable beneficiary under the Medicare coverage gap discount program (Medicare Part D).

**What are “safe harbor” regulations?**

Because the language of the anti-kickback statute is so broad that it could encompass many harmless, yet beneficial and efficient, commercial arrangements, Congress directed DHHS to promulgate regulations specifying those payment practices which, although potentially capable of inducing referrals of business under Medicare or Medicaid, would not be considered kickbacks for purposes of criminal prosecution or imposition of civil penalties under the anti-kickback law.

DHHS has responded to that directive by promulgating 25 final safe harbors. Most of these safe harbors contain multiple enumerated requirements which must be met in order to achieve safe harbor protection. The enumerated requirements typically include, among other things, requirements that the amounts paid be consistent with fair market value and not be determined in a manner that takes into account, directly or directly, the volume or value of referrals.

If a remuneration arrangement fully complies with all of the enumerated requirements of a specific final safe harbor, the remuneration arrangement will not be subject to criminal prosecution or imposition of civil penalties under the Medicare-Medicaid anti-kickback statute.

**What happens if a remuneration arrangement does not fit entirely within a safe harbor?**

If a remuneration arrangement fails to fully comply with all of the enumerated requirements of a specific final safe harbor, there is no absolute protection from criminal or civil anti-kickback statute enforcement actions. That does not mean, however, that all remuneration arrangements which do not fit squarely within the confines of a specific final safe harbor necessarily will be deemed criminal offenses or will be prosecuted under the anti-kickback law. It means simply that, where individuals and entities have entered into arrangements covered by the statute, but have failed to fully comply with an applicable final safe harbor or exception, they risk scrutiny and may be subject to civil or criminal enforcement action. The degree of risk depends on an evaluation of many which are the basis of the decision making process to select cases for investigation and prosecution.

**What areas are covered by the safe harbors?**

DHHS has promulgated the safe harbors for:

* Payments that are returns on certain investment interests.
* Payments made for certain space rentals.
* Payments made for certain equipment rentals.
* Payments made for services provided under certain personal services and management contracts.
* Payments made for certain sales of practices by one practitioner to another practitioner.
* Payments made in connection with certain referral services.
* Payments made under certain warranties provided by a manufacturer or supplier.
* Certain discounts on goods and services received by a buyer.
* Amounts paid by an employer to an employee who has a true employment relationship with the employer.
* Certain payments made by a vendor of goods and services to certain group purchasing organizations.
* Certain waivers of beneficiary co-insurance and deductibles by hospitals for inpatient hospital services, as well as waivers of Part B co-insurance and deductibles by federally qualified health care centers or other health care facilities for individuals who qualify for subsidized services under the Public Health Services Act.
* Certain incentives (such as increased coverage, reduced cost-sharing amounts or reduced premium amounts) which health maintenance organizations (HMOs), preferred provider organization (PPO), competitive medical plans (CMPs), pre-paid health plans (PHPs), or other health plans under contract with the Centers for Medicare and Medicaid Services (CMS)), or a state health care program provided to enrollees.
* Certain price reductions offered to health plans.
* Certain payments made to recruit practitioners to rural areas.
* Certain obstetrical malpractice insurance subsidies in health professional shortage areas.
* Payments that are returns on certain investment interests in group practices composed exclusively of active investors.
* Certain payments made between a cooperative hospital service organization and its patron hospital.
* Payments that are returns on certain investment interests in ambulatory surgical centers.
* Certain referral agreements for specialty services.
* Certain price reductions offered to eligible managed care organizations.
* Certain price reductions offered by contracts with substantial financial risk to managed care organizations.
* Replenishing of ambulance drugs or medical supplies.
* Certain transfers of goods, items, services, donations, loans, or combinations thereof from an individual or entity to a federally qualified health center.
* The provision of nonmonetary remuneration (consisting of hardware, software or information technology and training services) to transmit or receive electronic prescription information.
* The provision of nonmonetary remuneration (consisting of hardware, software or information technology and training services) to transmit or receive electronic health records.

**NOTE**: Because most of the safe harbors contain multiple enumerated requirements which must be met in order to achieve safe harbor protection, physicians are well-advised to seek legal advice before assuming that their remuneration arrangements do not violate the anti-kickback law.

**Are there any “Fraud Alerts” which describe particular payment practices targeted by the agencies charged with the enforcement of the Medicare-Medicaid fraud and abuse and anti-kickback laws?**

Yes. The Office of Inspector General (OIG) has published a number of “Fraud Alerts” concerning certain kinds of remuneration arrangements, not protected by existing final safe harbors, which may be violative of the Medicare-Medicaid anti-kickback statute. The topics addressed by these Fraud Alerts are too numerous to list, but include:

* Joint venture arrangements.
* Routine waiver of co-payments or deductibles under Medicare.
* Financial arrangements between hospitals and hospital-based physicians.
* Hospital incentives to referring physicians.
* Prescription drug marketing schemes.
* Arrangements for provision of clinical laboratory services.
* Home health fraud.
* Medical supplies to nursing facilities.
* Provision of services in nursing facilities.
* Nursing home arrangement with hospice.
* Physician liability for certification in the provision of medical equipment and supplies and home health services.
* Rental of space in physician offices by persons or entities to whom the physicians refer.
* Telemarketing by durable medical equipment suppliers

**Where can a physician obtain copies of Fraud Alerts?**

Physicians can obtain copies of Fraud Alerts from the Office of the Inspector General, Department of Health and Human Services, 200 Independence Avenue S.W., Washington, D.C. 20201, telephone number 1‑800‑368‑5779. Information related to fraud alerts may also be found at <http://oig.hhs.gov/compliance/alerts/index.asp>.

The homepage for the Office of the Attorney General is: <http://oig.hhs.gov/>.

**Does Washington also have an anti-kickback law?**

Yes. See [Rebates](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/civil-andor-criminal-liability-under-selected/rebates).

**Does compliance with the Medicare-Medicaid anti-kickback law ensure compliance with Washington’s anti-rebate law?**

No, not necessarily. See [Rebates](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/civil-andor-criminal-liability-under-selected/rebates).

**Are there any physician self-referral prohibitions under the Medicare-Medicaid laws?**

Yes. See [Medicare-Medicaid Physician Self-Referral Prohibitions (Stark Laws).](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/civil-andor-criminal-liability-under-selected/medicare-medicaid-physician-self-referral-pro)

**Does compliance with the Medicare-Medicaid anti-kickback law ensure compliance with the STARK laws?**

No. The Medicare-Medicaid anti-kickback law and the STARK laws address different evils and contain different prohibitions and exceptions. Physicians need to examine their financial relationships with other health care providers and entities separately under each of these laws. Physicians are well-advised to seek legal advice concerning any financial relationships they have with referral sources.

### Medicare – Medicaid Physician Self-Referral Prohibitions (Stark Laws)

**NOTE**: Analysis of potential physician self-referral issues is very complex and fact-specific. The Stark law and how it is interpreted changes frequently. Almost all of the exceptions to the laws and regulations prohibiting self-referral require compliance with multiple specific conditions. Physicians are well-advised to seek legal advice before assuming that their ownership or investment interests or compensation arrangements with referral sources do not violate the Stark laws. The Legal Resource Center of the Washington State Medical Association (www.wsma.org) can assist you in identifying attorneys experienced in Stark and other self-referral questions.

**What are the Stark laws?**

Stark I, a federal law which became effective on January 1, 1992, prohibits a physician from referring patients for Medicare covered services to a clinical laboratory with whom the physician has a financial relationship.

Stark II, a federal law which became effective on January 1, 1995, expands the physician referral prohibitions of Stark I to include Medicaid and to embrace 10 other designated health services. Stark II prohibits a physician from making a referral of a Medicare or Medicaid patient to an entity for the provision of certain “designated health services,” if the physician, or an immediate family member of the physician, has a financial relationship (whether through an ownership or investment interest or a compensation arrangement) with the entity.

Stark II also prohibits an entity providing designated health services from billing for any designated health services furnished pursuant to a prohibited referral.

Further, Stark II requires each entity which provides designated health services to report information concerning the entity’s ownership, investment and compensation arrangements.

The Centers for Medicare and Medicaid Services (CMS) released Phase III of their final regulations (Stark III) on September 5, 2007. Stark III is a response to comments CMS received on Phase II. Stark III addresses the entire group of regulations regarding self-referral, and expands upon, but does not alter, concepts that were introduced in Stark I and II.

**What are designated health services?**

The “designated health services” encompassed in the Stark laws and regulations include:

* Clinical laboratory services.\*
* Physical therapy, occupational therapy, and outpatient speech-language pathology services.\*
* Radiology services, including x-rays, magnetic resonance imaging, computerized axial tomography scans, positive emission tomography, ultrasound services, and nuclear medicine.\*
* Note that with regard to certain imaging services, including MRI, CT, and PET scans, the referring physician must provide written notice (which must meet certain requirements set forth in regulations) to the patient at the time of the referral that the patient may receive the same service from a person other than the referring physician or the physician’s group.
* Radiation therapy services and supplies.\*
* Durable medical equipment and supplies.
* Parenteral and enteral nutrients, equipment and supplies.
* Prosthetics, orthotics and prosthetic devices and supplies.
* Home health services.
* Outpatient prescription drugs.
* Inpatient and outpatient hospital services.

\*The list of CPT and HCPCS codes for the specific services that are considered DHS under the above categories that are followed by an asterisk is updated annually in the physician fee schedule final rule and on the CMS website.

**Are there are any exceptions to the self-referral prohibitions of the Stark laws?**

Yes. Stark sets forth a number of statutory and regulatory exceptions to the physician self-referral prohibitions. The Stark statutory and regulatory exceptions include:

* Physicians’ services provided personally by, or under the personal supervision of, another physician in the same group practice as the referring physician.
* In-office ancillary services.
* Services provided within certain prepaid health plans.
* Certain services provided within a faculty practice plan associated with a hospital, institution of higher education, or medical school with an approved medical residency program.
* Implants furnished by an ambulatory surgery center.
* EPO and other dialysis-related drugs.
* Preventive screening tests, immunization, and vaccines.
* Eyeglasses and contact lenses following cataract surgery.
* Intra-family rural referrals.
* Ownership or investment interests in certain publicly traded investment securities and mutual funds.
* Ownership of investment interests in hospitals in Puerto Rico, rural providers who meet certain conditions, and hospitals outside of Puerto Rico if:
* The referring physician is authorized to perform services at the hospital;
* The hospital was not a specialty hospital from December 8, 2005 through June 7, 2005;
* The ownership or investmentis in the whole of a hospital, not merely a subdivision; and
* The hospital met certain statutory requirements by September 22, 2012.
* Payments made for certain office space and equipment rentals.
* Payments made by an employer to an employee who has a true (“bona fide”) employment arrangement with the employer.
* Payments made under certain personal service arrangements.
* Payments made under certain physician incentive plans, involving such things as withholds, capitation, and bonuses, which may have the effect of reducing or limiting services a physician provides to enrolled individuals.
* Remuneration by hospitals which is unrelated to the provision of designated health services.
* Certain hospital physician recruitment incentives.
* Payments made in connection with isolated financial transactions, such as a one-time sale of property or Practice.
* Certain group practice arrangements with a hospital which were in effect before December 19, 1989.
* Payments by a physician for items or services furnished at a price consistent with fair market value.
* Bona fide charitable donations made by a physician (or immediate family member).
* Nonmonetary compensation up to $300 per calendar year.
* Fair market compensation.
* Medical Staff non-cash incidental benefits from a hospital to a member of the Medical Staff used on the hospital campus (such as low-cost meals for physicians) or used away from campus to access hospital information (such as pagers or internet access).
* Risk-sharing arrangements between a physician and a managed care organization (MCO) or independent physician organization (IPO) for services provided to enrollees of a health plan.
* Compliance training for physicians (or to the physicians’ immediate family member or office staff).
* Certain indirect compensation arrangements.
* Referral services.
* Obstetrical malpractice insurance subsidies.
* Professional courtesy to physician or physician family members under certain circumstances.
* Retention payments in underserved areas.
* Access to community-wide information systems.
* Electronic prescribing items and services.
* Certain arrangements involving temporary non-compliance.
* Electronic health records items and services.
* Other financial relationships which the Department of Health and Human Services (DHHS) determines do not pose a risk of program or patient abuse and specifies in regulations.

Most of the Stark statutory and regulatory exceptions contain multiple enumerated requirements which must be met in order to come within the exception. Under Stark, physician referrals of Medicare and Medicaid patients for designated health services to an entity with whom the physician, or an immediate family member of the physician, has a financial relationship are absolutely prohibited unless the ownership or investment interest or the compensation arrangement squarely fits within all of the enumerated requirements of one of the Stark exceptions.

**What are the penalties for violating the Stark laws?**

The sanctions for violations of the Stark laws include:

* No payment for a designated health service furnished pursuant to a prohibited referral.
* Repayment of all amounts improperly billed.
* Civil money penalties of up to $15,000 per each improperly billed service.
* Civil money penalties of up to $100,000 against any physician or entity that enters into any circumvention arrangement or scheme which the physician or entity knew or should have known has a principal purpose of assuring referrals.
* Civil money penalties of up to $10,000 each day for which a required report has not been made.
* Exclusion from participation in Medicare or Medicaid.
* Assessment of not more than three times the amount claimed for each item or service improperly claimed.

**Does compliance with the Stark laws ensure compliance with the Medicare-Medicaid anti-kickback law or Washington’s anti-rebate law?**

No. See [Medicare-Medicaid Fraud And Abuse](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/civil-andor-criminal-liability-under-selected/medicare-medicaid-fraud-and-abuse); and [Rebates](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/civil-andor-criminal-liability-under-selected/rebates).

**Where can physicians find more information concerning the Stark laws?**

The federal government website related to physician self-referral, under the Centers for Medicare & Medicaid Services is: <http://www.cms.hhs.gov/PhysicianSelfReferral>.

### Rebates

**May a physician receive a payment for referring a patient to another physician?**

No. Under Washington law, it is both a misdemeanor and unprofessional conduct for a physician to receive any rebate, refund, commission, unearned discount or profit or compensation for referring patients. The physician’s license may even be revoked under such circumstances. See Unprofessional Conduct.

**What does Washington’s anti-rebate law prohibit?**

Under Washington’s anti-rebate statute, it is a misdemeanor for any person or entity to pay, offer to pay, allow, request, or receive, directly or indirectly, any rebate, refund, commission, unearned discount or profit by means of a credit or other valuable consideration from a third party (someone other than the patient) in connection with:

* The referral of patients.
* The furnishing of any medical, surgical or dental care diagnosis, treatment or service.
* The sale, rental, furnishing or supplying of:
* Any clinical laboratory supplies or services of any kind.
* Drugs, medications or medical supplies.
* Any other goods, services or supplies prescribed for medical diagnosis, care or treatment.

The statute does not prevent a patient from paying a physician for services rendered or prescriptions received, nor does it prevent a physician from making a profit on the furnishing of goods or care to a patient.

**Are there any exceptions to Washington’s anti-rebate prohibitions?**

Yes. Under Washington’s anti-rebate law, a physician who has an ownership interest in an entity which furnishes clinical laboratory or other diagnostic services may refer a patient to that entity, if and only if:

* The physician affirmatively discloses to the patient, in writing, the fact that the physician has a financial interest in the entity.
* The physician provides the patient with a list of effective alternative facilities.
* The physician informs the patient that the patient has the option of using one of the alternative facilities.

The physician assures the patient that the patient will not be treated differently if the patient chooses one of the alternative facilities.

**Does compliance with the exception to Washington’s anti-rebate prohibition ensure compliance with either the Medicare-Medicaid anti-kickback law or the Medicare-Medicaid physician self-referral prohibitions?**

No. See [Medicare-Medicaid Fraud And Abuse](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/civil-andor-criminal-liability-under-selected/medicare-medicaid-fraud-and-abuse) and [Medicare-Medicaid Physician Self-Referral Prohibitions (Stark Laws)](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/civil-andor-criminal-liability-under-selected/medicare-medicaid-physician-self-referral-pro) for information concerning compliance with those laws.

## Subpoenas

**What is a subpoena?**

A subpoena is a form of compulsory legal process that requires a person to produce documents or to personally appear to give testimony, either at a deposition or in court. A subpoena may be issued by an attorney, a court, or a governmental agency.

**What are the consequences if a physician does not comply with a properly issued subpoena?**

If a physician fails to comply with a properly issued subpoena, the physician may be held in contempt and punished by a fine, imprisonment until he or she complies, and/or other sanctions. [See Disclosure Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/hippa/disclosure-and-protection-of-health-care-info) for when a physician must and must not comply with a subpoena issued by an attorney for release of a patient’s health care information.

**Are there special rules which apply to release of mental health records under a subpoena?**

Yes. Mental health records can only be released under certain circumstances. Mental health records must be released pursuant to a lawful order (subpoena) of a court. Mental health records should not be released pursuant to a subpoena issued by an attorney except to the patient’s attorney at any time in order to prepare for involuntary commitment or recommitment proceedings, reexamination appeals, or actions related to detention, admission, commitment, or patient’s rights.

**What should a physician do upon receipt of a subpoena?**

Upon receiving a subpoena, a physician should read the subpoena carefully to determine what information is being requested, when, and by whom. If the physician has any doubt about the appropriate response to the subpoena, the physician should contact an attorney immediately. If the physician has any reason to believe that his or her care and treatment may be called into question, the physician should not speak to the patient’s attorney, and should contact his or her attorney or malpractice carrier for advice.

If the subpoena is from a government agency, the physician should contact an attorney and his or her malpractice carrier immediately.

If the subpoena is from an attorney and seeks either a copy of a patient’s medical record or the physician’s testimony concerning a patient’s health care information, the physician should:

* Verify whether the required 14-day advance notice or a valid patient authorization was received. See [Disclosure Of Health Care Information](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/subpoenas/subpoenas).
* Verify whether a protective order has been entered.
* If no 14-day advance notice or valid patient authorization was received, the physician should not release the requested health care information and should notify the attorney issuing the subpoena that the physician cannot comply with the subpoena.
* If the 14-day advance notice or a valid patient authorization was received, and no protective order has been received, the physician should comply with the subpoena according to its terms.
  + If the subpoena is for the physician’s testimony at a deposition or trial and the date and time on the subpoena are not convenient, the physician should contact the attorney who issued the subpoena to arrange a more convenient date and time and to attempt to reach an agreement regarding the reasonable compensation to be paid for the physician’s time.See [Physician As Witness](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/physician-as-witness/physician-as-witness)
  + If an agreement is reached regarding compensation, the physician should confirm it in writing.
  + If no agreement can be reached as to date and time or compensation, and the physician cannot appear at the date or time stated in the subpoena, the physician should consult an attorney.
* If a protective order has been entered, the physician should comply with the terms of the protective order.
* Place the subpoena, and a notation about the physician’s response to the subpoena, in the patient’s medical record.
* If there is any question, contact an attorney.

**What must a physician do in order to comply with a valid subpoena for documents?**

A physician must produce the documents as they are kept in the usual course of business, or may organize and label them to correspond with categories in the subpoena.

**May a physician charge for time spent in testifying or for producing copies of a patient’s Health Care Information in response to a subpoena?**

Yes. See [Physician As Witness](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/physician-as-witness/physician-as-witness); and [Disclosure Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/hippa/disclosure-and-protection-of-health-care-info) for issues related to charges.

## Physician as Witness

**May a physician serve as a witness in a lawsuit?**

Yes. Physicians are often asked to serve as witnesses in lawsuits. A physician may serve as either a fact or an expert witness.

**What is the difference between a physician serving as a fact witness or as an expert witness?**

The distinction between a physician who is testifying as a fact witness and an expert witness is whether the physician’s opinions were obtained for the specific purpose of the lawsuit.

**When is a physician a fact witness?**

When a physician testifies in his or her capacity as a treating physician, the physician is a fact witness and not an expert witness.

**How does the physician-patient privilege affect what information the treating physician may disclose?**

By placing his or her medical condition at issue the patient waives the physician-patient privilege with respect to information relative to that condition. Thus, a physician may testify as to opinions held and facts observed by the physician. But see [Disclosure Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/hippa/disclosure-and-protection-of-health-care-info); and [Subpoenas](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/subpoenas/subpoenas) for when patient authorization is needed and when health care information can be disclosed in response to a subpoena. The fact that a physician’s testimony regarding facts or causation is harmful to the patient’s position in a lawsuit does not prohibit a physician from testifying.

**May a physician fact witness charge for his or her time?**

Yes. The party seeking testimony from a treating physician must pay the physician a reasonable fee for the time spent. Generally, the physician is advised to reach an agreement concerning the fee for the physician’s time in advance with the party making the request. If an agreement over the fee is not reached in advance the physician must respond to the request for information or deposition unless the court has issued an order to the contrary. The physician make later seek a order from the court setting the fee to be paid by the party who sought information from the physician.

**May a treating physician meet privately with an attorney to discuss a patient?**

Generally, no. A physician may not discuss a patient with an attorney, other than the physician’s own attorney, without a signed patient authorization, a subpoena issued in compliance with the requirements of the Uniform Health Care Information Act, or a court order. See [Disclosure Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/hippa/disclosure-and-protection-of-health-care-info). This rule, however, does not apply in workers’ compensation cases. See [Workers’ Compensation.](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/workers-compensation/workers-compensation)

**When is a physician an expert witness?**

A physician who is retained for the purpose of litigation and who develops facts or forms opinions for the purpose of litigation is an expert witness.

**May a physician expert witness charge for his or her time?**

Yes. A physician serving as an expert witness is entitled to a reasonable fee for time spent. A physician should bill the time spent reviewing the case, meeting with the party who retained the physician, or testifying at trial to the party who requested the expert’s services. Time spent at a deposition generally is billed to the party taking the deposition.

A physician is well-advised to discuss fees for serving as an expert witness in advance with the attorney or party retaining the physician and to confirm in writing any agreement reached.

**May a physician expert witness be asked in deposition or at trial how much time they spend testifying for plaintiffs or defendants or how much they earn from testifying?**

Generally, yes.

**May a physician expert witness performing an independent medical examination be required to permit an attorney or other legal representative to be present during the examination?**

Yes. The court rules permit the party being examined to have a representative present at an independent medical examination. The representative may observe the examination but may not interfere with or obstruct the examination.

**May a physician expert witness performing an independent medical examination be required to permit an audiotape of the examination?**

Yes. Unless otherwise ordered by the court, the party being examined or the party’s representative may make an audiotape recording of the examination, but any audiotape recording must be done in an unobtrusive manner. A videotape recording may only be made on agreement of the parties or by order of the court.

# Privacy Issues

## HIPAA

Disclosure And Protection Of Health Care Information

**What is the Health Insurance Portability and Accountability Act?**

The Health Insurance Portability and Accountability Act (HIPAA) is a detailed federal statute, with related regulations, governing access to, disclosure of, and security of a patient’s health care information. HIPAA contains both a Privacy Rule and a Security Rule with which physicians must comply.

Although the full scope and content of the HIPAA Privacy Rule and Security Rule are beyond the scope of this Guide, physicians and physician groups are well-advised to apprise themselves of the scope and content of the Rules and related regulations and to incorporate their requirements into their practices. The HIPAA Rules and related regulations, among other things:

* Apply to all health information whether electronic, paper or oral.
* Require physicians to designate a privacy officer to assist staff and patients with questions or complaints as well as to ensure compliance with the HIPAA regulations.
* Require physicians to designate a security official who is responsible for the development and implementation of the policies and procedures required to comply with the Security Rule.
* Require physicians to ensure the confidentiality, integrity, and availability of all electronic protected health information that the physician creates, receives, maintains, or transmits.
* Require covered entities to create a Notice of Privacy Practices – a HIPAA mandated notice that informs patients about protected health information and their rights, and explains some of the limits on an entity’s ability to use and disclose this information.
* Require covered entities to inform patients about the right to request that their PHI not be disclosed to a health carrier, so long as the patient has paid for the services out of pocket. Covered entities and business associates are required to abide by these requests when properly made.

**What constitutes health information, and protected health information, under HIPAA?**

“Health information” is defined to include: any information, whether oral or recorded in any form or medium, that is created or received by a health care provider and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of healthcare to an individual.

“Protected health information” is health information, as defined above, that identifies the individual or as to which there is a reasonable basis to believe it could be used to identify the individual, that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium (with limited exceptions).

**What is the HITECH Act?**

HITECH stands for “Health Information Technology for Economic and Clinical Health,” and it is a new law that was designed to both promote the use of electronic records as a tool for care providers, as well as protect patients’ health information. The HITECH Act establishes payments under Medicare and Medicaid to incentivize using technology properly, strengthens enforcement procedures and penalties, and clarifies disclosure requirements.

**What is the GINA?**

GINA stands for the Genetic Information Nondiscrimination Act. It was designed to prohibit the use of genetic information for certain health insurance and employment uses. GINA prohibits group health plans and health insurers and even employers from excluding individuals because of their genetic information or disposition to developing a disease in the future.

**What is the Uniform Health Care Information Act?**

The Uniform Health Care Information Act (UHCIA) is a detailed Washington statute governing access to and disclosure of a patient’s health care information. In 2005, the UHCIA was amended to make the requirements under Washington law more closely aligned with the requirements of HIPAA.

**What are recent changes to the laws that regulate health information?**

In early 2013, the Department of Health and Human Services (HHS) published a final rule, changing parts of the HIPAA Privacy, Security, Breach Notification, and Enforcement Rules. Some of these are changes required by the HITECH Act or by GINA. These two laws, and the changes adopted by the final rule, reflect the health industry’s growing reliance on electronically stored information, as well as Congress’s concern for patient information to be kept safe.

Notably, HITECH changes HIPAA’s data breach notification requirements, requirements for business associates, restrictions on marketing, revision of the minimum necessary standard, restrictions on the sale of protected health information and Electronic Health Records, requirements for certain requests to restrict use or disclosure of protected health information, provision related to Electronic Health Records, and enhanced enforcement of HIPAA Privacy and Security provisions.

**What constitutes health care information under the UHCIA?**

Under the UHCIA, “health care information” is defined to include any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient, including a patient’s DNA and sequence of chemical base pairs, and directly relates to the patient’s health care. The term includes any required accounting of disclosures of health care information.

**What kinds of requirements do these health care related laws set forth?**

HIPAA, UHCIA, HITECH, and GINA set forth specific rules for such things as:

* When a health care provider may disclose a patient’s health care information without the patient’s consent.
* What an authorization must contain in order to be valid and permit disclosure of a patient’s health care information.
* What a health care provider must do when a patient asks to examine or copy his or her medical record.
* What a health care provider must do when a patient asks to have his or her medical record amended or corrected.
* When a health care provider may disclose health care information about a patient to an attorney.
* What notice a health care provider must give to patients regarding disclosure of health care information.
* What a health care provider may charge for duplicating or searching a patient’s medical record.
* What civil and criminal penalties an entity may face when it misuses or inappropriately discloses PHI.

**Which takes precedence – HIPAA or the UHCIA?**

Where HIPAA and the UHCIA provide different privileges, rights or obligations, the law that affords patients the greater access to their own health care information, the greater rights and remedies, or the greater protection of the privacy and security of their health care information governs.

**When is it appropriate for a physician to disclose a patient’s health care information?**

As a general rule under the UHCIA and HIPAA, a physician, an individual assisting a physician in the delivery of health care, or an agent and employee of a physician, may not disclose health care information about a patient to any other person without the patient’s written authorization. See a discussion of exceptions to this general prohibition below. Disclosures made pursuant to a patient’s written authorization must conform to the terms of the authorization.

**What is required for a valid patient authorization under the UHCIA?**

To be valid, a patient authorization must generally:

* Be in writing.
* Be signed and dated by the patient.
* Identify the nature of information to be disclosed.
* Identify the name, and institutional affiliation of the person, or class of persons, to whom the information is to be disclosed.
* Identify the provider, or class of providers, who is to make the disclosure.
* Identify the patient.
* Contain an expiration date or an expiration event related to the patient or the purpose of the disclosure.

NOTE: The HIPAA Privacy Rules also require a description of each purpose of the requested use or disclosure. The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose. In addition, the Privacy Rules require that the authorization be written in plain language, and that a copy of the authorization be given to the patient if the physician seeks an authorization for use or disclosure.

**What other statements do the HIPAA Privacy Rules require a valid authorization to include?**

The HIPAA Privacy Rules require that an authorization must contain statements to place the patient (or representative) on notice of:

* The individual’s right to revoke the authorization in writing, and either (i) the exceptions to the right to revoke and a description of how the individual may revoke the authorization; or (ii) a reference to the privacy notice (see below) posted in the physician’s office if the notice includes the rights related to revocation of an authorization.
* The ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the authorization; and
* The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient, which would no longer be protected under the HIPAA Privacy Rules.

**Must the physician retain a copy of an authorization for release of health care information?**

Yes. A health care provider or health care facility must retain the original or a copy of each authorization (or revocation) pertaining to release of health care information.

**How long is a patient authorization to release information valid?**

A patient authorization to release information is valid until the expiration date or the expiration event noted in the authorization. However, when the authorization permits disclosure to a financial institution or an employer of the patient for purposes other than payment, the authorization as it pertains to those disclosures shall expire 90 days after the authorization is signed, unless renewed by the patient.

**When may a patient revoke an authorization to disclose health care information?**

A patient may revoke in writing an authorization to release health care information at any time, unless the physician has already taken action in reliance on the authorization or disclosure of information is required for matters related to payments for care that has already been provided to the patient. An authorization is no longer valid if it is revoked in writing by the patient before the physician has taken substantial action in reliance on the authorization.

**May a physician be held liable for disclosing information pursuant to a revoked authorization?**

Yes, if the health care provider had actual notice that the authorization had been revoked. A patient may not maintain an action against a health care provider, however, for disclosures made in good faith reliance on an authorization if the health care provider had no actual notice that the authorization had been revoked.

**What is a breach?**

A breach can refer to any acquisition, access, use, or disclosure of patient information (be it the patient’s name, address, SSN, or other identifying information or health information) in a manner not permitted by HIPAA. There is a presumption that any impermissible use or disclosure of such information constitutes a breach, which then requires the covered entity to notify the proper parties.

The covered entity may overcome this presumption by demonstrating that there is “a low probability” of risk that the information has been compromised. Patients must be notified of a breach, therefore, in every situation when PHI is acquired, accessed, used, or disclosed in a manner not permitted under the Privacy Rule, except when a covered entity (or Business Associate, when applicable) demonstrates that there is a low probability that the PHI has been compromised, using an objective risk assessment, based upon at least the following four factors,unless regulatory exclusions apply (see exclusions discussed in the next paragraph):

* The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification,
* The unauthorized person who used the PHI or to whom the disclosure was made,
* Whether the PHI was actually acquired or viewed, and
* The extent to which the risk to the PHI has been mitigated.
* The covered entity should document and retain the risk assessment in which they engage, and should note additional factors they considered when assessing the risk.

**What are the exclusions; what isn’t considered a breach?**

There are three exceptions to the general breach rule:

1. The unintentional use of the information by member of the covered entity’s workforce;

2. Inadvertent disclosure by the covered entity to authorized person; and

3. When the recipient does not retain the protected health information.

It should be noted that the final rule has removed a prior exception that existed for the disclosure of data, so long as the disclosed information did not include any dates of birth or zip codes. Now, a covered entity should always perform a risk assessment after any improper use or disclosure of PHI to determine whether a breach notification should be given.

**What kind of notification is a covered entity required to give and when?**

When a covered entity discovers a breach, it is required to notify the affected individuals, HHS, and – if appropriate – the media. A covered entity needs to keep a record of discovered breaches affecting less than 500 patients, which is submitted to and published by HHS.

The covered entity is ultimately responsible for notifications, regardless of any business associate involvement or fault. Business associates are responsible only for informing the covered entity of any discovered breach. Media outlets are not required to print or broadcast these notifications, and covered entities are not required to pay for notifications to be printed or broadcasted. Covered entities are, however, required to deliver notice directly to the prominent media outlets being notified. Finally, in the event that a notice to a patient is returned to the covered entity as undeliverable, either direct written notice using updated contact information or substitute notice (consistent with regulatory guidelines) must be given within the original 60-day deadline.

**Does a patient have a right to be informed of other disclosures of health care information?**

Yes. A patient has a right to receive an accounting of disclosures of health care information made by a health care provider or a health care facility in the six years before the date on which the accounting is requested, except for disclosures:

* To carry out treatment, payment, and health care operations.
* To the patient, of his or her own health care information.
* Incident to a use or disclosure that is otherwise permitted.
* Pursuant to a valid authorization where the patient authorized the disclosure of health care information about himself or herself.
* Of directory information.
* To persons involved in the patient’s care.
* To authorized federal officials for certain national security or intelligence purposes.
* To correctional institutions or law enforcement officials having lawful custody of the person if necessary for certain purposes.
* Of a limited data set that excludes direct identifiers of the patient or of relatives, employers, or household members of the patient when done so for certain limited purposes.

**How must a physician respond to a patient’s request for an accounting?**

Within 60 days after receipt of a request for an accounting, a physician must provide the accounting requested. If unable to do so within 60 days, the physician may extend the time by no more than 30 days provided that, within the initial 60 days, the physician provides the patient with a written statement of the reasons for the delay and the date by which the accounting will be provided. Only one such request for an extension is allowed under HIPAA.

**What must be included in an accounting?**

The accounting must be in writing and must include:

* The date of disclosure.
* The name of the entity or person who received the protected health information and, if known, the address.
* A brief description of the protected health information disclosed.
* A brief statement of the purpose of the disclosure that reasonably informs the patient of the basis for the disclosure or a copy of the written request.

**May a physician charge for providing an accounting?**

The first request for an accounting in any 12-month period must be provided without charge. Any additional request in the same 12-month period may be subject to a reasonable, cost-based fee provided that the physician informs the patient in advance of the fee and provides the patient the opportunity to withdraw or modify the request in order to avoid or reduce the fee.

**Is a specific authorization required for release of some types of health care information?**

Yes. Laws other than the UHCIA and HIPAA require specific authorizations for the release of:

* Records of mental health services.
* Records of drug or alcohol abuse treatment and rehabilitation.
* Information regarding AIDS and other sexually transmitted diseases. See [AIDS/HIV/STD.](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd)
* A separate authorization is required for the release of psychotherapy notes.
* When the patient is a minor, who must provide authorization for release of the minor’s health care information?

If the patient is a minor and is authorized to consent to health care without parental consent under federal or state law, only the minor may authorize the release of information pertaining to health care to which the minor lawfully consented. In cases where parental consent is required for the minor’s treatment, parental authorization is required for the release of the minor’s health care information. See [Minors, Treatement of](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/treatment-of-minors/minors-treatment-of) for circumstances in which a minor is authorized to consent to health care.

**May a parent obtain access to a child’s health care information?**

In some circumstances, yes. A minor’s parent may obtain access to information pertaining to health care of the minor for which parental consent was required. A parent may not, without the minor’s consent, obtain access to information about health care of the minor which the minor could obtain without parental consent under state or federal law. See [Minors, Treatment of](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/treatment-of-minors/minors-treatment-of).

**When the parents of a child are legally separated or divorced, which parent is entitled to access to the child’s health care information?**

Absent a court order to the contrary, each parent is entitled to have full and equal access to the health care records of the child which pertain to health care for which parental consent was required and neither parent may veto the access requested by the other parent.

**Who may authorize release of health care information concerning a deceased patient?**

The personal representative of the deceased patient or, if there is no personal representative, a person who would have been authorized to make health care decisions for the deceased patient when the patient was alive may authorize the release of health care information about the deceased patient. Recent amendments to the Privacy Rule now limit the period for which covered entities must protect health information to 50 years after the patient’s death. Additionally, now individuals who were involved in a patient’s care or payment for care – but who were not the decedent’s personal representative - may request the decedent’s records after death. These kinds of disclosures are permitted, but not required, and need to be relevant to the requesting individual’s involvement. If a physician questions the relationship between the decedent and the requesting individual, the physician may refuse to disclose the information so long as the physician abides by certain requirements.

**May a physician disclose health care information to another health care provider without the patient’s authorization?**

In certain circumstances, yes. A physician may disclose health care information to another health care provider without the patient’s authorization to the extent the health care provider needs to know the information in the following circumstances:

* If the health care provider is assisting the physician in the delivery of health care and the physician reasonably believes that the health care provider will not use or disclose the health care information for another purpose and will take appropriate steps to protect the information.
* If the physician reasonably believes that the health care provider is providing health care to the patient.
* To the extent necessary to provide health care to the patient if the physician reasonably believes that the health care provider previously provided health care to the patient and if the patient has not instructed the physician in writing not to make such a disclosure.
* If the health care provider is the successor in interest to the physician.

**May a physician disclose health care information to a patient’s family members without the patient’s authorization?**

In certain circumstances, yes. If the patient is present or otherwise available prior to such disclosure, the physician may disclose health information if he or she obtains the patient’s oral agreement, provides the patient with an opportunity to object and the patient does not object, or the physician reasonably infers from the circumstances, based on professional judgment, that the patient does not object. If the patient is not present or otherwise available a physician may disclose health care information without the patient’s authorization to immediate family members of the patient or to any other individual with whom the patient is known to have a close personal relationship if in the exercise of professional judgment the physician determines that disclosure is in the patient’s best interest and the disclosure is limited to that information directly relevant to the person’s involvement with the patient’s health care, unless the patient has instructed the physician in writing not to make such disclosure.

**Are there other circumstances where a physician may disclose a patient’s health care information without the patient’s consent?**

Yes. Both the UHCIA and HIPAA delineate various other circumstances under which disclosure of health care information may be made without patient consent or authorization. The circumstances under which such disclosures may be made are fact-specific, sometimes complicated, and not necessarily the same under both statutes. What may be permissible under the UHCIA is not always permissible under HIPAA and vice versa. With that caveat, the following is a general listing of the other types of disclosures that may be permissible under the UHCIA or HIPAA without patient consent under the right circumstances.

Under the UHCIA, a physician may disclose health care information about a patient without the patient’s consent to the following persons to the extent they need to know the information:

* To any person who requires health care information for health care education.
* To any person who requires the health care information to provide planning, quality assurance, peer review, or administrative, legal, financial or actuarial services to the physician.
* To any person when the physician reasonably believes the disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, but there is no obligation to do so.
* To a person for use in a research project that an institutional review board has determined is of sufficient importance to outweigh the intrusion into the privacy of the patient and cannot be done as a practical matter without the use or disclosure of health care information in individually identifiable form, provided certain safeguards against redisclosure are in place.
* To a person who obtains information for purposes of an audit, if the person agrees in writing to remove or destroy, at the earliest practical opportunity, information that would enable the patient to be identified and not to disclose the information further, except to accomplish the audit or to report unlawful or improper conduct involving fraud in payment for health care by the physician or the patient, or other unlawful conduct by the physician.
* To an official of a penal or other custodial institution in which the patient is detained.
* To federal, state, or local law enforcement authorities if the health care provider believes in good faith that the health care information disclosed constitutes evidence of criminal conduct that occurred on the premises of the health care provider.
* To another health care provider, health care facility or third-party payor that has a relationship with the patient whose health care information is being requested, if the disclosure is for the purpose of conducting quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner, provider, and third-party payor performance, or conducting training programs.
* For payment.

Under the UHCIA, a health care provider or hospital may also report to fire, police, sheriff, or another public authority, that brought a patient to a health care facility or health care provider the patient’s name, residence, sex, age, occupation, condition, diagnosis, or extent and location of injuries, whether a patient was conscious when admitted, and the actual or estimated date of discharge.

