Elliott, Ashley

Subject: "Public Comment for Nov 16 I-900 Meeting" Performance Audit – Medical Discipline in WA

From: katurnage@comcast.net [mailto:katurnage@comcast.net]
Sent: Tuesday, November 15, 2016 12:59 PM
To: zzJLARC Pub Officer <JLARCPUBOF@leg.wa.gov>
Cc: katurnage@comcast.net
Subject: "Public Comment for Nov 16 I-900 Meeting" Performance Audit â€“ Medical Discipline in WA

JLARC email which is: JLARC@leg.wa.gov
"Public Comment for Nov 16 I-900 Meeting" Performance Audit – Medical Discipline in WA

Dear Chair Sen. Braun and the Members of JLARC Committee,

First, I would like to thank the SAO for performing the medical board audits to evaluate whether they are adequately protecting the public. I know, as an auditor myself, this took a great deal of effort. However, the audit did not review the correctness of the boards' decisions to investigate or the final disposition of complaints. The SAO also did not examine licensing functions and educational requirements (which should always be performed during audits) as these would have addressed the intent and scope of the audit to evaluate if the boards are adequately protecting the public. To the public, we do not feel the SAO can adequately make the determination until these other reviews are completed.

This is a first step in what the public wants: regular more detailed performance audits of the Washington State medical boards.

I was one of many patient advocates that asked the SAO to perform an audit of the MQAC. My son, Mark Turnage, died at Valley Medical Center due to a horrendous amount of medication errors, 4 hospital acquired infections (sterilization issues and cross-contamination), the doctors not reading the lab results, and too many to list in this letter. Another patient safety advocate sent in his story to the SAO about his wife's death at this same hospital (involving the same doctors).

After filing my initial complaint with the MQAC it was quickly closed. I knew that a House Bill had just been approved (HB1493, *Providing greater transparency to the health professions disciplinary process)* so I asked the MQAC to consider new information and re-open my son's case. I was told by the MQAC investigation focals, that my complaint with new information would be the first that went through the new HB 1493 process at the MQAC. What I learned is there was no greater transparency in the process. From my initial complaint (3/22/2011) to the final closure letter (4/11/2013) it took the MQAC 751 days (2 years and 20 days) to tell me that I complained too much, I didn't know what I was talking about, the hospital had to pay a lot of money (my son was triple covered with insurance – total bill was over $1.2M which was paid-in-full), my expectations were too high, but I had valid points. All my board complaints were closed even though one of the DOH investigators was mentally incompetent and still poses great risks to her community (Nursing Commission complaint and police reports were ignored).

In summary, the MQAC complaint process (and other medical boards) leaves the public at risk. Until regular, more detailed audits are performed patients will continue to be harmed. Thank you again, SAO, for conducting these audits. The public will continue to work with the SAO and our State of Washington representatives to allow these audits to continue on a more detailed and frequent basis.

Thank you for the ability to provide public comment.

Karie Fugate (formerly Karie Turnage)
2417 NE 23rd Street
Renton, WA 98056

425-941-3067

I have attached my original email to the SAO and the MQAC response letter (received 2 years and 20 days after initiating a complaint).

As a Member of the Public I make the following public recommendations:

The SAO didn't look at a complaint through the investigative process. The SAO determined that the medical boards have met the expectation to protect the public, however, this intent was not in the audit scope. The audit was performed using the GAO Auditing Standards for the guidelines. The GAO Auditing Standards is 241-page guidance document that provides the framework for auditors of government entities and entities that receive government awards. It defines the type of audits they perform (financial, attestation engagements and performance audits). The auditors in this case focused on providing objective evidence to improve program performance and operations, reducing costs, and facilitating decision making by parties with responsibility to oversee or initiate corrective actions and contribute to public accountability. <u>If the SAO did not examine licensing functions and educational requirements or the correctness of the boards' decisions to investigate or the final disposition of complaints how could the SAO say the medical boards are adequately protecting the public? This does not make sense.</u>

It appears that the SAO auditors didn't feel they have the medical knowledge necessary to complete all elements of the actual audit. Another way to accomplish this would have been to hire 3rd party independent medical auditors (which would ensure public safety and save taxpayer dollars).

The public wants to work with the MQAC and legislature to adopt preponderance of evidence as the standard of proof and recommended that a "letter of concern" be transparent to the public; Washington is not in alignment with other states. We need to provide consistent outcomes across the nation, which in turn will protect the public.

The public supports the SAO's recommendation for regular evaluations on whether the boards meet their mission to protect the public. The public wants tighter oversight, accountability, transparency, and for the public to have the power to voice their concerns. The public recommends regular sunset reviews of all medical/regulatory boards. Currently, 20 states have regular scheduled sunset reviews.

The public wants the ability to attend MQAC Business Meetings (and other medical boards) electronically. Some of us work other jobs and can't drive to the meetings; others are handicapped and/or disabled and can't obtain transportation. The public wants these meetings to either 1) be recorded or posted to the DOH website, or 2) for the boards to provide online meeting access (WebEx, etc.) so that we may attend, make notes, and comment. This would also increase communication with the public without costing the taxpayer any money (this software technology is used in all businesses and the government) and also follow guidelines for the ADA (this population needs special accommodations). Meeting minutes do not include all the other interactions that occur in board meetings.

The medical boards need skill requirement checklists developed and interviews to ensure these Governor appointed members are the cream of the crop. These medical professionals need to have current, up-to-date knowledge of emerging technologies, diseases, medications and interactions, etc. In my complaint, George Heye, MD (MQAC gatekeeper to the investigative process) was over 70 years old, had no specialized training to understand the detail of my son's case, and was grandfathered in per the DOH website (requiring no CME). In aviation, CME is a critical part of a working Quality System and the only way to ensure all parties have the most current information on a variety of aviation topics, regulations, rule changes, etc. Healthcare should be no different. The public also recommends that MQAC hire experts when case reviewers do not have the expertise; the public also recommends appointing younger doctors that understand the value of patient engagement and safety more than their older counterparts.

The medical boards need investigation process checklists developed for all complaints to go through the same process of review (which ensures standardization, consistency and public safety). We can't have one MQAC doctor recommending to close a complaint and another member wanting to investigate. The public is concerned this simple tool does not exist (and should). This tool would aide with auditing the investigative process.

The public supports the SAO's recommendation for the medical boards to improve communication and interaction with people who filed complaints. Let these discussions be a way to engage the public and hear their concerns. We get talked at not listened to. I personally noticed, after filing a complaint, that I was investigated more (and criticized) versus them actually reviewing my son's case. As an example of the MQAC communication at previous business meetings:

I have personally attended MQAC Business Meetings and have heard from their chief investigator and board members: "Our job is to get them (the doctors) out of a malpractice suit." "All they (the public) wants is to chop off the doctor's head [I heard this MANY times]." "The public isn't smart enough." I think the MQAC communicated what they actually think of the public.

There is no real appeal process with the medical boards. The public wants this addressed.

It also appears, to the public, that certain complaints may involve MQAC and hospital/doctor conflicts of interest. The public wants this addressed.

The public supports the SAO's recommendation that MQAC and BOMS be merged. This would ensure standardization and consistency of the investigative process, enhance public safety, and save taxpayer dollars (from the duplication of efforts).

