

**Maine Board Of Licensure In Medicine
State Examination Review Materials
Summaries of Rules, Resource Materials, and Relevant Laws
For The Practice Of Medicine In The State Of Maine
Second Edition, 2006; Revised March 30, 2011**

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BOARD RULES

1. Chapter 1: RULES AND REGULATIONS FOR PHYSICIAN LICENSING (Excerpts)

§ 3 LICENSE STATUS

All licensees shall be subject to the Medical Practice Act and the Rules of the Board.

1. STATUS CATEGORIES

- A. Active status** – The licensee may practice medicine or surgery in Maine. An initial license will only be issued as Active status, to qualified applicants. Active Status will be clearly marked on the license and on qualifying renewals.
- B. Inactive status** – The licensee cannot practice medicine or surgery nor prescribe medications to any person in Maine. Inactive status may be issued at renewal if all requirements for Active status are not met, or if inactive status is requested by licensee.
- C. Pending status** – The existing license status remains unchanged because the board has not taken final action on an application for renewal.
- D. Volunteer Status** – The physician has retired or is retiring from the active practice of medicine and wishes to donate his or her expertise for the medical care and treatment of indigent and needy patients in the clinic setting of clinics organized, in whole or in part, for the delivery of health care services without charge.

§ 8 CONTINUING MEDICAL EDUCATION (CME)

The following establishes the rules and regulations for a course or system of continuing medical education required for Active status license renewal beginning September 2002 and all subsequent biennial re-registrations with this Board.

1. REQUIREMENTS

A. Each physician licensed by this Board who is actively practicing medicine and surgery shall complete during each biennial licensing period, a minimum of one hundred (100) credit hours of continuing medical education subject to the following:

1. At least forty (40) hours must be in Category 1 as defined in Sub-§2, Sub-¶A below.
2. The total one hundred (100) hours may be in Category 1.
3. No more than sixty (60) credit hours may be in Category 2 as defined in Sub-§2, Sub-¶B below.

B. If appropriate CME is not completed and submitted, then an Inactive status license renewal will be issued unless the Board has granted an extension of time or deferment as described in Sub-§4, sub-¶A below.

3. EVIDENCE OF COMPLETION

At the time of application for renewal of licensure evidence of completion of CME shall be provided as required on the renewal application, and described in Sub-§ 2: Definitions of Categories.

Board staff shall perform random audits of listed CME for items not requiring proof with submittal of application for renewal, by requesting that the applicant present verification of any or all category 1 and 2 CME claimed on the renewal application.

4. EXCEPTIONS/DEFERMENTS TO CME REQUIREMENTS

A. The Board, at its discretion, may grant an extension of time or deferment to a licensee who because of prolonged illness, undue hardship, or other extenuating circumstances has been unable to meet the requirements of CME.

B. Physicians who become licensed for the first time in the State of Maine in the course of a calendar year will not be required to fulfill the full CME requirements for first

renewal, but shall complete pro rata requirements as instructed.

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2. Chapter 2: PHYSICIAN ASSISTANTS (Excerpts)

§ 6. SCOPE OF PRACTICE

Physician Assistants practice medicine with physician supervision.

A. DELEGATED AUTHORITY

Physician assistants may perform only those medical activities that have been delegated to the physician assistant by a supervising physician. Medical activities that may be delegated include the following:

1. The ordering of diagnostic, therapeutic and other medical services;
2. The prescribing and dispensing of drugs and medical devices to the extent permitted by state and federal law. Prescribing and dispensing drugs may include Schedule III through V substances and all legend drugs. A Physician Assistant and Primary Supervising Physician (PSP) may together request individual consideration for authorization to prescribe schedule II drugs under specific individual guidelines detailed by the Board. Physician assistants may request, receive, and sign for professional samples and may distribute professional samples to patients; and
3. The performance of tasks that are not routinely within the practice or regularly performed by the PSP so long as adequate oversight, secondary supervisory, and referral arrangements are in place to ensure competent provision of services by the physician assistant.

§ 7. SUPERVISION CRITERIA OF PHYSICIAN ASSISTANTS

Supervision shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place that the services are rendered.

A. SUPERVISORS

Physician assistants may practice medicine and perform medical activities only when provided supervision by the following:

1. A PSP or secondary supervising physician; or

2. A physician in an organized health care delivery system in which there is a PSP, or

3. A physician licensed by the Board of Osteopathic Licensure who is permitted under rules promulgated by that Board to be a secondary supervisor of physician assistants.

B. QUALIFICATION FOR APPROVAL AS PRIMARY SUPERVISING PHYSICIAN

1. Except as otherwise provided in this chapter, any physician must be approved by the Board, before the physician may become a PSP, for each individual wishing to be supervised. The Board may grant approval to a physician to become a PSP who:

a. has an active, unrestricted, permanent license to practice medicine in this state;

b. submits a statement to the Board that the licensee will oversee and accept responsibility and liability for the medical activities delegated to the physician assistant. If the physician is to serve as the PSP for an Organized Health Care Delivery System or Group Practice, the statement must so indicate;

c. submits an affidavit that a written Plan of Supervision addressing the technical requirements of supervision (as set forth in this Section of this Chapter) is on file in the practice setting; and

d. pays the appropriate fee as determined by the Board.