Under HIPAA, a physician may disclose health care information about a patient without the patient’s authorization under certain circumstances:

* When required by law.
* For public health activities.
* When a victim of abuse, neglect or domestic violence.
* For health oversight activities.
* For judicial and administrative proceedings.
* For law enforcement proceedings.
* About decedents.
* For cadaveric organ, eye or tissue donation procedures.
* For research purposes.
* To avert a serious threat to health or safety.
* For specialized government functions.
* For worker’s compensation.

Because the determination of whether the UHCIA and HIPAA permit disclosure of a patient’s health care information under any of these circumstances is a fact-specific inquiry that can be quite complicated, physicians are well-advised to consult with legal counsel or someone else well-versed in the UHCIA and the HIPAA regulations before disclosing information in such circumstances without patient authorization.

**Under what circumstances must a physician disclose health care information about a patient without the patient’s consent?**

A physician must disclose health care information about a patient without the patient’s consent if the disclosure is:

* To federal, state, or local public health authorities, when the physician is required by law to make the report, or when the disclosure is needed either to determine compliance with state or federal licensure laws or to protect the public health.
* To federal, state, or local law enforcement authorities when the health care provider is required to make the disclosure by law. See [Reproting Requirements](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/reporting-requirements).
* To federal, state, or local law enforcement authorities, when a patient receives treatment for an injury from a firearm, knife or other sharp object, or a blunt force injury that the authorities reasonably believe resulted from a criminal act. The authorities must first make a request for such disclosure to a nursing supervisor, administrator, or designated privacy official. The information to be disclosed, if known, includes the patient’s name, address, sex, age, condition, diagnosis or extent and location of injuries, whether the patient was conscious upon admission, the name of the health care provider treating the patient, whether the patient has been transferred to another facility, and the patient’s discharge time and date.
* To county coroners and medical examiners for investigation of death.
* Pursuant to compulsory process, such as a properly issued subpoena or a court order. See [Subpoenas](http://legalguide.wsma.org.onexcale.net/privacy-issues/medical-records/subpoenas).

**How must a physician respond to a patient’s request to examine or copy his or her own medical records?**

A physician must respond to a patient’s written request to examine or copy his or her records no later than 15 working days after the written request is received. If the request is made orally, the physician must respond within 30 days of the oral request unless the information is not maintained or accessible on site, in which case the physician must respond within 60 days of the oral request. A physician may require requests for access or copies of records to be made in writing as long as the physician informs patients of the requirement in advance, such as by including notice of this requirement in the physician’s Notice of Privacy Practices.

In responding to a request to examine or copy records, the physician must do one of the following:

* Make the information available for examination during regular business hours and provide a copy, if requested, to the patient.
* Inform the patient that the information does not exist or cannot be found.
* Provide the name and address of the health care provider who maintains the patient’s records if the health care provider receiving the request from the patient does not maintain the records.
* Specify in writing the reasons why handling the request will be delayed and the earliest date on which the information will be available for examination or copying. When responding to a written request, that date may not be later than 21 working days after receiving the written request for examination or copying. When responding to an oral request, where the delay is for any reason other than the fact that the information is not maintained or accessible on site, the physician may extend the time for response by 30 days provided the physician provides the written explanation for the delay within the initial 30-day period for response.
* Deny the request or any part of the request and inform the patient.
* If the patient requests, the physician must provide an explanation of any code or abbreviation used in the health care information.
* A physician is not required to create a new record or reformulate an existing record in order to respond to a patient’s request to examine or copy his or her own records.

**When may a physician deny a patient access to his or her medical records?**

Under the UHCIA, a physician may deny access to health care information to a patient if:

* Knowledge of the health care information would be injurious to the health of the patient.
* Knowledge of the health care information could reasonably be expected to allow a patient to identify an individual who provided the information in confidence under circumstances in which confidentiality was appropriate.
* Knowledge of the health care information could be expected to cause danger to the life or safety of any individual.
* The health care information was compiled and used solely for litigation, quality assurance, peer review, or administrative purposes.
* Access to the health care information is otherwise prohibited by law.

Under HIPAA, a patient does not have a right of access to inspect and obtain a copy of psychotherapy notes. Washington State law also places restrictions on disclosure of mental health records.

**What must a physician do if the physician denies a patient’s request to examine or copy the patient’s medical record?**

If a physician denies a request for examination and copying of any portion of the patient’s health care information, the physician must, to the extent possible, segregate out the health care information for which access was denied and permit the patient to examine or copy the rest.

If examination or copying of health care information is denied because it would be injurious to the health of the patient or because it would cause danger to the life or safety of another individual, the physician must inform the patient that the patient has a right to select another health care provider, who is licensed to treat the patient for the same condition, to review the information. If the patient selects another qualified provider to review the record, the physician must provide the information to that health care provider.

The physician must provide a written statement advising the patient of the basis of the denial, the right to have the denial reviewed, how to have the denial reviewed, and how to make a complaint to the physician or to the Secretary of Health and Human Services, including the name or description of the contact person and phone number.

**May a physician charge for responding to a patient’s request or a subpoena for copies of the patient’s medical record?**

Yes. A physician may charge a reasonable cost-based fee including only the cost of supplies for and labor of copying, not to exceed actual cost, and postage (if the patient has requested the records be mailed, for responding to a patient’s request or a subpoena for copies of the patient’s medical record. Under Washington State law, effective through June 30, 2015, such “reasonable fee” may include a clerical fee not to exceed $24.00 for searching and handling the records, labor, and copying charges not to exceed $1.09 per page for the first 30 pages, and $0.82 per page for additional pages. These maximum charges are subject to adjustment by the Secretary of Health every two years. A physician is not required to permit examination or copying until the fee is paid. Retail sales tax should be collected if a fee is charged for the release of records. Finally, if the party requesting the records requests or agrees to receive in lieu of the records an explanation or summary, and the individual agrees in advance, the physician may charge a reasonable cost-based fee for preparing the explanation or summary.

If editing of the records is required by statute and is done by the physician, the physician may charge a fee equal to the usual and customary charge for a basic office visit.

**May a patient request that a physician correct or amend the patient’s medical record?**

Yes. A patient may request that his or her record be corrected or amended.

**What must a physician do upon receipt of request to correct or amend a patient’s record?**

A physician, within 10 days of receiving a patient’s written request to correct or amend the patient’s record, must take one of the following five actions:

* Make the requested correction or amendment and inform the patient.
* Inform the patient that the record no longer exists or cannot be found.
* Inform the patient of the name and address of the person who maintains the record.
* Inform the patient of the reasons for delay in handling the patient’s request and inform the patient, in writing, of the earliest date on which action will be taken on the patient’s request. The action must be taken not later than 21 days after receiving the written request.
* Inform the patient in writing of the physician’s refusal to correct or amend the record and the patient’s right to add a statement of disagreement.

If the request to correct or amend is made orally, then the physician has 60 days to take one of the following three actions:

* Make the requested correction or amendment and so inform the patient.
* Inform the patient in writing, in plain language, of the physician’s refusal to correct or amend the record and the patient’s right to add a statement of disagreement.
* Provide the patient with a written statement explaining the reasons why the physician is unable to act within the 60 days, and the date by which the physician will respond to the request. Such new date cannot extend the time for response by more than 30 days, and the physician may have no more than one such 30-day extension.

A physician may require patients to make requests to correct or amend in writing as long as the physician informs the patient of the requirement in advance, such as by including notice of this requirement in the physician’s Notice of Privacy Practices.

**If a physician agrees to make the patient’s proposed correction or amendment, what must the physician do?**

In making a correction or amendment requested by a patient, a physician must:

* Add the amending information as part of the medical record.
* Mark the challenged entry or entries as corrected or amended and indicate where in the record the corrected or amended information may be found.
* Obtain the patient’s identification of, and agreement for notification to be made to, persons with whom the amendment needs to be shared.

**If a physician refuses to make the patient’s proposed correction or amendment, what must the physician do?**

If the physician refuses to make the patient’s proposed correction or amendment, the physician must:

* Advise the patient of the right to submit a written statement disagreeing with the denial and how to file such a statement.
* Advise the patient that, if the patient does not submit a statement of disagreement, the patient may request the physician provide the patient’s request for amendment or correction and the denial with any future disclosures of information that is the subject of the request for correction or amendment.
* Provide the patient with a description of how the patient may complain to the physician or to the Secretary of the Department of Health and Human Services, including the name or title and telephone of the contact person.
* Permit the patient to file as part of the medical record a concise statement of the requested correction or amendment and the reasons for it. The physician may prepare a rebuttal statement, but must provide a copy to the patient.
* Mark the challenged entry to indicate that the patient claims the entry is inaccurate or incomplete and indicate where in the record the patient’s statement of disagreement may be found.

**Must a physician notify anyone of a correction or amendment to, or a refusal to correct or amend a patient’s medical record?**

Yes. A physician must forward any change made in a health care information or medical record to a third party payor or insurer to which the physician had previously disclosed the health care information that is the subject of the patient’s request to correct or amend. The physician must also obtain the patient’s identification of, and agreement to have the physician notify, relevant persons with whom the amendment needs to be shared.

**What is required before a physician may respond to an attorney’s discovery request or subpoena for health care information about a patient?**

Under the UHCIA, an attorney must provide 14 days advance notice to the physician and to the patient or the patient’s attorney, through service of process or first class mail, before the attorney may serve a discovery request or subpoena on a health care provider for health care information about a patient. The advance notice must contain the following information:

* The name of the physician from whom the information is sought.
* What health care information is sought.
* The date by which a protective order must be obtained to prevent the physician from complying with the discovery request or subpoena.

The advance notice provision is designed to give the patient and the physician adequate time to seek a protective order in the event they wish to limit or prevent the disclosure of health care information.

Absent written consent of the patient, a physician who receives a discovery request or subpoena from an attorney for health care information may not disclose the health care information if the attorney has not complied with the advance notice requirement.

If the attorney has complied with the advance notice requirement and no protective order has been issued by a court, the physician must disclose the requested information.

If the physician complies with the discovery request or subpoena, the discovery request or subpoena must be made a part of the patient’s record.

The notice of intent procedure under the UHCIA should satisfy the corresponding requirements under HIPAA.

**Must a physician, when releasing a record, provide a certification of record upon request?**

Yes. Under the UHCIA, upon the request of the person requesting the record, a physician must certify the record and may charge a fee of $2.00 for such certification. The physician need not certify the record until the fee is paid. The certification must be attached to the record and must contain:

* The identity of the patient.
* The kind of health care information involved.
* The identity of the person to whom the information is being furnished.
* The identity of the physician or facility furnishing the information.
* The number of pages of the health care information.
* The date on which the health care information is furnished.
* That the certification is to fulfill and meet the certification requirements of the UHCIA.

**May a physician discuss a patient with an attorney, other than the physician’s own attorney, without the patient’s consent?**

Generally, no. A physician may not discuss a patient’s health care information with an attorney, other than the physician’s own attorney, without a signed patient authorization, a subpoena issued in compliance with the requirements of the UHCIA, or a court order. This general rule, however, does not apply in workers’ compensation cases. See [Worker's Compensation](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/workers-compensation/workers-compensation).

**May a physician discuss a patient with the physician’s own attorney without the patient’s consent?**

Generally, yes. But before doing so the physician should obtain a signed HIPAA-compliant business associate agreement with the attorney.

**What is a business associate agreement?**

A business associate agreement is a document that sets forth the obligations a business associate must meet in order to adequately protect health information the business associate may receive from the physician. Physicians are required to have business associate agreements in place with all of their business associates with whom they share patients’ protected health information. Business associates are persons or entities, other than employees, who on behalf of the physician perform or assist in performing a function or activity that involves the use or disclosure of protected health information maintained by the physician. Examples of business associates include a physician’s billing agent, attorney, accountant, and collection agency, but do not include the physician’s employees.

A HIPAA-compliant sample business associate agreement may be found at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html>.

**When does a physician need to obtain a business associate agreement?**

A physician needs to obtain a signed business associate agreement from every business associate with which the physician may share protected health information in order for the business associate to perform or assist in performing a function on behalf of the physician. The new changes have expanded the kinds of entities that are considered business associates, and make business associates liable for certain HIPAA violations. Where provided, the standards, requirements, and implementation specifications of the HIPAA Privacy, Security, and Breach Notification Rules also apply to business associates, not just the covered entity.Any person or entity (other than a member of the covered entity’s workforce) who creates, receives, maintains, or transmits PHI on behalf of the covered entity is considered a business associate. The new changes have added the word “maintains” to the definition, so that entities that never or infrequently view the PHI they maintain are still responsible for its security. This will include subcontractors who create, receive, maintain or transmit PHI on behalf of a business associate. Covered entities are not required to enter into Business Associate Agreements with subcontractors, but the business associate is required to do so.

**Under the UHCIA, what type of notice regarding medical record disclosure must be made to patients?**

Under the UHCIA, physicians must provide notice to patients stating substantially the following:

*“We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.”*

This notice must be given by posting it in a conspicuous place, including it on a consent form, providing it with billing or otherwise directly sending it to patients.

**Under HIPAA, what type of notice regarding disclosure of health care information must be given to patients?**

Under HIPAA, a physician must provide each patient, no later than the first date of service or, in the case of emergency, as soon as practicable, with a copy of the physician’s Notice of Privacy Practices, and should obtain an acknowledgment of receipt. The Notice of Privacy Practices must also be posted in a clear and prominent location, and a copy must be made available on request. Whenever the Notice of Privacy Practices is revised, a copy of the new notice must be made available in the physician’s office.

The Notice of Privacy Practices must be written in plain language and is to provide notice to patients of the uses and disclosures of protected health information that may be made by the physician and of the patient’s rights and the physician’s legal duties with respect to protected health information. As of September 23, 2013, providers are required to expand what is included in the Notice of Privacy Practices provided to their patients. Notices must now clearly explain patients’ rights to restrict disclosures, the type of disclosures that would require a patient’s authorization (see answer to the question “When must a provider get the patient to authorize the use and disclosure of PHI?” below), and their rights as individual patients to opt out of certain communications (see answer to the question “Can a provider use patient information for fundraising purposes?” immediately below). The notice must contain a statement briefly explaining the individual’s rights, and the patient’s ability to request restrictions on certain uses and disclosures of PHI.

Additionally, the covered entity must now inform patients about their rights to notice if there is an information breach, as well as their rights regarding the use of their genetic information for health plan underwriting purposes. In addition to these new requirements, HIPAA sets forth a very long list of items that must be included in the Notice of Privacy Practices that are too detailed to be included in this Guide. September 23, 2013 is the deadline by which covered entities must be in compliance with these new requirements, or else risk facing patient complaints, governmental investigations, and civil and criminal penalties. For assistance in preparing a plain language Notice of Privacy Practices, please go to <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html>.

**Can a provider use patient information for fundraising purposes?**

There are six categories of health information that may be used and disclosed for the purpose of fundraising, even without a patient’s prior consent. This includes:

* Patient demographic information
* Health insurance status
* Dates of patient health care services
* General department of service information
* Treating physician information
* Outcome information

Despite this, patients must still be given the ability to “opt out” of fundraising. Providers must either tell or provide in writing an explanation of the patient’s right to opt out that:

* Is clear, written in plain language, and a conspicuous part of the materials provided to the patient; and
* Describes a simple way for the patient to opt out from receiving any other fundraising materials from the provider.

**When must a provider get the patient to authorize the use and disclosure of PHI?**

Generally, except as otherwise permitted or required by this statute, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives an authorization for the use or disclosure of PHI, the covered entity can only use or disclose the PHI in a manner consistent with the authorization. Additionally, the following require specific authorizations:

* The use or disclosure of psychotherapy notes
* The use or disclosure of PHI for marketing, except in specific situations permitted by the statute
* The sale of PHI

**What may happen if a physician fails to comply with requirements of the UHCIA?**

If a physician fails to comply with UHCIA requirements, a patient may bring a lawsuit against a physician who fails to comply with the requirements of the UHCIA. In such a lawsuit, the patient may obtain a court order compelling the physician to comply with the law and may recover any actual damages sustained as a result of the physician’s failure to comply with the law. If the patient prevails, the patient may also recover reasonable attorneys’ fees and expenses incurred in bringing the action.

**What may happen if a physician fails to comply with HIPAA requirements?**

If a physician fails to comply with HIPAA requirements, a patient may file a complaint with the Office for Civil Rights (OCR), who may in turn investigate the physician. The physician must cooperate with the investigation and give the OCR access to the physician’s facilities, books, and records. If the OCR finds that the physician has violated HIPAA, it may impose civil monetary penalties of up to $100 per person for each violation, and up to $25,000 for violations of a single standard within the calendar year.

A new, four-level tiered civil money penalty structure has been created by the HITECH Act. Penalties are now assessed depending on the covered entity’s culpability; the minimum penalty amount for each violation has been is set at $100 for each HIPAA violation, and the maximum penalty has been increased to $1.5 million dollars annually. Additionally, covered entities may no longer avoid monetary penalties by using the affirmative defense that they did not know (and would not have known if they had been reasonably diligent) of the violation. Previously, the Secretary could not impose a monetary penalty if the covered entity could demonstrate that it did not know and could not have known of the violation, but this is no longer true.

State Attorney Generals may now bring civil actions on behalf of the residents of the state, if it can be shown that the residents were harmed by a covered entity’s non-compliance.

Criminal penalties for wrongful disclosure of protected health information can also be imposed which, upon conviction, could result in fines of up to $50,000 and imprisonment for up to one year, or both. For criminal offenses involving conduct, the possible penalties include fines of up to $250,000 and imprisonment for up to 10 years.

**Does the UHCIA supersede all other special rules governing disclosure of health care information?**

No. In particular, the UHCIA does not alter the terms and conditions of disclosure of health care information contained in statutes and regulations governing workers’ compensation, control and treatment of sexually transmitted diseases, mental health treatment, drug and alcohol abuse treatment, juvenile justice, or marital dissolutions.

Under the UHCIA, how long must a physician maintain a record of existing health care information following receipt of a valid patient authorization?

Under the UHCIA, a record of existing health care information must be maintained for at least one year following receipt of a valid patient authorization, and during the pendency of a request for examination and copying or a request for correction or amendment. See also [Retention of Records](http://legalguide.wsma.org.onexcale.net/privacy-issues/medical-records/retention-of-records).

**Under HIPAA, how long must a physician maintain sufficient information to respond to a patient’s request for an accounting?**

HIPAA requires a physician to maintain sufficient information to respond to a patient’s request for an accounting of disclosures made during the six years preceding the request.

**What safeguards must physicians take to protect health care information?**

Physicians must take reasonable safeguards to ensure the confidentiality, integrity and availability of health care information they maintain. HIPAA’s Security Rule also imposes a wide range of obligations for maintaining the security of health care information which are beyond the scope of this Guide.

**Are there specific safeguards related to telephone or facsimile numbers that must be taken for the security of health care information?**

Yes, action must be taken to delete outdated and incorrect facsimile or other telephone numbers from computers, facsimile machines, or other databases. When transmitting health care information by facsimile to a recipient that is not regularly sent such information, the physician must verify that the number is accurate before transmitting the information.

**Where can more detailed information about the federal privacy and security regulations under HIPAA are obtained?**

More information about the HIPAA Privacy and Security Rules and related regulations may be obtained from the following web site: <http://www.hhs.gov/ocr/hipaa>.

## Medical Records

### Confidential and Privileged Information

**What is the physician-patient privilege?**

The physician-patient privilege protects the patient in a civil action from the physician’s disclosure—without the patient’s consent—of any information that the physician acquires in the course of attending the patient that was necessary to enable the physician to prescribe or act for the patient. Privileged information is not limited to communications between the physician and the patient, but also covers all information acquired by the physician in the course of attending the patient, including tests conducted, xrays, prescriptions, and statements in hospital charts or other records.

**Are there exceptions to the physician-patient privilege?**

Yes. The physician-patient privilege has several specific exceptions, including the following:

* There is no privilege in any judicial proceeding regarding a child’s injury, neglect, sexual abuse, or their respective causes.
* When a patient files an action for wrongful death or personal injury, the patient is deemed to have waived the privilege 90 days after filing. But see [Disclosure Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/hippa/disclosure-and-protection-of-health-care-info) concerning when a physician may disclose a patient’s health care information in litigation.
* The privilege does not apply when a patient has an active workers’ compensation claim and a treating physician is asked to testify concerning, or to provide information relevant to, the worker’s occupational injury or illness. See [Workers’ Compensation](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/workers-compensation/workers-compensation).
* Information communicated to a physician in an effort to unlawfully procure a controlled substance or to procure the administration of a controlled substance is deemed not to be a privileged communication.
* The privilege may be waived, in the court’s discretion, in involuntary civil commitment proceedings for chemical dependency or mental illness, and the privilege is waived in proceedings relating to the administration of anti-psychotic medications. The waiver, however, is limited to records or testimony relevant to evaluation of the detained person for purposes of the proceeding.
* Neither the victim nor the alleged perpetrator of a crime can assert the privilege to prevent the State from offering evidence of the victim’s injuries or other evidence of the crime.
* The privilege does not prevent a court-appointed investigator from obtaining a child’s medical information in a custody dispute, but the child’s permission is generally required if the child is age 12 or older.

**Who is bound by the physician-patient privilege?**

The physician and any agents or employees of the physician who have access to the patient’s health care information are bound by the privilege.

**When does the physicianpatient privilege arise?**

In general, the physicianpatient privilege arises when a person consults a physician for treatment or medical advice. Whether a physician-patient relationship is created depends on whether the patient believes that the patient’s contact with the physician was for the purposes of treatment. Therefore, each situation is highly dependent on the facts. See [Physician-Patient Relationship](http://legalguide.wsma.org.onexcale.net/privacy-issues/physician-patient-relationship/physician-patient-relationship).

**Who may waive the physicianpatient privilege?**

The privilege belongs to the patient and, except where the privilege is waived by law, only the patient or the patient’s legal representative may waive the privilege.

**Does the physicianpatient privilege terminate upon the patient’s death?**

No. Except where the privilege is waived by law, only the personal representative or an heir of the patient’s estate may waive the privilege after the patient’s death.

**When may medical records or privileged health care information be disclosed?**

See [Disclosure Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/hippa/disclosure-and-protection-of-health-care-info).

**May medical records and privileged health care information be released in response to a subpoena?**

Under certain circumstances, yes. See [Disclosure Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/hippa/disclosure-and-protection-of-health-care-info); and [Subpoenas](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/subpoenas/subpoenas) .

### Disclosure and Protection of Health Care Information

**What is the Health Insurance Portability and Accountability Act?**

The Health Insurance Portability and Accountability Act (HIPAA) is a detailed federal statute, with related regulations, governing access to, disclosure of, and security of a patient’s health care information. HIPAA contains both a Privacy Rule and a Security Rule with which physicians must comply.

Although the full scope and content of the HIPAA Privacy Rule and Security Rule are beyond the scope of this Guide, physicians and physician groups are well-advised to apprise themselves of the scope and content of the Rules and related regulations and to incorporate their requirements into their practices. The HIPAA Rules and related regulations, among other things:

* Apply to all health information whether electronic, paper or oral.
* Require physicians to designate a privacy officer to assist staff and patients with questions or complaints as well as to ensure compliance with the HIPAA regulations.
* Require physicians to designate a security official who is responsible for the development and implementation of the policies and procedures required to comply with the Security Rule.
* Require physicians to ensure the confidentiality, integrity, and availability of all electronic protected health information that the physician creates, receives, maintains, or transmits.

**What constitutes health information, and protected health information, under HIPAA?**

“Health information” is defined to include: any information, whether oral or recorded in any form or medium, that is created or received by a health care provider and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of healthcare to an individual.

“Protected health information” is health information, as defined above, that identifies the individual or as to which there is a reasonable basis to believe it could be used to identify the individual, that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium (with limited exceptions).

**What is the Uniform Health Care Information Act?**

The Uniform Health Care Information Act (UHCIA) is a detailed Washington statute governing access to and disclosure of a patient’s health care information. In 2005, the UHCIA was amended to make the requirements under Washington law more closely aligned with the requirements of HIPAA.

**What constitutes health care information under the UHCIA?**

Under the UHCIA, “health care information” is defined to include any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient, including a patient’s DNA and sequence of chemical base pairs, and directly relates to the patient’s health care. The term includes any required accounting of disclosures of health care information.

**What kinds of requirements do HIPAA and the UHCIA set forth?**

HIPAA and the UHCIA set forth specific rules for such things as:

* When a health care provider may disclose a patient’s health care information without the patient’s consent.
* What an authorization must contain in order to be valid and permit disclosure of a patient’s health care information.
* What a health care provider must do when a patient asks to examine or copy his or her medical record.
* What a health care provider must do when a patient asks to have his or her medical record amended or corrected.
* When a health care provider may disclose health care information about a patient to an attorney.
* What notice a health care provider must give to patients regarding disclosure of health care information.
* What a health care provider may charge for duplicating or searching a patient’s medical record.

**Which takes precedence – HIPAA or the UHCIA?**

Where HIPAA and the UHCIA provide different privileges, rights or obligations, the law that affords patients the greater access to their own health care information, the greater rights and remedies, or the greater protection of the privacy and security of their health care information governs.

**When is it appropriate for a physician to disclose a patient’s health care information?**

As a general rule under the UHCIA and HIPAA, a physician, an individual assisting a physician in the delivery of health care, or an agent and employee of a physician, may not disclose health care information about a patient to any other person without the patient’s written authorization. Disclosures made pursuant to a patient’s written authorization must conform to the terms of the authorization.

**What is required for a valid patient authorization under the UHCIA?**

To be valid, a patient authorization must generally:

* Be in writing.
* Be signed and dated by the patient.
* Identify the nature of information to be disclosed.
* Identify the name, and institutional affiliation of the person, or class of persons, to whom the information is to be disclosed.
* Identify the provider, or class of providers, who is to make the disclosure.
* Identify the patient.
* Contain an expiration date or an expiration event related to the patient or the purpose of the disclosure.

NOTE: The HIPAA Privacy Rules also require a description of each purpose of the requested use or disclosure. The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose. In addition, the Privacy Rules require that the authorization be written in plain language, and that a copy of the authorization be given to the patient if the physician seeks an authorization for use or disclosure.

**What other statements do the HIPAA Privacy Rules require a valid authorization to include?**

The HIPAA Privacy Rules require that an authorization must contain statements to place the patient (or representative) on notice of:

* The individual’s right to revoke the authorization in writing, and either (i) the exceptions to the right to revoke and a description of how the individual may revoke the authorization; or (ii) a reference to the privacy notice (see below) posted in the physician’s office if the notice includes the rights related to revocation of an authorization.
* The ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the authorization; and
* The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient, which would no longer be protected under the HIPAA Privacy Rules.

**Must the physician retain a copy of an authorization for release of health care information?**

Yes. A health care provider or health care facility must retain the original or a copy of each authorization (or revocation) pertaining to release of health care information.

**How long is a patient authorization to release information valid?**

A patient authorization to release information is valid until the expiration date or the expiration event noted in the authorization. However, when the authorization permits disclosure to a financial institution or an employer of the patient for purposes other than payment, the authorization as it pertains to those disclosures shall expire 90 days after the authorization is signed, unless renewed by the patient.

**When may a patient revoke an authorization to disclose health care information?**

A patient may revoke in writing an authorization to release health care information at any time, unless the physician has already taken action in reliance on the authorization or disclosure of information is required for matters related to payments for care that has already been provided to the patient. An authorization is no longer valid if it is revoked in writing by the patient before the physician has taken substantial action in reliance on the authorization.

**May a physician be held liable for disclosing information pursuant to a revoked authorization?**

Yes, if the health care provider had actual notice that the authorization had been revoked. A patient may not maintain an action against a health care provider, however, for disclosures made in good faith reliance on an authorization if the health care provider had no actual notice that the authorization had been revoked.

**Does a patient have a right to be informed of disclosures of health care information?**

Yes. A patient has a right to receive an accounting of disclosures of health care information made by a health care provider or a health care facility in the six years before the date on which the accounting is requested, except for disclosures:

* To carry out treatment, payment, and health care operations.
* To the patient, of his or her own health care information.
* Incident to a use or disclosure that is otherwise permitted.
* Pursuant to a valid authorization where the patient authorized the disclosure of health care information about himself or herself.
* Of directory information.
* To persons involved in the patient’s care.
* To authorized federal officials for certain national security or intelligence purposes.
* To correctional institutions or law enforcement officials having lawful custody of the person if necessary for certain purposes.
* Of a limited data set that excludes direct identifiers of the patient or of relatives, employers, or household members of the patient when done so for certain limited purposes.

**How must a physician respond to a patient’s request for an accounting?**

Within 60 days after receipt of a request for an accounting, a physician must provide the accounting requested. If unable to do so within 60 days, the physician may extend the time by no more than 30 days provided that, within the initial 60 days, the physician provides the patient with a written statement of the reasons for the delay and the date by which the accounting will be provided. Only one such request for an extension is allowed under HIPAA.

**What must be included in an accounting?**

The accounting must be in writing and must include:

* The date of disclosure.
* The name of the entity or person who received the protected health information and, if known, the address.
* A brief description of the protected health information disclosed.
* A brief statement of the purpose of the disclosure that reasonably informs the patient of the basis for the disclosure or a copy of the written request.

**May a physician charge for providing an accounting?**

The first request for an accounting in any 12-month period must be provided without charge. Any additional request in the same 12-month period may be subject to a reasonable, cost-based fee provided that the physician informs the patient in advance of the fee and provides the patient the opportunity to withdraw or modify the request in order to avoid or reduce the fee.

**Is a specific authorization required for release of some types of health care information?**

Yes. Laws other than the UHCIA and HIPAA require specific authorizations for the release of:

* Records of mental health services.
* Records of drug or alcohol abuse treatment and rehabilitation.
* Information regarding AIDS and other sexually transmitted diseases. See AIDS/HIV/STD.

Also, a separate authorization is required for the release of psychotherapy notes.

**When the patient is a minor, who must provide authorization for release of the minor’s health care information?**

If the patient is a minor and is authorized to consent to health care without parental consent under federal or state law, only the minor may authorize the release of information pertaining to health care to which the minor lawfully consented. In cases where parental consent is required for the minor’s treatment, parental authorization is required for the release of the minor’s health care information. See MINORS, TREATMENT OF for circumstances in which a minor is authorized to consent to health care.

**May a parent obtain access to a child’s health care information?**

In some circumstances, yes. A minor’s parent may obtain access to information pertaining to health care of the minor for which parental consent was required. A parent may not, without the minor’s consent, obtain access to information about health care of the minor which the minor could obtain without parental consent under state or federal law. See MINORS, TREATMENT OF.

**When the parents of a child are legally separated or divorced, which parent is entitled to access to the child’s health care information?**

Absent a court order to the contrary, each parent is entitled to have full and equal access to the health care records of the child which pertain to health care for which parental consent was required and neither parent may veto the access requested by the other parent.

**Who may authorize release of health care information concerning a deceased patient?**

The personal representative of the deceased patient or, if there is no personal representative, a person who would have been authorized to make health care decisions for the deceased patient when the patient was alive may authorize the release of health care information about the deceased patient.

**May a physician disclose health care information to another health care provider without the patient’s authorization?**

In certain circumstances, yes. A physician may disclose health care information to another health care provider without the patient’s authorization to the extent the health care provider needs to know the information in the following circumstances:

* If the health care provider is assisting the physician in the delivery of health care and the physician reasonably believes that the health care provider will not use or disclose the health care information for another purpose and will take appropriate steps to protect the information.
* If the physician reasonably believes that the health care provider is providing health care to the patient.
* To the extent necessary to provide health care to the patient if the physician reasonably believes that the health care provider previously provided health care to the patient and if the patient has not instructed the physician in writing not to make such a disclosure.
* If the health care provider is the successor in interest to the physician.

**May a physician disclose health care information to a patient’s family members without the patient’s authorization?**

In certain circumstances, yes. If the patient is present or otherwise available prior to such disclosure, the physician may disclose health information if he or she obtains the patient’s oral agreement, provides the patient with an opportunity to object and the patient does not object, or the physician reasonably infers from the circumstances, based on professional judgment, that the patient does not object. If the patient is not present or otherwise available a physician may disclose health care information without the patient’s authorization to immediate family members of the patient or to any other individual with whom the patient is known to have a close personal relationship if in the exercise of professional judgment the physician determines that disclosure is in the patient’s best interest and the disclosure is limited to that information directly relevant to the person’s involvement with the patient’s health care, unless the patient has instructed the physician in writing not to make such disclosure.

**Are there other circumstances where a physician may disclose a patient’s health care information without the patient’s consent?**

Yes. Both the UHCIA and HIPAA delineate various other circumstances under which disclosure of health care information may be made without patient consent or authorization. The circumstances under which such disclosures may be made are fact-specific, sometimes complicated, and not necessarily the same under both statutes. What may be permissible under the UHCIA is not always permissible under HIPAA and vice versa. With that caveat, the following is a general listing of the other types of disclosures that may be permissible under the UHCIA or HIPAA without patient consent under the right circumstances.

Under the UHCIA, a physician may disclose health care information about a patient without the patient’s consent to the following persons to the extent they need to know the information:

* To any person who requires health care information for health care education.
* To any person who requires the health care information to provide planning, quality assurance, peer review, or administrative, legal, financial or actuarial services to the physician.
* To any person when the physician reasonably believes the disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, but there is no obligation to do so.
* To a person for use in a research project that an institutional review board has determined is of sufficient importance to outweigh the intrusion into the privacy of the patient and cannot be done as a practical matter without the use or disclosure of health care information in individually identifiable form, provided certain safeguards against redisclosure are in place.
* To a person who obtains information for purposes of an audit, if the person agrees in writing to remove or destroy, at the earliest practical opportunity, information that would enable the patient to be identified and not to disclose the information further, except to accomplish the audit or to report unlawful or improper conduct involving fraud in payment for health care by the physician or the patient, or other unlawful conduct by the physician.
* To an official of a penal or other custodial institution in which the patient is detained.
* To federal, state, or local law enforcement authorities if the health care provider believes in good faith that the health care information disclosed constitutes evidence of criminal conduct that occurred on the premises of the health care provider.
* To another health care provider, health care facility or third-party payor that has a relationship with the patient whose health care information is being requested, if the disclosure is for the purpose of conducting quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner, provider, and third-party payor performance, or conducting training programs.
* For payment.

Under the UHCIA, a health care provider or hospital may also report to fire, police, sheriff, or another public authority, that brought a patient to a health care facility or health care provider the patient’s name, residence, sex, age, occupation, condition, diagnosis, or extent and location of injuries, whether a patient was conscious when admitted, and the actual or estimated date of discharge.

Under HIPAA, a physician may disclose health care information about a patient without the patient’s authorization under certain circumstances:

* When required by law.
* For public health activities.
* When a victim of abuse, neglect or domestic violence.
* For health oversight activities.
* For judicial and administrative proceedings.
* For law enforcement proceedings.
* About decedents.
* For cadaveric organ, eye or tissue donation procedures.
* For research purposes.
* To avert a serious threat to health or safety.
* For specialized government functions.
* For worker’s compensation.

Because the determination of whether the UHCIA and HIPAA permit disclosure of a patient’s health care information under any of these circumstances is a fact-specific inquiry that can be quite complicated, physicians are well-advised to consult with legal counsel or someone else well-versed in the UHCIA and the HIPAA regulations before disclosing information in such circumstances without patient authorization.

**Under what circumstances must a physician disclose health care information about a patient without the patient’s consent?**

A physician must disclose health care information about a patient without the patient’s consent if the disclosure is:

* To federal, state, or local public health authorities, when the physician is required by law to make the report, or when the disclosure is needed either to determine compliance with state or federal licensure laws or to protect the public health.
* To federal, state, or local law enforcement authorities when the health care provider is required to make the disclosure by law. SeeREPORTING REQUIREMENTS.
* To federal, state, or local law enforcement authorities, when a patient receives treatment for an injury from a firearm, knife or other sharp object, or a blunt force injury that the authorities reasonably believe resulted from a criminal act.The authorities must first make a request for such disclosure to a nursing supervisor, administrator, or designated privacy official.The information to be disclosed, if known, includes the patient’s name, address, sex, age, condition, diagnosis or extent and location of injuries, whether the patient was conscious upon admission, the name of the health care provider treating the patient, whether the patient has been transferred to another facility, and the patient’s discharge time and date.
* To county coroners and medical examiners for investigation of death.
* Pursuant to compulsory process, such as a properly issued subpoena or a court order. SeeSUBPOENAS.

**How must a physician respond to a patient’s request to examine or copy his or her own medical records?**

A physician must respond to a patient’s written request to examine or copy his or her records no later than 15 working days after the written request is received. If the request is made orally, the physician must respond within 30 days of the oral request unless the information is not maintained or accessible on site, in which case the physician must respond within 60 days of the oral request. A physician may require requests for access or copies of records to be made in writing as long as the physician informs patients of the requirement in advance, such as by including notice of this requirement in the physician’s Notice of Privacy Practices.

In responding to a request to examine or copy records, the physician must do one of the following:

* Make the information available for examination during regular business hours and provide a copy, if requested, to the patient.
* Inform the patient that the information does not exist or cannot be found.
* Provide the name and address of the health care provider who maintains the patient’s records if the health care provider receiving the request from the patient does not maintain the records.
* Specify in writing the reasons why handling the request will be delayed and the earliest date on which the information will be available for examination or copying. When responding to a written request, that date may not be later than 21 working days after receiving the written request for examination or copying. When responding to an oral request, where the delay is for any reason other than the fact that the information is not maintained or accessible on site, the physician may extend the time for response by 30 days provided the physician provides the written explanation for the delay within the initial 30-day period for response.
* Deny the request or any part of the request and inform the patient.

If the patient requests, the physician must provide an explanation of any code or abbreviation used in the health care information.

A physician is not required to create a new record or reformulate an existing record in order to respond to a patient’s request to examine or copy his or her own records.

**When may a physician deny a patient access to his or her medical records?**

Under the UHCIA, a physician may deny access to health care information to a patient if:

Knowledge of the health care information would be injurious to the health of the patient.

* Knowledge of the health care information could reasonably be expected to allow a patient to identify an individual who provided the information in confidence under circumstances in which confidentiality was appropriate.
* Knowledge of the health care information could be expected to cause danger to the life or safety of any individual.
* The health care information was compiled and used solely for litigation, quality assurance, peer review, or administrative purposes.
* Access to the health care information is otherwise prohibited by law.

**Under HIPAA, a patient does not have a right of access to inspect and obtain a copy of psychotherapy notes. Washington State law also places restrictions on disclosure of mental health records.**

**What must a physician do if the physician denies a patient’s request to examine or copy the patient’s medical record?**

If a physician denies a request for examination and copying of any portion of the patient’s health care information, the physician must, to the extent possible, segregate out the health care information for which access was denied and permit the patient to examine or copy the rest.

If examination or copying of health care information is denied because it would be injurious to the health of the patient or because it would cause danger to the life or safety of another individual, the physician must inform the patient that the patient has a right to select another health care provider, who is licensed to treat the patient for the same condition, to review the information. If the patient selects another qualified provider to review the record, the physician must provide the information to that health care provider.