The public wants "Public Members" not associated with the healthcare industry to be appointed to the medical boards which would ensure the patient's perspective is always heard. This also improves communication.

The public agrees with the SAO's interpretation that the boards are not totally transparent even with HB1493, *Providing greater transparency to the health professions disciplinary process* approved into our state laws. I was told by Dani Newman and Melissa McEachron, MQAC investigation focals, that my complaint with new information would be the first that went through this new HB 1493 process at the MQAC. There was no greater transparency in the process; I had to beg for status and even that took 2 years and 20 days for the MQAC to say I submitted no new information (and there were hundreds of pages of root cause analysis, medical records, etc.).

The public supports the SAO's recommendation that more transparent doctor profiles be posted on the DOH website to include previous convictions, malpractice, CME, etc. In the past, CME information was available on the DOH provider search website; this is now missing.

The public also wants more data and demographics of doctors that have been sanctioned to ensure that the sanctions are consistent. The public would like to be more involved in the analysis of this performance data.

The public supports more detailed information on the DOH website for what is needed is needed to file a complaint so it isn't ignored and immediately closed (RCA for Unprofessional Conduct, etc.). In my experience, there are a few things listed on the DOH website but there should be more detail. I initially sent in a 3-page complaint with details and it was immediately closed.

The public supports the SAO's recommendation to follow MQAC's own policy for unannounced office visits.

The public supports broadening UDA based on the FSMB's standards.

The public wants repeated offenders be taken into special consideration when screening cases.

My complaint/MQAC response timeline (it took over a year and a half for a new information review):

3/22/11 Letter	Complaint letter sent in
3/31/11 Email	Email to MQAC to ensure letter received
4/4/11 Email	Email response – MQAC did not receive. Resubmitted.
4/8/11 Letter	Letter. Case opened 2011-155137MD
4/18/11 Letter	My Authorizations sent to MQAC with additional information included for Jim Smith
5/3/11 Call	Connie Pyles calls; she is the PA and Jim Smith is the chief. I will receive a closure letter in 3 to 6 months. This can be opened by Commission Members. She will go out and get records and statements. A report will be done. This report is copied and sent to the staff attorney who may request additional information and records. If they receive adequate evidence this is presented to panels each 6 weeks. Commission members can send the case back for expert review (ID, intensivists, etc.). The Commission can decide to go further. There are lots of players. This process can take 1 year; case load is high. I can call for status at any time. I will receive a closure letter. Connie knows about HB1493. My data made her job much easier and if I locate any additional information please forward to her
6/8/11	Closure letter from MQAC received
6/13/11	Letter to Connie Pyles with additional information after our 5/3/11 conversation)
7/18/11 Letter	Letter – Records request and process for submitting new information per HB1493
8/2/11 Call	Call from Dani and Melissa. They discuss the process w/new info: they notify the license holder (Valley) and Valley has 30 days to respond.
9/19/11 Letter	Letter from MQAC
10/7/11 Letter	New information with 2 binders to the MCAC (hundreds of pages and medical records)
11/7/11 Letter	My letter to Melissa regarding whistleblower and other patient acquiring the same bacteria Mark did
11/28/11 Letter	More new information: Letter; binder
1/3/12	Call to Melissa for status. Melissa said she hasn't touched anything yet; she wanted to make sure all new information had been received before submitting as a complainant only has 1 time to submit. Melissa says this should be "interesting" what Fred Dore the commission member says (Fred will review this since he reviewed the old data).
3/27/12	Call Melissa and leave voice mail @ 9:15 am reference the status. Melissa calls back on 3/29/12 and says that the commission still has (and investigating and there is no status yet.
5/29/12	Call Melissa on 5/29/12 and leave a message. She calls back leaves generic message on 5/30/12 – no status given.
6/6/12	I call Melissa back 6/6/12 and leave another message. I don't hear from Melissa and call her back on 6/8/12 and reach her. Melissa says the case is still closed and the new information is still under review – i.e. no status.
10/17/12	Letter to Melissa on status. Pending.

4/11/13	I receive a closure letter from the MQAC. Investigation closed, no action.

January 29, 2014

Mr. Troy Kelley
Washington State Auditor's Office
ATTN: Hotline
P.O. Box 40021
Olympia WA 98504-0031

Reference: Case Numbers 155173FS, 155306FS, Complaint Number 35998 (Case 2012-425), and 2011-155137MD (also listed as 155137UK)

Mr. Kelley,

I am writing to you to express my grave concerns that state medical boards fail to do proper investigations, they do not provide explanations for their decisions, there is still no transparency, and they fail to follow the new law for case reconsideration.

I have personally witnessed this gross mismanaging of public funds and resources in dealing with the Department of Health (DOH) Medical Quality Assurance Commission (or MQAC – regulation of doctors, etc.) and the DOH Facilities and Licensing (they regulate the hospitals). I also plan on contacting other officials in our state (Governor, Representatives, Senators, DOH, etc.) and agencies at a Federal level. This poses a danger to the Public Health and Safety.

My son, Mark David Turnage Jr., died from a horrendous amount of medical errors and 4 hospital acquired bacteria at Valley Medical Center in Renton, Washington. Due to his death from these errors, I initiated complaints with the above DOH agencies. Of course, both groups ordered a few medical records and immediately closed my original complaints after short reviews with their teams.

Because of the new legislation in Washington State a complainant is able to order the investigation records of closed cases and provide new information and request the complaint to be reopened; this is due to HB1493, *Providing greater transparency to the health professions disciplinary process.* I took advantage of this and ordered the investigation records from both agencies. What I received back from the MQAC was appalling – most of the investigation materials was the information I sent in, a report by the MQAC (bashing me for making a complaint – then making comments that were not based on the facts and data [they didn't read my complaint]) and records showing they were searching for me on My Space and a blog I set up detailing the errors to the public. What I received back from Facilities & Licensing was worse; mainly a 4 paragraph report from an investigator named Jill Stevens, Rn that said she went to Valley Medical and watched the staff washing their hands – and even looked at an audit log of the staff saying they were doing that. How on earth can you audit hand washing?

I informed both agencies that I was sending in new information because of HB 1493 and requesting these be reopened. I was told by Dani Newman and Melissa McEachron, MQAC investigation focals, that my complaint new information would be the first that went through this new HB 1493 process at the MQAC. What happened from there? The MQAC took 1 year to investigate and the same investigator, George Heye, MD said I had no new information to add (in these 2 binders I sent in) and they refused to reopen my complaint. After receiving the records from their investigation, the MQAC ordered nothing new. What was amazing is that Valley Medical Center told the MQAC investigator that they had specialists look at my son's case and an outside review done – the DOH investigator failed to obtain these records.