The physician must provide a written statement advising the patient of the basis of the denial, the right to have the denial reviewed, how to have the denial reviewed, and how to make a complaint to the physician or to the Secretary of Health and Human Services, including the name or description of the contact person and phone number.

**May a physician charge for responding to a patient’s request or a subpoena for copies of the patient’s medical record?**

Yes. A physician may charge a reasonable cost-based fee including only the cost of supplies for and labor of copying, not to exceed actual cost, and postage (if the patient has requested the records be mailed, for responding to a patient’s request or a subpoena for copies of the patient’s medical record. Under Washington State law, effective through June30, 2013, such “reasonable fee” may include a clerical fee not to exceed $23.00 for searching and handling the records, labor, and copying charges not to exceed $1.04 per page for the first 30 pages, and $0.79 per page for additional pages. These maximum charges are subject to adjustment by the Secretary of Health every two years. A physician is not required to permit examination or copying until the fee is paid. Retail sales tax should be collected if a fee is charged for the release of records. Finally, if the party requesting the records requests or agrees to receive in lieu of the records an explanation or summary, and the individual agrees in advance, the physician may charge a reasonable cost-based fee for preparing the explanation or summary.

If editing of the records is required by statute and is done by the physician, the physician may charge a fee equal to the usual and customary charge for a basic office visit.

**May a patient request that a physician correct or amend the patient’s medical record?**

Yes. A patient may request that his or her record be corrected or amended.

**What must a physician do upon receipt of request to correct or amend a patient’s record?**

A physician, within 10 days of receiving a patient’s written request to correct or amend the patient’s record, must take one of the following five actions:

* Make the requested correction or amendment and inform the patient.
* Inform the patient that the record no longer exists or cannot be found.
* Inform the patient of the name and address of the person who maintains the record.
* Inform the patient of the reasons for delay in handling the patient’s request and inform the patient, in writing, of the earliest date on which action will be taken on the patient’s request. The action must be taken not later than 21 days after receiving the written request.
* Inform the patient in writing of the physician’s refusal to correct or amend the record and the patient’s right to add a statement of disagreement.
* If the request to correct or amend is made orally, then the physician has 60 days to take one of the following three actions:
* Make the requested correction or amendment and so inform the patient.
* Inform the patient in writing, in plain language, of the physician’s refusal to correct or amend the record and the patient’s right to add a statement of disagreement.
* Provide the patient with a written statement explaining the reasons why the physician is unable to act within the 60 days, and the date by which the physician will respond to the request. Such new date cannot extend the time for response by more than 30 days, and the physician may have no more than one such 30-day extension.

A physician may require patients to make requests to correct or amend in writing as long as the physician informs the patient of the requirement in advance, such as by including notice of this requirement in the physician’s Notice of Privacy Practices.

**If a physician agrees to make the patient’s proposed correction or amendment, what must the physician do?**

In making a correction or amendment requested by a patient, a physician must:

* Add the amending information as part of the medical record.
* Mark the challenged entry or entries as corrected or amended and indicate where in the record the corrected or amended information may be found.
* Obtain the patient’s identification of, and agreement for notification to be made to, persons with whom the amendment needs to be shared.

**If a physician refuses to make the patient’s proposed correction or amendment, what must the physician do?**

If the physician refuses to make the patient’s proposed correction or amendment, the physician must:

* Advise the patient of the right to submit a written statement disagreeing with the denial and how to file such a statement.
* Advise the patient that, if the patient does not submit a statement of disagreement, the patient may request the physician provide the patient’s request for amendment or correction and the denial with any future disclosures of information that is the subject of the request for correction or amendment.
* Provide the patient with a description of how the patient may complain to the physician or to the Secretary of the Department of Health and Human Services, including the name or title and telephone of the contact person.
* Permit the patient to file as part of the medical record a concise statement of the requested correction or amendment and the reasons for it. The physician may prepare a rebuttal statement, but must provide a copy to the patient.
* Mark the challenged entry to indicate that the patient claims the entry is inaccurate or incomplete and indicate where in the record the patient’s statement of disagreement may be found.

**Must a physician notify anyone of a correction or amendment to, or a refusal to correct or amend a patient’s medical record?**

Yes. A physician must forward any change made in a health care information or medical record to a third party payor or insurer to which the physician had previously disclosed the health care information that is the subject of the patient’s request to correct or amend. The physician must also obtain the patient’s identification of, and agreement to have the physician notify, relevant persons with whom the amendment needs to be shared.

**What is required before a physician may respond to an attorney’s discovery request or subpoena for health care information about a patient?**

Under the UHCIA, an attorney must provide 14 days advance notice to the physician and to the patient or the patient’s attorney, through service of process or first class mail, before the attorney may serve a discovery request or subpoena on a health care provider for health care information about a patient. The advance notice must contain the following information:

* The name of the physician from whom the information is sought.
* What health care information is sought.
* The date by which a protective order must be obtained to prevent the physician from complying with the discovery request or subpoena.

The advance notice provision is designed to give the patient and the physician adequate time to seek a protective order in the event they wish to limit or prevent the disclosure of health care information.

Absent written consent of the patient, a physician who receives a discovery request or subpoena from an attorney for health care information may not disclose the health care information if the attorney has not complied with the advance notice requirement.

If the attorney has complied with the advance notice requirement and no protective order has been issued by a court, the physician must disclose the requested information.

If the physician complies with the discovery request or subpoena, the discovery request or subpoena must be made a part of the patient’s record.

The notice of intent procedure under the UHCIA should satisfy the corresponding requirements under HIPAA.

**Must a physician, when releasing a record, provide a certification of record upon request?**

Yes. Under the UHCIA, upon the request of the person requesting the record, a physician must certify the record and may charge a fee of $2.00 for such certification. The physician need not certify the record until the fee is paid. The certification must be attached to the record and must contain:

* The identity of the patient.
* The kind of health care information involved.
* The identity of the person to whom the information is being furnished.
* The identity of the physician or facility furnishing the information.
* The number of pages of the health care information.
* The date on which the health care information is furnished.
* That the certification is to fulfill and meet the certification requirements of the UHCIA.

**May a physician discuss a patient with an attorney, other than the physician’s own attorney, without the patient’s consent?**

Generally, no. A physician may not discuss a patient’s health care information with an attorney, other than the physician’s own attorney, without a signed patient authorization, a subpoena issued in compliance with the requirements of the UHCIA, or a court order. This general rule, however, does not apply in workers’ compensation cases. See WORKERS’ COMPENSATION.

**May a physician discuss a patient with the physician’s own attorney without the patient’s consent?**

Generally, yes. But before doing so the physician should obtain a signed HIPAA-compliant business associate agreement with the attorney.

**What is a business associate agreement?**

A business associate agreement is a document that sets forth the obligations a business associate must meet in order to adequately protect health information the business associate may receive from the physician. Physicians are required to have business associate agreements in place with all of their business associates with whom they share patients’ protected health information. Business associates are persons or entities, other than employees, who on behalf of the physician perform or assist in performing a function or activity that involves the use or disclosure of protected health information maintained by the physician. Examples of business associates include a physician’s billing agent, attorney, accountant, and collection agency, but do not include the physician’s employees.

A HIPAA-compliant sample business associate agreement may be found at http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html.

**When does a physician need to obtain a business associate agreement?**

A physician needs to obtain a signed business associate agreement from every business associate with which the physician may share protected health information in order for the business associate to perform or assist in performing a function on behalf of the physician.

**Under the UHCIA, what type of notice regarding medical record disclosure must be made to patients?**

Under the UHCIA, physicians must provide notice to patients stating substantially the following:

“We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.”

This notice must be given by posting it in a conspicuous place, including it on a consent form, providing it with billing or otherwise directly sending it to patients.

**Under HIPAA, what type of notice regarding disclosure of health care information must be given to patients?**

Under HIPAA, a physician must provide each patient, no later than the first date of service or, in the case of emergency, as soon as practicable, with a copy of the physician’s Notice of Privacy Practices, and should obtain an acknowledgment of receipt. The Notice of Privacy Practices must also be posted in a clear and prominent location, and a copy must be made available on request. Whenever the Notice of Privacy Practices is revised, a copy of the new notice must be made available in the physician’s office.

The Notice of Privacy Practices must be written in plain language and is to provide notice to patients of the uses and disclosures of protected health information that may be made by the physician and of the patient’s rights and the physician’s legal duties with respect to protected health information. HIPAA sets forth a very long list of items that must be included in the Notice of Privacy Practices that are too detailed to be included in this Guide. For assistance in preparing a plain language Notice of Privacy Practices, please go to http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html.

**What may happen if a physician fails to comply with requirements of the UHCIA?**

If a physician fails to comply with UHCIA requirements, a patient may bring a lawsuit against a physician who fails to comply with the requirements of the UHCIA. In such a lawsuit, the patient may obtain a court order compelling the physician to comply with the law and may recover any actual damages sustained as a result of the physician’s failure to comply with the law. If the patient prevails, the patient may also recover reasonable attorneys’ fees and expenses incurred in bringing the action.

**What may happen if a physician fails to comply with HIPAA requirements?**

If a physician fails to comply with HIPAA requirements, a patient may file a complaint with the Office for Civil Rights (OCR), who may in turn investigate the physician. The physician must cooperate with the investigation and give the OCR access to the physician’s facilities, books, and records. If the OCR finds that the physician has violated HIPAA, it may impose civil monetary penalties of up to $100 per person for each violation, and up to $25,000 for violations of a single standard within the calendar year. Criminal penalties for wrongful disclosure of protected health information can also be imposed which, upon conviction, could result in fines of up to $50,000 and imprisonment for up to one year, or both. For criminal offenses involving conduct, the possible penalties include fines of up to $250,000 and imprisonment for up to 10 years.

**Does the UHCIA supersede all other special rules governing disclosure of health care information?**

No. In particular, the UHCIA does not alter the terms and conditions of disclosure of health care information contained in statutes and regulations governing workers’ compensation, control and treatment of sexually transmitted diseases, mental health treatment, drug and alcohol abuse treatment, juvenile justice, or marital dissolutions.

**Under the UHCIA, how long must a physician maintain a record of existing health care information following receipt of a valid patient authorization?**

Under the UHCIA, a record of existing health care information must be maintained for at least one year following receipt of a valid patient authorization, and during the pendency of a request for examination and copying or a request for correction or amendment. See also [Retention Of Records](http://legalguide.wsma.org.onexcale.net/privacy-issues/medical-records/retention-of-records).

**Under HIPAA, how long must a physician maintain sufficient information to respond to a patient’s request for an accounting?**

HIPAA requires a physician to maintain sufficient information to respond to a patient’s request for an accounting of disclosures made during the six years preceding the request.

**What safeguards must physicians take to protect health care information?**

Physicians must take reasonable safeguards to ensure the confidentiality, integrity and availability of health care information they maintain. HIPAA’s Security Rule also imposes a wide range of obligations for maintaining the security of health care information which are beyond the scope of this Guide.

**Are there specific safeguards related to telephone or facsimile numbers that must be taken for the security of health care information?**

Yes, action must be taken to delete outdated and incorrect facsimile or other telephone numbers from computers, facsimile machines, or other databases. When transmitting health care information by facsimile to a recipient that is not regularly sent such information, the physician must verify that the number is accurate before transmitting the information.

**Where can more detailed information about the federal privacy and security regulations under HIPAA are obtained?**

More information about the HIPAA Privacy and Security Rules and related regulations may be obtained from the following web site: http://www.hhs.gov/ocr/hipaa.

### Retention of Records

**How long must a physician retain a patient’s medical record?**

There are no specific statutory or regulatory requirements for how long a physician must retain a patient’s medical record, which would include electronic medical records, except for the following:

* A physician must maintain a patient’s medical record for at least one year after receipt of an authorization to release the record.
* A physician must maintain a patient’s medical record during the pendency of a patient’s request either to examine or copy the record or to correct or amend the record.

Because a patient’s medical record is essential for the defense of a medical malpractice action, however, the statute of limitations and statute of repose provides some guidance for how long physicians should retain patients’ medical records. See Statute Of Limitations. As a practical guideline, physicians should retain medical records, including electronic medical records, and x-rays for at least:

* 6 years from the date of a patient’s death;
* 10 years from the date of a patient’s last visit, prescription refill, telephone contact, test, or other patient contact;
* 21 years from the date of a minor patient’s birth (applies to both obstetrical records and neonatal/pediatric records);
* Indefinitely if the patient is incompetent or if the physician is aware of any problems with a patient’s care or has any reason to believe the patient may sue.

To be absolutely safe, a physician should, if at all possible, retain patients’ medical records indefinitely.

In addition, appointment books and computer scheduling records should be retained for at least 10 years. Such records are often the only source of documentation of canceled appointments, no-shows, or other pertinent information about a physician’s schedule.

**Must records be retained in their original form?**

No. The retained medical records do not need to be the original documents so long as the physician can present an accurate reproduction of the original records.

**How long must a hospital retain a patient’s medical record?**

Under Washington law, a hospital must retain a patient’s medical record as follows:

* If the patient is an adult, a hospital must retain and preserve the medical record for at least 10 years following the patient’s most recent discharge.
* If the patient is a minor, a hospital must retain and preserve the medical record for at least three years following the minor’s 18th birthday, or 10 years following the patient’s most recent discharge, whichever is longer.

**How long must a private alcohol and chemical dependency hospital retain a patient’s medical record?**

A private alcohol and chemical dependency hospital must retain a patient’s medical record as follows:

* Records of adult patients must be retained and preserved for a minimum of 10 years following the most recent discharge.
* Records of minors at the time of care, treatment, or diagnosis must be retained and preserved for a minimum of three years following the minor’s 18th birthday, or 10 years following the patient’s most recent discharge, whichever is longer.

**How long must a private psychiatric and alcoholism hospital retain a patient’s medical record?**

A private psychiatric and alcoholism hospital must retain and preserve a patient’s medical record as follows:

* Records of adult patients must be retained and preserved for a minimum of 10 years following the most recent discharge.
* Records of minors the time of care, treatment, or diagnosis must be retained and preserved for a minimum of three years following the minor’s 18th birthday, or 10 years following the patient’s most recent discharge, whichever is longer.

### Subpoenas

**What is a subpoena?**

A subpoena is a form of compulsory legal process that requires a person to produce documents or to personally appear to give testimony, either at a deposition or in court. A subpoena may be issued by an attorney, a court, or a governmental agency.

**What are the consequences if a physician does not comply with a properly issued subpoena?**

If a physician fails to comply with a properly issued subpoena, the physician may be held in contempt and punished by a fine, imprisonment until he or she complies, and/or other sanctions. See DISCLOSURE OF HEALTH CARE INFORMATION for when a physician must and must not comply with a subpoena issued by an attorney for release of a patient’s health care information.

**Are there special rules which apply to release of mental health records under a subpoena?**

Yes. Mental health records can only be released under certain circumstances. Mental health records must be released pursuant to a lawful order (subpoena) of a court. Mental health records should not be released pursuant to a subpoena issued by an attorney except to the patient’s attorney at any time in order to prepare for involuntary commitment or recommitment proceedings, reexamination appeals, or actions related to detention, admission, commitment, or patient’s rights.

**What should a physician do upon receipt of a subpoena?**

Upon receiving a subpoena, a physician should read the subpoena carefully to determine what information is being requested, when, and by whom. If the physician has any doubt about the appropriate response to the subpoena, the physician should contact an attorney immediately. If the physician has any reason to believe that his or her care and treatment may be called into question, the physician should not speak to the patient’s attorney, and should contact his or her attorney or malpractice carrier for advice.

If the subpoena is from a government agency, the physician should contact an attorney and his or her malpractice carrier immediately.

If the subpoena is from an attorney and seeks either a copy of a patient’s medical record or the physician’s testimony concerning a patient’s health care information, the physician should:

* Verify whether the required 14-day advance notice or a valid patient authorization was received. See DISCLOSURE OF HEALTH CARE INFORMATION.
* Verify whether a protective order has been entered.
* If no 14-day advance notice or valid patient authorization was received, the physician should not release the requested health care information and should notify the attorney issuing the subpoena that the physician cannot comply with the subpoena.
* If the 14-day advance notice or a valid patient authorization was received, and no protective order has been received, the physician should comply with the subpoena according to its terms.
  + If the subpoena is for the physician’s testimony at a deposition or trial and the date and time on the subpoena are not convenient, the physician should contact the attorney who issued the subpoena to arrange a more convenient date and time and to attempt to reach an agreement regarding the reasonable compensation to be paid for the physician’s time. See PHYSICIAN AS WITNESS
  + If an agreement is reached regarding compensation, the physician should confirm it in writing.
  + If no agreement can be reached as to date and time or compensation, and the physician cannot appear at the date or time stated in the subpoena, the physician should consult an attorney.
* If a protective order has been entered, the physician should comply with the terms of the protective order.
* Place the subpoena, and a notation about the physician’s response to the subpoena, in the patient’s medical record.
* If there is any question, contact an attorney.

**What must a physician do in order to comply with a valid subpoena for documents?**

A physician must produce the documents as they are kept in the usual course of business, or may organize and label them to correspond with categories in the subpoena.

**May a physician charge for time spent in testifying or for producing copies of a patient’s medical records in response to a subpoena?**

Yes. See PHYSICIAN AS WITNESS; and DISCLOSURE OF MEDICAL RECORDS for issues related to charges.

## Physician-Patient Relationship

**When is the physician-patient relationship created?**

Generally, the physician-patient relationship is created when a patient consults a physician for the purpose of health care, including prevention, treatment, management of illness, and preservation of mental and physical well-being. It is not necessary for the creation of the relationship that the physician actually treat the patient. Whether a physician-patient relationship is created depends on whether the patient believes that the patient’s contact with the physician was for the purposes of treatment. Regarding a child, parents do not have a physician-patient relationship themselves with a physician treating their child, but have the right to act as in a representative capacity for their child with regard to informed consent.

Usually, no relationship is formed when the physician is merely evaluating the patient at the request of a third party. However, workplace examinations of employees may, depending on the circumstances, give rise to a physician-patient relationship.

**Is the physician-patient relationship created when a patient calls for an appointment?**

If confidential information is given or medical advice is conveyed over the phone, the physician-patient relationship may have been created.

**Does the initial appointment create the relationship?**

Generally, yes.

**What can patients expect from the physician-patient relationship?**

The American Medical Association encourages physicians to foster certain rights for patients in order to maximize the effectiveness of medical treatment. These rights include the patients’ right to:

* Receive information from the physician and to discuss the risks and benefits, and the costs, of appropriate treatment alternatives;
* Make decisions regarding health care that is recommended by the physician, including the right to refuse care;
* Courtesy, respect, dignity, responsiveness, and timely attention to their needs;
* Confidentiality;
* Continuity and coordination of health care; and
* Have adequate health care available.

**Must a physician render medical care to anyone requesting it?**

Generally, no. A managed care contract, however, may require a physician to treat any of the health plan’s members who select the physician. Moreover, a physician is prohibited from refusing treatment on the basis of sex, race, national origin, religion, or disability. See [Discrimination](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/discrimination) and [Americans With Disabilities Act](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/americans-with-disabilities-act). A physician also may not refuse to treat a patient because the patient has AIDS or is HIV positive. See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd).

A physician may refuse to withdraw or withhold life support services. See [End of Life Care Documents](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/advance-directivespolst/end-of-life-care-document). A physician may also refuse to perform an abortion. See [Abortion](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/abortion/abortion).

**How does a physician terminate a physician-patient relationship?**

A physician may terminate a relationship with a patient by written notice to the patient which provides adequate time and opportunity for the patient to obtain care from another physician.

**What steps should a physician take to properly terminate a patient relationship?**

Generally, a physician should take at least the following steps to properly terminate a physician-patient relationship:

* Make sure the patient is stabilized.
* Assuming the patient is stabilized, inform the patient verbally and in writing of what follow-up care, if any, is needed.
* Inform the patient in writing, by letter sent certified mail return receipt requested, of the physician’s intent to terminate the physician-patient relationship and of the specific date that the physician intends to stop rendering care.
* Make sure the date specified in the letter gives the patient adequate time to find another suitable physician to provide care.
* If possible, provide the patient with a list of physicians qualified to treat the patient’s condition to contact for alternative referrals.
* Advise the patient that the physician will remain available to render care until the date specified in the letter.
* Inform the patient that copies of the patient’s medical record will be made available either to the patient or to the patient’s new physician upon request and with a valid authorization.

A physician’s failure to properly terminate the physician-patient relationship can result in allegations of abandonment.

**Must a physician follow and treat a patient with a chronic illness?**

Generally, once the physician begins care, the obligation to provide treatment continues until the patient is stabilized and the physician-patient relationship is properly terminated. It is advisable for a physician to formally terminate the relationship once a physician decides not to continue to seeing the patient. Because questions as to whether to terminate a physician-patient relationship are often fact-specific, a physician is well-advised to consult an attorney.

# Business Issues

## Asset Protection

**What is “asset protection?”**

Generally, “asset protection” is a set of legal techniques and a set of laws (sometimes referred to as debtor-creditor law) that deals with protecting the assets of individuals and/or business entities from civil money judgments. A goal of asset protection planning is to insulate assets from claims by creditors, but without concealment or tax evasion. Some examples of assets that are protected from creditors can be home equity, certain retirement plans and interests in LLCs

**What is the best way to protect assets against the reach of creditors?**

The best way to protect one’s assets from the reach of creditors is through a carefully planned program combining various tools, such as liability and life insurance plans, trusts, the choice of business form, and selected vehicles for funding retirement plans. The very best programs are structured so that they not only may protect one’s assets, but also make sense in the context of the individual’s business, lifestyle choices, financial goals and testamentary plans. The programs most likely to survive attack are those that make sense for the above reasons and are implemented well in advance of litigation being filed.

Transfers done on the eve of entry of an adverse judgment, and that are susceptible to no explanation other than a desire to remove the assets from the reach of a potential judgment creditor, are unlikely to succeed.

Great care should be taken before embarking on any “asset protection” program. Obtaining the advice of experienced legal counsel to help develop the appropriate estate and asset conservation plan is highly advisable. The assets one may protect purely under statute from the reach of creditors are limited.

**What are the laws that govern asset protection?**

The United State federal bankruptcy laws and ERISA exempt certain assets from creditors. While they may vary, all fifty states also have laws that exempt certain assets from creditors. Creditors also have laws that work against the laws that provide asset protections. Those laws are at the state and federal level and are called “fraudulent transfer” laws. The federal fraudulent transfer law is referred to as the Bankruptcy Code. Most states have adopted the Uniform Fraudulent Transfer Act. The Act defines what constitutes a fraudulent transfer. Washington State has garnishment and other laws that addressed the treatment of assets that will be discussed below.

**What assets are protected by state law from the reach of creditors?**

State law exempts a series of assets from the reach of most creditors. The exemptions are not applicable against a voluntary security interest in the assets (e.g., a mortgage or deed of trust on one’s home), certain tax claims, and judgments for the purchase price of the otherwise exempt item. Recent amendments to the state statutes further limit the homestead exemption so that it is not applicable to liens for labor or materials provided to the home or liens for homeowner association claims. As a general rule, assets are not exempt from claims for child support or, in some instances, claims for spousal maintenance.

A list of general exemptions under state law includes:

* $125,000 in value of real or personal property utilized as the owner’s principal residence (e.g., a house or mobile home). If homestead property is sold, the proceeds are entitled to the same protection as homestead property. This is commonly referred to as the “homestead” exemption.
* All wearing apparel is exempt, but the exemption for furs, jewelry, and personal ornaments is limited to $3,500.
* Each individual is entitled to an exemption for a private library, including electronic media such as audiovisual, entertainment or reference media in digital or analog format, not to exceed $3,500 in value.
* Professionals such as a physician, surgeon, attorney, or clergyman, have an additional $10,000 exemption for the individual's library, office furniture, office equipment and supplies.

To each individual or, as to community property of spouses or domestic partners maintaining a single household as against a creditor of the community, to the community:

* The individual’s or community’s household goods, appliances, furniture, and home and yard equipment, not to exceed $6,500 in value for the individual, or $13,000 for the community, said amount to include provisions and fuel for the comfortable maintenance of the individual or community.
* Other personal property, except personal earnings, not to exceed $3,000 in value, of which not more than $1,500 in value may consist of cash, and of which not more than $200 in value may consist of bank accounts, savings and loan accounts, stocks, bonds, or other securities for debts owing to the state or a state agency, or not more than $500 of such assets for all other debts.
* For an individual, a motor vehicle used for personal transportation, not to exceed $3,250, or for a community two motor vehicles used for personal transportation, not to exceed $6,500 aggregate value.
* Any past due, current or future child support paid or owed to the debtor, which can be traced.
* All professionally prescribed health aids for the debtor or a dependent of the debtor.
* The right to, or proceeds of, a payment not to exceed $20,000 on account of personal bodily injury, but not including pain and suffering or compensation for monetary loss, of the debtor or an individual of whom the debtor is a dependent; or the similar rights to, or proceeds of, a payment in compensation for future earnings of the debtor or an individual of whom the debtor is or was a dependent, to the reasonable extent to support the debtor or a dependent of the debtor. This exemption is subject to the rights of Washington State or its agents or assignees as lien holder or subrogee.
* Tuition units purchased more than two years prior to the date of a bankruptcy filing or court judgment.
* To each qualified individual, one of the following exemptions:
  + To a farmer, farm trucks, farm stock, farm tools, farm equipment, supplies and seed, not to exceed $10,000 in value.
  + To a physician, surgeon, attorney, member of the clergy, or other professional person, the individual’s library, office furniture, office equipment and supplies, not to exceed 10,000 in value.
  + To any other individual, the tools and instruments and materials used to carry on his or her trade for the support of himself or herself or family, not to exceed $10,000 in value.

It is important to note that, for the purposes of measuring exempt value under either the state or federal exemptions, “value” means the reasonable market value of the debtor’s interest in the item, exclusive of any and all liens and encumbrances against the item. Thus, if a physician owns a $30,000 automobile subject to a $20,000 purchase money security interest, the value of his or her interest in the vehicle is at most $10,000. The net amount of the value actually owned may be further reduced by the potential cost of sale of the vehicle.

The separate property of one spouse or domestic partner is also exempt from the claims of creditors of the other spouse or the community. Claims of separate property, however, are subject to rigorous analysis and challenge. Maintaining the integrity of the separate nature of separate property can be difficult and the separate nature of the property can easily be lost through commingling.

A wide range of government and private based pension, annuity, retirement and death benefits are also exempt. Many of these otherwise exempt payments, however, are susceptible to efforts to collect back child support.

Washington wage garnishment statutes also provide a form of exemption, which generally makes 75 percent of a defendant’s disposable earnings exempt. This amount is less if the garnishment action is based on unpaid family support obligations.

**What assets are exempt in the bankruptcy context?**

Physicians seeking to protect assets in the bankruptcy context, or contemplating bankruptcy protection, should seek expert legal advice.

Means test and the homestead exemption. Federal laws may impact a physician’s individual bankruptcy, including restrictions on an individual’s ability to claim the generous homestead exemptions available in some states (e.g., Florida and Texas) without having lived in those states for at least 3 and 1/3 years before the bankruptcy filing, and imposing a “means test” on individuals filing a Chapter 7 (straight liquidation) bankruptcy. The “means test” is intended to require individuals to pay some part of their debts back if their income exceeds the average of the given state that and their required expenses do not exceed certain amounts. As applied, the means test is less draconian than it sounds, but nonetheless may be a significant factor in deciding whether, or how, to seek bankruptcy court protection.

An individual filing bankruptcy can choose to utilize either the state scheme of exemptions (described above) or the federal scheme, but not both. Spouses filing joint bankruptcy cannot, however, “stack” the exemptions by having one spouse claim the federal scheme and the other spouse claim the state scheme.

The federal exemptions (the dollar amount of which are adjusted by an inflation factor every three years) are basically as follows:

* Up to $21, 625 in value of the debtor’s interest in real or personal property that the debtor or dependent of the debtor uses as a residence or in a burial plot for the debtor or a dependent of the debtor. This is often referred to as the “federal homestead exemption.”
* Up to $3,450 in value in one motor vehicle.
* Up to $550 in interest in any particular item of household furnishing, household goods, wearing apparel, appliances, books, animals, crops, or musical instruments held primarily for the person, family or household use of the debtor or dependent of the debtor. The aggregate value of these items cannot exceed $11,525.
* Up to $1,450 in value of jewelry.
* Up to $2,175 of interest in any implements, professional books or tools of the trade of the debtor or the trade of a dependent of the debtor.
* Any unmatured life insurance contract owned by the debtor other than a credit life insurance contract.
* Up to $11, 525 in loan value of a life insurance policy.
* Professionally prescribed health aids.
* Debtor’s right to receive social security benefits, unemployment compensation, welfare benefits, veterans benefits, disability, alimony and payments under stock bonus, pension, profit sharing, annuity received on account of illness, disability, death, age or length of service to the extent reasonably necessary for the support of the debtor or the debtor’s dependents.
* Right to receive criminal restitution, wrongful death payments, life insurance benefits, compensation for loss of future earnings and up to $21, 625 for certain kinds of personal injury.
* Retirement funds to the extent that they are in a fund or account that is exempt from taxation.

**Are exemptions automatic?**

Unless one files bankruptcy, the federal exemptions are inapplicable. One can avail oneself of the state set of exemptions, however, without filing bankruptcy.

One’s homestead is an automatic exemption as to the house in which one resides. If one wishes to claim the homestead exemption in property other than one’s main residence, however, a specific filing must be made.

One claims exemptions under the state law as to personal property by delivering to the “officer making the levy” (usually the sheriff of the county in which the debtor resides) a separate list of the items claimed as exempt, along with certain other information. An appraisal may be required prior to the sale.

Both the federal and state sets of exemptions are designed to give a debtor “a fresh start.” They are certainly not significant enough to protect most physicians’ assets from the reach of creditors. The best way to maximize one’s chances of accomplishing that goal is through a timely, carefully thought out, and well-coordinated plan. Obtaining advice from experienced legal counsel is advisable.

## Advertising

**May a physician advertise?**

Yes. An osteopathic physician may include in publicity or advertising:

* Name, including name of professional service corporation or clinic, and names of professional associates, addresses and phone numbers.
* Date and place of birth.
* Date and fact of admission to practice in Washington and other states.
* Accredited schools attended with dates of graduation, degrees and other scholastic distinction.
* Teaching positions.
* Membership in osteopathic or medical fraternities, societies and associations.
* Membership in scientific, technical and professional associations or societies
* Whether credit cards or other credit arrangements are accepted.
* Office and telephone answering service hours.
* Fee for an initial examination and/or consultation.
* Availability upon request of a written schedule of fees or range of fees for specific services.
* The range of fees for specified routine professional services, provided that the statement discloses that the specific fee within the range which will be charged will vary depending upon the particular matter to be handled for each patient, and that the patient is entitled without obligation to an estimate of the fee within the range likely to be charged.
* Fixed fees for specified routine professional services, the description of which must not be misunderstood by or be deceptive to a prospective patient, provided that the statement discloses that the quoted fee will be available only to patients whose matters fall into the services described, and that the client is entitled without obligation to a specific estimate of the fee likely to be charged.

**What forms of advertising are prohibited?**

All advertising which is false, fraudulent or misleading is considered unprofessional conduct which may subject a physician to disciplinary action. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct).

False, fraudulent, or misleading advertising, as with any other unfair or deceptive act or practice in the conduct of trade or commerce, may also subject a physician to civil liability.

Advertising that is false, deceptive or misleading is also a misdemeanor crime. Advertisements containing the words: “lost manhood,” “lost vitality,” “lost vigor,” “monthly regulations for women” or other synonymous words are assumed to be false advertising in violation of the criminal law.

**Are there specific limitations on osteopathic physician advertising?**

Yes. An osteopathic physician is specifically prohibited from using any advertising or public communication which:

* Is false, fraudulent, deceptive, or misleading.
* Uses testimonials.
* Guarantees any treatment or result.
* Makes claims of professional superiority.
* States or includes prices for professional services except for:
  + A range of fees for specified routine professional services, if the statement discloses that the specific fee within the range will vary upon the particular matter to be handled for each patient and that the patient is entitled without obligation to an estimate of the fee likely to be charged; or
  + Fixed fees for specified routine professional services, the description of which would not be misunderstood by, or deceptive to, a prospective patient, if the statement discloses that the quoted fee will be available only to patients whose matters fall into the services described, and that the patient is entitled without obligation to a specific estimate of the fee likely to be charged.
* Fails to identify the physician as an osteopathic physician.

## Closing/Relocating a Practice

**What notice should be given to patients when a physician terminates or relocates his or her practice?**

Washington law contains no specific statutory or regulatory requirements for notice of the closure or relocation of a practice. Taking the following measures, however, will help to provide prompt notification to patients:

* Provide patients with at least 30 days (preferably 90 days if possible) advance written notice of the planned office closure so that patients will have sufficient time to obtain other physicians. With the advance written notice, consider enclosing an authorization form for the patient to complete and sign that authorizes the patient’s records to be sent to another physician of the patient’s choice. For current patients, the written notice and authorization form can be enclosed with the patients’ monthly statement or billing. The written notice to other patients will need to be mailed separately.
* Retain a copy of the advance written notice and a list of all patients to whom the written notice was sent.
* Publish a notice of closure or relocation in a newspaper of general circulation in each area where the physician practices.
* At least 30 days prior to closure or relocation of the practice, conspicuously post an announcement in the physician’s office.
* Review all managed care contracts for, and comply with, any notification provisions they contain.

The notices and the posted announcement should state the date the physician’s practice will close or relocate and should advise patients as to what they need to do to obtain or transfer their medical records either at that time or after the date of closure or relocation.

**How long should patients’ medical records be retained?**

Because a patient’s medical records are often a physician’s chief source of defense in the event a lawsuit is filed, medical records--including case histories, treatment records, x-rays, laboratory reports, and correspondence with physicians and others--should not be destroyed until the statute of limitations has expired with regard to each patient. See [Retention Of Records](http://legalguide.wsma.org.onexcale.net/privacy-issues/medical-records/retention-of-records); and [Statute Of Limitations](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-malpractice/statute-of-limitations).

**Must a patient be informed of the location of their medical records prior to closing or relocating?**

Patients have a general right to know what is in their medical records and thus physicians should let their patients know where and how they can obtain their records. Copies of records can be given to the patient or forwarded to another physician of the patient’s choosing with the patient’s written request or consent.

**How should accounts receivable be handled?**

Not all patients will have paid their bills by the time a practice is closed. It is advisable to have someone available to accept, record, and deposit payments received after the official closing of the practice. After a suitable waiting period (three or four months), it may be desirable to turn over any invoices that are still unpaid to a reputable collection agency.

**How long should income tax records be retained?**

Copies of income tax returns and all supporting documentation, including ledgers and accounting records, should be preserved until the Internal Revenue Service can no longer assess additional tax. For federal returns filed on time and containing all correct and pertinent data, this is usually three years; for returns in which gross income has been understated by 25% or more, it is six years. Physicians are well advised to work closely with their attorneys, accountants, or business managers with respect to the tax aspects of closing their practices.

**What happens to the physician’s license upon retirement?**

Upon retirement, a physician may:

* Allow the license to lapse for failure to submit the biennial renewal form and fee.
* Request a retired active license status. Retired active licenses are for individuals already licensed who wish to practice only in emergent or intermittent circumstances and without compensation. See [Licensure-Medical Doctors](http://legalguide.wsma.org.onexcale.net/physicians/allopathic-physicians/licensure---medical-doctors) for more information about retired active licenses.

**What should a physician do about professional liability insurance when closing a practice?**

Because medical malpractice claims can be brought years after the physician treated the patient, the physician should contact his or her professional liability insurance carrier, or insurance agent or broker, to arrange for post-practice continuation of professional liability insurance coverage. This “tail” coverage protects against acts or omissions that occurred prior to closure of the practice.

The physician should also contact his or her agent or broker or other insurance companies to arrange for continued insurance coverage for other types of claims.

**What are some of the other issues a physician should consider in deciding to close or relocate his or her practice?**

The physician should consider the effect of closure or relocation on any existing real property leases, equipment leases, contracts, employment agreements, partnership or shareholder agreements, and retirement and benefit plans the physician may have.

## Employee Contracts

Noncompete And Non-Solicitation Clauses

**What is a noncompete or noncompetition clause?**

A noncompetition clause is a provision, typically found in an employment contract or a contract for sale of a practice, in which an employee or seller of a practice agrees not to compete with the employer or purchaser of a practice within a certain geographic area for a certain period of time following termination of the employment relationship or purchase of the practice.

**Are noncompete clauses enforceable against physicians?**

Generally, yes. Noncompete clauses are generally enforceable, as long as the duration, geographic area, and scope covered by the noncompete restriction are reasonable.

A physician should carefully review any contract containing a noncompete clause before signing to ensure that the duration, and geographic area, and scope of the noncompete area restriction are acceptable.

**What is a non-solicitation clause?**

A non-solicitation clause is a provision, typically found in an employment contract, or contract for sale of a practice, in which an employee or seller of a practice agrees not to solicit business from patients or referral sources of the employer or purchaser of the practice following termination of the employment relationship or purchase of the practice.

**Are non-solicitation clauses enforceable?**

Generally, yes. Non-solicitation clauses are a type of covenant not to compete, and are therefore generally enforceable as long as they are reasonable.

## Business Entities

Partnerships and Corporations

**What organizational forms are available for a physician’s practice?**

Generally, a physician’s practice may be organized as:

* A sole proprietorship.
* A professional service corporation of the physician alone or with other physicians and certain other healthcare professionals.
* A partnership with other physicians.
* A limited liability partnership with other physicians and certain other healthcare professionals.
* A limited liability company of the physician alone or with other physicians and certain other healthcare professionals.

**What is a partnership?**

A partnership is an association of two or more persons to carry on a business for profit as co-owners. A partnership is an entity distinct from its partners.

**What is the liability of the partnership as a distinct entity for conduct of the partners?**

A partnership is liable for any loss or injury to a person, or for any penalty which may be incurred, as a result of a wrongful act or omission, or other actionable conduct, of a partner who is acting in the normal course of business of the partnership. A partnership is also responsible for any loss which result if a partner acting in the normal course of partnership business, or with the authority of the partnership, misapplies money or property the partner has received, or received on behalf of the partnership.

**What is the liability of one partner for the acts of the partnership or another partner?**

Generally, a partner’s liability is as follows:

* Partners are liable for their own acts and omissions, except that a person admitted into a partnership is not personally liable for any partnership obligation incurred before the person’s admission as a partner.
* Partners are jointly and severally liable for all obligations of the partnership unless otherwise agreed upon or provided for in law.

**What is a Limited Liability Partnership (LLP)?**

An LLP is a partnership, with statutory limitations on the partners’ liabilities. The name of a limited liability partnership must contain the words “limited liability partnership” or the abbreviation “L.L.P” or “LLP” as the last words or letters of its name.

**What is the liability of one partner in an LLP for the acts of the partnership or another partner?**

Generally, in an LLP, a partner’s liability is as follows:

* Partners are liable for their own acts and omissions.
* Partners are liable for the acts and omissions of those they supervise.
* Partners are not personally liable for the acts and omissions of other partners or of employees they do not supervise.
* The LLP is liable for the acts and omissions of its partners and employees.

**Are there special considerations for LLPs whose partners are physicians?**

Yes. Licensed individuals, such as physicians, may organize and become members of a LLP for the purpose of rendering professional services. In the case of an LLP of licensed professionals, if the partnership fails to maintain professional liability insurance or some other equivalent type of financial responsibility of at least one million dollars, the partners are personally liable for any amounts that would have been covered had the professional liability insurance been maintained.

**What is a Professional Service Corporation (PS or PC)?**

A professional service corporation is a corporation organized for the purpose of providing professional services and comprised of individuals or groups of individuals licensed to render the same professional services. Its existence is legally independent from any individual shareholder. It has the capacity to act as a distinct legal entity and be held liable for its actions.

**What is the liability of PS or PC shareholders?**

Generally, PS or PC shareholders’ liability is as follows:

* Shareholders are liable for their own acts and omissions.
* Shareholders are liable for the acts and omissions of those they supervise.
* Shareholders are not personally liable for the acts and omissions of other shareholders or employees they do not supervise.
* The corporation is liable for the acts and omissions of shareholders and employees.
* The corporation is liable for its contracts, including debt, and other liabilities.

**What is a Professional Limited Liability Company (PLLC)?**

A PLLC is a limited liability company organized for the purpose of rendering professional services, comprised of individuals or groups of individuals who are licensed to render the same professional services, and subject to the same laws which govern professional service corporations, but which have statutory limitations on the members’ liabilities. A PLLC must contain either the words “Professional Limited Liability Company,” or the words “Professional Limited Liability” and the abbreviation “Co.,” or the abbreviation “:P.L.L.C.” or “PLLC.”

Typically, a PLLC combines features of both a partnership and a corporation. A PLLC may function similarly to a partnership in terms of taxation, admission of members, voting and classes of membership, and in other ways provided for in the limited liability company agreement among its members.

**What is the liability of members of a PLLC?**

Generally, the liability of members of a PLLC is as follows:

* Members are liable for their own acts and omissions.
* Members are liable for the acts and omissions of those they supervise.
* Members are not personally liable for the acts and omissions of other members or employees they do not supervise.
* The PLLC is liable for the acts and omissions of members and employees.
* The PLLC is liable for its contracts, including debt, and other liabilities.
* If the PLLC fails to maintain professional liability insurance or some other equivalent form of financial responsibility of at least $1 million, the members of the PLLC are personally liable for any amounts that would have been covered had professional liability insurance been maintained.

**May physicians combine with any other health care professionals to form, and render their professional services through, a professional service corporation, a professional limited liability partnership, or a professional limited liability company?**

In certain circumstances, yes. Under Washington law provides for licensed individuals to incorporate (or form a PLLC) to render the same professional service. Physicians may combine with any of the following licensed health care professionals to form, and render their professional services, through a professional service corporation, a professional limited liability partnership, or a professional limited liability company:

* East Asian Medicine Practitioners.
* Mental health counselors, marriage and family therapists, and social workers.
* Podiatrists.
* Chiropractors.
* Dental hygienists.
* Dispensing opticians.
* Audiologists and speech language pathologists.
* Naturopaths.
* Midwives
* Optometrists.
* Ocularists.
* Osteopathic physicians.
* Osteopathic physician assistants.
* Pharmacists.
* Physicians.
* Physician assistants.
* Nurses.
* Psychologists.
* Respiratory care practitioners.
* Massage practitioners.
* Dietitians and nutritionists.

**Are combinations of partnerships and corporations possible?**

Yes. The law allows any number of combinations of corporate and individual partners and/or corporations.

**What are some of the factors to consider in choosing the organizational form for a physician?**

Choosing the best organizational form largely depends upon the physician or physicians’ personal preferences and consideration of such factors as:

* Taxation issues.
* The impact of the securities laws.
* The time and money required to maintain the business form.
* Entity governance.
* Scope of limitation on personal liability.
* Type of qualified retirement plan desired.
* Requirements of managed health care contracts.

Proper formation and maintenance of whatever business entity is chosen for physician practices requires detailed compliance with specific laws and regulations. Thus, physicians are well-advised to seek legal advice before choosing or changing a practice’s organizational form.

# Practice Management Issues

## Insurance and Billing

**May a physician charge interest or a late fee on an unpaid balance?**

Generally, yes. Regularly extending credit to patients, especially credit payable in four or more installments, however, could require a physician to comply with strict state and federal rules governing retail installment credit.

If a physician intends to charge interest or assess a late fee on unpaid balances, the physician should notify patients in writing, through a disclosure statement on bills and a sign conspicuously posted in the office, of the amount of, and the terms and conditions under which, interest or a late fee will be charged.

**What is the maximum rate of interest which a physician may charge on an unpaid balance?**

Generally, the maximum rate of interest that may be charged in Washington is 12% per annum. The actual maximum rate varies monthly. The current rate may be obtained by calling the State Treasurer’s Office in Olympia (360-902-0200), or visiting the Washington State Treasurer’s website, http://www.tre.wa.gov/investments/historicalUsuryRates.shtml.

**May a physician “balance bill” a patient for amounts not paid by third-party payors?**

It depends upon who the third party payor is and what payment rules the third party payor has established.

* Managed Care Organizations

If the patient is a managed care subscriber, the physician’s contract with the managed care organization (MCO) may require the physician to accept the MCO’s payment as payment in full and may preclude the physician from billing the patient for any additional amounts other than co-insurance and deductibles. The extent to which a physician may bill a patient for services will generally be governed by the terms of the managed care contract.

Under state law, except with respect to emergency care by a non-participating provider, out-of-area services, and certain other exceptional situations approved in advance by the insurance commissioner, contracts between a health maintenance organization and its participating providers must set forth that, in the event the health maintenance organization fails to pay for health services as set forth in the agreement, the enrolled participant shall not be liable to the provider for any sums owed by the health maintenance organization.

* Medicare

If the patient is a Medicare beneficiary and the physician is a Medicare participating provider or has agreed to accept assignment, the physician must accept Medicare’s payment as payment in full and may not charge the patient for any additional amounts other than the Medicare Part B deductible and co-insurance. If a patient is eligible for both Medicare and Medicaid, charges for services covered under Medicare must be submitted first. Medicaid may make additional payment after Medicare reimburses the physician.

If the patient is a Medicare beneficiary and the physician is not a Medicare participating provider and has not agreed to accept assignment, Medicare will pay the patient directly. The patient is then responsible for paying the physician. The nonparticipating physician is not required to accept Medicare’s payment amount as payment in full, but cannot charge the patient more than the Medicare “limiting charge” which, for nonparticipating physicians, is 15% above the Medicare-approved charge.

There are two other limitations on what a nonparticipating physician can charge a patient on nonassigned Medicare claims:

* + A physician generally cannot charge a Medicare patient anything for services which Medicare finds were not reasonable and necessary.
  + A physician cannot charge a Medicare beneficiary more than the Medicare-approved charge for elective surgery costing more than $500 unless the patient is informed in writing of the difference between the physician’s charge and the approved charge.
* Medicaid

If the patient is a Medicaid patient, the fees and rates the Department of Social and Health Services (DSHS) establishes are the maximum allowable payments to physicians for covered medical care and services. Generally, a physician may not bill a Medicaid patient for a service included in the patient’s Medicaid scope of benefits and must refund any payment received from a Medicaid patient for which DSHS is responsible for payment. A Medicaid patient is not liable for services included in the patient’s scope of benefits even if DSHS denies payment if the physician failed to properly bill DSHS for services DSHS was responsible to pay or failed to satisfy DSHS’ conditions for payment.

**Must a physician refund a payment that is over the Medicare “limiting charge”?**

Yes. A nonparticipating physician who charges and collects from a patient more than the limiting charge must, not later than 30 days after the date the physician is notified by the carrier of a violation, refund the difference.

**Is there a penalty for purposely billing over the Medicare “limiting charge”?**

Yes. If a nonparticipating physician knowingly and willfully bills or collects an amount above the limiting charge or fails to refund such an excessive charge, the physician could be sanctioned, including: (1) exclusion from participation in the Medicare program for up to five years, and/or (2) imposition of a civil monetary penalty or assessment.

**May a physician routinely waive Medicare Part B co-insurance and deductibles?**

No. The Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) has issued a Fraud Alert indicating that the routine waiver of Medicare Part B co-insurance and deductibles is unlawful because it results in false claims, violation of the Medicare-Medicaid anti-kickback statute and excessive utilization of items and services payable under Medicare. The routine waiver of Medicare Part B co-insurance and deductibles can result in severe penalties such as imprisonment, criminal fines, civil monetary penalties, civil damages and forfeiture, and exclusion from participation in Medicare and Medicaid.

The OIG has acknowledged one important exception to the prohibition against waiving Medicare Part B copayments and deductibles. A physician may on occasion forgive a copayment in consideration of an individual patient’s special financial hardship or special financial needs. It may not be done, however, on a routine basis.

**Where can a physician find out more information about Medicare compliance?**

A Medicare compliance guide for individual and small practices is available from the DHHS at: <http://oig.hhs.gov/authorities/docs/physician.pdf>. Physician education training materials may be found at: <https://oig.hhs.gov/compliance/physician-education/index.asp>.

**How long does a physician have to submit a Medicaid claim?**

Physicians must submit initial claims and have a Transaction Control Number (TCN) assigned within 365 from the date the service was provided, the date a final hearing decision is rendered that impacts the claim, the date a court orders coverage of the service, or the date that DSHS grants delayed certification. Physicians may resubmit, modify, or adjust any timely initial claim except prescription drug claims, or claims for major trauma services, for a period of 24 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

**Under what circumstances may a physician bill a Medicaid patient for services not covered by the Medicaid program?**

The physician may bill a Medicaid patient for a noncovered service only when one of the following conditions is met:

* The patient signs a specific written agreement with the physicians that states:
  + The anticipated date the service will be provided (which must be less than 90 days from the date of the signed agreement).
  + Each service that will be furnished.
  + Treatment alternatives that may have been covered by DSHS or managed care organization.
  + The total amount the patient must pay for the service(s).
  + What items or services are included in this amount (such as pre-operative care and post-operative care).
  + That the patient has been fully informed of all available medically appropriate treatments, including services that may be paid for by DSHS or managed care organization, and that the patient chooses to get the specified service(s).
  + That the patient may request an exception to the rule when DSHS denies a request for a noncovered service other than a nonformulary drug, and that the patient may choose not to do so.
  + That the client and the physician may request a nonformulary justification for a nonformulary drug, and that the patient may choose not to do so.
  + That the patient may request an administrative hearing to appeal a DSHS denial of a request for prior authorization of a covered service, and that the client may choose not to do so.

The agreement may only be completed after the physician and the patient have exhausted all applicable DSHS or managed care processes necessary to obtain authorization of the requested service, except that the patient may choose not to request an exception to the rule or an administrative hearing regarding denial of authorization for the requested service.

The agreement must specify that one of the reasons below applies:

* The service(s) is not covered by Medicaid or the Medicaid managed care plan, and the exception to the rule process, or nonformulary justification process, has been exhausted and the services(s) denied; or
* The service(s) is not covered by Medicaid or the Medicaid managed care plan, and the client has been informed of his or her rights to the exception to the rule, or nonformulary justification, process, and the patient has chosen not to pursue the relevant process; or
* The service(s) is covered by Medicaid or the Medicaid managed care plan, requires authorization, the physician has completed all necessary requirements, but DSHS has denied the service as not medically necessary; or
* The service(s) is covered and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which DSHS or the Medicaid managed care plan does not pay for and the specific type is not medically necessary for the patient.
* The patient received reimbursement directly from a third party for services for which DSHS has no payment responsibility.
* The patient refuses to sign insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered during a period of eligibility.
* The provider has documentation that the client represented himself/herself as a private pay client and was not receiving medical assistance, when the client was eligible for, and was receiving benefits under a Medicaid program.
* The bill counts toward a spenddown liability, emergency medical expense requirement, or copayment as described under DSHS regulations.

**How should a physician handle a patient who becomes eligible for a covered service after that service has been provided?**

If a client becomes eligible for a covered service because the client applied for benefits later in the same month that the service was provided, receives a delayed certification, or receives a retroactive certification for benefits, the physician must:

* Not bill, demand, collect or accept payment for the service.
* Promptly refund the total payment received from the patient, and then bill Medicaid for the services.

**May a physician bill services provided to minors to the minor’s parents or guardians?**

Generally, yes. A physician, however, may not, without the minor’s consent, release information concerning a minor’s care to the minor’s parent, if the minor was entitled to receive the care without the parent’s consent. In this situation, the physician should not bill a minor’s parent for the treatment provided absent the minor’s consent. See [Minors, Treatment Of](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/treatment-of-minors/minors-treatment-of). A minor receiving mental health treatment, and responsible others, is liable for the costs of such treatment, care, and transportation to the extent of available resources and ability to pay. Moreover, under Washington law, a minor’s parent or guardian is not liable for:

Care rendered to a minor age 14 or older who requests treatment for a sexually transmitted disease. See [AIDS/HIV/STD.](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd)

Treatment for alcoholism, intoxication or drug addiction of a minor age 13 or older to which the parent or guardian did not join in giving consent.

**May a physician charge for producing copies of medical records?**

Yes, generally. See [Physician As Witness](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/physician-as-witness/physician-as-witness) and [Disclosure Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/hippa/disclosure-and-protection-of-health-care-info) for permissible charges. However, a physician may not bill a patient receiving Medicaid benefits, or anyone on that patient’s behalf, for copying or transferring health care information to another health care provider. Such information includes, but is not limited to:

* Medical charts.
* Radiological or imaging films.
* Laboratory or other diagnostic test results.

**Are there any other prohibitions on charging a Medicaid patient?**

Yes. Regardless of any written, signed agreement to pay, a physician may not bill, demand, collect, or accept payment from a patient, or anyone on the patient’s behalf for:

* Missed, cancelled, or late appointments.
* Shipping and/or postage charges.
* “Boutique,” “concierge,” or enhanced service packages (such as newsletters, 24/7 access to the physician, and health seminars) as a condition for access to care.
* The difference in price between an authorized service or item and an “upgraded” service or item.

**Is there any generally applicable legal requirement that physicians bill for services within a specified period of time?**

No, apart from specific contractual, regulatory, or other payor-specific billing requirements, there is no generally applicable legal requirement that physicians bill within a specified period of time. As a matter of sound business practice, physicians are well-advised not only to comply with all contractual, regulatory, and other payor-specific billing requirements, but also, in the absence of such specific requirements, to bill for services in a prompt and timely manner.

**What should a physician practice do if it owes the patient a refund, but cannot locate the patient?**

If a physician practice owes the patient a refund, but cannot locate the patient, the practice should either file an electronic report with the Department of Revenue at: <http://ucp.dor.wa.gov/holderContent.aspx> , or forward the refund, together with any report the Department of Revenue may require, to:

Washington State

Department of Revenue

Unclaimed Property Section

P.O. Box 34053

Seattle, Washington 98124-10537477

(360) 570-3264 (option 4)

Upon payment or delivery to the department, the state assumes custody and responsibility for the money, and the person who delivered the payment in good faith is relieved of liability to the extent of the value paid or delivered.

**Is there a deadline by which health carriers must request a refund from a physician?**

Yes, generally. Except in specified circumstances, a carrier may not request a refund unless it does so in writing within 24 months after the date of the payment. If the carrier is involved in a coordination of benefits with another carrier, or an entity responsible for payment, a request for a refund must be made in writing with 30 months of the date of the payment. A carrier may not request that a contested refund be paid sooner than 6 months after receipt of the request.

At any time, a carrier may request a refund of a payment previously made if a third party is found legally liable for satisfaction of the claim, and the carrier is unable to recover directly from the third party because the third party has already paid, or will pay, the physician for the health care services covered by the claim.

## Managed Care

Contracting Issues Related To Managed Care Organizations

**What general issues should a physician consider before signing a managed care contract?**

Before signing, a physician should carefully review all provisions of any managed care contract to be sure that he or she fully understands and accepts the rights, obligations, and liabilities under the contract, as well as the compensation, termination, and other provisions of the contract. Often, terminology in managed care contracts is unclear or undefined, and documents referenced in the contract are not attached. Because a physician who signs a managed care contract is presumed to have understood and to have agreed to be bound by both the contract and the documents referenced in the contract, a physician should make sure before signing the contract that any unclear or undefined terms are clarified in writing and that all documents referenced in the contract are attached and made available for the physician’s review.

It is also worthwhile for a physician to investigate the financial solvency or strength of the managed care organization (MCO) and/or the payor or payors under a managed care contract. Such an investigation reduces the chances that the physician will not be fully compensated for the services the physician will provide under the contract.

As a practical matter, physicians should consult with experienced legal counsel before signing any contract.

**What types of entities fall within the rubric of an “MCO” as that terminology is used in this Guide?**

As used in this Guide, “MCO” is meant to include any health care organization, health carrier, or health plan—such as a health insurer, disability insurer, health care service contractor, health maintenance organization, preferred provider organization, and even a governmental agency—that enters into managed care contracts with physicians to provide health services to its enrollees.

**What is a “liability assumed by contract”?**

A “liability assumed by contract” is a liability that a person has agreed in a contract to accept. For example, a physician may be deemed to have assumed a liability by contract when the physician enters into a managed care contract that contains a provision requiring the physician to indemnify or hold harmless the MCO for any losses the MCO sustains as a result of the physician’s services rendered under the contract.

**Is a “liability assumed by contract” something that a physician’s insurance policies generally cover?**

No. Many professional liability insurance policies—and other types of policies as well—exclude coverage for liabilities assumed by contract. Thus, a physician who signs a managed care contract containing a “hold harmless” or “indemnification” provision may financially responsible personally for such liability.

When faced with a request to sign any type of contract that includes a “hold harmless” or “indemnification” clause, a physician should seek legal advice and discuss the issue with his or her professional liability insurance carrier.

**May an MCO refuse to allow a physician to be on its list of providers?**

Generally, yes. Refusing to allow a physician the opportunity to be on an MCO’s list of providers does not generally, by itself, constitute a violation of Washington law. Although health carriers are required to maintain sufficient numbers and types of physicians to assure that all health plan services to covered persons will be accessible without unreasonable delay, health carriers are not prohibited from using restricted networks and may select the individual providers with whom they will contract or whom they will reimburse. Depending on the circumstances, however, antitrust considerations may force an MCO to allow a physician to be a participating provider. An MCO may also be precluded from excluding a physician for discriminatory reasons. See DISCRIMINATION.

Health carriers are required to develop selection standards for participating providers and facilities. Those selection standards must not be established in a manner that would exclude providers or facilities because they are located in geographic areas that contain populations presenting a risk of higher-than-average claims, losses, or health care utilization; or because they treat or specialize in treating persons with such higher-than-average risks; or because they treat or specialize in treating minority or special populations.

**When may an MCO or a physician terminate a managed care contract?**

The circumstances under which an MCO or a physician may terminate a managed care contract depend on the terms of the managed care contract. The contract will usually set forth the bases for termination by the MCO or the physician, the amount of notice required for such termination, and the rights and obligations of the parties upon delivery and receipt of a termination notice.

**What should a physician do when an MCO refuses to approve or pay for treatment the physician has recommended to a patient?**

To minimize a physician’s risk of malpractice liability when confronted with an MCO’s managed care decision that conflicts with the physician’s treatment recommendations, the physician should:

* Make his or her objection to the MCO’s decision known to the MCO, preferably in writing.
* Exhaust all available appeal opportunities for the patient.
* Advise the patient of the MCO’s adverse decision, the physician’s recommendation notwithstanding the adverse decision, the options available to the patient, and the risks inherent in each of those options, including the option of non-treatment.
* Document in the patient’s chart what steps were taken to change the MCO’s adverse decision, what advice was given to the patient, and what decision the patient made.

**May an MCO preclude a physician from advocating on behalf of a patient with the MCO?**

No. Under Washington law, no health carrier may prohibit or discourage a physician from advocating on behalf of a patient with a health carrier, nor may the health carrier penalize the physician for doing so. Moreover, no health carrier may in any way preclude or discourage a physician from informing patients of the care they require, which includes informing them of various treatment options and whether in the physician’s view such care is medically necessary, medically appropriate, or otherwise covered by the patient’s service agreement with the health carrier.

**May an MCO preclude a physician from discussing the comparative merits of different health carriers with their patients?**

No. Under Washington law, no health carrier may preclude or discourage patients from discussing the comparative merits of different health carriers with their physicians, nor may any health carrier prohibit physicians from or limit them in participating in those discussions even if critical of a carrier.

**May a health carrier penalize a physician who reports the carrier for an action or practice that the physician feels may jeopardize the patient’s health?**

No. A health carrier cannot penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare or that may violate state or federal law.

**May a managed care contract between a physician and a certified health plan contain a “most favored nations” clause?**

No. "’Most favored nation’ provisions in managed care contracts require physicians to give the payer the benefit of the lowest rate the physician negotiates with any other payer.” Under Washington law, the use of “most favored nations” clauses in contracts between a health care provider or facility and a certified health plan is prohibited.

**When may a managed care contract between a physician and a certified health plan or health care network contain an exclusive dealing clause?**

A contract between a certified health plan or a health care network and a health care provider or health care facility may contain an exclusive dealing clause if the certified health plan or health care network holds 20% or less of the relevant market.

But a contract between a certified health plan or health care network and a health care provider or health care facility may not contain an exclusive dealing clause if the certified health plan or health care network holds more than 40% of the relevant market.

When the certified health plan or health care network holds between 20% and 40% of the relevant market, then a contract between the plan or network and a health care provider or health care facility may contain an exclusive dealing clause only if the Department of Health has explicitly permitted such a clause to be used. There is some ambiguity in the law, so it is recommended that to obtain such approval, the plan or network should request an informal opinion as to the use of the clause in the particular circumstances or must seek approval by written petition.

**What resources does the WSMA have available that provide additional information on managed care contracting issues?**

The WSMA has available a Model Health Insurance Physician Contract, a contract evaluation service, and a scoring guide that provide additional information on managed care contracting issues. Visit the WSMA web site at www.wsma.org.

## Reimbursement

Liens For Services Related To Traumatic Injury

**Does a physician have a lien for services to persons with traumatic injury?**

Yes. Any physician who renders services to a patient due to a traumatic injury may place a lien upon any claim, right of action, and/or money (except a claim, right of action or money accruing under Washington’s Workers’ Compensation Act) which the patient is entitled to receive from a person or the insurer of a person who tortiously caused the traumatic injury.

**What is the value of the lien?**

The lien is for the value of the services provided, together with those costs and reasonable attorney’s fees incurred in enforcing the lien which the court may allow.

The lien, however, shall not exceed 25% of the amount of any award, verdict, report, decision, judgment, or settlement the patient receives from the person or insurer of the person who tortiously caused the traumatic injury. The lien does not apply to any claim, right of action, or money recovered under the workers’ compensation law.

Washington law does not preclude a physician from contracting with the patient for medical services, and does not restrict the physician from collecting the remaining balance of the value of his or her services in the event a lien was filed. If the physician chooses not to file a lien, he or she is entitled to collect the entire value of services provided from the patient directly, before or after the patient has received the settlement or litigation proceeds.

**How is the lien claimed?**

In order to claim and be entitled to the lien, the physician must file a notice with the county auditor of the county in which services were provided within 20 days after the date of injury or receipt of services, or, if settlement has not been reached and payment has not been made to the injured patient, at any time prior to settlement and payment to the patient. The notice must be verified under oath by the person claiming the lien and must state:

* The name and address of the person claiming the lien.
* The services provided.
* The identity of the parties.
* The circumstances of the injury.
* The name and address of the patient.
* The time and place where the alleged fault or negligence of the tortfeasor occurred.
* The nature of the injury.
* The name and address of the tortfeasor, if known.

**How is the lien enforced?**

The lien may be enforced by a lawsuit brought within one year after the lien is filed.

## Discrimination

### Americans with Disabilities Act

**What is the Americans with Disabilities Act (ADA)?**

The Americans with Disabilities Act is a far reaching and complex federal law which prohibits discrimination against persons with disabilities.

**What is a “disability” for purposes of the ADA?**

The ADA defines a “disability” in three ways:

* A disability is a mental or physical impairment that substantially limits one or more “major life activities” such as walking, seeing, hearing, sleeping, or taking daily care of one’s self.
* A disability is having a record of such a mental or physical impairment.
* A disability is also “being regarded as having such an impairment.”

Whether an individual has a disability under the ADA is a legal, not medical, question.

**Does the ADA prohibit physicians from discriminating against persons with disabilities in the delivery or provision of health care services and treatment?**

Yes. The ADA forbids disability-based discrimination in the delivery of health care services and treatment in two contexts – “public accommodation” and “public entity.” The standards to be applied in each of these two contexts differ.

The ADA forbids discrimination against disabled individuals “in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.” Under the ADA, the term “public accommodation” includes “professional offices of health care providers.”

The ADA also prohibits public entities such as state universities, state hospitals, public schools, local health departments, or state or local government funded clinics from denying or excluding qualified individuals with disabilities from participation in the benefits of that entity’s services, programs, or activities.

**Is a physician prohibited from refusing to treat persons who have AIDS, are HIV positive, appear to have AIDS, appear to be HIV positive, or have hepatitis C?**

Yes. Under the ADA, it is unlawful conduct for a physician, who is otherwise qualified to treat the patient’s condition, to refuse treatment to a patient because the patient has AIDS, is HIV positive, or is perceived to have either condition. An individual is considered to have a "disability" if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. Persons with HIV disease, both symptomatic and asymptomatic, have physical impairments that substantially limit one or more major life activities and are, therefore, protected by the law.

Also, under Washington State’s Law Against Discrimination, it is also unlawful to discriminate against a patient that has HIV or hepatitis C. See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd); and [Discrimination](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/discrimination).

**Does the ADA require barrier-free architecture for physical access to hospitals, clinics, and private physician offices?**

Generally, yes. The ADA dictates barrier-free architecture in new construction and modification or removal of physical barriers in existing construction for places of public accommodation and public entities. If such premises are physically inaccessible to disabled persons, then these places discriminate against disabled persons by effectively denying them access to the services provided.

Of particular importance are structural barriers to parking spaces, entrances, doors, hallways, exits, restrooms, water fountains, and telephones. Structural barriers to physical access must be removed unless it is structurally impractical to do so or unless it would result in a significant, burdensome expense.

**Does the ADA require hospitals, clinics, and private physician offices to furnish “auxiliary aids and services” to individuals with disabilities to assure effective communication?**

Generally, yes. Unless the provision of “auxiliary aids and services” would result in significant difficulty or expense, places of public accommodation such as hospitals, clinics, and private physicians’ offices must enable individuals with disabilities to communicate effectively.

The ADA defines the term “auxiliary aids and services” to include qualified interpreters (or other effective of making aurally delivered materials available to individuals with hearing impairment),, qualified readers taped text (or other effective of making visually delivered materials available to individuals with visual impairment), acquisition or modification of equipment or devices, and other similar services and actions. The federal regulations implementing the ADA, list examples for individuals with hearing and visual impairments, which include qualified interpreters, notetakers, assistive listening devices, Brailled materials, taped texts, and qualified readers. See [Interpreter Services](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/interpreter-services).

**May a physician discuss a patient’s disability or need for accommodation directly with the patient’s employer or a physician representing the patient’s employer?**

Generally, no. A physician may only discuss a patient’s condition with the patient’s employer after the physician has received written permission from the patient to do so.

**May a physician recommend that a patient’s employer make a specific accommodation for a patient?**

Generally, yes. A physician may, with the patient’s consent, recommend a specific accommodation to a patient’s employer. However, a physician should keep the following non-medical considerations in mind:

* Whether an accommodation is reasonable is an employment decision, not a medical conclusion.
* Whether a patient is disabled under the ADA is ultimately a legal, not medical, decision;
* When attempting to advise an employer about the need for accommodation, the physician should connect the specific accommodation requested to the nature of the patient’s condition.
* Because the Washington Law Against Discrimination defines “disability” differently than the federal law, a physician should specify what condition a patient has and whether that condition is cognizable and capable of being diagnosed.
* When addressing accommodation, a physician should state the physician’s source of information about the patient’s job duties. Unless the physician has done an on-site evaluation of the patient’s job or has received an official job description, the physician is relying exclusively on the patient’s description of the patient’s job functions. Other information may enable the physician to provide more accurate and realistic suggestions.
* When discussing a particular medical condition and any recommended accommodations or work restrictions, a physician should discuss the patient’s individual medical situation and individual needs and their impact on the patient’s specific job rather than make generalized statements about the condition.

**May a physician refuse to recommend a specific accommodation?**

Yes.

**What is a “medical examination” in the context of determining disability accommodations between an employer and an employee?**

A "medical examination" is a procedure or test that seeks information about an individual's physical or mental impairments or health. The guidance on Preemployment Questions and Medical Examinations lists the following factors that should be considered to determine whether a test (or procedure) is a medical examination: (1) whether the test is administered by a health care professional; (2) whether the test is interpreted by a health care professional; (3) whether the test is designed to reveal an impairment or physical or mental health; (4) whether the test is invasive; (5) whether the test measures an employee's performance of a task or measures his/her physiological responses to performing the task ; (6) whether the test normally is given in a medical setting; and, (7) whether medical equipment is used.

In many cases, a combination of factors will be relevant in determining whether a test or procedure is a medical examination. In other cases, one factor may be enough to determine that a test or procedure is medical.

Medical examinations include, but are not limited to, the following:

* Vision tests conducted and analyzed by an ophthalmologist or optometrist;
* Blood, urine, and breath analyses to check for alcohol use;
* Blood, urine, saliva, and hair analyses to detect disease or genetic markers (e.g., for conditions such as sickle cell trait, breast cancer, Huntington's disease);
* Blood pressure screening and cholesterol testing;
* Nerve conduction tests (i.e., tests that screen for possible nerve damage and susceptibility to injury, such as carpal tunnel syndrome);
* Range-of-motion tests that measure muscle strength and motor function;
* Pulmonary function tests (i.e., tests that measure the capacity of the lungs to hold air and to move air in and out);
* Psychological tests that are designed to identify a mental disorder or impairment; and,
* Diagnostic procedures such as x-rays, computerized axial tomography (CAT) scans, and magnetic resonance imaging (MRI).

There are a number of procedures and tests employers may require that generally are not considered medical examinations, including:

* Tests to determine the current illegal use of drugs;
* Physical agility tests, which measure an employee's ability to perform actual or simulated job tasks, and physical fitness tests, which measure an employee's performance of physical tasks, such as running or lifting, as long as these tests do not include examinations that could be considered medical (e.g., measuring heart rate or blood pressure);
* Tests that evaluate an employee's ability to read labels or distinguish objects as part of a demonstration of the ability to perform actual job functions;
* Psychological tests that measure personality traits such as honesty, preferences, and habits; and,
* Polygraph examinations. (Note: Under the ADA, polygraph examinations which purportedly measure whether a person believes he/she is telling the truth in response to a particular inquiry, are not medical examinations. However, an employer cannot ask disability-related questions as part of the examination.

**Does the ADA prohibit employment discrimination against persons with disabilities?**

Yes. The ADA mandates equal employment opportunities for “qualified” individuals who are also “disabled” and prohibits discrimination against them in job application procedures, hiring, advancement, compensation, training, benefits, discharge, or other terms and conditions of employment. Under some circumstances, the ADA further requires employers to provide a “reasonable accommodation” to a qualified individual with a disability. See [Discrimination](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/discrimination).

**Who is a “qualified” individual to whom the ADA applies?**

Under the ADA, a “qualified individual with a disability” is an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires.

Employees whose disabilities can be corrected with eyeglasses or contact lenses may not be covered under the ADA as having an impairment that substantially limits one or more major life activities, but the employee still may be considered disabled under the “record of” or “regarded as having” definitions of disability. However, determining whether an impairment substantially limits a major life activity must be made without taking into account mitigating measures such as medication, medical supplies, equipment, or appliances, low-vision devices (other than ordinary eyeglasses or contact lenses), prosthetics, hearing aids and cochlear implants, mobility devices, oxygen therapy or supplies, assistive technology, reasonable accommodation or auxiliary aids or services, or learned behavioral or adaptive neurological modifications.

**What is a “reasonable accommodation”?**

Generally, a reasonable accommodation is something that enables a disabled employee to perform the essential functions of the job or permits an employee to enjoy similar benefits to those which other employees enjoy. Under the ADA, “reasonable accommodation” may include making existing facilities used by employees readily accessible to, and usable by, individuals with disabilities, and other modifications including job restructuring, part-time or modified work schedules, reassignment to a vacant position, modification of equipment or devices, appropriate adjustment or modification of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations.

The ADA does not require wholesale job restructuring or shifting of the essential functions of the job to other employees. The ADA also does not require the creation of a job.

An employer may be relieved of any obligation to provide a reasonable accommodation if the individual’s employment poses a direct threat to the health or safety of others that cannot be eliminated by reasonable accommodation. Fear of a direct threat, however, is not enough to relieve an employer of the obligation to provide a reasonable accommodation.

**May someone other than the individual with a disability request a reasonable accommodation on behalf of the individual?**

Yes, a family member, friend, health professional, or other representative may request a reasonable accommodation on behalf of an individual with a disability. Of course, the individual with a disability may refuse to accept an accommodation that is not needed.

**Does the ADA’s prohibition against employment discrimination apply to all employers?**

No. Job discrimination against people with disabilities is illegal if practiced by:

* Private employers,
* state and local governments,
* employment agencies,
* labor organizations, and
* labor-management committees.

The part of the ADA enforced by the EEOC outlaws job discrimination by all employers, including State and local government employers, with 15 or more employees after July 26, 1994.

The Washington Law Against Discrimination, however, also prohibits employment discrimination based on the presence of a physical, mental or sensory disability by all employers with eight or more employees. See [Discrimination](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/discrimination).

### Discrimination

**On what bases is a physician prohibited from denying a person access to professional services or treatment?**

Washington law and various federal laws prohibit physicians from denying a person access to professional services or treatment based on the following particular individual attributes:

* Race.
* Creed.
* Color.
* Sex.
* National origin or ancestry.
* Sensory, mental, or physical handicap or disability.
* A disabled person’s use of a trained guide dog or service animal.

Washington law also prohibits this kind of discrimination on the basis of sexual orientation (including gender identity) or honorably discharged veteran or military status.

The following conduct, if based on one or more of these particular individual attributes of a patient or a prospective patient, can constitute unlawful discrimination in Washington:

* Denying a person entrance to a hospital, clinic, or physician’s office.
* Denying a person professional treatment or services.
* Causing a person seeking such services to be treated as not welcome, accepted, desired, or solicited.

**Can a physician be personally liable for discrimination in the access to or delivery of medical treatment?**

Yes. Almost all hospitals, clinics, laboratories, physician offices, universities, colleges, schools, and other places where medical treatment is delivered are places of public accommodation that are prohibited from discriminating in the access to or delivery of medical care. The Washington Law Against Discrimination (WLAD) permits not only injunction, but recovery of actual damages sustained by the aggrieved individual (or both) and attorneys’ fee against persons found to have violated the WLAD, including in places of public accommodation.

**Is it a criminal offense for a physician to withhold professional services or treatment from a person based on the person’s race, creed or color?**

Yes. In Washington, it is a misdemeanor to deny a person access to professional services or treatment based on the person’s race, creed or color.

**Is a physician prohibited from refusing to treat persons who have AIDS, are HIV positive, appear to have AIDS, appear to be HIV positive, or have hepatitis C?**

Yes. Under the ADA, it is unlawful conduct for a physician, who is otherwise qualified to treat the patient’s condition, to refuse treatment to a patient because the patient has AIDS, is HIV positive, or is perceived to have either condition. An individual is considered to have a "disability" if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. Persons with HIV disease, both symptomatic and asymptomatic, have physical impairments that substantially limit one or more major life activities and are, therefore, protected by the law. See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/discrimination#/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd) and [Americans With Disabilities Act.](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/americans-with-disabilities-act)

**Under what circumstances do the laws prohibiting discrimination on the basis of national origin require physicians to provide foreign language interpreter services to patients with limited English proficiency?**

See [Interpreter services](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/interpreter-services).

**Under what circumstances do the laws prohibiting discrimination require physicians to provide auxiliary aids, including qualified sign language interpreters, to patients with hearing, speech, or visual impairments?**

See [Interpreter services](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/interpreter-services).

**Can a physician be discriminated against for refusing to perform an abortion?**

No. A physician may not be discriminated against for refusing to perform an abortion. See [Abortion](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/abortion/abortion).

**Can a physician be discriminated against for refusing to withhold or to withdraw life sustaining treatment?**

No. A physician may not be discriminated against for either participating in or refusing to participate in the withholding or withdrawal of life sustaining treatment. See [End of Life Care Documents](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/advance-directivespolst/end-of-life-care-document) for the procedure to follow in refusing to comply with a patient’s living will.

**On what bases is an employer generally prohibited from engaging in discrimination?**

Federal, state, and applicable local laws prohibit employers from basing employment decisions on the following particular individual attributes:

* Age.
* Sex. See [Sexual Harassment](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/sexual-conductharassmentabuse#sexualharassment).
* Race.
* Religion.
* Creed.
* Color.
* National origin.
* Presence of any sensory, mental, or physical handicap, or use of a trained guide dog or service animal by a disabled person. See [Americans With Disabilities Act.](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/americans-with-disabilities-act)

The State of Washington also prohibits employment discrimination based on:

* Marital status.
* Sexual orientation (including gender identity).
* Honorably discharged veteran or military status.
* HIV or Hepatitis C infection.

The City of Tacoma also prohibits employment discrimination based on:

* Familial status (whether one has children).
* Sexual orientation.
* Gender identity.
* Marital status.
* Honorably discharged veteran or military status.

The City of Seattle also prohibits employment discrimination based on:

* Marital status.
* Sexual orientation.
* Gender identity.
* Political ideology.
* Honorably discharged veteran or military status.
* Genetic information.

The City of Spokane also prohibits employment discrimination based on:

* Sexual orientation.
* Marital status.
* Familial status.

Unincorporated King County also prohibits employment discrimination based on:

* Marital status.
* Sexual orientation (including gender identity).

The following conduct, if based on one or more of these particular attributes of an employee or prospective employee, can constitute employment discrimination:

* Refusing to hire the prospective employee.
* Refusing to promote the employee.
* Denying the employee a benefit.
* Creating a hostile work environment for the employee.
* Discharging the employee.
* Taking other adverse action regarding the employee’s compensation or other terms or conditions of employment.

The federal, state, and local laws governing employment discrimination set minimum standards only. Hospitals and other businesses may have internal policies that offer their employees more protection than these laws provide. A physician who violates these policies may be subject to discipline by the hospital or business even though the physician has not necessarily violated any laws.

**Can a particular individual attribute be considered by an employer in a nondiscriminatory way?**

In some circumstances, yes. It is not unlawful to consider any of the particular individual attributes identified above in an employment decision if it can be demonstrated that the particular attribute is a bona fide occupational qualification. This exception is narrowly applied and may be difficult to establish.

**What employers are subject to these various federal, state, and local laws against discrimination?**

Whether an employer is subject to the various anti-discrimination laws depends on the number of employees, the employer’s status as a public or private sector employer, and the geographical location of the employer’s business.