The other new information/request to reopen was sent to the DOH Facilities and Licensing dealing with the closure of my original complaints. My new information included a detailed audit/review of 42 CFR 482.42 - Condition of participation: Infection control and 42 CFR 482.13 - Condition of participation: Patient's rights (which involves a variety of patient rights and the use of restraints (physical and chemical - sedatives)). Both of the original cases were to remain closed and a new one opened. After a Public Disclosure request and receiving the investigation records, there are no records on why the Infection Control case was closed (even though my son acquired 4 hospital bacteria and Valley Medical Center gave the bacteria to another patient); the new case review that was completed sampled current patients at the hospital and no review was completed based on my complaint. What is interesting is that the State of Washington DOH has a Healthcare Associated Infection Advisory Committee and a validation model - my complaint on the bacteria should have been validated through that office instead of the investigator looking at a log (audit) of hand washing. I know this because I attend those meetings and am a delegate now for one of their members.

I would also like to comment that the DOH investigator Jill Stevens, Rn should have never been investigating cases in the first place; Jill has been arrested a few times now for violating no contact orders and will face jail time if she violates it again. You may want to order these records – I have never heard of a person drunk that early in the morning and yelling profanities to the neighbors and police. I even saw the video with her yelling that she was a f___ing nurse with the DOH; the police department documented Jill Stevens calling them and hanging up. With all this going on, Jill Stevens, Rn renewed her nursing license last April I believe.

I also opened a complaint with Qualis – the Medicare beneficiary audit group. Qualis only allows 1 time (for the original complaint) going into the system as the coordinator forms the complaint into questions for the doctors, hospital, and staff (for their audit). Qualis made Standard of Care findings and Quality concerns (without reviewing or investigating the new information); the DOH did not find any. It's amazing that even though they would not accept new information, they found 4 violations that the DOH didn't and/or ignored.

I have also sent in correspondence to Governor Gregoire after attending the MQAC business meetings and their chief investigator, Jim Smith, walking past me and saying their job (the MQAC) is to get the doctors out of a malpractice suit. Other times, the MQAC members mention “all the public wants to do is to cut their (the doctors) heads off,” at least 12 times in one of their meetings. Other public members attended this same meeting and had the same comments I just made.

I am looking forward to discussing my findings with all those that are involved in the State of Washington. This cannot continue to happen; my tax dollars should not be wasted paying for these arrogant, self serving individuals that have no concept of what an audit/investigation is all about. I know as I received my certification back in 2005 as a 3rd party QMS auditor. Because there are no consequences or check and balance system in place at the DOH, they have become a dangerous group. They are not protecting the public; they are protecting the hospitals and doctors.

Respectfully,

Karie Fugate

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

April 11, 2013

Karie Fugate
PO Box 1951
Renton, Washington 98057

Re: Case #2011-155137MD

Dear Ms. Fugate:

The Medical Quality Assurance Commission (Medical Commission) completed its evaluation of your request for reconsideration concerning the closure of your complaint against physicians at Valley Medical Center (VMC). The Medical Commission takes each request for reconsideration seriously. I also wanted to say how truly sorry I am for your loss and to thank you for your patience during the reconsideration process.

In your complaint and multiple information submittals, it is clear you believe that Valley Medical Center is responsible for your son, Mark's death. You write that the Valley Medical Center, its staff, and doctors involved in his care failed to appropriately provide Mark the medical care and treatment he needed. Mark sought emergency care for pain at Valley Medical Center emergency room and was admitted to the hospital. Once admitted at VMC, you say that Mark was forced to stay and suffer - at a facility you think was not properly equipped to provide advanced medical treatment for pancreatitis. As importantly, after Mark was admitted and still able to move between hospitals, Valley Medical Center and its staff failed to arrange a transfer for Mark to Swedish Hospital even though all the doctors providing his on-going medical care and treatment were located at Swedish.

You describe how the VMC doctors failed to timely review an ultrasound showing gallstones and gallbladder sludge, which you believe were the source of pain that originally sent Mark to seek emergency care at VMC. You state that the doctors also failed to understand the etiology of pancreatitis and did not take the genetic study information and other research you provided seriously. The information you provided outlined the known interactions between the new regimen of drugs prescribed at VMC and the medications Mark was using. As importantly, the doctors did not follow the treatment plan recommendations properly, especially the antibiotic treatment components described in the culture and sensitivity plan recommendations.

As a result, you saw Mark suffer from withdrawal symptoms due to medication changes, from a toxic reaction to the new medications, and from the effects of multiple instances of liver failure.

In addition, the Valley Medical Center and its staff failed to establish and use proper infectious disease control protocols during intubation procedures, which caused several types of bacterial infections.

The Medical Commission focused its review on the actions of the physicians and physician assistants involved with your son's care rather than all staff of Valley Medical Center, as the Medical Commission has legal authority over the practice of medicine by a physician or physician assistant.

A panel of the Medical Commission carefully reviewed the information you submitted, which includes hundreds of pages of charts, notes, correspondence, pictures on DVD, and other information, in conjunction with the original investigation case file. Taking your concerns into consideration, the Medical Commission re-examined the evidence.

A panel of the Medical Commission concluded that there is no compelling information that shows a specific physician or physician assistant provided inadequate or substandard care or acted in a manner that violated Washington laws regulating the practice of medicine. Therefore, this case remains closed.

Once again, thank you for bringing your concerns to the Medical Quality Assurance Commission's attention.

Sincerely,

Melissa McEachron, Projects Manager
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
melissa.mceachron@doh.wa.gov

MQAC CASE MANAGEMENT TEAM ASSESSMENT

CMT Wednesday - Phone Assessment

Respondent: Unknown Case Number: 2011-155137

Date: 12-5-12	Staff Attorney: Mager	Clerk: Kramer
Panel Chair: Harder	Concannon, Brantner, Clower, Cullen, Elders, Green, Johnson, Pattison, Winslow Ruiz, Burger, Cvitanovic, Gotthold, Harder, Hensley, Hopkins, Marsh, Schneeweiss, Terry	
Management: Staff Attorneys:	Jansen, Dr. Heye, Smith, Creighton, McEachron Farrell, Berg, Caille, Landreau, Mager, McLaughlin Kramer	

A. FILE CLOSED PRIOR INVESTIGATION (BEFORE)

☐ **BT1** - Advertising that is a technical violation	☐ **BT7** - Insufficient information	☐ **BT12** - Profession-Specific Threshold Explain:_____ a) Violating confidentiality b) Inappropriate delegation to unlicensed person that does not involve invasive procedures or piercing of skin (e.g., RN instructs NA to apply skin cream) c) Failure to supervise resulting in no harm or minor harm to a patient d) Isolated incidents which suggest little or no patient harm, not likely to reoccur
☐ **BT2** - Aged or outdated complaints	☐ **BT8** - Issues which have been otherwise resolved. Explain resolution:_____ (Detail corrective action: practitioner is already revoked; ongoing monitoring, etc.)	☐ **BT13** - Referral to another program or agency
☐ **BT3** - Billing and fee disputes except as designated by disciplining authority	☐ **BT9** - Lack of complaint credibility	☐ **BT14** - Risk minimal, not likely to reoccur
☐ **BT4** - Communication and personality issues	☐ **BT10** - No Jurisdiction	☐ **BT15** – Time practice on an expired credential for a period of time accepted by the disciplining authority
☐ **BT5** - Complainant withdrew	☐ **BT11** - No violation at the time the event occurred	☐ **BT16** – Unidentified complainant, client or patient name and no allegations of significant harm or potential harm
☐ **BT6** - If allegations are true, no violation of law occurred		Further explanation (if any):

B. SCOPE OF INVESTIGATION AUTHORIZED: ☐ Entire Complaint ☐ Limit ☐ Focus ☐ Expanded

Notes: _____

C. PRIORITY: ☐ A (risk of immediate danger) ☐ B (serious risk) ☐ C (Moderate risk) ☐ D (Minor risk) ☐ E (technical evidence)

D. CLOSED AFTER INVESTIGATION

☐ Application Investigation Only- License granted without conditions.	☐ A7-Mistaken identity
☐ A1-Care rendered was within standard of care	☐ A8-No jurisdiction
☐ A2-Complainant withdrew	☐ A11-No Whistleblower
☐ A3-Complaint - Unique closure	☐ A12-Risk minimal, not likely to reoccur
☐ A5-Evidence does not support a violation	
Further Explanation (if any) Request for Reconsideration Denied	

E. SEXUAL MISCONDUCT CASES RCW 18.130.062

☐ Authorized Investigation yes.no ☐ Set as Priority A yes/no

☐ Retain by MQAC, clinical or standard of care issues, do not refer ☐ Refer cases to Secretary for non clinical issues

GUIDE FOR CLOSURE CODES
November 2012

CODE	CLOSURE	DESCRIPTION
	Application	Decision to grant an unrestricted license.
A-1	Care rendered was within standard of care	The evidence establishes that the respondent met or exceeded the standard of care.
A-2	Complainant withdrew complaint	The complainant withdrew the complaint, and the complainant's testimony is necessary to meet the burden of proof.
A-3	Unique closure (Panel must explain)	Any concerns regarding Respondent have been resolved through corrective action, license revocation, and suspension, death of respondent, or other circumstances. Explain: _____ _____ _____
A-5	Evidence does not support a violation	• The evidence is not sufficient to establish by clear, cogent, and convincing evidence that Respondent violated any UDA provision. • This includes situations in which the investigator was unable to obtain all material evidence.
A-7	Mistaken Identity	The case was opened under the wrong Respondent's name.
A-8	No Jurisdiction	Respondent is not licensed in Washington, has never been licensed in Washington, and is not applying for a license in Washington.
A-11	No Whistleblower Release	Complainant would not sign a whistleblower release AND the release of complainant's identity is necessary to prove a UDA violation.
A-12	Risk Minimal – Not Likely to Reoccur	There is sufficient evidence that Respondent violated the UDA, but the evidence indicates that: (a) The violation is not likely to reoccur; and (b) Closure poses no more than a minimal risk to public

Revised 11/09/2012

MQAC RECONSIDERATION REQUEST
Case Number: 2011-155137

***Date: 11-26-2012**

Date: April 1, 2011
Presented by: **George Heye, MD**

Respondent:	**MEDICAL, UNKNOWN**	**King County**

Complainant:	**Ms. Karie Turnage**

CASE SUMMARY

The Respondent:

Board Certified:	Unknown
DOB:	Unknown
Licensed since:	Unknown
Expiration date:	Unknown
Medical School:	Unknown
Residency:	Unknown

The Complainant: The mother of a deceased 30-year-old male patient

Malpractice Settlement: N/A.

The Complaint: The mother of a deceased 30 y/o patient feels that her son's death was due to the improper treatment of the various infections that he acquired during his two month hospitalization. The patient was on dialysis for renal failure and was admitted with acute pancreatitis a day following his last dialysis. His condition deteriorated quickly leading to intubation and repeated but unsuccessful efforts to control persistent sepsis related to increasingly resistant organisms. He was treated by multiple specialists but the infections could never be adequately controlled or eradicated. After consultation with the family the decision was made to withdraw care and the patient died on 1/16/2011.

***Reconsidertion Request: 11-26-12**
This case was initially presented to the Commission on 6-2-11 and closed A-1, care rendered was within the standard. On July 18, 2011 the complainant sent in a request for reconsideration. Included with the request were about two hundred pages of material mostly consisting of pages from the hospital record along with comments from the complainant. A DVD was also included showing scenes from the hospital. The new material was sent to the RCM who still had his original evaluation in hand. After reviewing the new material the RCM replied that the majority of the information was again directed to the general care of her son which had already been reviewed. The small amount of new information offered reflected the impact of the son's demise on her. As with the original review of the case the RCM could not identify any standard of care issues in regard to the medical care of any specific doctor. His conclusion was that the case does not merit reconsideration.

Rec: Do not reopen.

gh

1/3/2012 Call from Ms. Fugate

She wanted to make sure we received her information. I said yes. I asked if she had any other information to submit. She indicated she did not think so

Melissa

Elliott, Ashley

From: Wayne Fugate <waynef@paladinaero.com>
Sent: Wednesday, November 16, 2016 7:52 AM
To: zzJLARC Pub Officer
Cc: katurnage@comcast.net
Subject: "Public Comment for Nov 16 I-900 Meeting" Performance Audit - Medical Discipline in WA

Dear Chair Sen. Braun and the Members of JLARC Committee,

First, I would like to thank the SAO for performing the medical board audits to evaluate whether they are adequately protecting the public. It does not take skilled medical professionals to audit policies and procedures that are developed to outline decisions to investigate or review the final disposition of complaints. In aviation, we have technical and non-technical auditors that regularly review our policies and procedures to ensure non-compliances are documented and addressed. Further, for those of us who make airworthiness deamination's recurrent training is required to ensure we are current with any changes in regulation or policy.

So, based on this, I do not feel the SAO can adequately make the determination that the public is protected until these other reviews are completed.

This is a first step in a long journey to save lives and hold the medical boards, health care providers and hospitals accountable – this what the public needs. We want regular more detailed performance audits going forward. How can you improve without having reliable 3rd party audits and timely corrective action for audit and compliance findings? Healthcare and aviation are in the same business – to prevent loss of human life. Why is aviation held to strict repeatable standards and healthcare is not? This would explain why over 400,000 people die each year from preventable medical error.

I personally witnessed my wife losing her son to preventable medical error and going through the medical board process of filing complaints. A personal hell no one needs or want to go through. It is time for the DOH to change the way they do business.

In summary, the MQAC complaint process (and other medical boards) leaves the public at risk. Until regular, more detailed audits are performed patients will continue to be harmed and/or killed. There is still more work to be done in the very near future.

Thank you for the ability to provide public comment.

Wayne Fugate
2417 NE 23rd Street
Renton, WA 98056
425-793-7377

The highest courage is to dare to be yourself in the face of adversity. Choosing right over wrong, ethics over convenience, and truth over popularity…these are the choices that measure your life. Travel the path of integrity without looking back for there is never a wrong time to do the right thing. Author unknown

Washington Advocates for Patient Safety

3941 NE 158th Lane Seattle, WA 98155
www.washingtonadvocatesforpatientsafety.org
wapatientrights@gmail.com

To: Joint Legislative Audit & Review Committee
From: Washington Advocates for Patient Safety and Consumers Union
Date: November 15, 2016
Re: **Performance Audit, Medical Discipline in Washington**

Dear Chair Sen. Braun, Vice Chair Rep. Stanford, and Members of the Committee:

This is a joint submission from Washington Advocates for Patient Safety (WAPS) and Consumers Union (the policy arm of Consumers Report) Safe Patient Project (CU SPP) in response to the State Auditor Office (SAO) report on medical discipline in Washington State. Together, we were instrumental in instigating the audit and we appreciate the acknowledgement by the SAO.