* Number of employees:
* Most federal laws apply only to employers who have 15 or more employees.
* Washington’s Law Against Discrimination technically applies only to employers who have eight or more employees, but Washington courts recognize a common law tort cause of action for discrimination against employers with fewer employees.
* The Seattle Municipal Code applies to employers who have one or more employees.
* The King County Code (which covers unincorporated King County) applies to employers with eight or more employees.
* The Tacoma Municipal Code applies to employers with eight or more employees.
* The Spokane Municipal Code applies to employers with eight or more employees.
* Washington’s equal pay statute applies to any employer who employs both males and females.
* Public or private sector. Certain federal and state laws apply to public sector employers no matter how few employees they may have. Public sector employers include the federal government and any of its agencies, departments, commissions, hospitals, or laboratories; and the state government and any of its agencies, boards, departments, school districts, colleges and universities, or hospitals.
* Certain federal laws apply to public and private employers who receive federal financial assistance.
* Private employers are subject to the law when the numerical thresholds for employees are met.
* Geographical location. The additional prohibitions imposed by unincorporated King County, the City of Seattle, the City of Tacoma, and the City of Spokane apply respectively only to employers whose businesses are located in those areas.

**Can a physician be personally liable for acts of employment discrimination?**

Yes. Washington’s Law Against Discrimination and Seattle’s Municipal Code permit an aggrieved employee to allege discrimination by any individual person acting in the interest of an employer. Thus, a physician in a supervisory, managerial, or other decision-making position may be personally liable for employment discrimination.

**Is an employee who reports an incident or files a charge of discrimination protected from retaliation?**

Yes. It is unlawful to retaliate against anyone who, in good faith, makes a formal or an informal complaint to management or files a charge or lawsuit alleging employment discrimination. It is also unlawful to retaliate against anyone who participates in the investigation of a complaint or charge or who testifies in any legal proceeding. Most public and private businesses also have internal policies that prohibit retaliation.

### Interpreter Services

**What functions and requirements are covered under the heading of “Interpreter Services”?**

Interpreter services include two broad areas: limited English proficiency and hearing/speech/visual impairments.

**Under what circumstances may physicians need to provide qualified foreign language interpreter services to patients with limited English proficiency?**

Physicians may need to provide qualified foreign language interpreter services to patients with limited English proficiency:

* To avoid prohibited discrimination on the basis of national origin under TitleVI of the Civil Rights Act of 1964.
* To avoid prohibited discrimination on the basis of national origin under the Washington Law Against Discrimination (WLAD).
* To avoid prohibited discrimination on the basis of national origin under any applicable local law.
* When necessary to obtain the patient’s fully informed consent.

See [Discrimination](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/discrimination); and [Informed Consent](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-malpractice/informed-consent).

**Is inadequate interpretation for patients with limited English proficiency a form of prohibited discrimination under TitleVI?**

Yes. The Department of Health and Human Services (DHHS) Office for Civil Rights has concluded that inadequate interpretation for patients with limited English proficiency is a form of prohibited discrimination on the basis of national origin under TitleVI. Under TitleVI, physicians who treat Medicaid patients (or who receive payment to treat patients under any other program that receives federal financial assistance from DHHS) are obligated to ensure that patients under such programs who have limited English proficiency have an opportunity equal to that of English speaking patients to receive and otherwise benefit from medical services confidentially, with effective communication, and with fully informed consent.

Physicians who treat Medicaid patients (or who receive payment to treat patients under any other program that receives federal financial assistance from DHHS) must take reasonable steps to ensure meaningful access to their services by persons with limited English proficiency. The starting point for a determination of the extent of the obligation to provide limited English proficiency services is an individualized assessment that balances 4 factors:

* The number or proportion of persons with limited English proficiency eligible to be served, or likely to be encountered.
* The frequency with which individuals with limited English proficiency come in contact with the provider.
* The nature and importance of the services provided to people’s lives.
* The resources available to the provider, and the attendant costs.

Thus, if a foreign language interpreter is needed to afford a Medicaid patient with limited English proficiency an opportunity equal to that of English-speaking patients to receive medical services confidentially, with effective communication, and with fully informed consent, then the failure to provide qualified foreign language interpreter services at no cost to the patient may constitute prohibited discrimination on the basis of national origin under TitleVI.

**Has the DHHS Office of Civil Rights issued any policy guidance to clarify the responsibilities of providers of health services who receive federal financial assistance from DHHS and assist them in fulfilling their responsibilities to persons with limited English proficiency under TitleVI?**

Yes. On August8, 2003, the DHHS Office of Civil Rights published, subject to modification after review of comments, its “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” at 68 Fed. Reg. 47311. Copies of that policy guidance can be found at: <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>.

**Are there any exceptions under Title VI of the Civil Rights Act of 1964?**

Yes. In medical emergencies, a physician or other recipient of federal funds does not violate TitleVI if the immediate provision of a service is necessary to prevent the death or serious impairment of the patient’s health, and such service cannot be provided except through a medical facility which refuses or fails to comply with TitleVI requirements.

**Is inadequate interpretation for patients with limited English proficiency also a form of prohibited discrimination under the WLAD?**

Probably yes. Although there are no regulations or cases interpreting the WLAD’s prohibition of discrimination on the basis of national origin, the Washington State Human Rights Commission (WSHRC) and the state courts typically will resort to interpretations of similar federal laws in interpreting the provisions of the WLAD. Because the DHHS Office of Civil Rights has concluded that inadequate interpretation for patients with limited English proficiency is a form of prohibited discrimination on the basis of national origin under TitleVI of the Civil Rights Act of 1964, the WSHRC and the state courts likely would conclude that inadequate interpretation for patients with limited English proficiency is a form of prohibited discrimination on the basis of national origin under the WLAD. Unlike TitleVI of the Civil Rights Act of 1964, however, the WLAD is broadly applicable to any place of public accommodation, which includes any place where medical service or care is available, and is not limited in applicability just to recipients of federal financial assistance.

**Who is responsible for paying for the interpreter services?**

The physician or practice is responsible. In fact, patients must be fully informed of the availability of a qualified interpreter at no cost to the patient. Qualified interpreters are considered “auxiliary aids” under the Americans with Disability Act. Physicians are placed in the position of either paying for the costs of the interpreter or being subject to potential liability in tort (failure to get informed consent) and administrative sanctions from federal and state agencies for language discrimination.

**Are there any state programs that cover the cost of interpreter services?**

Yes. The Washington State Department of Social and Health Services (DSHS) will reimburse physicians for the cost of interpreter services when treating Medicaid patients so long as the interpreter is a contracted vendor with DSHS. For information on reimbursement for interpreter services for Medicaid patients go to the DSHS website at: <http://hrsa.dshs.wa.gov/InterpreterServices/>.

**How do I find an interpreter?**

Washington State has established procedures for identifying qualified interpreters and translators, in both foreign languages and American Sign Language. Effective September, 2012, the Health Care Authority has entered into an agreement with a single state-wide vendor for interpreter services for Medicaid patients. Information about this program may be found at: <http://hrsa.dshs.wa.gov/InterpreterServices/>. The Northwest Translators & Interpreters Society is a helpful resource for locating medical interpreters and can be located at <http://www.notisnet.org/>.

**May family members or friends of the patient be used to provide the foreign language interpreter services?**

Generally no. Family members or friends of the patient, or other unqualified interpreters, should not be used unless the patient so chooses, without coercion, after being fully informed of the availability of qualified foreign language interpreters at no cost to the patient. If a person with limited English proficiency voluntarily chooses to provide his or her own interpreter, a physician should consider making a record of that choice, and of the physician’s offer of assistance. The physician should consider issues of competence, appropriateness, conflicts of interest, and confidentiality in determining if the desire of the person with limited English proficiency to use an interpreter of his or her own choosing should be respected. A physician may not require a patient to use a family member as an interpreter.

**Even if the failure to provide a qualified foreign language interpreter for a patient with limited English proficiency did not constitute prohibited discrimination under laws prohibiting discrimination on the basis of national origin, should a physician nonetheless provide one?**

Yes, in order to assure that informed consent to treatment is obtained. If the physician’s failure to provide a qualified foreign language interpreter were to result in a failure to obtain informed consent, the physician could be exposed to civil liability under the medical malpractice laws.

**Under what circumstances may physicians need to provide auxiliary aids, including qualified sign language interpreters, to patients with hearing, speech, or visual impairments?**

* To avoid prohibited discrimination on the basis of disability under Section504 of the Rehabilitation Act of 1973. Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any Federal department or agency, including the U.S. Department of Health and Human Services (DHHS).
* To avoid prohibited discrimination on the basis of disability under TitlesII and III of the Americans with Disabilities Act.
* To avoid prohibited discrimination on the basis of disability under the WLAD.
* To avoid prohibited discrimination on the basis of disability under any applicable local law.
* To obtain the patient’s fully informed consent.

See [Americans With Disabilities Act](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/americans-with-disabilities-act); [Discrimination](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/discrimination); and [Informed Consent](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-malpractice/informed-consent).

**Is the failure to provide appropriate auxiliary aids, including qualified sign language interpreters, for patients with hearing, speech or visual impairments a form of prohibited discrimination under Section 504?**

Yes. The regulations implementing Section 504 specifically provide in connection with health care services that a recipient of federal financial assistance:

that employs fifteen or more persons shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.

The regulations further provide that auxiliary aids include such things as interpreters, brailled and taped material, and other aids for persons with impaired hearing or vision.

The DHHS Office for Civil Rights has concluded that the failure to provide a sensory-impaired patient with an appropriate auxiliary aid, including a qualified sign language interpreter for the hearing-impaired person whose primary or exclusive language is sign language, is a form of prohibited discrimination under Section 504. Thus, under Section 504, physicians (at least in practices with 15 or more employees) who treat Medicaid patients (or who receive payment under any other program which receives federal financial assistance from DHHS) are obligated to insure that patients under such programs with hearing, speech, or visual impairments have an opportunity equal to that of nonimpaired patients to receive medical services confidentially, with effective communication, and with fully informed consent.

If a Medicaid patient has a hearing, speech or visual impairment that substantially limits the ability to communicate such that an auxiliary aid, or service, such as a qualified sign language interpreter, is needed for effective communication, then the failure to provide an appropriate auxiliary aid, or qualified sign language interpreter, at no cost to the patient may constitute prohibited discrimination on the basis of disability under Section 504.

**Are there any exceptions?**

Other than the exceptions for practices with less than 15 employees, outlined above, no exceptions are stated in the regulations implementing Section 504.

A physician probably would not be deemed in violation of Section504 for providing emergency medical treatment to a hearing, speech or visually impaired Medicaid patient without a qualified sign language interpreter, or other appropriate auxiliary aid or service, if the exigencies of the emergency made it impractical to first obtain an interpreter or other appropriate auxiliary aid or service or to transport the patient to a hospital.

Hospitals which are recipients of federal financial assistance, however, are required to establish a procedure for effective communication with hearing-impaired persons for the provision of emergency health care.

**Is the failure to provide appropriate auxiliary aids, including qualified sign language interpreters, to patients with hearing, speech or visual impairments a form of prohibited discrimination under TitlesII and III of the ADA?**

Yes. The failure of a public entity (governed by TitleII of the ADA) or a public accommodation (governed by TitleIII of the ADA) to provide an appropriate auxiliary aid, or qualified sign language interpreter, at no cost to the patient, if necessary to afford a patient with a hearing, speech, or visual impairment an opportunity equal to that of nonimpaired patients to receive medical services confidentially, with effective communication, and with fully informed consent, may constitute prohibited discrimination on the basis of disability under TitleII or Title III of the ADA. See Americans With Disabilities Act.

Thus, a public entity or a public accommodation’s failure to provide an appropriate auxiliary aid, or qualified sign language interpreter, at no cost to the patient, if necessary to afford a patient with a hearing, speech, or visual impairment an opportunity equal to that of nonimpaired patients to receive medical services confidentially, with effective communication, and with fully informed consent, may constitute prohibited discrimination on the basis of disability under Title II or Title III of the ADA.

**Are there any exceptions?**

Yes. Neither a public entity nor a public accommodation is required to take any action or provide any auxiliary aid that it can demonstrate would fundamentally alter the goods, services, programs or activities being offered or would result in an undue burden. Both fundamental alteration and undue burden are difficult defenses to establish.

A “fundamental” alteration is a modification so significant that it alters the essential nature of the goods, services, facilities, privileges, advantages, accommodations, programs or activities being offered.

“Undue burden” means “significant difficulty or expense.” Relevant factors to be considered in determining whether there is significant difficulty or expense include:

* The nature and cost of the action.
* The overall financial resources of the site or sites involved; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements necessary for safe operation, including crime prevention measures; or any other impact of the action on the operation of the site.
* The geographic separateness, and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity.
* If applicable, the overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; the number, type and location of its facilities.
* If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure, and functions of the workforce of the parent corporation or entity.

Even if the provision of a particular auxiliary aid or service, including qualified sign language interpreter services, would result in a fundamental alteration or undue burden, the public entity or public accommodation must still provide an alternative auxiliary aid and/or service, if one exists, that would not result in a fundamental alteration or undue burden, but would nevertheless ensure that, to the maximum extent possible, individuals with disabilities receive the goods, services, facilities, privileges, advantages or accommodations offered by the public entity or public accommodation.

**What do “auxiliary aids and services” include under the ADA?**

Under both Titles II and III of the ADA, the term “auxiliary aids and services” includes:

* For hearing-impaired patients:
  + Qualified interpreters (on-site or through video remote interpreting).
  + Notetakers.
  + Real-time computer-aided transcription services.
  + Written materials.
  + Exchange of written notes.
  + Telephone handset amplifiers.
  + Assistive listening devices.
  + Assistive listening systems.
  + Telephones compatible with hearing aids.
  + Closed caption decoders.
  + Open and closed captioning (including real-time captioning).
  + Telecommunications devices for deaf or hearing impaired persons (including TTY’s, videophones, and captioned telephones).
  + Videotext displays.
  + Accessible electronic and information technology.
  + Other effective methods of making aurally delivered materials available to individuals with hearing impairments.
* For visually impaired patients:
  + Qualified readers.
  + Taped texts.
  + Audio recordings.
  + Brailled materials and displays.
  + Screen reader software.
  + Magnification software.
  + Optical readers.
  + Secondary auditory programs (SAP).
  + Large print materials.
  + Accessible electronic and information technology.
  + Other effective methods of making visually delivered materials available to individuals with visual impairments.

Auxiliary aids and services also include the acquisition and modification of equipment or devices and other similar services and actions.

Where a public entity communicates by telephone with applicants and beneficiaries, telecommunication devices for deaf persons (TDD’s), or equally effective telecommunication systems, must be used to communicate with individuals with impaired hearing or speech.

A public accommodation that offers a patient or participant the opportunity to make outgoing telephone calls on more than an incidental convenience basis must make available, on request, a TDD for use by an individual with impaired hearing or speech. A public accommodation, however, is not required to use a TDD for receiving or making telephone calls incident to its operations.

Neither public entities nor public accommodations are required to provide to individuals with disabilities personal devices, such as wheelchairs, individually prescribed devices, prescription eyeglasses or hearing aids, readers for personal use or study, or services of a personal nature including assistance in eating, toileting or dressing.

**Is the failure to provide appropriate auxiliary aids, including qualified sign language interpreters, for patients with hearing, speech or visual impairments a form of prohibited discrimination under the WLAD?**

Yes. The regulations interpreting the WLAD’s disability documentation prohibitions make clear that the purposes of the WLAD are best achieved when persons with disabilities are treated the same as if they had no disability. The regulations further require places of public accommodation to “reasonably accommodate” known physical, sensory, or mental limitations of persons with disabilities so that persons with disabilities receive and may fully enjoy the same service as persons without disabilities.

“Reasonable accommodation” is action, reasonably possible in the circumstances, to make the regular services of a place of public accommodation accessible to persons who otherwise could not use or fully enjoy the services because of the person’s sensory, mental, or physical disability.

For physicians, this means that if a patient has a hearing, speech or visual impairment that limits the ability to communicate such that a reasonable accommodation like an auxiliary aid or service, including a qualified sign language interpreter, is needed for the patient to receive medical services confidentially, with effective communication, and with fully informed consent, then the failure to provide a reasonable accommodation (auxiliary aid or service, such as a qualified sign language interpreter) at no cost to the patient may constitute prohibited discrimination on the basis of disability under the WLAD.

**Are there any exceptions?**

Yes. Current rules incorporate the concept of “arranged service” within the scope of “reasonable accommodation.” “Arranged service,” which was formerly set forth in regulations implementing the WLAD, provided that when same service will not carry out the purpose of the law and no accommodation is reasonable, then the place of public accommodation should use the third best solution – “arranged service.”

"Arranged service” means “making the services or goods of a place of public accommodation available to a person with a disability or a person with a disability using a trained guide dog or service animal at a place or in a way that is different from the place or way that the service is offered to the public in general, in order to serve the person.”

Arranged service is fair, however, only when neither the same service nor reasonable accommodation is possible and the choice is between arranged service and no service.

In addition, the Washington State Human Rights Commission (WSHRC) has the power to grant exceptions in specific instances to any rules it adopts. Requests for exceptions must be in writing and filed with the clerk of the WSHRC.

**May family members or friends of the patient be used to provide interpreter services when that is the auxiliary aid or reasonable accommodation that is needed?**

Generally no. Family members or friends of the patient, or other unqualified interpreters, should not be used unless the patient so chooses, without any coercion, after being fully informed of the availability of qualified interpreters at no cost to the patient.

**Even if the failure to provide an appropriate auxiliary aid, including a qualified sign language interpreter, for patients with hearing, speech or visual impairments did not constitute prohibited discrimination, should a physician nonetheless do so?**

Yes, in order to assure that informed consent to treatment is obtained. If the physician’s failure to provide an appropriate auxiliary aid or a qualified sign language interpreter were to result in a failure to obtain informed consent, the physician could be exposed to civil liability under the medical malpractice laws.

## Health Care Representatives

### Guardians and Attorneys-in-Fact

**Who may have a guardian?**

A county’s superior court may appoint a guardian for an incapacitated person. An “incapacitated” person is:

* A person under 18 years of age; or
* A person whom the court determines has a significant risk of personal harm based upon a demonstrated inability to adequately provide for nutrition, health, housing, or physical safety; or
* A person whom the court determines is at significant risk of financial harm based upon a demonstrated inability to adequately manage property or financial affairs.

**Who is an “incompetent” person for purposes of giving informed consent for health care?**

For purposes of giving informed consent for health care, an “incompetent” person is:

* A person so affected by mental illness, developmental disability, senility, habitual drunkenness, excessive use of drugs, or other mental incapacity that caring for himself or herself or managing his or her property, or both, is impossible.
* A person who is “incapacitated” as set forth above.

**Who may be a guardian?**

Any suitable person over the age of 18, or any parent under the age of 18, may be appointed guardian of an incompetent patient.

A person may not act as guardian if he or she is of unsound mind or has been convicted of a felony or of a misdemeanor involving moral turpitude.

The court may refuse to appoint a person as guardian if the court finds that person unsuitable.

**Can a guardian give informed consent?**

Yes. If a patient is incompetent to give informed consent, a physician may obtain valid consent from the patient’s court-appointed guardian. A physician’s duties to the guardian are the same as to the patient. The guardian must be informed of all material risks, benefits, and alternatives. See [Informed Consent](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-malpractice/informed-consent). A consent form is valid if signed by the patient’s court-appointed guardian. A guardian may not involuntarily commit the alleged incapacitated person for mental health treatment, observation, or evaluation unless the procedures for involuntary commitment have been followed. A guardian may not give consent to psychosurgery, to therapy or any other procedures that induce convulsions, or to any psychiatric or mental health procedures that restrict the patient’s ability to move or, if the patient has been involuntarily committed, in any way restrict the rights granted to involuntarily committed patients under Washington law. A guardian may authorize consent for electroconvulsive therapy, however, if the alleged incapacitated person consented to inpatient admission and electroconvulsive therapy in a mental health advance directive.

**Who may be an attorney-in-fact?**

A person may designate another person to act as his or her attorney-in-fact by signing a document called a “power of attorney.” The writing must show the intent of the person that the authority conferred on the attorney-in-fact shall be exercisable in the event of the person’s later disability or incapacity. All acts done by the attorneyinfact during any period of disability, incompetence, or uncertainty as to whether the person is dead or alive, have the same effect as if the person were alive, competent, and not disabled.

**What should a physician do before relying on an attorney-in-fact?**

The physician should be provided with a power-of-attorney that requests the physician to accept the attorney-in-fact’s authority to act on behalf of the patient. The attorney-in-fact should also present a sworn affidavit verifying his or her identity and the conditions under which he or she has assumed the role of attorney-in-fact. Such conditions must include, among others, that the patient was competent and not under undue influence when the power of attorney was signed, and that the attorney-in-fact has no knowledge that the power-of-attorney has been revoked, modified, or limited. (See RCW 11.94.040 for the complete list of conditions.) Once the physician has examined the power-of-attorney and confirmed the identity of the attorney-in-fact, the physician may rely on the power-of-attorney, so long as that reliance is in good faith, and the physician has no reason to know that any of the statements in the sworn affidavit are untrue.

**May a person authorize an attorney-in-fact to provide informed consent for health care decisions?**

Yes. A person may authorize his or her attorney-in-fact to provide informed consent for health care decisions on the person’s behalf by so stating in the written power of attorney.

The following persons, however, may not act as the attorney-in-fact to provide informed consent for a person unless they are the spouse, state registered domestic partner, adult child, or brother or sister of the person:

* The person’s physicians.
* The physician’s employees.
* The owners, administrators, or employees of the health care facility or long-term care facility where the person resides or receives care.

### Powers of Attorney

See [Guardians and Attorneys-In-Fact](http://legalguide.wsma.org.onexcale.net/practice-management-issues/health-care-representatives/guardians-and-attorneys-in-fact) for the nature and effect of a Power of Attorney.

## Medical Waste

**Are there regulations which govern the disposal of medical waste/biomedical waste?**

Yes. There are specific state and federal regulations governing the disposal of biomedical waste. State rules require that biomedical waste be disposed according to applicable state and county regulations. Each county in Washington has regulations that require specific management and disposal of biomedical waste. Please check with your county health department for rules specific to your area.

**What is biomedical waste?**

Biomedical waste includes:

* Animal waste, including animal carcasses, body parts or bedding of animals known to have been infected with human pathogenic microorganisms.
* Biosafety Level 4 disease waste which includes waste contaminated with blood, excretions, exudates, or secretions from humans or animals which are isolated to prevent contact with highly communicable infectious diseases designated as Biosafety Level 4 under CDC standards.
* Cultures and stocks, which include cultures and stocks of microbiological agents, human serums, live and attenuated vaccines, human blood specimens, including culture dishes, blood specimen tubes and devices to transfer, inoculate and mix cultures.
* Human blood and blood products, meaning discarded human blood and blood components, and materials containing these fluids.
* Pathological waste, including human biopsy material, tissue and anatomical parts that emanate from surgery, obstetrical procedures, autopsy and laboratory procedures (this does not include teeth or remains intended for internment or cremation).
* “Sharps waste” which includes hypodermic needles, syringes with needles attached, IV tubing with needles attached, scalpel blades and lancets that have been removed from their original sterile packages.

**How must biomedical waste be disposed of?**

All biomedical waste must be contained in a manner which complies with federal and state regulations. Contaminated sharps must be disposed of immediately or as soon as possible in an appropriate container. Containers for contaminated sharps waste must be closable, puncture resistant, leakproof on the sides and bottom, and labeled with the word “Biohazard” and display the federally mandated biohazard symbol, or color-coded according to OSHA guidelines. Other biomedical waste must be placed in containers which are closable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping, labeled or color-coded according to OSHA guidelines, and closed prior to removal to prevent spillage or protrusion of the contents. If outside contamination of the container occurs, the container must be placed in a second container that prevents leakage and is color-coded.

Biomedical waste or any material in a container labeled as containing biomedical waste must not be compacted.

Biomedical waste may only be disposed of at a treatment and disposal site that meets all applicable regulations. Prior to shipping biomedical waste to a disposal site, the generator must sign a shipping paper which contains the following information:

* Name and address of generator of the biomedical waste.
* Name of the generator representative signing the shipping papers.
* Name of the carrier transporting the waste.
* Date and time of collection.
* Destination and final treatment, storage and disposal of the biomedical waste.
* The general type and quantity of biomedical waste collected.
* Signature by an authorized representative of the biomedical waste generator acknowledging delivery and compliance with all applicable federal, state and local rules regarding packaging and containment.
* Signature by a representative of the company transporting the biomedical waste, acknowledging receipt.

There are more detailed requirements for the safe handling of sharps and bloodborne pathogens as governed by the Department of Labor and Industries. Also see [Hypodermic Needles And Syringes](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/prescription-drugs/hypodermic-syringes-and-needles).

**Are there special regulations governing the disposal of hypodermic needles and syringes used at home?**

Yes. State law prohibits intentionally placing unprotected sharps or a sharps waste container in a recycling container provided by a city, county, or solid waste collection company unless it is specifically designated as a drop-off for sharps waste, or in trash cans or bins if there is a separate collection service available for residential sharps waste. Residential sharps waste must be disposed of in accordance with procedures adopted by local solid waste utilities. These regulations vary from region to region, and the local solid waste utility should be consulted before disposing of residential sharps.

**Must a physician employer who has employees who may come in contact with bloodborne pathogens take special precautions with respect to the working environment?**

Yes. Employers whose employees may come into contact with blood-borne pathogens must prepare and implement exposure control plans to eliminate or minimize the risk of occupational exposure to bloodborne pathogens and needlestick or sharps injuries. See [Hypodermic Needles And Syringes](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/prescription-drugs/hypodermic-syringes-and-needles).

Note that the Department of Labor & Industries provides a free consultation service, which is available to all employers. Assistance may include advice on health and safety matters, an analysis of health and safety issues in the work place, or help with a particular problem or question related to employee safety and health. Assistance may be obtained by contacting the Department of Labor & Industries Safety and Health Information Line at: 1-800-423-7233.

**Must a physician employer meet certain requirements for their employees to dispose of medical waste?**

Yes. Employers whose employees may come into contact with bloodborne pathogens must prepare and implement exposure control plans to eliminate or minimize the risk of occupational exposure to bloodborne and needlestick or sharps injuries.

## Office-Based Laboratories

**Must office based laboratories be licensed?**

Yes. Washington law requires that any “medical test site,” meaning any facility performing testing on material derived from the human body (e.g., tissue, blood, urine, etc.) for heath care, treatment, or screening be licensed. Such facilities also must be certified by the Secretary of Health and Human Services under the Clinical Laboratory Amendments of 1988 (CLIA).

**What kinds of licenses are required?**

The kind of license required depends on the complexity of the testing to be performed at the medical test site. If all the tests to be performed are cleared by the Food and Drug Administration (FDA) for home use, and are determined by the Centers for Disease Control (CDC) or FDA to be so simple and accurate that there is little risk of error and no reasonable risk of harm to the patient, then the laboratory can qualify, and apply, for a Certificate of Waiver under Washington law and CLIA.

**How long is a certificate of waiver valid?**

A certificate of waiver issued by the Department of Health & Human Services (DHHS) is valid for no more than two years. An application for renewal of a certificate of waiver must be completed and returned to DHHS not less than nine months, but not more than one year, before the expiration of the certificate.

**What laboratory tests may be waived under CLIA and Washington law?**

Waived tests are those tests that are cleared by the FDA for home use, that are so simple that there is little risk of error, and that pose no reasonable risk of harm to the patient if performed incorrectly. The specific tests that are subject to waiver include:

* Dipstick or Tablet reagent urinalysis (non-automated) for the following:
* Bilirubin.
* Glucose.
  + Hemoglobin.
  + Ketones.
  + Leukocytes.
  + Nitrite.
  + pH.
  + Protein.
  + Specific gravity.
  + Urobilinogen.
* Fecal occult blood.
* Ovulation tests – visual color comparison tests for luteinizing hormones.
* Urine pregnancy tests – visual color comparison.
* Erythrocyte sedimentation rate (non-automated).
* Hemoglobin – copper sulfate (non-automated).
* Blood glucose by glucose monitoring devices cleared by the FDA specifically for home use.
* Spun microhematocrit.
* Hemoglobin by single analyte instruments with self-contained or component features to perform specific reagent interaction, providing direct measurement and readout.

**Is anything further required of an office-based laboratory that obtains and operates under a Certificate of Waiver?**

Yes, laboratories operating under a Certificate of Waiver must enroll in the CLIA program, pay applicable certificate fees biennially, comply with on-site inspection rules, and follow manufacturers’ test instructions.

**Are office-based laboratories subject to inspection even if they have been granted a Certificate of Waiver?**

Yes. One of the requirements for the issuance of a waiver is that the laboratory issued a certificate of waiver must permit announced or unannounced inspections by the DHHS in accordance with the CLIA rules. The Center for Medicare and Medicaid Services (CMS) has indicated that it will visit 2% of all laboratory types, including physician office laboratories, annually. Inspectors will focus on the education and training of testing personnel to ensure quality testing. If quality problems are identified, the inspectors will provide assistance to the laboratories to achieve accurate and reliable results. The inspectors will also verify that the laboratories are operating under the correct certificates. Inspections may also be performed by the Washington State Department of Health to ensure compliance with applicable laws and regulations.

## Professional Courtesy

**Is professional courtesy prohibited by law in Washington?**

No. A physician may provide care free of charge or at reduced rates as a professional courtesy to other physicians and their families. Offering professional courtesy is not an ethical requirement according to the American Medical Association.

A physician should be careful, however, about extending professional courtesy by forgiving coinsurance or copayments, as forgiveness of coinsurance or copayments may be forbidden by certain managed care contracts. Moreover, routine waiver of Medicare deductibles or coinsurance is prohibited. The Office of the Inspector General of the Department of Health & Human Services has stated that routine waivers of Medicare deductibles and copayments are unlawful because they result in:

* False claims;
* Violations of the anti-kickback statute; and
* Excessive utilization of services paid for by Medicare.

See also [Billing](http://legalguide.wsma.org.onexcale.net/practice-management-issues/insurance-and-billing/billing).

# Clinical Practice Issues

## Workers’ Compensation

**NOTE: The Department of Labor & Industries (L&I) is in a statutorily-mandated process of implementing a new L&I provider network to care for injured workers and expanding Centers for Occupational Health and Education (COHEs). Rulemaking for the network and COHE expansion is not complete as of July 1, 2013. The provider netowrk has been implemented effective January 1, 2013. We will update the Legal Guide when new rules become implemented.**

**May a physician refuse to treat a patient with a worker’s compensation claim?**

Yes. There is no legal requirement that a physician must treat a patient with a workers’ compensation claim. But see [Physician-Patient Relationship](http://legalguide.wsma.org.onexcale.net/privacy-issues/physician-patient-relationship/physician-patient-relationship) for information as to how to terminate an existing physician-patient relationship.

**What is the Department of Labor & Industry (L&I) provider network?**

Legislation passed in the 2011 legislative session directed L&I to establish a medical provider network, which will become effective on January 1, 2013, and to expand Centers for Occupational Health and Education (COHEs). Physicians (and all other health care providers) who wish to participate in the L&I provider network must meet minimum standards, and must agree to follow L&I evidence-based coverage decisions, treatment guidelines, and policies. Detailed information about the background of the L&I provider network, and the expansion of COHEs, including a link to sign up, may be found on the L&I website at: <http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/ProvNetwork/default.asp> .

**What are the minimum standards for a physician to participate in the L&I provider network?**

To be eligible for enrollment and participation in the L&I provider network a physician must meet and maintain the minimum health care provider network standards. The physician must:

* Submit an accurate and complete provider application, and sign a L&I provider agreement without modification;
* Submit proof of professional liability coverage;
* Not have had clinical admitting and management privileges denied, limited, or terminated for quality of care issues;
* Not have been excluded, expelled, terminated, or suspended from any federally or state funded health care programs (such as Medicare and/or Medicaid) on cause or for quality of care issues;
* Not have made any material misstatement or omission to L&I regarding licensure, disciplinary history, or other material matter covered in the application or credentials materials;
* Not have been convicted of a felony or pled guilty or no contest to a felony for a crime including (but not limited to) health care fraud, patient abuse, or the unlawful manufacturing, distribution, prescription, or dispensing of controlled substances;
* Be currently licensed in Washington or in any other jurisdiction where the physician treats injured workers; and
* Have a current DEA registration.

**What is a physician’s duty to a patient with respect to a worker’s compensation claim?**

A physician has a duty under Washington law to lend all necessary assistance to a patient in making an application for workers’ compensation benefits. If a physician fails to do so, then the physician may be subject to civil liability. A physician’s duty is to:

* Tell the worker about the relationship of his or her specific injury to the worker’s rights for compensation.
* Make it possible for the worker to furnish the Department of Labor & Industries (L&I) with accurate and complete information in support of his or her application for workers’ compensation benefits.

It is not the purpose of the statute to place upon the physician the primary duty of timely making a claim. The responsibility of initiating a claim is on the worker.

The worker initiates a claim by filling out the “Worker Information” section of the “Report of Industrial Injury or Occupational Disease” form and presenting it to the physician for completion of the “Doctor Information” section. Once this section has been completed by the physician, the form is processed by the physician’s office as indicated on the form (page one is sent to L&I and the remainder of the form is sent to the employer).

**How long does a patient have from the time of industrial injury to make a claim for workers’ compensation?**

The claim form must be received by L&I within one year after the date of the injury. If the claim is not filed within one year, the claim will not be allowed.

This means a physician must promptly complete and forward a claim form to L&I and employer once it has been received from the patient.

**How long does a patient have to file a workers’ compensation claim relating to an occupational disease, infection or hearing loss?**

A worker has two years from the date that the worker had written notice from a physician: (1) of the existence of an occupational disease, infection or hearing loss, and (2) that a claim for disability benefits may be filed.

A physician must file a copy of the written notice to the patient with L&I, and the notice must contain a statement that the worker has two years from the date of the notice to file a claim.

**How does a physician process a “Report of Industrial Injury or Occupational Disease” once it has been signed by the physician?**

The patient must complete the “Worker Information” portion of the form and give it to the physician for completion of the “Doctor Information” section.

The physician must then forward one part of the application to L&I and forward another part of the application to the employer within five days of treatment. The physician may transmit the completed application electronically using facsimile.

**What should a physician do if a patient believes that the injury or disease is work-related, but the physician does not agree?**

If the patient wants to file a workers’ compensation claim, but a physician does not believe that an injury or disease is work related or believes that the relationship between the injury or disease and the patient’s work are unlikely, then the physician should so indicate in the space provided in the “Doctor Information” section on the “Report of Industrial Injury or Occupational Disease” form, and should then sign the form and process it as described above.

The physician should also specifically advise the patient of the physician’s opinion that the injury or disease is not work-related and should make a notation of that discussion in the patient’s medical record.

**What should a physician do if the physician believes the injury or disease is work-related, but the patient does not agree or does not want a claim filed?**

If a physician believes an injury or disease to be work related, the physician must notify the worker. Once the determination of work relatedness has been made by either the physician or the patient, a “Report of Industrial Injury or Occupational Disease” must be filed with L&I.

**May a physician collect the difference between the usual and customary fee and the amount allowed by the Department of Labor and Industries for the patient?**

No. When a claim has been accepted by L&I, the worker may not be charged for anything related to the medical care or management of his claim. A physician also may not charge a worker a fee for writing a report that is required by L&I, for interest, or for completion of forms related to a claim.

In cases, however, where there is questionable eligibility (i.e., a particular service is not usually allowed or a claim investigation by the L&I is ongoing), a physician may require the worker to pay for the treatment rendered. If the claim is subsequently allowed, the physician must promptly refund fees received from the worker (or insurer if applicable) and bill L&I for services rendered at fee schedule rates.

**May a physician charge a worker for a missed appointment?**

A physician may charge a worker for a missed appointment if the appointment for an examination was arranged by L&I or a self-insurer. In addition, a physician may charge a worker for a missed appointment if the physician has a missed appointment policy that applies to all of the physician’s patients, and the physician routinely notifies all patients of the missed appointment policy. Implementing such a policy is between the physician and the worker.

**Will L&I pay the physician to prepare reports?**

Yes. L&I will pay the physician, according to a L&I schedule, for preparing narrative reports that L&I requests.

**Is there a physician-patient privilege in workers’ compensation proceedings?**

Yes and no. With respect to inquiries about the physician’s care and treatment of the patient from the general public, the physician-patient privilege exists. However, with respect to actions or proceedings before L&I or the Board of Industrial Insurance Appeals, and inquiries from L&I, claims adjusters, vocational rehabilitation providers, the employer’s representatives, or attorneys for any party involved in the workers’ compensation claim, there is no physician-patient privilege.Under those circumstances the physician may discuss the claim, the patient, and the patient’s care and treatment with such persons inquiring about the claim.

**Must a physician, upon request in workers’ compensation cases, make reports and release medical information in the physician’s possession?**

Yes. Physicians examining or attending injured workers must, upon request by L&I or the employer, make reports concerning the worker’s condition or treatment and must, upon request of L&I, the employer, or the worker’s representative, release all medical information about the worker relevant to the worker’s occupational injury or disease which is in the physician’s possession or control. Under workers’ compensation law, physicians do not incur legal liability for releasing such information.

**May a physician meet with the employer’s attorney, L&I representative, or the claims adjuster without notice to or the presence of the patient (claimant) or the patient’s representative?**

Yes, although there is a general prohibition against such contacts between the defendant’s attorney and the treating physician in civil cases, see [Confidential And Privileged Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/medical-records/confidential-and-privileged-information), no such prohibition exists in a workers’ compensation case, as long as the inquiry relates to the workers’ compensation claim.

Direct contact with a physician without notice to the patient/claimant by the employer, claims adjuster or their representatives or L&I is common practice in the administration of workers’ compensation cases as it helps to expedite claim resolution.

**Must a physician meet with the employer, the employer’s attorney, the L&I, or the claims adjuster without notice to, or presence of, the patient or the patient’s representative in workers’ compensation cases?**

No. A physician is not required by law to meet with the employer, claims adjuster or their representatives without notice to or the presence of the patient/claimant.

**What should a physician do if a patient has questions about the administrative handling of a workers’ compensation claim?**

Refer the patient to L&I or advise the patient to consult an attorney.

L&I’s “help” number is printed on the patient’s claim card. It is 1-800-LISTENS (1-800-547-8637).

A physician should not volunteer or attempt to resolve such questions for the patient. It is the patient’s responsibility to obtain legal help when necessary. A physician is not expected to give legal advice.

**What are quick resources for the physician in the event of a question regarding a workers’ compensation claim?**

The L&I website ([www.lni.wa.gov](http://www.lni.wa.gov)) provides extensive information for physicians treating workers’ compensation patients. The providers’ section of the L&I website has information about treating injured workers, drugs and prescriptions, helping a worker return to work, treatment guidelines, and information concerning independent medical examinations. In addition, L&I publishes a physician’s guide, the “Attending Doctor’s Handbook,” (<http://www.lni.wa.gov/FormPub/results.asp?Keyword=Medical%20Providers> ) that provides substantial information regarding workers’ compensation claims.

L&I also provides assistance through its provider hotline at 1-800-848-0811. A substantial amount of general information about the workers’ compensation system can also be found on the claim application form.

**What role can physician assistants take in handling workers’ compensation claims?**

Physician assistants (PAs) are “treating providers” under the L&I rules, and be approved for payment for the medical services they provide under the supervision of a licensed physician. Beginning in 2013, PAs must also be an approved provider in the L&I provider network. PAs may treat L&I patients within the scope of their license. PAs may also sign and attest to any certificates, cards, forms or other documentation required by L&I that the supervising physician could sign, so long as such actions are within the PAs’ practice arrangement. This includes reports of accident or provider’s initial report forms, time-loss certification, referrals for consultations, facilitating early return to work, and expediting the vocational process by estimating the worker’s physical or mental capacities.