We are pleased with the audit results and not surprised that deficiencies were found. Clearly this audit was needed. We agree with the Auditor's comments, support the recommendations, and encourage the legislature and the appropriate agencies to act on them through new rules and legislation so that the medical boards are best able to protect the public. We look forward to working with legislators on these issues.

For a brief background, WAPS is a non-profit, grass roots organization. Most of our members have personally been affected by preventable medical errors, the third leading cause of death now in the US. To prevent what has happened to us from happening to others, we have become patient safety experts to bring patients' voices into the health care system to improve quality of care, patient safety, healthcare transparency and accountability. Nationally, we are a member of Consumers Union Patient Safety Network, the Patient, Consumer, and Public Health Coalition, and Consumers United for Evidence-based Healthcare. In recognition of our knowledge on patient safety issues and advocacy, our members have been invited to work on a variety of patient safety projects. Examples include teaching at the University of Washington for AHRQ's national TeamSTEPPS program to improve medical team communications and teaching at the UW medical school on interprofessional care and shared-decision making. We have members serving on the Medical Device Epidemiology Network Initiative (MDEpiNet), a national patient panel to adviser FDA on medical device safety, the state Healthcare Associated Infections Advisory Committee, the Patient Safety Committee of the National Quality Forum, a FDA advisory committee, and several other healthcare committees. In addition, in 2014, Governor Inslee appointed our president to be a public member serving on MQAC. Our members also devote much of our volunteer time going out into the community to do educational presentations on patient empowerment and healthcare infection prevention. These are just a few of the many public services that WAPS members provide as volunteers for patient safety.

Prior to the formation of WAPS, two of our members worked closely with then Rep. Jamie Pederson to successfully get a bill passed into law in 2011 to require medical boards to be more transparent to the public. Since then, we have continued to work on improving the boards' transparency for the protection of the public, which was a reason we asked for an audit of the medical boards.

The following are our specific comments in response to the SAO's recommendations.

1. "Preponderance of Evidence" vs. "Clear and Convincing" (p5, p14, p22, p48, & p58)

As pointed out in the SAO report, "*Washington's Supreme Court requires that state regulatory bodies meet a higher standard of proof, 'clear and convincing,' which can make it more difficult for boards to take action against a provider*." According to the Federation of State Medical Boards (FMSB), about 75% of all state medical boards use a lower standard of "preponderance of evidence". We recommend that the legislature revisit the issue of using "preponderance of evidence" as adopted by the majority of all US medical boards.

In addition, the SAO suggested that medical boards be allowed to issue "Letter of Concern" in cases that do not rise to the level of sanctions. In 2015, HB 1135 was introduced to allow boards to send out "letters of concern" to physicians. We supported the bill with the recommendation that this bill be amended to require public transparency – that is, any Letter of Concern would be posted on each physician's website profile. As amended, the bill was passed by the full House but did not get out of the Senate Health committee. We would recommend that this bill be revisited by the legislature.

2. Improve Communication and Interaction with Concerned Patients (p6 & p23)

We support the SAO's recommendation to improve the board's communications and their interaction with concerned patients. This has been one of the primary concerns expressed since our first interaction with the medical board. Often, the boards do not explain their decisions, including why a case is closed before investigation or why it was closed after. This lack of information and communications has over the years frustrated many patients who filed complaints.

We need specific rules and laws to require such communications with concerned patients or as has been shown in the SAO report, the medical boards do not consistently do this. For example, the previous MQAC director when asked for an explanation of a board decision stated, "The law does not require me to tell you anything, so I will not." She made it very clear that she would not disclose any information unless it was required by law; therefore, we need a law to require medical boards to communicate the reasoning behind their actions to concerned patients. In addition, if an investigation is authorized on a case, the boards should be required to communicate with the patient who filed the complaint to verify that the board understands the complaint thoroughly. After all, the board's duty is to protect the public and this cannot be done without good communications. At the conclusion of an investigation, patients should be given a chance to respond and be provided with a detailed explanation on the investigation and how the board came to its decision on each concern. One sentence that just says the care met the standard is not acceptable. We are pleased that the SAO recommended these changes and that state medical boards are working on improving its communications with people who file complaints.

3. Medical Board Transparency

We support the SAO's recommendations to improve medical board transparency and to make provider information more easily accessible to the public. Specifically, we support:

- Signs in the doctor's office informing patients how to file a complaint and where to look up information about their doctors (p7 & p30, Items 3, 8, & 9);
- Summaries of disciplinary actions. These should be standardized, so that the reasons for the action, types of disciplinary actions taken, and any restrictions on a physician's license are clearly included in these public descriptions (p7 & p30, Item 7, & p25);
- Better usability of the website to communicate with the public and improve search capacities (p7 & p30, Item 6);
- More information on the physicians' profile in particular, medical malpractice, sanctions by other states, and hospital privilege actions. (p7 & p30, Item 7) (as per the Consumers Report: https://consumersunion.org/wp-content/uploads/2016/03/Chart-website-review-CR-blobs-all-states-FINAL-4.pdf);
- To improve medical boards' transparency and encourage public participation in the state regulatory process, we recommend that medical boards make their public meetings readily accessible using live webcast, social media platforms like twitter and Facebook, and archives of past meetings.

4. Law or Rule Changes

In areas where the medical boards will need help from legislators, we agree with and support the following SAO recommendations:

- MQAC formal policy regarding their definition of "unprofessional conduct" should be broadened following the best practice of the Federation of State Medical Boards (FSMB) (p5 & p23), to include:
    - Signing a blank, undated or predated prescription forms [p47, Item 25]
    - Failure to provide medical records to patients or other physicians when requested [p47, Item 36];
- MQAC should have clear authority to order biological testing of doctors on probation for substance abuse issues [p47, Item 20];
- MQAC should follow their own policy on unannounced visits to physicians the agency is monitoring (p28).

In addition to the recommendations by the SAO, we recommend that medical boards consider a doctor's prior disciplinary history when screening complaints. This was not addressed by the report but should be considered by the legislature. Repeat offenders need to be recognized as a higher threat to public safety.

5. Correctness of the Medical Board Decisions on Investigation (p3 & p16)

The SAO did not review the correctness of the actual decisions to open or close a case, the quality of the investigations, the decisions on whether to sanction a physician, or which sanctions were given. Since this is a critical part of the whole disciplinary process, we believe the audit is incomplete and the SAO is premature in saying that the boards met the legislative intent to support quality of care and patient safety.

We have first hand knowledge of patients who submitted convincing evidence to the boards which was ignored without investigations or ignored after investigations. We know of some cases where the substandard care and patient harm were substantiated by medical experts or by federal agencies like CMS, yet there were neither investigations nor sanctions by the state boards. What we have seen indicates to us that the correctness of the actual decisions to open or close a case, the quality of the investigations should be examined in order to protect the public.