## Pain Management and Controlled Substances

### Addiction

**Can a physician be disciplined for personal misuse of alcohol or drugs?**

Yes. A physician’s current misuse of alcohol, controlled substances or legend drugs is considered unprofessional conduct. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct).

However, license holders voluntarily participating in an approved program without being referred by the Medical Quality Assurance Commission (MQAC) shall not be subject to disciplinary action for their substance abuse, and shall not have their participation made known to the MQAC, if they meet the requirements set forth in law, and those of the program in which they are participating.

**Does a physician have an obligation to report another physician’s drug or alcohol problem to the Department of Health?**

Since 2007, all professions licensed by the Washington State Department of Health must report anyone else licensed by the Department of Health if there is actual knowledge of (i) any conviction, determination, or finding that that the other practitioner has committed an act of that constitutes unprofessional conduct; or (ii) the other practitioner may not be able to practice with reasonable skill and safety due to a mental or physical condition. Provided there is no patient harm or sexual misconduct, reports of an inability to practice with reasonable skill and safety due to a mental or physical condition may be submitted to one of the approved impaired practitioner or voluntary substance abuse programs or to the Department of Health.

The MQAC may impose disciplinary sanctions, including license suspension or revocation, on any physician who fails to make a required report. See [Medical Discipline](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/medical-discipline).

**What is the Washington Physician’s Health Program?**

The Washington Physicians Health Program (WPHP) began in 1986 as the Washington Monitored Treatment Program (WMTP), founded by concerned members of the Washington State Medical Association (WSMA). Under the provisions of the above laws, the WPHP is able to provide a confidential conduit for healthcare practitioners so that they can get the help they need for their mental or physical condition. WPHP provides these services as a therapeutic alternative to discipline.

The Washington Physician’s Health Program is a program administered by a committee of physicians who have expertise in the treatment of alcoholism, drug abuse, and mental illness.

The committee may receive and evaluate reports of physician drug or alcohol abuse or mental illness from any source, intervene in verified cases, refer physicians for treatment, and monitor the impaired physician’s condition.

The committee will report a physician to the Medical Quality Assurance Commission (MQAC) if the committee believes the physician is an imminent danger to the public because of drug or alcohol abuse or mental illness.

The committee will also report a physician to the MQAC if the physician refuses to cooperate with the committee, if the physician refuses to submit to treatment, or if the physician’s drug or alcohol abuse or mental illness is not substantially alleviated by treatment and the physician, in the opinion of the committee, is unable to practice medicine with reasonable skill and safety.

**May a physician who prescribes potentially addictive drugs be liable if the patient becomes addicted?**

Yes. If a patient becomes addicted to prescription drugs, the physician may be liable to the patient if the physician negligently prescribed the drugs or failed to warn of the addictive nature of the drugs.

**May a physician prescribe drugs for himself or herself?**

It is unprofessional conduct for a physician to self-prescribe controlled substances or to misuse controlled substances or legend drugs. See [Controlled Substances](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/pain-management-and-controlled-substances/controlled-substances); [Legend Drugs](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/prescription-drugs/legend-drugs); and [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct).

**May a physician prescribe drugs for the physician’s family members?**

Washington law does not specifically prohibit a physician from prescribing drugs for the physician’s family members. Caution should be exercised, however, to keep thorough medical records and to avoid manipulation by family members. See [Controlled Substances](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/pain-management-and-controlled-substances/controlled-substances) and [Legend Drugs](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/prescription-drugs/legend-drugs).

### Controlled Substances

**What is a controlled substance?**

A controlled substance is a drug, substance, or immediate precursor to a drug included in Schedules I through V under federal and state law.

**What are the characteristics of controlled substances?**

*Schedule I*:Substances having no currently accepted medical uses in treatment in the U.S.; lacking accepted safety for use in treatment under medical supervision; and having a high potential for abuse.

*Schedule II*:Substances having currently accepted medical uses in treatment in the U.S. (possibly with severe restrictions); having a high potential for abuse; and, if abused, leading potentially to severe psychological or physical dependence.

*Schedule III*:Substances having currently accepted medical uses in treatment in the U.S.; having a potential for abuse less than substances listed in Schedules I and II; and, if abused, leading potentially to moderate or low physical dependence or high psychological dependence.

*Schedule IV*:Substances having currently accepted medical uses in treatment in the U.S.; having a low potential for abuse relative to substances listed in Schedule III; and, if abused, leading potentially to limited physical dependence or psychological dependence relative to the substances in Schedule III.

*Schedule V*:Substances having currently accepted medical uses in treatment in the U.S.; having a low potential for abuse relative to substances listed in Schedule IV; and, if abused, leading potentially to limited physical dependence or psychological dependence relative to the controlled substances listed in Schedule IV.

**Must a physician be registered in order to prescribe, dispense, or administer controlled substances?**

A physician must be registered with the federal Drug Enforcement Administration (DEA) before prescribing, dispensing, administering, or distributing controlled substances, unless exempted from registration by federal regulation. Physicians who prescribe or dispense narcotics to patients for maintenance treatment or detoxification treatment must obtain a separate registration for that purpose. Applications for registration may be obtained at any regional office of the DEA, or by writing to the Drug Enforcement Administration, Attn: Registration Section/ODR, P.O. Box 2639, Springfield, Virginia 22152-2639, or by calling the DEA at 1-800-882-9539 (or 206-553-5443 locally).

Physicians licensed in the State of Washington are exempted from registering with the State, but this exemption may be revoked.

**May a physician’s controlled-substances registration be suspended or revoked?**

Yes. A physician’s federal registration may be suspended or revoked upon a finding that:

* the physician materially falsified the registration application;
* the physician has been convicted of a felony relating to any controlled substance;
* the physician has had his or her state license or registration suspended, revoked, or denied by the state authority and is no longer authorized by the state to prescribe, dispense, or administer controlled substances or has had the suspension, revocation, or denial of the physician’s registration recommended by a state authority;
* the physician has committed acts that, in the context of controlled substances, would render his or her registration inconsistent with the public interest; or
* the physician has been excluded (or has been directed to be excluded) from participation in a federal health care program.

A registration to dispense narcotics for maintenance treatment or detoxification treatment may be suspended or revoked if the physician fails to comply with the specific requirements of the registration.

Under Washington law, a physician’s exemption from state registration requirements may be suspended or revoked, precluding the physician from prescribing, dispensing, or administering controlled substances, upon a finding that:

* the physician furnished false or fraudulent material information in a registration application;
* the physician has been convicted of a felony under any state or federal law relating to any controlled substance;
* the physician’s federal registration has been suspended or revoked; or
* the physician committed acts that, in the context of controlled substances, are inconsistent with the public interest.

**What are the recognized purposes for prescribing controlled substances?**

Federal regulations specify the legitimate purposes for prescribing controlled substances as follows:

* A prescription for a controlled substance is effective only if it is issued for a legitimate medical purpose by a physician acting in the usual course of his or her professional practice.
* A prescription may not be issued in order for a physician to obtain controlled substances for general dispensing to patients. A physician must use DEA Form 222 or its electronic equivalent to obtain Schedule I or II controlled substances for office use through regular supply sources. A physician who orders controlled substances for use by all physicians in an office or clinic must register with the DEA as a distributor.
* A physician may not issue prescriptions for detoxification or maintenance treatment unless the physician complies with certain other federal regulations and the prescription is for a Schedule III, IV, or V narcotic drug approved by the federal Food and Drug Administration (FDA) specifically for this kind of use. A physician may administer or dispense directly (but not prescribe) a narcotic drug to a narcotic-dependent person for maintenance or detoxification treatment if the physician is separately registered with the DEA as a narcotic treatment program and the physician complies with DEA regulations regarding treatment qualifications, security, records, and unsupervised use of the drugs. However, a physician not registered as a narcotic treatment program can administer (but not prescribe) narcotic drugs to a patient daily for up to three days to relieve acute withdrawal symptoms while arrangements are being made for referral to an existing narcotic treatment program.

**Are there requirements for legibility of prescriptions?**

Yes. Prescriptions must be hand-printed, typewritten, or electronically generated.

**What are the rules governing electronic communication of prescriptions?**

Electronic transmission of prescription information means the communication from an authorized prescriber to a pharmacy (or between pharmacies) by computer, facsimile, or other electronic means (but not voice communication) of original prescription or prescription refill information for a legend drug or controlled substance. Over-the-counter, legend drug, and controlled substance prescriptions may be transmitted electronically, consistent with federal and state laws. Only exact visual images of Schedule II prescriptions, however, may be transferred electronically. Both the system used for transmitting and the system used for receiving electronically communicated prescription information must be approved by the Washington State Board of Pharmacy. The system must have adequate security and system safeguards designed to prevent and detect unauthorized access, modification, or manipulation of prescription information. Policies and procedures that ensure the integrity and confidentiality of the electronically transmitted information and that do not restrict patients’ access to the pharmacy of their choice must also be in place. These rules do not apply, however, to facsimile transmission of an exact visual image of the prescription. Transmission of original prescriptions must include all of the following:

* Prescriber’s name and address.
* Prescriber’s DEA registration number where required for controlled substance prescriptions.
* Date the prescription was issued.
* Patient’s name and address.
* Drug name, dose, route, form, directions for use, and quantity.
* Electronic, digital, or manual signature of the prescriber.
* Refills or renewals authorized, if any.
* A place to note allergies and a notation for the purpose of the drug.
* Indication of preference for a generic equivalent drug substitution.
* Any other requirements consistent with state and federal laws related to prescription form and content.
* Identification of the electronic system readily retrievable for Board of Pharmacy inspection.

Information concerning electronic systems approved by the Board of Pharmacy may be found at: <http://www.doh.wa.gov/Portals/1/Documents/2300/ElectronicPresc.pdf>.

Email may be used to transmit prescription information if the system meets requirements for security and confidentiality.

**Are there special rules related to use of facsimile machines to transmit prescription information?**

Yes. Prescription orders transmitted via fax from a prescriber to a pharmacist must meet the following requirements:

* The order contains the date, time, and telephone number and location of the transmitting device.
* Prescriptions for Schedule III, IV, and V drugs may be transmitted at any time.
* Prescriptions for Schedule II drugs may be transmitted only under the following conditions:
  + The order is for an injectable Schedule II narcotic substance that is to be compounded by the pharmacist for patient use, or the prescription is written for patients in a long-term care facility or a hospice program.
  + The prescription must be signed by the prescriber.
  + In a non-emergent situation, an order for Schedule II controlled substances may be prepared for delivery to a patient pursuant to a facsimile transmission but may not be dispensed to the patient except upon presentation of a written order.
  + In an emergent situation, an order for Schedule II controlled substances may be dispensed to the patient upon the verbal orders of a prescriber, provided that the prescription is promptly transmitted in written form. The pharmacy has seven days to obtain a written prescription that covers an emergency prescription of this kind.
  + The prescription is to a hospital for a patient admitted to or being discharged from the hospital.

Refill authorizations for prescriptions may be electronically transmitted.

**Is there a limitation on the quantity of controlled substances that may be prescribed to a patient?**

There is no statutory limitation. A physician is limited, however, by the exercise of sound medical judgment required by the applicable standard of care.

**Is there a limitation on refills of controlled substances?**

Yes. A prescription for a Schedule II substance may not be refilled. A prescription for a Schedule III or IV substance may not be refilled more than six months after the prescription’s date and may not be refilled more than five times, unless the physician renews the prescription.

**May a physician prescribe controlled substances for himself or herself?**

No. It is unprofessional conduct to self-prescribe controlled substances. See Unprofessional Conduct.

**May a physician prescribe controlled substances for family members?**

Washington law does not specifically prohibit it. However, a physician may prescribe a controlled substance only for a legitimate medical purpose while acting in the usual course of his or her professional practice. Furthermore, a physician may not issue a prescription to dispense narcotic drugs for detoxification or maintenance treatment of a person who is dependent on narcotic drugs unless the FDA has approved those drugs for such a purpose and the physician complies with certain federal regulations. Thus, a physician should exercise great caution before prescribing controlled substances for family members, should keep thorough medical records, and should avoid manipulation by family members.

**May a physician be subject to criminal prosecution for violating the controlled substances laws?**

Yes. A physician’s violation of the laws governing controlled substances may result in criminal prosecution. Furthermore, the physician’s medical license will be suspended for the term of a sentence resulting from violation of the laws related to controlled substances.

**May a physician be disciplined for conduct related to controlled substances?**

Yes. A physician’s violation of the laws governing controlled substances may result in disciplinary action. In particular, a physician may be disciplined for:

* The possession, use, prescription for use, or distribution of controlled substances in any way other than for legitimate or therapeutic purposes.
* Diversion of controlled substances.
* Violation of any drug law.
* Prescribing controlled substances for oneself.
* Personal misuse of controlled substances.

**How should controlled substances be stored?**

Physicians must store controlled substances in their offices or clinics in a securely locked, substantially constructed cabinet or safe. Access to the storage area should be kept to a minimum. A sufficiently detailed record of the receipt, use, and disposition of all controlled substances must be maintained. An inventory of all controlled substances in the physician’s possession must be completed every two years and the inventory records kept for two years. See also Legend Drugs.

**How should physicians dispose of controlled substances?**

Physicians should contact the local DEA office for specific instructions on the disposal of controlled substances. The local DEA office will instruct the physician to either transfer the controlled substances to the local DEA office (or such other person or entity as arranged by the DEA) or to destroy the substances in the presence of a DEA agent.

**Must a physician report the theft or loss of a controlled substance?**

Yes. Any loss or theft of controlled substances must be reported to a DEA field office using DEA Form 106, with a copy sent to the Washington State Board of Pharmacy. DEA Form 106 is available at: <http://www.deadiversion.usdoj.gov/21cfr_reports/theft/index.html>.

Washington law further requires that the theft or loss of a precursor drug be reported to the state Board of Pharmacy within seven days of discovery. Knowingly providing false information constitutes a Class C felony.

**May an Advanced Registered Nurse Practitioner (ARNP) prescribe controlled substances?**

Upon approval from the Nursing Care Quality Assurance Commission (NCQAC), an ARNP may prescribe Schedule V controlled substances and, subject to statutory guidelines, controlled substances contained in Schedules II through IV. See [Nurses](http://legalguide.wsma.org.onexcale.net/other-health-care-professionals/nurses/nurses).

**May a Physician Assistant (PA) prescribe controlled substances?**

A physician assistant may prescribe controlled substances only if specifically approved by the Medical Quality Assurance Commission (MQAC). A certified physician assistant may prescribe controlled substances, subject to certain conditions. See [Physician Assistants](http://legalguide.wsma.org.onexcale.net/other-health-care-professionals/physicians-assistants/physician-assistants).

### Medical Cannabis

**NOTE:** On November 6, 2012, voters in Washington State approved an initiative which would legalize small amounts of marijuana for most adults, and impose a tax on the sale of marijuana. At this time, the effect of passage of the initiative on the authorization of medical cannabis is not known. This Legal Guide will be updated as soon as new information becomes available.

**Does Washington law permit the medical use of cannabis?**

Yes. In November 1998, the people of the State of Washington passed Initiative 692, allowing some patients with certain terminal or debilitating conditions, under the care of their physician, to produce, possess, and use a limited amount of marijuana for medical purposes. In 2011, the legislature changed the requirements for providing medical cannabis recommendations to qualifying patients by passing ESSB 5073.

It is still against federal law, however, to distribute or manufacture cannabis, or to possess it with intent to distribute or manufacture. There is no medical necessity exception to those federal law prohibitions. Cannabis is currently classified as a Schedule I drug, meaning that it has no generally recognized medical use.

The Department of Health has developed a list of Frequently Asked Questions about requirements and practice standards when recommending medical cannabis.

**Who can recommend the use of medical cannabis?**

The following health care providers may recommend medical marijuana (cannabis):

* Medical doctors (MDs)
* Physician assistants (PAs)
* Osteopathic physicians (DOs)
* Osteopathic physician assistants (OPAs)
* Naturopathic physicians (NDs)
* Advanced registered nurse practitioners (ARNPs)

**What patients qualify for medical use of cannabis?**

To qualify for medical use of cannabis, a patient:

* Must be under the care of a health care professional licensed in Washington State.
* Must be diagnosed by that physician as having one of the following terminal or debilitating conditions:
  + Cancer.
  + Human immunodeficiency virus (HIV).
  + Multiple sclerosis.
  + Epilepsy or other seizure disorder.
  + Spasticity disorders.
  + Intractable pain, limited for purposes of the medical cannabis law to mean pain unrelieved by standard medical treatments and medications.
  + Glaucoma, either acute or chronic, limited for the purposes of the medical cannabis law to mean increased intraocular pressure unrelieved by standard treatments or medications.
  + Crohn’s disease with debilitating symptoms unrelieved by standard treatments or medications.
  + Hepatitis C with debilitating nausea and/or intractable pain unrelieved by standard treatments or medications.
  + Diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, and/or spasticity, when those symptoms are unrelieved by standard treatments or medications.
  + Chronic renal failure.
  + Such other conditions as may be approved by the Medical Quality Assurance Commission (MQAC)
* Must have been a resident of Washington State at the time of diagnosis.
* Must have been advised by the health care professional of the risks and benefits of the medical use of cannabis.
* Must have been advised by the health care professional that he or she might benefit from the medical use of cannabis.

Note that a healthcare provider cannot have a business or practice which consists solely of authorizing the medical use of cannabis or include any statement or reference on the medical use of cannabis in advertisements. The law also restricts a healthcare provider from benefiting in certain ways for recommending medical cannabis.

**Who is a “designated provider” under Washington law, and what may a “designated provider” do”**

Designated providers must be 18 years of age or older, have been designated in writing by a patient to service as the designated provider, are prohibited from consuming marijuana obtained for the personal medical use of the patient, and is the designated provider to only one patient at any one time. The designated provider may possess cannabis within statutory limits for use by a qualifying patient.

**What risks are there to recommending medical marijuana (cannabis) to a qualifying patient?**

State law establishes provider immunity against prosecution when appropriately recommending medical use of cannabis, but not federal law. Failure to adhere to state law requirements exposes the healthcare provider to risk of prosecution under state law and may also result in disciplinary action by the licensing authority. Healthcare providers might also incur other penalties from privileging hospitals, medical malpractice insurers or certification boards.

**What are the requirements for providing a recommendation?**

The requirements for providing a recommendation are:

* The patient must have a new or existing documented relationship with a primary care provider or specialist relating to the diagnosis and ongoing treatment or monitoring of the patient’s terminal or debilitating medical condition.
* The provider may only provide a recommendation after:
  + Completing a physical examination;
  + Documenting the terminal or debilitating medical condition in the patient’s medical record and that the patient may benefit from treatment of the condition or its symptoms with the medical use of cannabis;
  + Informing the patient of other options for treating the terminal or debilitating condition; and
  + Documenting other measures attempted to treat the terminal or debilitating medical condition that do not involve medical cannabis.

**How much cannabis may a qualifying patient possess?**

The law is not very specific; it only states that a qualifying patient or designated provider may possess no more than fifteen (15) cannabis plants and (i) no more than twenty four(24) ounces of useable cannabis; or (ii) no more cannabis product than what could reasonably be produced with no more than twenty four (24) ounces of useable cannabis; or a combination of useable cannabis and cannabis product that does not exceed a combined total of twenty four (24) ounces of useable cannabis. If an individual is both a qualifying patient and a designated provider for another qualifying patient, the individual can possess no more than twice the amounts described above.

**What does the medical cannabis law allow a physician to do?**

The medical cannabis law exempts physicians from state criminal laws, and protects physicians from being penalized or denied any right or privilege under state law, for:

* Advising a qualifying patient about the risks and benefits of medical use of cannabis.
* Advising a qualifying patient that he or she may benefit from the medical use of cannabis where such advice and use is within a professional standard of care or appropriate in the individual physician’s medical judgment.
* Providing a qualifying patient with valid documentation, based upon the physician’s assessment of the qualifying patient’s medical history and current medical condition, that the potential benefits of the medical use of cannabis would likely outweigh the health risks for the particular qualifying patient.

**Under the medical cannabis law, may physicians prescribe cannabis?**

Physicians or the other authorized licensed health care professionals must not prescribe marijuana. It is prohibited under federal law to knowingly or intentionally distribute, dispense or possess marijuana. The terms "distribute" and "dispense" have been broadly interpreted, and physicians and the other authorized licensed health care professionals may be found in violation of federal law for writing a prescription for a substance, such as marijuana, for which federal law has no recognized medical use. Violation of federal laws can bring significant penalties, including imprisonment and fines. In addition, violating federal law (or aid and abet in its violation) may result in other federal sanctions, such as a revocation of a health care provider's DEA registration.

**Must a physician authorize the use of medical cannabis?**

No, nothing in the medical cannabis law requires any physician to authorize the use of medical cannabis for a patient.

**If a physician wishes to authorize the use of medical cannabis for a qualifying patient, what documentation should the physician give the patient?**

Under the medical cannabis law, valid documentation is a statement signed by the qualifying patient’s physician, or a copy of the patient’s pertinent medical records, that states that, in the physician’s professional opinion, the potential benefits of the medical use of cannabis would likely outweigh the health risks for the patient.

**How should a physician prepare a recommendation for medical cannabis?**

Recommendations must include information required in the law and must be written on tamper-proof paper. The paper must meet one or more of the following industry-recognized features:

* One or more features designed to prevent copying of the paper; or
* One or more features designed to prevent the erasure or modification of the information on the paper; or
* One or more features designed to prevent the use of counterfeit valid documentation.

Also, a sample form for a recommendation entitled, “Documentation of Medical Authorization to Possess Cannabis for Medical Purposes in Washington State” may be obtained from the WSMA, [www.wsma.org/medical-cannabis](http://www.wsma.org/medical-cannabis).

**Can a physician own or have an interest in a medical cannabis enterprise**

No. A physician who recommends the use of medical cannabis to qualifying patients may not have an ownership interest in a medical cannabis enterprise.

**Are there any other Washington laws dealing with the therapeutic use of cannabis?**

Yes, the Controlled Substances Therapeutic Research Program Act, which established the Washington State Controlled Substances Therapeutic Research Program, administered by the Department of Health.

**Is participation in the Controlled Substances Therapeutic Research Program limited?**

Yes. Participation in the program is generally limited to cancer chemotherapy and radiology patients and glaucoma patients who are certified by a physician as being involved in a life-threatening or sense-threatening situation. No patient may be admitted to the Controlled Substances Therapeutic Research Program without full disclosure by the physician of the experimental nature of the program and of the possible risks and side effects of the proposed treatment.

**How can a patient qualify to participate in the Controlled Substance Therapeutic Research Program?**

In order to receive cannabis for therapeutic use, a patient and the patient’s physician must apply to the Patient Qualification Review Committee for approval to participate in the Controlled Substance Therapeutic Research Program.

### Opiate Substitution

**Is there a fundamental right to opiate substitution treatment?**

No. The Washington legislature has declared that there is no fundamental right to opiate substitution treatment.

**Are clinical uses of opiate substitution drugs used in the treatment of opiate addiction regulated by the state?**

Yes. Because opiate substitution drugs used in the treatment of opiate dependency are addictive and are ScheduleII controlled drugs, the state has declared its authority, in cooperation with authorizing counties, to control and regulate carefully all clinical uses of opiate substitution drugs used in the treatment of opiate addiction.

**What factors are considered by the Department of Health in its certification of a proposed opiate substitution program?**

The department will consult with the county and city legislative bodies in an area where a proposed treatment program may be located. Only the facilities that are in accordance with local land use regulations and permitting processes may be eligible for certification. Discrimination based on the corporate structure of the applicant is prohibited. The department will consider the size of the population and the need for a new facility, the availability of other certified programs, the transportation systems that would provide service to the program, and consider whether the applicant has previously demonstrated the ability to provide appropriate services to those using the program to meet the goals established by the legislature. At least one public hearing must be held before the certification process may be completed.

**Are there any restrictions on the caseloads of opiate substitution treatment programs?**

Yes, an opiate substitution treatment program may not have a caseload in excess of 350 persons.

**Are there any reporting requirements applicable to certified substitution treatment programs?**

Yes. As a condition of certification, opiate substitution treatment programs must submit an annual report to the Department of Health and the county legislative authority, including such data as the Department of Health specifies as necessary for outcome analysis.

**How does a physician apply for certification as a chemical dependency service provider?**

A physician seeking certification to provide chemical dependency services must request an application packet of information on how to become a certified chemical dependency services provider from the Department of Social and Health Services. The physician must submit a completed application to DSHS. Information required for the application depends on whether the physician is applying as a sole provider, partnership, limited liability corporation (LLC), or as a corporation.

**Are there any special requirements when providing opiate substitution treatment to pregnant women?**

Yes. A pregnant woman must receive at least one-half hour of counseling and education, verbally and in writing, each month on:

* Matters relating to pregnancy and street drugs;
* Pregnancy spacing and planning; and
* The effects of substitution treatment on the woman and fetus when opiate substitution treatment occurs during pregnancy.

In addition, the pregnant client must be educated as to the benefits and risks of opiate substitution treatment before such medication is administered. The health education information provided to pregnant clients must also include referral options for the addicted baby. An opiate substitution program may waive the requirement of a one year history of addiction for pregnant patients so long as the program physician certifies the pregnancy.

### Pain management

**Has the Medical Quality Assurance Commission (MQAC) adopted guidelines for the management of pain?**

Yes. Effective January 2, 2012, the MQAC has adopted new rules for the management of chronic non-cancer pain. The guidelines specifically address the patient evaluation and treatment plan, informed consent, periodic reviews, use of consultations, and the necessity for maintaining accurate and complete medical records.

**Do the pain rules apply to all physicians’ practices?**

The newly adopted MQAC rules for the management of chronic non-cancer pain (pain rules) apply to physicians who treat patients with opioids for chronic non-cancer pain (as defined in the rules).

The rules do not apply to physicians who provide palliative care, hospice care, or other forms of end-of-life care. The rules also do not apply to the management of acute pain related to an injury or surgical procedure.

**What is chronic non-cancer pain according to the pain rules?**

The pain rules define chronic non-cancer pain as a pain not related to cancer which persists beyond the usual course of an acute disease, or the healing of an injury. Chronic non-cancer pain may or may not be associated with a pathologic process (acute or chronic) that causes continuous or intermittent pain over months or years. There is no minimum duration of pain which triggers the definition of chronic non-cancer pain and application of the rules. Of note, however, is that “acute pain” is described as something which is “time limited, often less than three months in duration, and usually less than six months.”

**What does “MED” mean?**

MED is an abbreviation for “morphine equivalent dose,” which means a conversion of the dose of various opioids to the equivalent dose of morphine as designated in an accepted conversion table. One such table may be found on the Washington State Agency Medical Directors Group website at: http://www.agencymeddirectors.wa.gov/opioiddosing.asp#CME, and click on “Dose Calculator.” The calculator can be saved on a personal computer for convenience.

**Do the pain rules require physicians to take CME courses in order to treat patients with chronic non-cancer?**

In general, taking a CME course is not required to treat patients with chronic non-cancer pain. However, 12 hours of pain-related Category I CME (including at least 2 hours related to long-acting opioids such as methadone) is required if the physician wishes to be exempt from having to send his/her patients for a mandatory consultation with a pain specialist under certain circumstances (see below).

Further, the rules suggest, but do not require, a one-time (lifetime) completion of at least four hours of CME related to long-acting opioids (including methadone) if a physician prescribes those medications.

**Are the pain rules guidelines, or do the pain rules impose mandatory requirements on a physician’s practice?**

The intent section of the rules states that the rules “are not inflexible rules or rigid practice requirements.” The section goes on to say that the “ultimate propriety of any specific procedure or course of action must be made by the practitioner based on the circumstances presented.” In addition, the intent section clearly states that the rules do not establish a standard of care. A course of treatment which differs from the rules may not be a violation of the rules so long as the physician documents that the variance was based on reasonable judgment, was indicated by the patient’s condition, was taken because of limited resources or because of advances in knowledge or technology subsequent to the rules becoming effective. The MQAC has published an interpretive statement regarding the pain rules which is available at: http://www.doh.wa.gov/LicensesPermitsandCertificates/MedicalCommission/MedicalResources/PainManagement.aspx

That being said, most of the rules are nonetheless written as imperatives (i.e. “shall” and “must”). It is unclear how a court might reconcile the apparent conflict between the intent section (rules do not establish a standard of care; rules as guidelines) and the remainder of the pain rules. Until there are clear answers on these points it is safest for physicians to follow the requirements of the rules, unless the physician can provide adequate documentation to support an alternate course of action.

**What is inappropriate treatment of pain under the pain rules?**

According to the introductory intent section of the pain rules, “inappropriate treatment of pain” includes not only overtreatment and the continuation of ineffective treatments, but also includes non-treatment and under-treatment of chronic non-cancer pain.

The implications of this statement regarding inappropriate treatment of pain are unclear. The pain rules require a defined treatment plan and periodic reviews of the effects of treatment (see below). Therefore it would appear that whatever treatment a physician provides must have a demonstrated positive effect. Otherwise the treatment may have to be modified to avoid having the treatment considered “inappropriate.”

**What must a physician do before treating a patient with chronic non-cancer pain?**

Before initiating treatment for a patient with chronic non-cancer pain the physician must perform a thorough history and physical evaluation of the patient.

The history must include:

* Current and past treatments for pain;
* Any co-morbidities; A risk screening for potential co-morbidities, includes a history of:
  + Addiction;
  + Abuse of opioid medications or aberrant behavior related to that use;
  + Psychiatric conditions, including poorly controlled depression or anxiety;
  + Along with use of opioids, any concomitant use of benzodiazepines, alcohol, or other medications which can affect the central nervous system;
  + Significant adverse events such as falls or fractures (or risk thereof);
  + Receiving opioids from more than one physician and/or physician group;
  + Repeated visits to an emergency department seeking opioids;
  + Sleep apnea or other respiratory risk factors;
  + Possible or current pregnancy; and
  + Allergies or intolerances.
* Any history of substance abuse;
* A review of pain-related issues including:
  + The nature and intensity of the pain;
  + The effect of the pain on the patient’s physical and psychological function; and
  + A list of the patient’s medications, including their indications, date, type, dosage, and quantity prescribed

The history should include:

* A review of any available prescription monitoring program or emergency department- based information; and
* Any relevant information a pharmacist has provided to the physician.

The physician must perform a physical examination.

Documentation in the health record must be readily available for review and should include:

* The diagnosis, treatment plan (see below), and objectives of treatment;
* The presence of one or more indications for the use of pain medications;
* Medications prescribed;
* Results of periodic reviews (see below);
* Written agreements for treatment between the physician and the patient (see below); and
* The physician’s instructions to the patient.

**What is the written treatment plan required in the pain rules?**

The written treatment plan must state the objectives which will be used to determine the effectiveness of treatment.

The written treatment plan must include at least:

* Any changes in pain relief;
* Any changes in the patient’s physical and/or psychosocial function; and
* Any additional diagnostic evaluations or other treatments that are planned.

**Are there specific requirements for providing informed consent in the pain rules?**

Yes. The physician must obtain informed consent from the patient (or surrogate/ guardian with legal decision-making authority for the patient). As with any other informed consent the physician must discuss the nature of the proposed treatment, and the risks and benefits of the treatment, as well as those related to alternative treatments.

**What is the written treatment agreement in the pain rules?**

For patients the physician feels are at high risk for medication abuse, have a history of substance abuse, or any psychiatric co-morbidities, the physician must use a written treatment agreement which outlines the patient’s responsibilities.

The written treatment agreement must include:

* The patient’s agreement to provide suitable samples for urine/serum drug screening when requested by the physician;
* The patient’s agreement to comply with the dose and frequency the physician prescribes for their medications, and to comply with a protocol for lost drugs or prescriptions;
* Reasons which the physician states will result in discontinuation of drug therapy, such as violation of the written treatment agreement;
* The patient’s agreement to have all prescriptions for medications used to treat the patient’s chronic non-cancer pain filled by a single pharmacy or pharmacy system;
* The patient’s agreement not to abuse alcohol or use other medically unauthorized substances;
* The patient’s written authorization:
  + For the physician to release a copy of the treatment agreement to local emergency departments, urgent care facilities, and pharmacies;
  + For other physicians to report violations of the treatment agreement back to the treating physician; and
  + For the physician to notify the proper authorities if the physician has reason to believe the patient has engaged in illegal activities.
* The patient’s acknowledgement:
  + That a violation of the written treatment agreement may result in a tapering or discontinuation of the patients prescriptions for chronic non-cancer pain;
  + That it is the patient’s responsibility to keep all medications safe and secure; and
  + That if the patient violates the terms of the agreement the physician will document the violation, any change in the patient’s treatment plan, and the rationale for those changes.

**What is a periodic review, and when is a periodic review required?**

The physician must periodically review the course of treatment of his/her patients with chronic non-cancer pain, the patients’ state of health, and any new information regarding the etiology of their pain. Such a review must take place at least every six (6) months. However, a periodic review may be performed at least annually for patients whose condition is stable, and whose dose of opioids is not escalating and is less than forty (40) MED per day. In addition, the physician should periodically review any relevant information from any available prescription monitoring program or emergency department-based information exchange, and any information provided by pharmacists about the physician’s patients.

During the periodic review the physician must:

* Determine the patient’s compliance with any medication treatment plan;
* Determine if the patient’s pain, function, or quality of life have improved or diminished using objective evidence, and considering input from family members and other caregivers;
* Determine if the patient’s pain medications should continue or be modified based on the patient’s progress in reaching treatment objectives;
* Assess the appropriateness of the continuation of the current treatment plan if the patient’s progress under, or compliance with, the current treatment plan is unsatisfactory.
* Consider tapering, changing, or discontinuing treatment when:
  + The patient’s level of function or pain has not improved after a suitable trial period;
  + There is evidence of significant adverse effects from the current treatment;
  + The physician determines other treatment modalities would be indicated; or
  + There is evidence of misuse, addiction, or diversion of prescribed medications.

**Do the pain rules specifically address long-acting opioids such as methadone?**

Yes. The rules state that if a physician prescribes long-acting opioids, including methadone, the physician should be familiar with the risks and uses of such medications, and should be prepared to conduct any necessary, careful monitoring. This is especially important for patients who are initiating treatment with such medications. If a physician uses long-acting opioids, including methadone, the rules recommend that the physician should have a one-time (lifetime) completion of at least four (4) hours of CME related to such medications.

**What do the pain rules say about treating a patient with chronic non-cancer pain who presents for emergency or urgent care (episodic care)?**

The pain rules include recommendations and requirements when a physician evaluates a patient with chronic non-cancer pain for what is termed “episodic care,” such as emergency or urgent care.

When providing episodic care for a patient with chronic non-cancer pain a physician should:

* Review any available information from a prescription monitoring program or emergency department-related information exchange or other tracking system regarding the patient;
* Avoid providing opioids for the management of the patient’s chronic non-cancer pain;
* Limit the use of opioids for treatment of chronic non-cancer pain to the minimum amount necessary to control the pain or until the patient can receive care from his/her primary care physician if the treating physician feels that prescription of opioids is indicated; and
* Report known violations of a patient’s written treatment agreement to the patient’s primary care physician if the patient has such an agreement, and has provided a written authorization to release the agreement (see above) to physicians who provide episodic care.

When providing episodic care for a patient with chronic non-cancer pain a physician must:

* Include the indications for use on any prescription for opioids, or include the ICD code related to the patient’s diagnosis on the prescription; and
* Write on the prescription that photo identification is required for the prescription to be picked up in order for the prescription to be filled.

**What is a “pain management specialist” under the pain rules?**

A pain management specialist is a physician, osteopathic physician, dentist, advanced registered nurse practitioner (ARNP), or podiatrist who has satisfied the minimum criteria for training as established in the pain rules, and may see patients with chronic non-cancer pain in consultation as provided in the pain rules.

**What are the requirements for a physician to be considered a pain management specialist under the pain rules?**

In order to be considered to be a pain management specialist a physician must:

* Be board-certified or eligible by an American Board of Medical Specialties (ABMS)-approved board in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology; or
* Have a subspecialty certificate in pain medicine by an ABMS-approved board; or
* Have a minimum of three (3) years of clinical experience in a chronic pain management care setting, and
  + Be credentialed in pain management by an entity approved by the MQAC; and
  + Successfully complete a minimum of at least eighteen (18) CME hours in pain management during the past two (2) years (for physicians); and
  + Have a current practice which consists of at least thirty (30) % direct provision of pain management care, or practice in a multidisciplinary pain clinic.

***Note: The criteria for osteopathic physicians to become pain specialists are slightly different than those for medical doctors. Please review the full text of the pain rules for the criteria for osteopathic pain management specialists.***

**When are consultations with a pain management specialist recommended under the pain rules?**

A physician should consider, and document the rationale for, a consultation with a pain management specialist as needed to achieve the treatment objectives the physician has set for patients being treated for chronic non-cancer pain. In particular, special attention, or consultation, is advised for patients with chronic non-cancer pain who:

* Are under eighteen (18) years of age;
* Are at risk for medication abuse or diversion;
* Have a history of substance abuse; or
* Have co-morbid psychiatric disorders.

**Are there mandatory consultation requirements under the pain rules?**

Yes. Unless a physician qualifies for an exemption (see below), the physician must obtain a consultation from a pain management specialist if the physician prescribes a dose of opioids which exceeds one hundred twenty (120) mg MED per day.

The mandatory consultation must consist of at least:

* An office visit with the patient and a pain management specialist; or
* A telephone consultation between the treating physician and the pain management specialist; or
* An electronic consultation between the treating physician and the pain management specialist; or
* An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with the treating physician or another licensed health care practitioner the treating physician has designated or who has been designated by the pain management specialist.

The physician must document each mandatory consultation, and the physician must maintain any written consultation report as part of the patient’s medical record. The pain management specialist must also maintain a record of each consultation report as a patient medical record.

A consultation with a pain management specialist may also be required as part of a contract with an individual, insurance companies, or other entities.

**Are there special circumstances where a physician is exempt from the mandatory consultation requirement under the pain rules?**

Yes. A physician may be exempt from the mandatory consultation requirement of the pain rules under certain exigent and special circumstances when the physician has otherwise documented adherence to all other applicable standards as set forth in the pain rules.

Exigent and special circumstances in which a physician may be exempt from the mandatory consultation requirement include situations when:

* The patient is taking more than 120 mg MED per day of opioids but is following a tapering schedule; or
* The patient requires a temporary augmentation of the dose of opioids for treatment of acute pain which exceeds the 120 mg MED per day threshold (which may or may not include hospitalization), and when the physician expects the dose of opioids to return to, or below, the patient’s baseline dosage level; or
* The physician documents reasonable attempts to obtain a consultation from a pain management specialist which have been unsuccessful, and in the physician’s clinical judgment the circumstances justify prescribing more than 120 mg MED per day without first obtaining the consult; or
* The physician documents that the patient’s pain and function are stable and the patient’s dose of opioids in not escalating.

**Is there any way a physician can become personally exempt from the mandatory consultation requirement of the pain rules?**

Yes. The pain rules provide four (4) specific ways a physician can become exempt personally from the mandatory consultation requirement of the pain rules. A physician may become exempt from the mandatory consultation requirement if the physician:

* Is a pain management specialist; or
* Has successfully completed a minimum of twelve (12) hours of Category I CME on chronic pain management, which must include at least two (2) hours related to long-acting opioids, within the last two (2) years; or
* Is a pain management practitioner working in a multidisciplinary pain treatment center, or a multidisciplinary academic research facility; or
* Has a minimum of three (3) years of clinical experience in a chronic pain management facility where at least thirty (30) % of the physician’s practice has been the direct provision of pain management care.

**What is the prescription monitoring program?**

The prescription monitoring program (PMP) is a patient safety toll which allows physicians to access information about the schedule II, III, IV, and V controlled substances their patients have been prescribed previously before the physician prescribes any new medications.

**What information is entered into the prescription monitoring program?**

All dispensers of controlled substances (i.e. the practitioner or pharmacist that delivers the controlled substance to the ultimate user) must report to the Department of Health the patient’s identity, drug dispensed, date of prescription, date of dispensing, quantity dispensed, refill information, prescriber, dispenser, and source of payment.

**Who can access the data in the prescription monitoring program?**

The PMP data may be provided to a physician for the purpose of providing medical care, pharmacists, the patient, health professional licensing, certification, or regulatory agency, law enforcement officials engaged in a specific investigation, state Medicaid officials, the director of Labor & Industries, the director of the Department of Corrections, pursuant to a grand jury subpoena, and Department of Health personnel.

**What must a physician do in order to access the prescription monitoring program data?’**

Physicians and other dispensers must be registered with the Department of Health before being able to access data in the PMP. Physicians may register at http://www.wapmp.org/practitioner/pharmacist/.

**Where can a physician find out more information about the prescription monitoring program?**

More information about the PMP may be found at: <http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP.as>

## Management of Specific Diseases and Conditions

### AIDS/HIV/Sexually Transmitted Diseases

**Is AIDS education mandatory for a physician?**

Yes. In order to be licensed, or to renew a license, a physician must have received at least four hours of continuing medical education on the prevention, transmission and treatment of AIDS. See [Continuing Medical Education](http://legalguide.wsma.org.onexcale.net/physicians/allopathic-physicians/continuing-medical-education).

**Is patient consent required for HIV testing?**

Yes. As a general rule, an HIV test cannot be performed without first obtaining the patient’s specific informed consent, separate from other consents.

The statutory exceptions to this consent requirement include:

* Incompetent persons. The consent of the person’s authorized to give consent must be obtained. See [Informed Consent](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-malpractice/informed-consent); and [Newborns: Testing and Reporting](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/neonatal-or-pediatric-conditions/newborns-testing-and-reporting).
* Seroprevalence studies where test subjects do not know the test results and test conductors do not know who is undergoing testing.
* When the Department of Labor and Industries (DLI) determines the test is relevant, the DLI may condition workers’ compensation payments on the taking of an HIV test.
* As otherwise expressly authorized in the statute. Testing performed under this exception generally is done or ordered by local health departments, or jail administrators with approval of local health departments and Department of Corrections administrators.

**Can a minor age 14 or older consent to testing for HIV or other sexually transmitted diseases (STDs)?**

Yes. An otherwise competent minor age 14 or older may give consent to testing for or treatment of STDs including HIV.

Consent of the parent or legal guardian is not necessary. The parents or legal guardian of the minor, however, are not liable for payment for STD treatment or testing of the minor to which they did not consent.

**What is HIV pretest counseling?**

Pretest counseling mean counseling aimed at helping the patient understand ways to reduce the risk of HIV infection, the nature and purpose of the tests, the significance of the results, and the potential dangers of the disease, and to assess the patient's ability to cope with the results.

**What should be included in HIV counseling?**

Physicians providing pretest or post-test HIV counseling shall assess the patient’s risk of acquiring and transmitting HIV by evaluating information about the patient’s possible risk behaviors and unique circumstances, and when appropriate, should:

* Base counseling on the recommendation of the Centers for Disease Control and Prevention as published in the Revised Guidelines for HIV Counseling, Testing, and Referral, November 2001 (Updated 2006).
* Assist the patient to set realistic behavior-change goals and establish strategies for reducing their risk of acquiring or transmitting HIV.
* Provide appropriate risk reduction skills-building opportunities to support behavior-change goals.
* Provide or refer for other appropriate prevention, support, or medical services, including those services for other bloodborne pathogens.

**What must a physician do when ordering or prescribing an HIV test for a patient?**

Except for individuals who are conducting seroprevalent tests, a physician who orders or prescribes an HIV test must obtain the informed consent of the patient, separately or as part of the consent for a battery of tests (so long as the patient is specifically informed verbally or in writing that an HIV test is included), and offer the patient an opportunity to ask questions and decline testing.

**What must a physician do if an HIV test is positive for, or suggestive of, HIV infection?**

If an HIV test is positive for, or suggestive of, HIV infection the physician must provide the name of the individual and locating information to the local health officer for follow-up to provide post-test counseling.

**What is HIV post-test counseling?**

Post-test HIV counseling means further counseling following testing usually directed toward increasing the patient’s understanding of the human immunodeficiency virus infection, changing the patient’s behavior, and, if necessary, encouraging the patient to notify persons with whom there has been contact capable of spreading HIV.

**What must a physician do when providing post-HIV test counseling to a patient?**

If an HIV test is positive for HIV infection, a physician must assess the patient’s risk of acquiring and transmitting human immunodeficiency virus (HIV) by evaluating information about the patient's possible risk-behaviors and unique circumstances, and as appropriate:

* Provide or arrange for at least one individual in-person counseling session based on the content recommended for HIV pretest counseling (see above).
* Inform the patient that the patient’s identity will be confidentially reported to the state or local health officer, unless the HIV testing was anonymous.
* Ensure compliance with the partner notification regulations (see below) and inform the patient of those requirements.
* Develop or adopt a system to avoid documenting the names of referred partners of the patient who tested positive for HIV.
* Offer referral for alcohol and drug and mental health counseling, including suicide prevention, if appropriate.
* Provide or refer for medical evaluation including services for other bloodborne pathogens, antiretroviral treatment, HIV prevention, and other support services.
* Provide or refer for tuberculosis screening.

**Is it permissible for information regarding positive testing for HIV or other sexually transmitted diseases to be disclosed to other persons who have been in contact with an infected patient?**

Information regarding the HIV positive status of a patient may be disclosed to any person who, because of their behavioral interactions with the infected patient, have been placed at risk for acquiring HIV or another sexually transmitted disease if a health officer, or authorized representative, believes that the exposed person was unaware that a risk of disease exposure existed, and that the disclosure of the identity of the infected patient in necessary.

**What are the requirements for notification of a partner of a patient who tests positive for HIV or other sexually transmitted disease?**

A local or state health officer, or authorized representative, must:

* Attempt to contact the principal health care provider of a patient who has tested positive for a previously unreported case of HIV infection within 3 working days of receiving the report of the test to seek input on the best means of conducting the case investigation required by law, and if appropriate, request that the health care provider contact the HIV positive patient.
* Contact the HIV-positive patient to discuss the need to notify sex or injection equipment-sharing partners, including spouses, that they may have been exposed to and infected with HIV, and that they should seek HIV testing, and offer assistance with partner notification as appropriate.

Unless the health officer, or designated representative, determines that partner notification is not needed, or if the HIV-infected patient refuses assistance with partner notification, the health officer, or designated representative, shall assist with notifying partners in accordance with the Recommendations for Partner Services Programs for HIV, Syphilis, Gonorrhea, and Chlamydial Infection as published by the Centers for Disease Control and Prevention.

If the local health officer, or designated representative, informs the HIV-positive patient’s principal health care provider that he/she intends to conduct a partner notification case investigation, the health care provider must attempt to inform the patient that the health officer will contact the patient for the purpose of providing assistance with the notification of partners.

**When must HIV post-test counseling be provided?**

Post test counseling must be provided by a local health officer or authorized representative to a patient whose test results are positive for, or suggestive of, HIV.

**May information related to HIV testing, HIV test results, or confirmed HIV or STD diagnosis be exchanged among health care providers?**

Generally, yes. Health care providers may exchange confidential medical information related to HIV testing, HIV test results, and confirmed HIV or STD diagnosis and treatment using customary methods to exchange medical information between health care providers in order to provide health care services to the patient, i.e., when the information shared impacts treatment decisions for the patient and the health care provider needs the information for the patient’s benefit.

Health care providers responsible for office management also may permit access to a patient’s medical information and medical record by office staff to carry out duties required for care and treatment of a patient and management of medical information and the patient’s medical record.

**Can the results of HIV or STD testing or treatment otherwise be disclosed?**

Generally, no. Strict confidentiality must be maintained. Disclosure of the identity, test results, diagnosis or treatment of a patient undergoing or investigating HIV or STD testing or treatment may only be disclosed to:

* The patient or the patient’s legal representative for health care decisions (except that, with a minor age 14 or older who is otherwise competent, disclosure is to be made to the minor, not to the minor’s legal representative).
* Any person who secures a specific written release of test results or of information related to HIV or diagnosis or treatment of any other STD executed by the patient or the patient’s legal representative (except that, with a minor age 14 or older who is otherwise competent, such a specific release must be signed by the minor).
* Public health officers in accordance with STD reporting requirements. See NOTIFIABLE CONDITIONS.
* A health facility or health care provider that processes, procures, distributes or uses human body parts, tissue, or blood from a deceased person, semen for the purposes of artificial insemination, or blood specimens.
* Any state or local public health officer conducting an authorized investigation, provided that such record was obtained by means of court ordered HIV testing.
* A person allowed access to the record by court order granted after application showing good cause.
* Persons who, because of their behavioral interaction with the infected individual, have been placed at risk for acquisition of an STD, if the health officer or authorized representative believes that the exposed person was unaware that a risk of disease exposure existed and that disclosure of the identity of the infected person is necessary.
* A law enforcement officer, firefighter, health care provider, health care facility staff person or other person who has requested a test of a person because of a substantial exposure to the person’s bodily fluids, if a public health officer performs the test.
* Claims management personnel employed by or associated with an insurer, health care service contractor, HMO, self funded health plan, and the like, where such disclosure is to be used solely for prompt and accurate evaluation and payment of medical or related claims.
* A DSHS worker, child placing agency worker, or guardian ad litem responsible for making or reviewing placement or case planning decisions or recommendations to the court regarding a child who is less than 14 years old, has an STD, and is in the custody of DSHS or a licensed child placing agency. When DSHS or a licensed child placing agency determines that disclosure is necessary for the provision of child care services, disclosure may be made to a person responsible for providing residential care for such a child.
* In addition to the allowable disclosures listed above, local health department personnel are authorized to use HIV identifying information obtained through the mandatory notification provisions of state law for the following purposes:
* Notification of persons with substantial exposure, including sexual or syringe-sharing partners.
* Referral of the infected patient to DSHS.
* Linkage to other public health data bases, provided that the identity or identifying information of the HIV-positive patient is not disclosed outside of the health department.
* For investigations related to examinations ordered by law.

**Is a general authorization for release of medical records sufficient to release information concerning HIV or STD testing?**

No. A general authorization for release of medical records is not sufficient to release information concerning the identity of the patient tested or the results of any HIV or STD testing. Either a court order or a specific written consent should be obtained. See [Disclosure And Protection Of Health Care Information.](http://legalguide.wsma.org.onexcale.net/privacy-issues/medical-records/disclosure-and-protection-of-health-care-info)

**What steps must be taken to maintain confidentiality?**

A physician must establish and implement policies and procedures to maintain confidentiality of a patient’s medical information. See [Disclosure And Protection Of Health Care Information](http://legalguide.wsma.org.onexcale.net/privacy-issues/medical-records/disclosure-and-protection-of-health-care-info).

When disclosure of the identity of a person tested for HIV or STD, or of the results of HIV or STD tests, or of treatment provided for HIV or STD is made to someone other than the patient, the patient’s legal representative, or another health care provider, the disclosure must be accompanied by a written statement which includes the following or substantially similar language:

“This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.”

An oral disclosure must be accompanied or followed by such a notice within 10 days.

**When must physicians report AIDS, HIV or STDs to state or local health departments?**

AIDS, HIV infection, chancroid, chlamydia trachomatis infection, gonorrhea, granuloma inguinale, genital and neonatal herpes simplex (initial infection only), lymphogranuloma venereum, and syphilis are notifiable conditions which must be reported to the local health department within three working days of diagnosis. See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions).

**Are there penalties for unauthorized AIDS, HIV or STD disclosure?**

Yes. Unauthorized disclosure is a gross misdemeanor. Washington law also provides a civil cause of action to any person aggrieved by a violation of the confidentiality provisions of the law.

**What is AIDS counseling?**

AIDS counseling means counseling directed toward:

* Increasing the patient’s understanding of acquired immunodeficiency syndrome (AIDS).
* Assessing the patient’s risk of HIV acquisition and transmission.
* Affecting the patient’s behavior in ways to reduce the risk of acquiring and transmitting HIV infection.

**Under what circumstances must a physician provide AIDS counseling to a patient?**

A physician who is a patient’s principal health care provider must counsel or ensure AIDS counseling for:

* Each pregnant woman.
* Each patient seeking treatment of an STD.
* Drug treatment programs also must provide or ensure AIDS counseling for each person in a drug treatment program.

**Must AIDS counseling be provided to pregnant women?**

Yes. Every physician attending a pregnant woman must provide or ensure AIDS counseling of the patient. The information regarding AIDS that must be discussed with a pregnant woman is available through the Department of Health (DOH) HIV Prevention Program at P.O. Box 47840, Olympia, WA 98504-7840. Additional information may be found in publications from the Centers for Disease Control and Prevention, including “Revised Guidelines for HIV Counseling, Testing and Referral,” and “Revised Recommendations for HIV Screening of Pregnant Women,” published on November 9, 2001. See the DOH website at: <http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/default.htm> to access these publications.

**Must a physician test a pregnant woman for STD?**

Yes, for syphilis. See [Pregnancy Care](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/pregnancy-care/pregnancy-care).

**Must AIDS counseling be provided to a patient seeking treatment for STD?**

Yes. A physician attending a patient seeking treatment for an STD must provide or ensure AIDS counseling.

**May a physician refuse to treat a patient who is HIV positive or who has AIDS?**

Generally, no. For purposes of equal access to medical treatment, a patient who has AIDS, is HIV seropositive, or is perceived to have AIDS or be HIV seropositive, is protected from discrimination under both federal and state law. See [Americans With Disabilities Act](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/americans-with-disabilities-act); and [Discrimination](http://legalguide.wsma.org.onexcale.net/practice-management-issues/discrimination/discrimination). Therefore, a physician otherwise qualified to treat the patient’s condition may not refuse to do so solely because that patient is HIV seropositive or has AIDS.

**Can the actions of a person with an STD be restricted, or can that person be involuntarily required to submit to medical testing, treatment, or counseling?**

Yes, but only as a last resort when attempts to obtain the voluntary cooperation of the person that may be subject to such an order have failed. When a state or local health official is informed through medical testimony, or testimony from those with direct knowledge, that a person has a STD and is engaging in specific conduct that endangers the public health, that official shall conduct an investigation to evaluate the facts, and the credibility of the witnesses. If the official is satisfied that the allegations are true, the person may be ordered to submit to medical testing, treatment or counseling. The person may also be ordered to cease and desist from the endangering activities. Exhaustion of these civil measures is not required before a person may be charged with criminal offenses related to the endangering behaviors. State and local health officers may examine and counsel a person reasonably believed to be infected or exposed to a STD.

### Animal Bites

**Must a physician report cases of animal bites?**

While not all animal bites require reporting, those bites in which human exposure to rabies is suspected is reportable to the local health jurisdiction. Principal health care providers should notify the local health department of animal bites immediately at the time of diagnosis or suspected diagnosis, by telephone or by secure facsimile transmission of a written case report. See Notifiable Conditions.

**What must a physician include in a report of a case of animal bite?**

See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions).

**Are there any penalties for failing to report an animal bite case?**

Failure to make a required report can constitute unprofessional conduct which may subject a physician to disciplinary action. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct).

### Communicable Diseases

**What must a physician do to prevent the spread of communicable diseases?**

A physician must provide adequate and understandable instructions in control measures designed to prevent the spread of a communicable disease to the following people:

* Each patient with a communicable disease under the physician’s care.
* Contacts who may have been exposed to the disease.
* Others as appropriate to prevent the spread of the disease.
* A physician must also ensure notification of the local health department concerning:
* Cases or suspected cases of notifiable conditions specified as notifiable to local health departments. See [Notifiable Conditions.](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions)
* Outbreaks or suspected outbreaks of disease, including, but not limited to, suspected or confirmed outbreaks of varicella, influenza, viral meningitis, health care associated infection suspected to be due to contaminated food products or devices, or environmentally related diseases.
* Known barriers which might impede or prevent compliance with orders for infection control or quarantine.
* Name, address, and other pertinent information for any case, suspected case or carrier refusing to comply with prescribed infection control measures.
* A physician must notify the Washington State Department of Health (DOH) concerning:
* Cases of notifiable conditions designated as notifiable to the DOH. See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions).
* Conditions designated as notifiable to the local health department when the local health department is closed or its representatives are unavailable at the time that a case or suspected case of an immediately notifiable condition or an outbreak or suspected outbreak of a communicable disease occurs. See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions).
* Any pesticide poisoning that is fatal, causes hospitalization or occurs in a cluster.

A physician also must:

* Assure that positive preliminary and final test results for notifiable conditions of specimens referred to laboratories outside Washington State for testing are correctly reported to the local health department of the patient’s residence, to the DOH, or both, by either:
  + Arranging for the referral laboratory to notify either the local health department, the DOH, or both; or
  + Forwarding the notification of the test result from the referral laboratory to the local health department, the DOH, or both.
* Cooperate with public health authorities during investigation of:
  + Circumstances of a case or suspected case of a notifiable condition or other communicable disease.
  + An outbreak or suspected outbreak of disease.
* Maintain responsibility for deciding the date of discharge for hospitalized tuberculosis patients.
* Notify the local health officer of the intended discharge of tuberculosis patients in order to assure that appropriate outpatient arrangements are made.
* When ordering a laboratory test for a notifiable condition, physicians must provide the laboratory with the following information for each test ordered:
  + The patient’s name;
  + The patient’s address, including zip code;
  + The patient’s date of birth;
  + The patient’s sex;
  + Name of the principal health care provider;
  + Type of test ordered;
  + Type of specimen; and
  + Date of ordering the specimen collection.

Additional duties are imposed on physicians who diagnose patients with AIDS, HIV, STDs or tuberculosis. See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd); and [Tuberculosis](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/tuberculosis).

**What is the time requirement for reporting outbreaks or suspected outbreaks of disease?**

A physician must immediately report to the local health officer any cluster or pattern of cases, suspected cases, deaths, or increased incidence of any disease or condition beyond that expected in a given period that may indicate an outbreak, epidemic, or related public health hazard. Such patterns include, but are not limited to, suspected or confirmed outbreaks of food-borne or water-borne disease, varicella, influenza, viral meningitis, health care associated infection suspected due to contaminated products or devices, or environmentally related disease. This reporting requirement applies twenty-four hours a day, seven days a week. A physician sending a report by secure facsimile copy or electronic transmission during normal business hours must confirm immediate receipt by a live person. A list of local health department numbers can be found at [www.doh.wa.gov/Portals/1/Documents/1200/phsd-LHJ.pdf](http://www.doh.wa.gov/Portals/1/Documents/1200/phsd-LHJ.pdf).

**What if the local health department cannot be contacted?**

Each local health jurisdiction maintains after-hours emergency phone contacts for the purpose of reporting immediately notifiable conditions, diseases, and outbreaks. A list of these emergency numbers can be found at [www.doh.wa.gov/Portals/1/Documents/1200/phsd-LHJ.pdf](http://www.doh.wa.gov/Portals/1/Documents/1200/phsd-LHJ.pdf). If, however, the local health department cannot be reached, the DOH’s office of Communicable Disease Epidemiology also has a 24-hour hotline number for these kinds of reports: toll free insider Washington only: (877) 539-4344(206). Consultations and technical assistance for reporting reportable diseases and conditions, outbreaks or suspected outbreaks is also available by telephone at: (206) 418-5500 (24 hour contact) and secure facsimile (206) 418-5515.

**What must the physician include in a communicable disease report?**

A physician must include the following information for each case or suspected case of a notifiable communicable disease:

* Name, address, telephone number, date of birth, and sex of the patient.
* Diagnosis or suspected diagnosis of disease or condition.
* Pertinent laboratory data, if available.
* Name, address, and telephone number of the principal health care provider.
* Name and telephone number of the person providing the report.
* Any other information that the DOH may require on forms it generates.
* Any other information of epidemiological or public health value that the local or state health officer may require.

**Must birth defects be reported?**

Yes. See [Birth Defects](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/neonatal-or-pediatric-conditions/birth-defects).

**Are there penalties for failing to file a required report?**

Yes. Failure to file a required report can constitute unprofessional conduct, which may result in disciplinary action. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct). Also, if the failure to file a required communicable disease report is the proximate cause of an actionable injury, it could subject the physician to civil liability.

### Driver’s License Certificate

**What role, if any, does a physician have in the issuance of a Washington State driver’s license?**

The Washington State Department of Licensing may require a person suffering from any physical or mental disability or disease that may affect that person’s ability to drive a motor vehicle to obtain a statement signed by a physician certifying the person’s condition.

The Department also may require a person applying for a license or instruction permit to have an eye examination by a competent vision authority (such as an ophthalmologist or optometrist) in instances where the applicant cannot demonstrate the visual acuity needed for a driver’s license.

A person who wishes to apply for a commercial driver’s license must first be medically examined to ensure that he or she is healthy enough to do so. New regulations require the Department of Licensing to keep either the original or a copy of the driver’s medical certificate on file for 3 years, if the driver was required to provide documentation of physical qualification.

**May the physician’s certifying statement be used in litigation?**

Generally, no. The statement is confidential and may be used only in determining the issuance of a driver’s license, in determining eligibility for or continuance of disability benefits, and as evidence in any administrative proceeding or court action concerning such disability benefits, or in an appeal from an order canceling or withholding a person’s driving privilege.

The certifying statement may not be used as evidence in any civil litigation against the physician or others.

**Must a physician report a patient whose driving ability is impaired?**

No. Washington law does not specifically require a physician to report a patient whose driving ability is impaired. A physician should decline to certify that a patient can safely drive a vehicle, however, if the physician believes the patient cannot.

**Should a physician report a patient whose driving ability is impaired?**

If asked to complete a certificate concerning the patient’s condition and its impact on the patient’s driving ability, the physician should truthfully report whatever information is requested. Because there is no other Washington requirement or procedure for reporting a patient’s impaired ability to drive and because an unsolicited report could breach patient confidentiality, a physician should not report a patient’s impaired driving ability without the patient’s written consent. Whenever a physician believes that a patient’s condition impairs the patient’s ability to drive, the physician should inform the patient that the patient should not drive, explain the reasons why the patient should not drive, and document the advice the physician gave in the patient’s medical record.

**Does a physician have any special responsibilities relating to the licensing of drivers of commercial vehicles?**

Yes. Drivers of some commercial vehicles must receive a physical exam as part of the state licensing process. Effective May 21, 2014, commercial driver’s license examinations may only be performed by health care providers who are certified and listed on the Federal Motor Carrier Safety Administration’s National Registry. Information about the National Registry and how a health care provider can apply to become a certified medical examiner for commercial driver’s licenses may be found at the FMCSA webpage for medical examiners: <http://nrcme.fmcsa.dot.gov/medical_examiners.aspx>.

As part of that required physical exam, the examining physician must complete an examination form called the Medical Examination Report for Commercial Driver Fitness Determination. Copies of the form are found at: <http://www.fmcsa.dot.gov/documents/safetyprograms/medical-report.pdf>. The physician must retain both the original Medical Examination Report and a copy at the physician’s office for at least three years.

If the physician finds the person examined physically qualified to drive a commercial vehicle, the physician must complete a certificate in the specific form available at: <http://www.fmcsa.dot.gov/documents/safetyprograms/Medical-Examiners-Certificate.pdf>. The physician must give the original certificate to the person examined and must give a copy to a prospective or current employing motor carrier who requests it.

If the examining physician finds a physical condition that is likely to interfere with the driver’s ability to operate or control a motor vehicle safely, the physician should not complete a certification. Instead, the physician should give a copy of the driver’s medical examination to the driver, who must in turn forward it immediately to the Washington State Department of Licensing, Responsibility Division, Medical Section, P.O. Box 9030, Olympia, WA 98507-9030. The Department will then determine whether to issue a clearance notification to the driver. Receipt of a clearance notification is sufficient cause for a physician to issue a certification.

### Notifiable Conditions

**What is the purpose of notifiable conditions reporting?**

The purpose of notifiable conditions reporting is to provide the information necessary for public health officials to protect the public’s health by tracking communicable diseases and other conditions and taking appropriate measures to prevent and control their spread.

**What is a notifiable condition?**

A notifiable condition means a disease or condition of public health importance, a case of which, and, for certain diseases, a suspected case of which, must be brought to the attention of the local health officer or the state health officer.

**What is an “immediately notifiable condition”?**

An immediately notifiable condition is a notifiable condition of urgent public health importance, a case or suspected case of which must be reported immediately at the time of diagnosis or suspected diagnosis.

**What notifiable conditions must physicians report?**

Physicians must notify public health authorities of the following notifiable conditions as follows:

|  |  |  |
| --- | --- | --- |
| **Notifiable Condition** | **Time Frame for Notification** | **Notifiable to Whom** |
| Acquired Immunodeficiency Syndrome (AIDS) | Within 3 work days | Local Health Department |
| Animal Bites | Immediately | Local Health Department |
| Anthrax | Immediately | Local Health Department |
| Arboviral Disease | Within 3 work days | Local Health Department |
| Asthma, occupational | Monthly | State Department of Health |
| Birth Defects — Autism Spectrum Disorders | Monthly | State Department of Health |
| Birth Defects — Cerebral Palsy | Monthly | State Department of Health |
| Birth Defects — Alcohol-related Birth Defects | Monthly | State Department of Health |
| Botulism (foodborne, infant, and wound) | Immediately | Local Health Department |
| Brucellosis (Brucella species) | Within 24 hours | Local Health Department |
| Burkholderia mallei (Glanders) and pseudomallei (Melioidosis) | Immediately | Local Health Department |
| Campylobacterosis | Within 3 work days | Local Health Department |
| Chancroid | Within 3 work days | Local Health Department |
| Chlamydia trachomatis infection | Within 3 work days | Local Health Department |
| Cholera | Immediately | Local Health Department |
| Cryptosporidiosis | Within 3 work days | Local Health Department |
| Cyclosporiasis | Within 3 work days | Local Health Department |
| Diphtheria | Immediately | Local Health Department |
| Disease of suspected bioterrorism origin | Immediately | Local Health Department |
| Domoic acid poisoning | Immediately | Local Health Department |
| E. coli Refer to “Shiga toxin-producing E. coli” | Immediately | Local Health Department |
| Emerging condition with outbreak potential | Immediately | Local Health Department |
| Giardiasis | Within 3 work days | Local Health Department |
| Gonorrhea | Within 3 work days | Local Health Department |
| Granuloma inguinale | Within 3 work days | Local Health Department |
| Haemophilius influenzae (invasive disease, children under age 5) | Immediately | Local Health Department |
| Hantavirus pulmonary syndrome | Within 24 hours | Local Health Department |
| Hepatitis A (acute infection) | Within 24 hours | Local Health Department |
| Hepatitis B (acute infection) | Within 24 hours | Local Health Department |
| Hepatitis B surface antigen pregnant women | Within 3 work days | Local Health Department |
| Hepatitis B (chronic infection) – Initial diagnosis, and previously unreported prevalent cases | Monthly | Local Health Department |
| Hepatitis C – (Acute infection) | Within 3 work days | Local Health Department |
| Hepatitis C – (Chronic infection) | Monthly | Local Health Department |
| Hepatitis D – (Acute and chronic infections) | Within 3 work days | Local Health Department |
| Hepatitis E – (acute infection) | Within 24 hours | Local Health Department |
| Herpes simplex, neonatal and genital (initial infection only) | Within 3 work days | Local Health Department |
| Human immunodeficiency virus (HIV) infection | Within 3 work days | Local Health Department |
| Influenza, novel or unsubtypable strain) | Immediately | Local Health Department |
| Influenza-associated death (lab confirmed) | Within 3 work days | Local Health Department |
| Legionellosis | Within 24 hours | Local Health Department |
| Leptospirosis | Within 24 hours | Local Health Department |
| Listeriosis | Within 24 hours | Local Health Department |
| Lyme Disease | Within 3 work days | Local Health Department |
| Lymphogranuloma venereum | Within 3 work days | Local Health Department |
| Malaria | Within 3 work days | Local Health Department |
| Measles (rubeola) – acute disease only | Immediately | Local Health Department |
| Meningococcal disease (invasive) | Immediately | Local Health Department |
| Monkeypox | Immediately | Local Health Department |
| Mumps (acute disease only) | Within 24 hours | Local Health Department |
| Outbreaks of suspected foodborne origin | Immediately | Local Health Department |
| Paralytic shellfish poisoning | Immediately | Local Health Department |
| Pertussis | Immediately | Local Health Department |
| Pesticide poisoning (hospitalized, fatal, or cluster) | Immediately | State Department of Health |
| Pesticide poisoning (all other) | Within 3 work days | State Department of Health |
| Plague | Immediately | Local Health Department |
| Poliomyelitis | Immediately | Local Health Department |
| Prion disease | Within 3 work days | Local Health Department |
| Psittacosis | Within 24 hours | Local Health Department |
| Q Fever | Within 24 hours | Local Health Department |
| Rabies (confirmed human or animal) | Immediately | Local Health Department |
| Relapsing fever (borreliosis) | Within 24 hours | Local Health Department |
| Rubella (including congenital rubella syndrome) (acute disease only) | Immediately | Local Health Department |
| Salmonellosis | within 24 hours | Local Health Department |
| SARS | Immediately | Local Health Department |
| Serious adverse reactions to immunizations | Within 3 work days | Local Health Department |
| Shiga toxin-producing E. coli infections (enterohemorrhagic E. coli including, but not limited to, E. coli O157:H7) | Immediately | Local Health Department |
| Shigellosis | Within 24 hours | Local Health Department |
| Smallpox | Immediately | Local Health Department |
| Syphilis | Within 3 work days | Local Health Department |
| Tetanus | Within 3 work days | Local Health Department |
| Trichinosis | Within 3 work days | Local Health Department |
| Tuberculosis | Immediately | Local Health Department |
| Tularemia | Immediately | Local Health Department |
| Vaccinia transmission | Immediately | Local Health Department |
| Vancomycin-resistant Staphylococcus aureus (not to include vancomycin-intermediate) | Within 24 hours | Local Health Department |
| Varicella-associated death | Within 3 work days | Local Health Department |
| Vibriosis | Within 24 hours | Local Health Department |
| Viral hemorrhagic fever | Immediately | Local Health Department |
| Yellow fever | Immediately | Local Health Department |
| Yersiniosis | Within 24 hours | Local Health Department |
| Other rare diseases of public health significance | Within 24 hours | Local Health Department |
| Unexplained critical illness or death | Within 24 hours | Local Health Department |

**How must reports of notifiable conditions be made?**

Conditions listed as immediately notifiable must be reported by telephone or by secure facsimile copy or secure electronic transmission of a written case report. A party sending information by facsimile or electronic transmission during business hours must confirm immediate receipt by a live person.

Conditions designated as notifiable within 24 hours must be reported to the local health officer or the Department of Health (as specified in the above list) within 24 hours of diagnosis or suspected diagnosis. Reports during normal business hours may be sent by secure electronic transmission, telephone, or secure facsimile copy.

Conditions listed as notifiable within three work days must be reported by written case report, secure electronic transmission, or secure facsimile copy.

Conditions listed as notifiable on a monthly basis must also be reported by written case report, secure electronic transmission, or secure facsimile copy.

For conditions designated as notifiable to the local health department, a physician must notify the state Department of Health when the local health department is closed or its representatives are unavailable at the time a case or suspected case of an immediately notifiable condition or an outbreak or suspected outbreak of a communicable disease occurs. The Department of Health has a 24-hour hotline number, (206) 418-5500 or (877) 539-4344 (Toll-free), for reporting notifiable conditions, outbreaks, or suspected outbreaks.

**What must a report of a notifiable condition contain?**

For each notifiable condition, physicians must provide the following information for each case or suspected case:

* Patient name, address, telephone number, date of birth, and sex.
* Diagnosis or suspected diagnosis of disease or condition.
* Pertinent laboratory data, if available.
* Name and address or telephone number of the principal health care provider.
* Name and address or telephone number of the person providing the report.
* Any other information the Department of Health may require on forms it generates.
* Any other information of epidemiological or public health value the local health officer or state health officer may require.

**What else must a physician do to prevent the spread of communicable diseases?**

See [Communicable Diseases](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/communicable-diseases) .

**Are there penalties for failing to file a required report?**

Yes. Failure to file a required report can constitute unprofessional conduct which may result in disciplinary action. See [Unprofessional Conduct](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/unprofessional-conduct) . Also, if the failure to file a required report is the proximate cause of an actionable injury, it could subject the physician to civil liability.

### Reporting Requirements

**Are there circumstances under which a physician is required by law to report a patient’s condition, illness, injury or disease?**

Yes. A physician is or may be required to make reports under certain circumstances concerning the following:

* Abortions. See [Abortion](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/abortion/abortion).
* AIDS, HIV, or STDs. See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd).
* Animal Bites. See [Animal Bites](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/animal-bites).
* Assisted reproductions. See [Assisted Reproduction](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/assisted-reproduction/assisted-reproduction).
* Births. See [Birth Certificates](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/birth-certificates/birth-certificates).
* Birth defects. See [Birth Defects](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/neonatal-or-pediatric-conditions/birth-defects).
* Child abuse. See [Child Abuse](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/child-abuse/child-abuse).
* Communicable diseases and outbreaks. See [Communicable Diseases](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/communicable-diseases); and [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions).
* Deaths. See [Death Certificates](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/death-certificates/death-certificates).
* Vulnerable adult abuse. See [Vulnerable Adult Abuse](http://legalguide.wsma.org.onexcale.net/end-of-life-issues/elder-abuse/vulnerable-adult-abuse).
* Gunshot wounds. See [Gunshot Woun](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/emergency-treatment/gunshot-wounds)ds.
* Pesticide poisonings. See [Pesticide Poisoning](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/pesticide-poisoning/pesticide-poisoning).
* Phenylketonuria. See [Newborns: Testing and Reporting](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/neonatal-or-pediatric-conditions/newborns-testing-and-reporting).
* Tuberculosis. See [Tuberculosis](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/tuberculosis).
* Other notifiable conditions. See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions).

**Are there circumstances when a physician must report another physician’s unprofessional conduct?**

Yes. See [Medical Discipline](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/medical-discipline).

**Must a physician selfreport any information to the Medical Quality Assurance Commission?**

Yes. See [Medical Discipline](http://legalguide.wsma.org.onexcale.net/liability-and-litigation-issues/medical-discipline-and-unprofessional-conduct/medical-discipline).

**Must a physician report the theft or loss of controlled substances?**

Yes. See [Controlled Substances](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/pain-management-and-controlled-substances/controlled-substances).

### Tuberculosis

**Must a physician report tuberculosis?**

Yes. Tuberculosis is a notifiable condition which must be reported immediately to the local health department. See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions). Moreover, physicians must maintain responsibility for deciding the date of discharge for hospitalized tuberculosis patients and must notify the local health department of intended discharge of tuberculosis patients in order to assure that appropriate outpatient arrangements are made.

**Can a physician be penalized for failing to file a report of tuberculosis?**

Yes. Failure to file the required report could subject a physician to civil liability if the failure to file is the proximate cause of an actionable injury. Also, failure to make a required report could constitute unprofessional conduct which may subject a physician to disciplinary action.

**Must a physician who provides HIV post-test counseling to a patient refer the patient for tuberculosis screening?**

Yes. A physician who provides HIV post-test counseling to a patient when the patient’s test result is positive or indeterminate, or when the patient reports the practice of high-risk behavior, must refer the patient for tuberculosis screening. See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd).

### Venereal Diseases

See [AIDS/HIV/STD](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/aidshivstd).

See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions).

See [Pregnancy Care](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/pregnancy-care/pregnancy-care).

See [Minors, Treatment Of](http://legalguide.wsma.org.onexcale.net/beginning-of-life-and-childhood-issues/treatment-of-minors/minors-treatment-of).

## Prescription Drugs

### Controlled Substances

**What is a controlled substance?**

A controlled substance is a drug, substance, or immediate precursor to a drug included in Schedules I through V under federal and state law.

**What are the characteristics of controlled substances?**

*Schedule I*:Substances having no currently accepted medical uses in treatment in the U.S.; lacking accepted safety for use in treatment under medical supervision; and having a high potential for abuse.

*Schedule II*:Substances having currently accepted medical uses in treatment in the U.S. (possibly with severe restrictions); having a high potential for abuse; and, if abused, leading potentially to severe psychological or physical dependence.

*Schedule III*:Substances having currently accepted medical uses in treatment in the U.S.; having a potential for abuse less than substances listed in Schedules I and II; and, if abused, leading potentially to moderate or low physical dependence or high psychological dependence.

*Schedule IV*:Substances having currently accepted medical uses in treatment in the U.S.; having a low potential for abuse relative to substances listed in Schedule III; and, if abused, leading potentially to limited physical dependence or psychological dependence relative to the substances in Schedule III.

*Schedule V*:Substances having currently accepted medical uses in treatment in the U.S.; having a low potential for abuse relative to substances listed in Schedule IV; and, if abused, leading potentially to limited physical dependence or psychological dependence relative to the controlled substances listed in Schedule IV.

**Must a physician be registered in order to prescribe, dispense, or administer controlled substances?**

A physician must be registered with the federal Drug Enforcement Administration (DEA) before prescribing, dispensing, administering, or distributing controlled substances, unless exempted from registration by federal regulation. Physicians who prescribe or dispense narcotics to patients for maintenance treatment or detoxification treatment must obtain a separate registration for that purpose. Applications for registration may be obtained at any regional office of the DEA, or by writing to the Drug Enforcement Administration, Attn: Registration Section/ODR, P.O. Box 2639, Springfield, Virginia 22152-2639, or by calling the DEA at 1-800-882-9539 (or 206-553-5443 locally).

Physicians licensed in the State of Washington are exempted from registering with the State, but this exemption may be revoked.

**May a physician’s controlled-substances registration be suspended or revoked?**

Yes. A physician’s federal registration may be suspended or revoked upon a finding that:

* the physician materially falsified the registration application;
* the physician has been convicted of a felony relating to any controlled substance;
* the physician has had his or her state license or registration suspended, revoked, or denied by the state authority and is no longer authorized by the state to prescribe, dispense, or administer controlled substances or has had the suspension, revocation, or denial of the physician’s registration recommended by a state authority;
* the physician has committed acts that, in the context of controlled substances, would render his or her registration inconsistent with the public interest; or
* the physician has been excluded (or has been directed to be excluded) from participation in a federal health care program.

A registration to dispense narcotics for maintenance treatment or detoxification treatment may be suspended or revoked if the physician fails to comply with the specific requirements of the registration.