6. Regular Evaluation of the Medical Boards (p7, Item 11, p31, Item 11, p50)

The State Auditor's Office "*recommend MQAC and BOMS modify current performance measure activities to regularly evaluate the nature and volume of complaints, the adequacy and consistency of enforcement actions, as well as how well the boards are meeting their mission to protect the public.*" We strongly support this recommendation.

Given the ever changing field of medical regulation, continuing regular performance reviews are necessary to protect patient safety and needs to be done not internally. Such reviews should be done by a third party such as through the SAO. The regular performance review can also be done by regular sunset reviews of state regulatory boards. According to the FSMB, regular sunset reviews have been adopted by many states in the US. A regular review process provides the public a place to voice their concerns on state regulatory policies and practices as well as providing an opportunity to participate in evaluating the state medical regulatory process. This will also help strengthen public oversight on state medical regulatory agencies. Presently, there is no such opportunity for the people of Washington to voice their concerns.

With preventable medical errors being the third leading cause of death in the US, and medical boards being the main authority to regulate and sanction medical professionals, the legislature needs to make sure that the state medical boards meet the legislative intent to best protect the public safety.

We thank you for this opportunity to address the committee and to respond to the SAO report on medical discipline in Washington State.

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Oral Testimony on the Auditors Report on Medical Boards

Good afternoon, Chairman Braun, Vice Chair Stanford, and Members of the JLARC Committee.

My name is Rex Johnson and I live in Seattle. I am a co-founder and board member of Washington Advocates for Patient Safety, also known as WAPS. I am also here today as a representative of Consumers Union, Safe Patient Project. Working together, we requested this audit of the state medical boards and we appreciate the acknowledgement in the report.

WAPS is a grass-roots non-profit. Most of our members have suffered from preventable medical errors. To prevent what has happened to us from happening to others, we have become patient safety experts. Our members now serve on various state and federal committees. We have also been invited to teach at the University of Washington Medical School on improving team care and communications. In addition, we volunteer countless hours going out into the community to educate the public about patient safety and empowerment.

We are pleased with this audit of the medical boards. We were not surprised that it found deficiencies. Clearly this audit was needed for the protection of the public. We agree with the Auditor's comments, support the recommendations, and encourage the legislature and appropriate agencies to act on them so that the medical boards are best able to protect the public. We look forward to working with legislators on these issues.

We have submitted a detailed joint written response by WAPS and Consumers Union. Let me highlight a few of our responses.

First, we agree with the auditor's comments on the problems of having to use "Clear and convincing" in determining disciplinary actions. This requirement puts significant restrictions on the medical boards' abilities to take appropriate actions to the public. According to the Federation of State Medical Boards, about 75% of all state medical boards use the "preponderance of evidence" standard. We recommend that the legislature adopt the "preponderance of evidence" as is currently used by the majority of all US medical boards.

Second, we support the auditor's recommendation to allow medical boards to issue a "Letter of Concern" in cases that do not rise to the level of sanctions. House Bill 1135 was introduced in 2015 to allow boards to send

out “letters of concern”. We supported this bill with a recommendation that it be amended to require transparency --- that is to post Letters of Concern under DOH providers’ profiles. The amended bill was passed by the full House. We would recommend that this bill be revisited.

Third, we support the auditor’s recommendation to improve the board’s communications with concerned citizens. It is common that the boards do not interact with people who file complaints nor explain their final decisions. This lack of communication has been a major frustration to patients.

We need specific rules and laws to guide the boards’ communications with concerned citizens. The board’s duty is to protect the public and this cannot be done without good communications. A letter with just one sentence that just says the care met the standard, is not acceptable. We would be glad to work with the boards to resolve these issues.

Lastly, I want to draw your attention to where the Auditor stated they did not look into whether cases were opened and resolved properly. This is unfortunate because whether a case is investigated and how the board reaches its final decision is undoubtedly one of the most critical issues in protecting the public.

Let me take a moment to share my personal story as an example. Several years ago we filed a complaint with MQAC due to what we believed was substandard care that led to my father-in-law’s death. Despite strong evidence, MQAC ruled that the care met the standard after their investigation. We then submitted the exact same evidence to the Centers for Medicare and Medicaid Services (CMS) and they found five violations of standard care. May I reiterate this? CMS found 5 violations and yet MQAC said the care met the standard. Unfortunately what happened to us, is not a rare event. We know of many other such cases. That is why we feel this audit is not complete. It needs to examine whether cases are being open, investigated, and resolved properly to protect the public.

In addition, as recommended by the Auditor, we agree that there should be regular evaluations of the boards’ performance. These regular evaluations are critical to make sure that these state agencies meet the legislative intent to best protect patient safety.

I thank you for this opportunity to address the committee.

I would be happy to answer any questions.

Rex Johnson
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From: Kimberly Yang
To: zzJLARC Pub Officer
Subject: Public comment for Nov. 16 1-900
Date: Tuesday, November 15, 2016 2:36:33 PM

Dear Committee Members,

My name is Kimberly Yang and I previously requested an audit of the WA State Medical Board to the State Audit office. I recently received a copy of the audit report.

My request was based on the facts that my father lost his life due to two different physicians' malpractice, which were substantiated by two different federal agencies, CMS and QUALIS. However, the Medical Board has continued to fail and refuse to substantiate these physicians' malpractice.

I do however appreciate the time and effort from the audit office, and I believe continuous improvements are needed within the Medical Board to better serve patients' safety and patients' rights. I am hopeful the State will require regular review of Medical Boards as is required by the State of California. I greatly appreciate the JLARC Commitee's concern and dedication.

Thank you.

Sincerely,

Kimberly Yang

COMMENTS ON SAO AUDIT OF MQAC Submitted by H. Fox

Dear JLARC,

When the MQAC audit was first announced , I was very pleased. The Washington DOH medical boards are in a dark corner that needs to have a light shined on it. I have experienced the complaint process first hand. I have been there.

Having reviewed the SAQ audit report, I believe it to be a valuable contribution. It is a good start. There is more to be done. The medical boards do good work, they can do better. I am writing you with the intent to contribute useful information and ideas to further your and the SAO interest. Please consider what follows:

IMPROVED COMMUNICATION (Based on personal experience)
My initial complaint (after my wife's death) was to the hospital. I complained someone failed to administer a medically ordered preoperative medication to my wife (the patient) The hospital forwarded it to DOH which notified me they opened two investigations (Nursing Care Quality and Medical Quality of Care). The only communication I received was a phone call from a nursing quality investigator who appeared totally ignorant of the rare disease that my wife suffered from. She made no effort to understand my input. I later received written notice that my complaint was closed. My wife's case was reopened after I wrote letters to all the members of the Board of Health citing DOH arrogance. I had to write another letter to learn of the reopening. At no time was I made aware that my inputs were welcome or even forwarded.

I wrote other letters to DOH pointing out inconsistencies in the resultant case reports by DOH investigators. Finally I received a letter from DOH informing me that they would file my letters but not necessarily reply. That is not communication that is arrogance.

Complainants should be made aware of available avenues of communications, allowed to prepare a statement for the board, be informedof their rights to challenge agencies actions, and communication should not be unilateral. Bureaucrats don't like complaints but squeaking wheels are a sign something needs fixing..