Under Washington law, a physician’s exemption from state registration requirements may be suspended or revoked, precluding the physician from prescribing, dispensing, or administering controlled substances, upon a finding that:

* the physician furnished false or fraudulent material information in a registration application;
* the physician has been convicted of a felony under any state or federal law relating to any controlled substance;
* the physician’s federal registration has been suspended or revoked; or
* the physician committed acts that, in the context of controlled substances, are inconsistent with the public interest.

**What are the recognized purposes for prescribing controlled substances?**

Federal regulations specify the legitimate purposes for prescribing controlled substances as follows:

* A prescription for a controlled substance is effective only if it is issued for a legitimate medical purpose by a physician acting in the usual course of his or her professional practice.
* A prescription may not be issued in order for a physician to obtain controlled substances for general dispensing to patients. A physician must use DEA Form 222 or its electronic equivalent to obtain Schedule I or II controlled substances for office use through regular supply sources. A physician who orders controlled substances for use by all physicians in an office or clinic must register with the DEA as a distributor.
* A physician may not issue prescriptions for detoxification or maintenance treatment unless the physician complies with certain other federal regulations and the prescription is for a Schedule III, IV, or V narcotic drug approved by the federal Food and Drug Administration (FDA) specifically for this kind of use. A physician may administer or dispense directly (but not prescribe) a narcotic drug to a narcotic-dependent person for maintenance or detoxification treatment if the physician is separately registered with the DEA as a narcotic treatment program and the physician complies with DEA regulations regarding treatment qualifications, security, records, and unsupervised use of the drugs. However, a physician not registered as a narcotic treatment program can administer (but not prescribe) narcotic drugs to a patient daily for up to three days to relieve acute withdrawal symptoms while arrangements are being made for referral to an existing narcotic treatment program.

**Are there requirements for legibility of prescriptions?**

Yes. Prescriptions must be hand-printed, typewritten, or electronically generated.

**What are the rules governing electronic communication of prescriptions?**

Electronic transmission of prescription information means the communication from an authorized prescriber to a pharmacy (or between pharmacies) by computer, facsimile, or other electronic means (but not voice communication) of original prescription or prescription refill information for a legend drug or controlled substance. Over-the-counter, legend drug, and controlled substance prescriptions may be transmitted electronically, consistent with federal and state laws. Only exact visual images of Schedule II prescriptions, however, may be transferred electronically. Both the system used for transmitting and the system used for receiving electronically communicated prescription information must be approved by the Washington State Board of Pharmacy. The system must have adequate security and system safeguards designed to prevent and detect unauthorized access, modification, or manipulation of prescription information. Policies and procedures that ensure the integrity and confidentiality of the electronically transmitted information and that do not restrict patients’ access to the pharmacy of their choice must also be in place. These rules do not apply, however, to facsimile transmission of an exact visual image of the prescription. Transmission of original prescriptions must include all of the following:

* Prescriber’s name and address.
* Prescriber’s DEA registration number where required for controlled substance prescriptions.
* Date the prescription was issued.
* Patient’s name and address.
* Drug name, dose, route, form, directions for use, and quantity.
* Electronic, digital, or manual signature of the prescriber.
* Refills or renewals authorized, if any.
* A place to note allergies and a notation for the purpose of the drug.
* Indication of preference for a generic equivalent drug substitution.
* Any other requirements consistent with state and federal laws related to prescription form and content.
* Identification of the electronic system readily retrievable for Board of Pharmacy inspection.

Information concerning electronic systems approved by the Board of Pharmacy may be found at: http://www.doh.wa.gov/Portals/1/Documents/2300/ElectronicPresc.pdf.

Email may be used to transmit prescription information if the system meets requirements for security and confidentiality.

**Are there special rules related to use of facsimile machines to transmit prescription information?**

Yes. Prescription orders transmitted via fax from a prescriber to a pharmacist must meet the following requirements:

* The order contains the date, time, and telephone number and location of the transmitting device.
* Prescriptions for Schedule III, IV, and V drugs may be transmitted at any time.
* Prescriptions for Schedule II drugs may be transmitted only under the following conditions:
* The order is for an injectable Schedule II narcotic substance that is to be compounded by the pharmacist for patient use, or the prescription is written for patients in a long-term care facility or a hospice program.
  + The prescription must be signed by the prescriber.
  + In a non-emergent situation, an order for Schedule II controlled substances may be prepared for delivery to a patient pursuant to a facsimile transmission but may not be dispensed to the patient except upon presentation of a written order.
  + In an emergent situation, an order for Schedule II controlled substances may be dispensed to the patient upon the verbal orders of a prescriber, provided that the prescription is promptly transmitted in written form. The pharmacy has seven days to obtain a written prescription that covers an emergency prescription of this kind.
  + The prescription is to a hospital for a patient admitted to or being discharged from the hospital.

Refill authorizations for prescriptions may be electronically transmitted.

**Is there a limitation on the quantity of controlled substances that may be prescribed to a patient?**

There is no statutory limitation. A physician is limited, however, by the exercise of sound medical judgment required by the applicable standard of care.

**Is there a limitation on refills of controlled substances?**

Yes. A prescription for a Schedule II substance may not be refilled. A prescription for a Schedule III or IV substance may not be refilled more than six months after the prescription’s date and may not be refilled more than five times, unless the physician renews the prescription.

**May a physician prescribe controlled substances for himself or herself?**

No. It is unprofessional conduct to self-prescribe controlled substances. See UNPROFESSIONAL CONDUCT.

**May a physician prescribe controlled substances for family members?**

Washington law does not specifically prohibit it. However, a physician may prescribe a controlled substance only for a legitimate medical purpose while acting in the usual course of his or her professional practice. Furthermore, a physician may not issue a prescription to dispense narcotic drugs for detoxification or maintenance treatment of a person who is dependent on narcotic drugs unless the FDA has approved those drugs for such a purpose and the physician complies with certain federal regulations. Thus, a physician should exercise great caution before prescribing controlled substances for family members, should keep thorough medical records, and should avoid manipulation by family members.

**May a physician be subject to criminal prosecution for violating the controlled substances laws?**

Yes. A physician’s violation of the laws governing controlled substances may result in criminal prosecution. Furthermore, the physician’s medical license will be suspended for the term of a sentence resulting from violation of the laws related to controlled substances.

**May a physician be disciplined for conduct related to controlled substances?**

Yes. A physician’s violation of the laws governing controlled substances may result in disciplinary action. In particular, a physician may be disciplined for:

* The possession, use, prescription for use, or distribution of controlled substances in any way other than for legitimate or therapeutic purposes.
* Diversion of controlled substances.
* Violation of any drug law.
* Prescribing controlled substances for oneself.
* Personal misuse of controlled substances.

**How should controlled substances be stored?**

Physicians must store controlled substances in their offices or clinics in a securely locked, substantially constructed cabinet or safe. Access to the storage area should be kept to a minimum. A sufficiently detailed record of the receipt, use, and disposition of all controlled substances must be maintained. An inventory of all controlled substances in the physician’s possession must be completed every two years and the inventory records kept for two years. See also LEGEND DRUGS.

**How should physicians dispose of controlled substances?**

Physicians should contact the local DEA office for specific instructions on the disposal of controlled substances. The local DEA office will instruct the physician to either transfer the controlled substances to the local DEA office (or such other person or entity as arranged by the DEA) or to destroy the substances in the presence of a DEA agent.

**Must a physician report the theft or loss of a controlled substance?**

Yes. Any loss or theft of controlled substances must be reported to a DEA field office using DEA Form 106, with a copy sent to the Washington State Board of Pharmacy. DEA Form 106 is available at: http://www.deadiversion.usdoj.gov/21cfr\_reports/theft/index.html.

Washington law further requires that the theft or loss of a precursor drug be reported to the state Board of Pharmacy within seven days of discovery. Knowingly providing false information constitutes a Class C felony.

**May an Advanced Registered Nurse Practitioner (ARNP) prescribe controlled substances?**

Upon approval from the Nursing Care Quality Assurance Commission (NCQAC), an ARNP may prescribe Schedule V controlled substances and, subject to statutory guidelines, controlled substances contained in Schedules II through IV. See NURSES.

**May a Physician Assistant (PA) prescribe controlled substances?**

A physician assistant may prescribe controlled substances only if specifically approved by the Medical Quality Assurance Commission (MQAC). A certified physician assistant may prescribe controlled substances, subject to certain conditions. See PHYSICIAN ASSISTANTS.

### Drug Substitution

**May a physician allow for the substitution of a therapeutically equivalent drug?**

Yes. Every prescription must contain an instruction indicating whether a therapeutically equivalent drug may be substituted.

A written prescription must have two signature lines at opposite ends on the bottom of the form. The words “DISPENSE AS WRITTEN” must be clearly printed under the line on the right side, and the words “SUBSTITUTION PERMITTED” must be clearly printed under the line on the left side. The physician must communicate the substitution instructions to the pharmacist by signing the appropriate line.

If the prescription is oral, the physician must instruct the pharmacist whether a therapeutically equivalent generic drug may be substituted.

### Hypodermic Syringes and Needles

**Is a prescription required for hypodermic needles or syringes?**

No. A prescription is not required for the purchase of hypodermic needles or syringes. But the retailer, at the time of sale, must be satisfied that the device will be used for the legal use intended.

**Are there special requirements for disposal of hypodermic needles and syringes?**

Yes. “Sharps waste” includes hypodermic needles, syringe IV tubing with needles attached, scalpel blades and lancets that have been removed from the original sterile package. See Medical Waste for disposal requirements.

**Must a physician who has employees who may have occupational exposure to bloodborne pathogens through needlestick or sharps injuries take special precautions to reduce the health risk to employees?**

Yes. Regulations have been promulgated under the federal Occupational Health and Safety Act (OSHA) and under the Washington Industrial Safety and Health Act (WISHA) requiring employers who have employees who face possible occupational exposure to bloodborne pathogens through needlestick or sharps injuries to adopt specific written exposure control plans to eliminate or minimize the risk of such exposure. Details of the required bloodborne pathogen exposure control plans under OSHA can be found at 29 C.F.R. §1910.1030 and under WISHA at WAC 296-823-11010.

### Legend drugs

**What are legend drugs?**

Legend drugs are drugs which may only be dispensed by prescription or are restricted for use by practitioners only. A prescription for legend drugs is valid only if issued for a legitimate medical purpose.

**Is the substitution of prescription drugs permitted?**

Yes. Every written or oral prescription must contain an instruction as to whether or not a generic drug may be substituted in its place. Every prescription must have two signature lines at opposite ends on the bottom of the form with the words “dispense as written” under the right line and “substitution permitted” under the left line See [Drug Substitution](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/prescription-drugs/drug-substitution).

**Is the prescription of steroids restricted?**

Yes. A physician may not prescribe, administer or dispense steroids for the purpose of manipulating hormones to increase muscle mass, strength, weight, or for the purpose of enhancing athletic ability, without a medical necessity to do so.

**Are there requirements for legibility of prescriptions?**

Yes. Prescriptions must be legible under the law. In order to be legible the prescription must be capable of being read and understood by the pharmacist. A prescription may be hand printed, typewritten, or electronically generated.

**Are there any specific requirements for the paper on which a prescription is written?**

Yes. Effective July 1, 2010, every prescription written in Washington by a licensed practitioner must be written on a tamper-resistant prescription pad or paper approved by the Board of Pharmacy BOP). A pharmacist may not fill a prescription not written on a tamper-resistant pad or paper (except to provide an emergency supply to the patient as allowed by the BOP and insurance contract requirements. Hard copies of electronic prescriptions must also be on tamper-resistant paper. Tamper-resistant prescription pads or paper does not have to be used for prescriptions transmitted to the pharmacy by telephone, facsimile, or electronic means. Physicians must employ reasonable safeguards to prevent to assure against theft or unauthorized use of the prescriptions.

Tamper-resistant prescription pads or paper must contain one or more industry-recognized features designed to prevent:

* Unauthorized copying of a completely blank form;
* The erasure or modification of information written on the prescription for by the physician; and
* The use of counterfeit prescription forms.

For more information about tamper-resistant prescription pads and paper, visit the BOP website: <http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/Pharmacy/TamperResistantPrescriptions.aspx>.

**What are the rules governing electronic communication of prescriptions?**

Over-the-counter, legend drug and controlled substance prescriptions may be transmitted electronically. Electronic transmission of prescription information means the communication from a prescriber to a pharmacy (or between pharmacies) by computer, facsimile, or other electronic means (not voice communication) of original prescription or prescription refill information for a legend drug or controlled substance. Both the system used for transmitting and the system used for receiving electronically communicated prescription information must be approved by the Board of Pharmacy. The system must have adequate security and systems safeguards designed to prevent and detect unauthorized access, modification, or manipulation of the records. Policies and procedures to ensure the integrity and confidentiality of the electronically transmitted information and that do not restrict patients’ access to the pharmacy of their choice must also be in place.

Transmission of original prescriptions must include all of the following:

* Prescriber’s name and address.
* Prescriber’s DEA number, when required for controlled substances.
* Date of the prescription.
* Patient’s name and address.
* Drug name, dose, route, form, directions for use, and quantity.
* Electronic, digital, or manual signature of the prescriber.
* Refills or renewals authorized, if any.
* A place to note allergies and a notation for the purpose of the drug.
* Indication of preference for a generic equivalent drug substitution.
* Any other requirements consistent with state and federal laws related to prescription form and content.
* Identification of the electronic system easily retrievable in case of Board of Pharmacy inspection.

Information concerning electronic prescriptions and electronic communication systems approved by the Board of Pharmacy may be found at: <http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/Pharmacy/ElectronicPrescriptions.aspx>.

E-mail may be used to transmit prescription information if the system meets requirements for security and confidentiality. Email systems must meet requirements for security, which include having documented formal procedures for selecting and executing security measures, physical safeguards to protect computer systems from intrusion, processes to protect, control, and audit access to confidential patient information, and processes to prevent unauthorized access to the data when it’s transmitted over a network or when data is physically moved from one location to another using media such as removable drives or data disks.

**Are there special rules related to use of facsimile machines to transmit prescription information?**

Yes. Prescriptions orders transmitted via facsimile from a prescriber to a pharmacist must meet the following requirements:

* The order must contain the date, time, and telephone number and location of the transmitting device.
* Prescriptions for Schedule III, IV, and V drugs may be transmitted without condition.
* Refill authorizations for prescriptions may be electronically transmitted.
* Prescriptions for Schedule II drugs may be transmitted only under the following conditions:
  + The order is for an injectable Schedule II controlled substance that is to be compounded by the pharmacist for patient use or the prescription is written for patients in a long-term care facility or a hospice program.
  + The prescription must be signed by the prescriber.
  + In a nonemergent situation, an order for Schedule II controlled substances may be prepared for delivery to a patient pursuant to a facsimile transmission but may not be dispensed to the patient except upon presentation of a written order.
  + In an emergent situation, an order for Schedule II controlled substances may be dispensed to the patient upon the verbal orders of a prescriber, provided that the prescription is promptly transmitted in written form. The pharmacy has seven days to obtain a written prescription that covers an emergency prescription.
  + When the prescription is transmitted to a hospital for a patient admitted to or being discharged from the hospital.

**Should a physician report the theft or loss of a legend drug?**

Although federal law requires that a physician, upon discovery, notify the DEA field office of the theft or loss of any controlled substance, see [Controlled Substances](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/pain-management-and-controlled-substances/controlled-substances), there is no specific requirement under Washington law for reporting the theft or loss of a legend drug.

Because theft is a crime, however, when a physician in good faith believes that there has been a theft of legend drugs, the physician may report the theft to the local law enforcement agency. A person who in good faith communicates a complaint or information to any federal, state or local government agency regarding any matter reasonably of concern to that agency is immune from civil liability for claims based on the communication to the agency.

**May a physician prescribe a legend drug for personal use?**

Washington law does not specifically prohibit a physician from self-prescribing a legend drug. It is unprofessional conduct, however, for a physician to self-prescribe a controlled substance. See CONTROLLED SUBSTANCES. Because a legend drug may only be prescribed for a legitimate medical purpose and because misuse of a legend drug by a physician can result in disciplinary action, caution should be exercised in self-prescribing legend drugs.

**May a physician prescribe a legend drug to a family member?**

Washington law does not specifically prohibit a physician from prescribing legend drugs for family members. A legend drug, however, may be prescribed only for a legitimate medical purpose. Thus, it is advisable to exercise caution before prescribing legend drugs to family members and to keep thorough medical records and to avoid manipulation by family members.

**May a physician obtain drug samples from a manufacturer without signing for them?**

No. Samples can only be secured with a written request that is signed and dated by the physician (or other individual authorized to prescribe drugs, such as an Advanced Registered Nurse Practitioner). The request must contain:

* The recipient’s name, address, and professional designation;
* The name, strength, and quantity of the drug samples delivered;
* The name or identification of the manufacturer and of the individual distributing the drug samples; and
* The dated signature of the practitioner requesting the drug sample.

**How must drug samples be stored?**

In addition to storing drug samples in compliance with any other requirements of federal and state laws, rules, and regulations, drug samples must be stored:

* In a locked area to which access is limited to persons authorized by the manufacturer.
* In a manner as to be free from contamination, deterioration, and adulteration.
* Under conditions of temperature, light, moisture, and ventilation so as to meet the label instructions for each drug.

Drug samples which have exceeded their expiration date must be physically separated from other drug samples until disposed of or returned to the manufacturer.

**What records must a physician maintain with respect to legend drug samples?**

A physician who purchases, dispenses, or distributes legend drugs (including samples) must maintain invoices or such other records as are necessary to account for the receipt and disposition of the legend drugs. In other words, all drug samples must be logged in and out of a medical practice. Such records must be maintained for two years.

**How must legend drug samples and legend drugs be labeled when dispensed to a patient?**

Legend drugs dispensed as a trial sample in its original package, and which is labeled in accordance with federal law or regulation must have the name of the issuing practitioner and the name of the patient. Otherwise every container of a legend drug which is dispensed by a physician must have a label bearing the name of the prescriber, complete directions for use, the name of the drug, strength per unit dose, and the name of the patient (unless the physician determines the patient should not be informed of the name and dosage of the medication).

**How should a physician dispose of drug samples?**

Surplus, outdated or damaged drug samples must be either returned to the manufacturer or destroyed before a witness by means which assure that the drug cannot be retrieved. However, specific rules apply to the disposition of controlled substances. See [Controlled Substances](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/pain-management-and-controlled-substances/controlled-substances).

**May a physician be disciplined for conduct related to legend drugs?**

Yes. A physician may be disciplined for:

* The possession, use, prescription for use, or distribution of legend drugs in any way other than for legitimate or therapeutic purposes.
* Diversion of legend drugs.
* Violation of any drug law.
* Misuse of legend drugs by oneself.

The sale, delivery or possession of legend drugs except by prescription is a crime.

**May an Advanced Registered Nurse Practitioner (ARNP) prescribe legend drugs?**

Yes. Upon approval of the Nursing Care Quality Assurance Commission (NCQAC), an ARNP may prescribe legend drugs. See [Nurses](http://legalguide.wsma.org.onexcale.net/other-health-care-professionals/nurses/nurses).

**May a Physician Assistant (PA) prescribe legend drugs?**

Yes. A certified physician assistant may prescribe legend drugs. A PA may prescribe legend drugs, when approved by the Medical Quality Assurance Commission (MQAC) and assigned by the supervising physician, for a patient who is under the care of the supervising physician. See [Physician Assistants](http://legalguide.wsma.org.onexcale.net/other-health-care-professionals/physicians-assistants/physician-assistants);see also [Osteopathic Physician Assistants](http://legalguide.wsma.org.onexcale.net/other-health-care-professionals/physicians-assistants/osteopathic-physicians-assistants).

## Involuntary Commitment

### Involuntary Commitment – Chemical Dependency

**Who may be involuntarily committed for chemical dependency?**

Persons who are incapacitated as a result of chemical dependency may be involuntarily committed. A person is deemed incapacitated as a result of chemical dependency if, as a result of the use of alcohol or other psychoactive chemicals, the person is in danger of serious physical because of a failure to provide for his or her essential needs, health and safety, demonstrates severe deterioration in his or her routine functioning due to escalating loss of cognition or control over his or her actions and is not receiving treatment, or the person presents a likelihood of serious harm to self, others, or property.

**How is the involuntary commitment process initiated for persons who, as a result of chemical dependency, are incapacitated?**

The involuntary commitment process for persons incapacitated by chemical dependency is usually initiated by the filing of a petition for commitment with the superior court by a county-designated chemical dependency specialist (CDS). When the CDS receives information that a person is incapacitated as a result of chemical dependency, the CDS investigates and evaluates the facts. If the CDS determines that a person is incapacitated as a result of chemical dependency, the CDS may file a petition for commitment.

**May a physician detain a person who is brought into an evaluation and treatment facility or hospital emergency room who appears to be incapacitated as a result of chemical dependency?**

Unlike the statutes for involuntary commitment for mental disorders, the statutes governing involuntary commitment for chemical dependency do not specifically address whether a physician may detain a person to enable the county-designated CDS to evaluate the person. However, the petition alleging that chemical dependency treatment is appropriate must be accompanied by a certificate of a licensed physician who has examined the person within five days before submission of the petition. If the person whose commitment is sought has refused to submit to a medical examination the fact of refusal shall be alleged in the petition. The certificate is required to set forth the licensed physician's findings in support of the allegations of the petition. A physician employed by the petitioning program or the department is eligible to be the certifying physician. The statutes governing involuntary commitment for chemical dependency do, however, permit a peace officer or staff designated by the county to detain and take into protective custody a person who appears to be incapacitated or gravely disabled by alcohol or other drugs and who is in a public place or who has threatened, attempted, or inflicted physical harm on himself, herself, or another. Within eight hours, the individual must be taken to an approved treatment program for treatment or to an emergency medical service customarily used for incapacitated persons.

**May the parent of a minor initiate inpatient chemical dependency treatment of the minor without the minor’s consent?**

Yes. A parent may bring, or authorize the bringing of, his or her minor child, even one who is age 13 or older, to a certified chemical dependency treatment program and request that an assessment be conducted by a professional person to determine whether the minor is chemically dependent and in need of inpatient treatment. Consent of the minor is not required for admission, evaluation, and treatment if the parent brings the minor to the program.

An appropriately trained professional person may evaluate whether the minor is chemically dependent. Such evaluation must be completed within 24 hours of the time the minor was brought to the program unless the professional person determines that the minor’s condition necessitates additional time for evaluation. In no event may the minor be held longer than 72 hours for evaluation.

If, in the judgment of the professional person, it is determined that it is a medical necessity for the minor to receive inpatient treatment, the minor may be held for treatment. Within 24 hours of completion of the evaluation, the professional person must notify DSHS if the child is held for treatment and of the date of admission.

No provider is obligated to provide treatment to a minor brought to a chemical dependency treatment program by a parent. Nor may a provider admit a minor to treatment under such circumstances unless it is medically necessary.

No minor receiving inpatient treatment under such circumstances may be discharged from the program based solely on his or her request, but must be discharged immediately upon written request of the parent.

**Does the state provide chemical dependency screening services for children?**

Yes. The Department of Social and Health Services contracts for chemical dependency specialist services at each office of children and family services. The specialist conducts on-site chemical dependency screening and assessments, among other designated duties.

### Involuntary Commitment – Mental Disorders

**Who may be involuntarily committed for mental disorders?**

Generally, persons suffering from a mental disorder may not be involuntarily committed. The exceptions to this general rule are:

* Minors, age 13 or older, who as a result of a mental disorder are gravely disabled or who present a likelihood of serious harm to themselves or others.
* Minors under age 13 admitted on the application of the minor’s parent.
* Persons who are developmentally disabled, impaired by chronic alcoholism or drug abuse, or dementia, if they are either gravely disabled or present a likelihood of serious harm to themselves or others.
* Persons voluntarily admitted who request release, and who, as a result of a mental disorder, present an imminent likelihood of serious harm to themselves or others, or who are gravely disabled.
* Persons who are found by the court to be sexual psychopaths.
* Persons committed or confined to a state correctional institution or facility, when in the judgment of the secretary of corrections, and with the consent of the secretary of DSHS, the welfare of such persons necessitates their transfer, for observation, diagnosis or treatment, to a state institution or facility for the care of the mentally ill.
* Criminal defendants charged with felonies who are found by the court to be incompetent to stand trial.
* Criminal defendants who pleaded guilty by reason of insanity, or if there are doubts about his or her competency may be committed without an initial assessment of the defendant’s mental condition if the defendant is charged with first or second degree murder, if it is likely that an assessment in jail will not be adequate, or if the court finds that assessment outside the jail setting is necessary for the health, safety, or welfare of the defendant.
* Criminal defendants acquitted of a felony by reason of insanity, if the court finds that they present either a substantial danger to others or a substantial likelihood of committing felonious acts jeopardizing public safety or security, unless kept under further control by the court or other persons or institutions.

**How is the involuntary commitment process initiated for persons who, as a result of a mental disorder, are gravely disabled or dangerous to themselves or others?**

The involuntary commitment process is usually initiated by the filing of a petition for initial detention by the county-designated Mental Health Professional (MHP). When the county-designated MHP receives information that a person, age 13 or older, as a result of a mental disorder, is gravely disabled or presents a likelihood of serious harm to self or others, the MHP investigates and evaluates the facts and interviews the person. If the county-designated MHP is then satisfied that the person is gravely disabled or dangerous as a result of a mental disorder and that the person will not voluntarily seek appropriate treatment, the MHP may take the minor into custody, transport the minor to an inpatient evaluation and treatment facility, and then file a petition for initial detention.

**May a physician detain a person who is brought to an evaluation and treatment facility or hospital emergency department in order to enable a county-designated MHP to evaluate the person?**

Yes, under certain circumstances. If the person is an adult and refuses voluntary admission, and if the professional staff of the facility or hospital believes that the person, as a result of a mental disorder, presents an imminent likelihood of serious harm to self or others, or presents an imminent danger because of grave disability, then the professional staff may detain the person for up to six hours to enable the county-designated MHP to evaluate the person. The six-hour period to detain a person does not begin until the hospital staff determines the necessity for further evaluation by the MHP.

If the person is a minor, age 13 or older, and if the professional person in charge determines that the minor suffers from a mental disorder, that inpatient treatment is required, and that the minor is unwilling to consent to voluntary admission, and if the professional person believes that the minor meets the criteria for initial detention, then the minor may be detained for up to 12 hours to enable the county-designated MHP to evaluate the minor.

**May a physician be held civilly or criminally liable with regard to decisions to admit, release, or detain a person for evaluation and treatment?**

Generally, no, as long as such decisions were made in good faith and without gross negligence.

**Does an involuntarily committed patient have a choice of physicians?**

Yes. Involuntarily committed patients must be given a reasonable choice of an available physician or other professional person qualified to provide the needed services.

**Can antipsychotic medication be administered to an involuntarily committed patient without the patient’s informed consent?**

Under limited circumstances, yes. If antipsychotic medication is used, the physician must attempt to obtain the patient’s informed consent. A patient’s right to refuse antipsychotic medications does not apply when a patient is gravely disabled or present a likelihood it is determined that the failure to medicate may result in a likelihood of serious harm or substantial deterioration, or substantially prolonging the length of involuntary commitment, so long as there is no less intrusive treatment that is in the patient’s best interests. Under state rules, Antipsychotic drugs may be administered without the patient’s consent when an emergency exists and there is a review of the decision by a second physician within 24 hours. For purposes of such administration, an “emergency” exists when the patient presents an imminent likelihood of serious harm to self or others, medically acceptable alternatives are unavailable or unlikely to be effective, and the patient’s condition is serious enough that the physician determines emergency treatment must be instituted before obtaining an additional concurring opinion by a second physician. Absent an emergency, antipsychotic may be administered over a patient’s objections or lack of consent when there is an additional concurring opinion by a second physician for treatment up to 30 days. Additional requirements apply for continued treatment beyond 30 days. In criminal cases, the court may authorize involuntary medication for the purpose of competency restoration if the defendant is charged with a serious offense.

**May a physician be held civilly or criminally liable for a decision to administer antipsychotic medications to an involuntarily committed person?**

Generally, no, as long as such decision was made in good faith and without gross negligence.

**What general rights are afforded to patients who are involuntarily committed?**

The following rights afforded to all patients who have been involuntarily committed:

* No person shall be presumed incompetent solely as a result of receiving an evaluation, or voluntary or involuntary treatment for a mental disorder.
* Each patient has the right to adequate care and individualized treatment.
* Each patient shall have the right to treatment by spiritual means through prayer in accordance with their beliefs.
* Each patient must be given a reasonable choice of available physician, or other health care provider qualified to provide treatment.

**Must a patient who is involuntarily committed for a mental disorder be provided with a statement of rights?**

Whenever a person is detained for evaluation and treatment, state law requires that both the person and, if possible, a responsible member of the person’s immediate family or the person’s guardian must be advised as soon as possible in writing or orally that unless the person is released or consents to voluntary admission for treatment within 72 hours of the initial detention that:

* A judicial hearing in the superior court will be held within 72 hours of the initial detention.
* The person has the right to communicate immediately with an attorney.
* The person has the right to remain silent and that any statement may be used against him or her at the hearing.
* The person has the right to present evidence and to cross-examine witnesses at the hearing.
* The person has the right to refuse medications, including antipsychotic medications, beginning 24 hours prior to the hearing.

In addition, state rules specifically require that patients who have been involuntarily committed must be informed orally and in writing in the primary language spoken/used/understood by the person, “You have the right to:

(1) Remain silent and any statement you make may be used against you.

(2) Access to attorneys, courts and other legal redress, including the name and address of the attorney the mental health professional has designated for you.

(3) Immediately be informed of your right to speak with an attorney and a review of the legality of your detention including representation at the probable cause hearing.

(4) Have access to a qualified language interpreter in the primary language understood by you, consistent with chapter 388-03 WAC.

(5) Have a responsible member of your immediate family if possible, guardian or conservator, if any, and such person as designated by you be given written notice of your inpatient status, and your rights as an involuntary consumer.

(6) A medical and psychosocial evaluation within twenty-four hours of admission to determine whether continued detention in the facility is necessary.

(7) A judicial hearing before a superior court if you are not released within seventy-two hours (excluding Saturday, Sunday, and holidays), to decide if continued detention within the facility is necessary.

(8) Not forfeit any legal right or suffer any legal disability as a consequence of any actions taken or orders made, other than as specifically provided.

(9) Not to be denied treatment by spiritual means through prayer in accordance with the tenets and practices of a church or religious denomination.

(10) Refuse psychiatric medication, except medications ordered by the court under WAC 388-865-0570 but not any other medication previously prescribed by an authorized prescriber.

(11) Refuse treatment, but not emergency lifesaving treatment unless otherwise specified in a written advance directive provided to the facility.

(12) Be given a copy of WAC 388-865-0585 outlining limitations on the right to possess a firearm."

A detained person retains certain other rights, including the rights to wear his or her own clothing, use personal possessions, use a reasonable amount of money for canteen expenses and small purchases, access individual storage space, receive visitors at reasonable times, have reasonable access to a telephone and writing materials, discuss treatment plans and decisions with professionals, refuse consent to antipsychotic medications (unless mandated pursuant to a hearing), refuse consent to electroconvulsive therapy or psychosurgery, and deal with property or contracts unless declared incompetent in a court proceeding.

A person must be given a written statement of his rights upon leaving a facility following evaluation or treatment for a mental disorder.

**May the parent of a minor initiate inpatient mental health treatment of the minor without the minor’s consent?**

Yes. A parent may bring, or authorize the bringing of, his or her minor child, even one age 13 or older, to an evaluation and treatment facility and request that the professional person examine the minor to determine whether the minor has a mental disorder and is in need of inpatient treatment. The consent of the minor is not required for admission, evaluation, and treatment if the parent brings the minor to the facility. Parental authorization, or the authorization of a person who may otherwise legally consent on behalf of a child, is required for inpatient treatment of a minor under 13 years of age.

An appropriately trained professional person (a physician or other mental health professional empowered by an evaluation and treatment facility with authority to make admission and discharge decisions) may evaluate whether the minor has a mental disorder. The evaluation must be completed within 24 hours of the time the minor was brought to the facility unless the professional person determines that the minor’s condition necessitates additional time for evaluation. In no event may the minor be held more than 72 hours for evaluation.

If, in the judgment of the professional person, it is determined that it is a medical necessity for the minor to receive inpatient treatment, the minor may be held for treatment. Within 24 hours of completion of the evaluation, the professional person must notify DSHS if the child is held for treatment and of the date of admission. Within not less than 7 nor more than 14 days after the date the minor was brought to the facility, DSHS must assure that any minor admitted to inpatient treatment at the initiation of a parent receives an independent review by a physician or other mental health professional to determine whether it is a medical necessity to continue the minor’s treatment on an inpatient basis.

No provider is obligated to provide treatment to a minor brought to an evaluation and treatment facility by a parent. Nor may a provider admit a minor under such circumstances unless it is medically necessary.

Parents of a child must be given a notice by the evaluation and treatment center that includes all of the available treatment options for the child allowed by law and the procedures to be followed to utilize the treatment options.

No minor receiving inpatient treatment under such circumstances may be discharged from the facility based solely on his or her request, but must be discharged immediately upon written request of the parent. Before the DSHS independent review is conducted, the professional person must notify the minor of his or her right to petition the superior court for release from the facility.

**Where may a physician find additional information regarding mental health services?**

More information regarding mental health services may be found at the Department of Social and Health Services website:http://www.dshs.wa.gov/dbhr/mhfaqs.shtml#dbhr .

## Women’s Care

### Women’s Direct Access

**Must health care carriers insure that female patients have direct access to timely and appropriate covered women’s health care services from certain types of health care providers of their choice?**

Yes. Health care carriers, policies, plans, and programs must provide women patients with direct access to certain types of health care providers of their choice for appropriate covered women’s health care services without the necessity of prior referral from another type of health care provider. Health care carriers, however, may restrict women patients to seeing only health care providers who have signed participating agreements with the health care carrier.

**What are the types of health care providers to which health care carriers must allow female patients direct access?**

The types of health care providers to which female patients are entitled direct access include the following, consistent with their lawful scopes of practice:

* Physicians who provide women’s health care services.
* Osteopathic physicians who provide women’s health care services.
* Physician’s assistants when providing women’s health care services.
* Osteopathic physician’s assistants when providing women’s health care services.
* Advanced registered nurse practitioners in women’s health and midwifery.
* Licensed midwives.

**What do women’s health care services include for purposes of direct access?**

Women’s health care services include:

* Maternity care.
* Reproductive health services.
* Gynecological care.
* General examination.
* Preventative care as medically appropriate.
* Medically appropriate follow-up visits for any of the above services.

### Domestic Violence

**What is Domestic Violence?**

Domestic violence is sometimes called Intimate Partner Violence or domestic abuse. In Washington, the law defines Domestic Violence as physical harm or the infliction of fear of imminent harm between family or household members, sexual assault of one family or household member by another, or stalking as defined by law of one family or household member by another. The term “family or household member” is defined in specific language in the Revised Code of Washington, and could include spouses, domestic partners, and adults who have a dating relationship or a child in common.

Though domestic abuse can involve emotional or verbal abuse, it often escalates and involves physical violence which can result in trips to the doctor or emergency room. As many as half of female abuse victims reported visiting an emergency room due to an injury in the past year, but men are also victims of domestic abuse.

**What are physicians’ legal obligations when treating patients who may have been injured by a partner?**

RCW 43.235.010-43.235.901. Washington has regional domestic violence review panels which DSHS can use to coordinate review of domestic violence fatalities. Medical personnel, coroners, or medical examiners and other with experience in forensic pathology are to work with local health department staff and other DV advocates to review suspected DV fatalities. Members of the panels are immune from civil liability for activities related to reviews.

Health care providers are not subject to mandatory reporting laws here in Washington even when they reasonably suspect that an adult patient has been abused. Some physicians fear that mandatory reporting laws violate confidentiality and patient autonomy, and discourage victims from seeking medical care. Hospitals are required to report bullet, gunshot, or stab wounds to local law enforcement, as soon as is reasonably possible.

RCW §43.70.610 mandates that the Department of Health establish an ongoing domestic violence education program as an integral part of its health professions regulation to educate healthcare professional to identify, treat, and refer victims of domestic violence.

**Am I allowed to break patient-physician confidentiality if I am worried about my adult patient’s safety?**

Generally, no. There are some exceptions to the blanket prohibition on disclosing patient information. See DISCLOSURE. For example, Washington requires health care providers to report suspected cases of child abuse or vulnerable adult abuse. See CHILD ABUSE; and VULNERABLE ADULT ABUSE. Some states have mandatory reporting laws for physicians who suspect domestic abuse, but Washington does not.

**What if my patient has been seriously injured?**

Washington law does require hospitals to report injuries like gunshot wounds, stab wounds, and bullet wounds as soon as reasonably possible. See REPORTING REQUIRMENTS; and GUNSHOT WOUNDS. If a patient is seeking treatment for a gunshot or stab wound, the hospital will need to report this injury, regardless of whether or not you believe a partner or household member was involved. Your name may be part of the required report submitted to the Department of Health by the facility if you were the primary care provider.

**Where can I find additional resources?**

Many organizations have supplied materials to help inform and guide physicians.

• Department of Health: Physicians interested in learning more can browse the Washington Department of Health website, which has Domestic Violence information for healthcare providers available at http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/ViolenceAgainstWomen.aspx. The Department of Health has also published an Injury and Violence Prevention Guide, which covers myriad subjects including sexual and domestic violence. It is available at http://www.doh.wa.gov/Portals/1/Documents/2900/InjuryReportFinal.pdf

• American Medical Association: The AMA has also made its opinions on physician ethics available to physicians to use as guidance. The AMA’s opinion piece, “Physicians’ Obligations in Preventing, Identifying, and Treating Violence and Abuse,” can provide helpful guidance to physicians, and is available on the AMA website (www.ama-assn.org).

• Blue Cross Blue Shield of Michigan and Blue Care Network: Those interested in a more comprehensive informational publication can read “Intervening in Domestic Violence and Abuse: The Health Care Provider’s Reference Guide to Partner and Elder Abuse.” This publication, which the authors call a tool kit, includes more in-depth information on domestic violence, helpful forms and paperwork for documenting abuse, and guidance for physicians working with abused patients, in order to formulate a safe discharge plan. The entire tool kit is available at http://www.bcbsm.com/pdf/DV\_ReferenceGuide.pdf.

## Pesticide Poisoning

**Must physicians report suspected or confirmed cases of pesticide poisoning?**

Yes. Cases or suspected cases of pesticide poisoning are notifiable conditions which physicians must report to the state Department of Health. See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions).

**How is pesticide poisoning defined?**

Pesticide poisoning means the any disturbance of function, structural damage, or illness in a human which is the result of inhalation, absorption, ingestion of, or contact with any pesticide.

**When must pesticide poisoning be reported?**

Hospitalized, fatal, or cluster cases of pesticide poisoning must be reported immediately to the state Department of Health. All other confirmed or suspected pesticide poisoning cases must be reported within three working days of diagnosis to the Department of Health. See [Notifiable Conditions](http://legalguide.wsma.org.onexcale.net/clinical-practice-issues/management-of-specific-diseases-and-condition/notifiable-conditions).

**Are there penalties for failing to comply with the pesticide poisoning reporting requirements?**

Yes. Failure to report cases or suspected cases of pesticide poisoning to the Department of Health may subject the physician to disciplinary action. No civil liability, however, may result from failure to file a report or for filing a report.