ADD TO THE UNIFORM DISCIPLINARY ACT (UDA)

Consider Rare Disease Patients The intent of the UDA is to assure the public of adequate professional competence and conduct of health care providers, some attention needs to be paid to the needs of populations of those citizens who suffer from rare diseases. According to NORD (National Organization for Rare Disorders) there are 30 million people in America who suffer from rare diseases. A typical example.....Addison's Disease -One case per 10,000 people. The point is they have appendixes and they break legs. How the rare disease will interact when another medical event that requires treatment can be life threatening. How does this affect UDA?

When a rare disease patient is hospitalized for another ailment like a broken leg for example, his or her caregivers should be required to become familiar with the does and don'ts of the rare disease. An education refresher should be required if the caregiver has not been involved in treating that exact type of rare disease patient in a reasonable period of time (6 months ?). Medical boards ruling on complaint investigations should require the services of a specialist familiar with their associated rare disease.

General practitioners will not hack it. In most cases physicians are lucky to properly diagnose a case of Addison's disease before a crisis occurs.

Review Testimony. I noticed in reviewing the record of DOH investigation of my complaint that there appeared to be a two tier procedure with respect to personnel giving testimony. Nurses and technicians testimony under a notice of perjury, doctors were not so cautioned. UDA should require that all testimony be under threat of perjury.

Involvement of non medical personnel in a complaint investigation. Today most hospitals have added a "Risk Assessment (RA)" function to their services in complaint investigations. I do not speculate whose risk is their concern. I noted that, in my experience, this person worked closely with medical board investigative personnel. Presentations were made to the investigator in which the RA from the hospital assembled selected hospital personnel to offer testimony, concerning the case, to the investigator. Not all the key personnel appeared to testify. Case record indicates that the investigator did not trouble to , later, interview those not invited to the presentation. While it is helpful to have a non licensed individual arrange a presentation it is too easy for a busy investigator to neglect to get all the facts from everyone involved. It could taint data delivered to the reviewing board and provoke wrong decision. UDA must include some mechanism to prevent this kind of helpful interference.

Excessively higher standard of proof. The requirement of a clear and convincing proof in not denying a complaint is not reasonable. Individuals have different levels before they are convinced. It is like nailing jello to a wall. The preponderance of evidence is enough for civil courts to fine people or send them to prison. The State Supreme Court functions successfully with split vote counts, recognizing that an important decision was reached without a "clear and convincing proof". A standard like this can negate the entire complaint process. I suggest the legislature request the court to quantify "clear and convincing" for inclusion in the UDA.

Thank you for considering my comments. The records of my experiences are available should you wish to refer to them.

Harry Fox (harifox@comcast.net)
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Des Moines, WA 98198

From: Tracy Jones
To: zzJLARC Pub Officer
Subject: Public Comment for Nov. 16 I 900 Meeting
Date: Tuesday, November 15, 2016 11:40:33 PM

Dear Chair Senator Braun and the Members of JLARC Committee:

I'm writing in regards to the Performance Audit that SAO did for the Washington State Medical board. I've had concerns about the way the state boards handle complaints for some time. I was both relieved and grateful when I found out the Auditors Office was conducting an audit of the Medical Board, I've been wanting to speak to someone for a long time about my own experience with a different state board, the Dental Quality Assurance Commission. In 2014 I was a victim of dental malpractice. I went to a dentist for a single filling issue. 10 months later I was experiencing severe jaw pain and dental issues. I went to another dentist for a second opinion and learned that due to treatments I was subjected to at the first dentists office, my jaw was so severely misaligned I would need jaw surgery, braces, gum grafts, and other treatments to correct the condition. I was horrified. My dentist never told me about any issues whatsoever. When I asked him what he had done to my teeth he abandoned care and refused to tell me what had happened. There was so much damage other dentists refused to take over my treatment. They also refused to tell me what he had done. Two and a half years later I'm still struggling to ascertain what happened and get appropriate treatment.

I contacted the Dental Quality Assurance Commission in 2014 asking them to open an investigation. Then later in 2015 I filed a second complaint. I made a total of 3 complaints with DQAC. I advised them that I had been injured. That I had been subjected by my dentist to treatments without my knowledge or consent. I also advised that my dentist had abandoned care and was obstructing me from getting corrective treatment by refusing to tell me the truth. Each time DQAC refused to open an investigation. I called multiple people at DOH and tried to explain. No one there was willing to help. I was advised after each complaint that it was outside the board's jurisdiction due to 'personality issues' between my dentist and myself or 'insufficient information'. Each time I was given a different reason. I was not allowed to submit any evidence. I was never allowed to present any facts or express my concerns about my dental provider. I have a document from another dentist stating my dentist caused significant, permanent injuries. I was never allowed to present that to the board.

That was 2 1/2 years ago. I never received corrective treatment for the injuries my dentist caused. I've spent $20,000 trying to get a diagnosis and treatment. Still, no one has told me exactly what my dentist did. If the Dental board or other dentists had intervened two years ago, at the time the injuries occurred, my prognosis today would be very different. There's so much damage now to my jaw and teeth my teeth will never look or function the same. I'm in constant pain.

This audit wasn't about DQAC. It was about MQAC. But from what I understand all the boards operate similarly. I can see SAO spent alot of time and effort on this audit which I so appreciate. By all accounts MQAC's mission is to regulate the medical profession and protect the public. The audit brought up some board deficiencies or inconsistencies. The SAO provided some excellent suggestions for improvement.

If the board is there to serve the public they need to have a dialogue with us. If someone files a complaint with the board we should be able to discuss our concerns with someone on the board or on behalf of DOH. Currently all a member of the public can do is to go to a meeting and 'talk at' the board i.e. make public comments but we can't have a conversation or exchange with them. And the board cannot respond to our comments. The board can't possibly determine whether or not a complaint is valid based on an initial complaint letter unless we can present evidence and the facts of our case. In my case with DQAC, I had a statement from another dentist stating my dentist had caused injuries. I was never allowed to present that document for consideration.

I support SAO's recommendation that MQAC improve communications with the public and create a dialogue with

people who have filed complaints. They cannot serve the public if they won't talk to us to hear our concerns. Nor can they make the determination as to whether or not a complaint is valid based on a short two or three paragraph initial complaint. We should be allowed to present our concerns and the facts of our case before the decision is made whether or not to open a complaint.

With regards to public outreach and increasing MQAC's visibility, as a member of the public I would recommend that the board meetings be made more accessible to the public. Not everyone has the ability to travel to MQAC's meetings and attend in person. Personally I've been wanting to go to both MQAC and DQAC meetings. It's not feasible for me to take time off of work to do so. Perhaps the meetings could be recorded and later uploaded to the website. Or there could be other ways for the public to participate in the meetings. I would ask the Committee Members to consider ways in which the public can participate and interact with the board at board meetings without physically having to drive to Tumwater. It limits accessibility and particpation from public members.

I saw many positive suggestions in SAO's audit. Including posting notices in doctors officers advising patients where complaints about medical providers can be filed. Providing the Medical board with more tools to address concerns such as a Letter of Concern. Or lowering the threshold for standard of proof from 'Clear and Concise' to a 'Preponderance of Evidence'. If the threshhold of proof is so high the board cannot act on reasonable concerns regarding standard of care issues, that should be looked at and perhaps amended. All of these are excellent suggestions which I hope the SAO and legislature will continue to explore and expand upon.

I believe that the only way that to achieve true accountability and transparency will be if all the state boards are subject to regular audits. Not every 5 years. Not because someone requested it. But regular, consistent audits to ensure that the board is regulating medical providers with fair and consistent metrics. And to ensure the public safety. As the report states, 'a medical error can have life altering consequences'. I never dreamed I would be a dental malpractice victim. I live with the pain and consequences every day from what should have been a simple procedure. If it can happen to me it could happen to anyone. In many cases, the state board is a patients only recourse. As patients we look to the boards for help and protection. To that end I hope that more assessments will be conducted by the committee and that the SAO will expand the audit to assess the boards disciplinary activities. And I sincerely hope that yourself and the committee, our legislators, will continue to examine ways for the board to better serve and protect the public. If anyone on the Committee or on the Medical board would like suggestions or input from a public member I would be happy to speak with them.

Thank you for your continued efforts. This audit pertains to each and every patient in this state

Sincerely,
Tracy Jones
206 284 3377

Public Comment for Nov 16 I-900 Meeting
MQAC Audit Report
November 16, 2016

Thank you, Chair Senator Braun and members of the JLARC Committee, for the opportunity to speak to you today in response to the State Audit of the Medical Quality Assurance Commission.

My name is Linda Radach, and I am here as an interested and concerned citizen. I have never filed a complaint with the MQAC, and would like to believe that doing so will never be necessary. However, I am aware that, as the audit report states, "In any profession, there is the possibility for error. In the practice of medicine, errors can have life-altering consequences." Therefore, partnering the fact that medical harm is the third leading cause of death in the United States with the rate at which medical treatments and healthcare delivery systems are changing, it is incumbent upon the state medical board to be see their work as a partnership with patients through open communication as well as being prepared to assess harm that may come in response to the evolving issues in healthcare. It is evident as well, that Americans are not going to back down from requests and expectations for greater transparency in medical care as well as the work of government entities. So first, let me say thank you for the work put into conducting this audit and for the opportunity to speak to my concerns related to the work of our state medical board.

First, I would like to address my overall concerns.

I understand that it was not within the scope of this audit to 'review the correctness of the board's decisions to investigate and the final disposition of complaints.' Perhaps the auditor's believed this to be outside their expertise due to the fact that these are medical determinations for which the auditors may not have been trained. Knowing the boundaries of those conducting an audit is critical, but from my perspective as a consumer, these limits render the audit incomplete. It is at this juncture – the central point of MQAC's work – where citizens are or are not protected. I strongly encourage that the audit be extended to verify the effectiveness and fulfillment of the board's mission as it relates to case review decisions. To fairly make such determinations, the auditors must be medically trained personnel, equipped to assess decisions in these areas.

Another area of concern that is at the foundation of the board's work, is the troubling fact that "Washington's standard of proof is higher than that required of most other state medical boards," namely the requirement for 'clear and convincing' evidence, rather than a 'preponderance of evidence.' I agree that our state standard of proof is a roadblock to the board being able to act upon concerns over a medical practitioner's decisions, behavior, or attitudes. I strongly encourage the legislature to make these changes. Further, I also agree that, in the absence of such a change, the board should be empowered to use a 'Letter of Guidance' or a 'Letter of Concern.' Although such letters would not be considered disciplinary, I believe their issuance should still be a matter of public record in Washington as well as being reported to the National Practitioner Data Base. Patients in our state deserve to know if their provider has received guidance about potential needed reforms in their practice. On a national level, as mobile as we are as a society, those letters being on record will provide medical boards in other states the additional background to any complaints which are newly received. MQAC's work is neither complete nor effective at protecting the public if they do not have this information from other states. It only makes sense that a letter of concern or guidance, when received more than once, should raise a red flag for medical boards everywhere. I support the adoption and use of a 'Letter of Concern or Guidance,' as long as the issuance of such a letter to a provider is public information. It is probably human nature within any profession, for practitioners to want to protect the reputation of other providers. In this regard, it is important to remember that in focusing the highest priority on protecting the public, the health and reputation of practitioners is also being protected. In the bigger picture, it is not helpful to other medical providers to allow doctors to continue to practice behind a privacy shield when they have demonstrated need for concern over their practices, decisions, behaviors or attitudes.

I applaud the report's conclusion that more needs to be done in terms of transparency and communication with the public. It would not be a stretch to say that the majority of the citizens are not even aware of MQAC's existence, let alone what the commission's responsibilities are, or how to access their help. This makes it very difficult for consumers to be engaged in their own healthcare decisions. To that end, the remainder of my comments will address ways in which communication to the public about the presence, mission, and accessibility of the medical board can be more effective.

Critical to meeting this goal, as pointed out in the audit report, is the need to raise the awareness of the public. That means accessibility of information. The audience for the board's message spans the generations of the young and mobile across the decades to the 'silver sneaker' generation. The single greatest tool available today is modern technology. This is never more evident than in watching the ways in which younger people find, share, and generate information. Keeping in mind that a percentage of the state's population may not be technologically savvy, thereby continuing to rely upon printed communication, I strongly support efforts to do the following in response to the need for transparency, openness, and effective communication:

- Update the web site in both form and content so that it is more user friendly and intuitive from the patient point of view. For someone outside the realm of government, it currently takes a few tries before landing in the correct place for information on medical harm and direction for filing a concern. The information must be kept up to date and written in language that is easily understood by those who use the site.

- Update the UDA to require that public notifications of how and where to file a complaint are posted in every clinical and hospital setting. The posting should offer the information in various languages, use color and graphics to draw attention to the notification, and the posted information should be accompanied by written instructions as well as directions for digital access.

- Because of my disability, I am not able to attend meetings unless someone else can drive me to Olympia or wherever the meetings are held. There no doubt are other citizens who would like to follow the board's proceedings, but are limited by work schedules, health, and family life from making the trip. Meeting dates, times and locations should be easily available on the web so citizens can plan ahead. Everyone should be able to follow the meeting on WebX as well as via the option of a recording for viewing at a later time. In addition, a very quick and effective way to disseminate information today is the use of a Twitter account. The state will always have a population of folks whom, for various reasons, need louder, slower, bigger forms of communication, but the younger generation is all about technology. Making an investment in upgrading the state's system is an investment in the future. Why wait to play catch up? Starting now will position MQAC to increase their effectiveness in protecting the public for years to come.

Finally, there are places in the report which talk about the role of patient advocates in initiating this audit. At times the language being used to communicate the historical background leading up to the audit comes across as a bit dismissive of citizens who have valid concerns over an encounter with a medical provider. If in fact I have picked up on an actual perception within the auditor's office, the legislature or the membership of MQAC, I must say that it is past time to put those lenses away. Providers and patients are not at war, and should be functioning in a partnership that is focused on strengthening the delivery of medical services and the health of the citizens of Washington State.

Thank you once again for your time and consideration.

Linda J L Radach

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