C. ELEMENTS AND TECHNICAL REQUIREMENTS OF SUPERVISION

As a part of the supervising physician/physician assistant team, a physician assistant is responsible for ensuring that:

1. the physician assistant's basic scope of practice and practice setting is identified;

2. the delegation of medical tasks is appropriate to the physician assistant's level of competence;

3. the relationship of, and access to, a supervising physician is defined; and

4. a process for evaluation of the physician assistant's performance is established.

D. WRITTEN PLAN OF SUPERVISION

Physician assistants licensed to practice in accordance with these rules and their PSP must prepare and have on file in the practice setting a written, dated plan of supervision that is signed by both the PSP and the P.A. and that contains specified practice descriptions of the elements of supervision as outlined in subparagraph C. This plan of supervision must be reviewed and updated as necessary, but in any event, whenever application is made for the physician assistant's license to be renewed, a copy of the updated plan must be submitted to the Board with the renewal application. A statement shall be attached to the plan stating the date the plan was reviewed and any changes to the plan, and shall be signed by the physician assistant and PSP. If a physician assistant is to be supervised by a secondary supervising physician(s), the secondary supervising physician(s) must accept delegation of supervision in writing as part of the plan of supervision. Appendix 1 of these Rules provides one sample format for a written plan of supervision.

E. PLAN TO BE AVAILABLE ON DEMAND

A physician assistant shall provide, at the request of any Board member or authorized persona copy of the plan of supervision and, if applicable, the document showing the delegation of that plan to a secondary supervising physician. Such request may be made in writing or by appearing at the practice setting in which case the plan shall be provided immediately. The Board may require the plan to be amended for purposes of ensuring public safety as required by state law.

§ 8. ASSUMPTION OF RESPONSIBILITY

If a physician assistant is employed by a physician or group of physicians, the physician assistant must still be provided supervision by an approved primary or secondary supervising physician. Liability under these rules for the physician assistant's medical activities shall remain that of the approved PSP or secondary supervising physician, including when the physician assistant provides care and treatment for patients in an organized health care delivery system facility. If a physician assistant is employed by or a principal in an organized health care delivery system facility, nothing in these rules shall be construed to limit the liability of the organized health care delivery system facility for the physician assistant's actions or omissions. A physician assistant who is employed by or who is

a principal in such facilities must still be provided supervision by an approved PSP or secondary supervising physician.

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3. Chapter 10: SEXUAL MISCONDUCT (Excerpts)

SUMMARY: This chapter defines sexual misconduct by physicians and physician assistants and sets forth the range of sanctions applicable to violations of this rule pursuant to Title 32 §3269 (7) and 3270-A, B, C., and 32 M.R.S.A. §2562, 2594-C.

§1 DEFINITIONS

1. "Physician" an individual who is qualified and licensed according to the provisions of 32 M.R.S.A. §3270 et seq. and 32 M.R.S.A. §2571 et seq.
2. "Physician Assistant" an individual who is qualified and licensed or certified according to the provisions of 32 M.R.S.A. § 3270-A and 3270-B and 32 M.R.S.A. § 2594-A and 2594-B.
3. "Physician/physician assistant sexual misconduct" is behavior that exploits the physician/physician assistant-patient relationship in a sexual way. This behavior is nondiagnostic and/or nontherapeutic, may be verbal or physical, and may include expressions or gestures that have a sexual connotation or that a reasonable person would construe as such. Sexual misconduct is considered incompetence and unprofessional conduct as defined by 32 M.R.S.A. 2591-A (2) and 32 M.R.S.A. 3282 -A (2).

There are two levels of sexual misconduct: sexual violation and sexual impropriety. Behavior listed in both levels may be the basis for disciplinary action.

- A. "Sexual violation" is any conduct by a physician/physician assistant with a patient that is sexual or may be reasonably interpreted as sexual, even when initiated by or consented to by a patient, including but not limited to:
 1. sexual intercourse, genital to genital contact;
 2. oral to genital contact;
 3. oral to anal contact or genital to anal contact;
 4. kissing in a sexual manner (e.g. - french kissing);
 5. any touching of a body part for any purpose other than appropriate examination, treatment, or comfort, or where the patient has refused or has withdrawn consent;

6. encouraging the patient to masturbate in the presence of the physician/physician assistant or masturbation by the physician/physician assistant while the patient is present; and,
 7. offering to provide practice-related services, such as drugs, in exchange for sexual favors.
- B. "Sexual impropriety" is behavior, gestures, or expressions by the physician/physician assistant that are seductive, sexually suggestive, or sexually demeaning to a patient, including but not limited to:
1. kissing;
 2. disrobing, draping practices or touching of the patient's clothing that reflect a lack of respect for the patient's privacy; deliberately watching a patient dress or undress, instead of providing privacy for disrobing;
 3. subjecting a patient to an examination in the presence of another when the physician/physician assistant has not obtained the verbal or written consent of the patient or when consent has been withdrawn;
 4. examination or touching of genitals without the use of gloves;
 5. inappropriate comments about or to the patient, including but not limited to making sexual comments about a patient's body or underclothing; making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation (homosexual, heterosexual, or bisexual); making comments about potential sexual performance during an examination or consultation (except when the examination or consultation is pertinent to the issue of sexual function or dysfunction); requesting details of sexual history or sexual likes or dislikes when not clinically indicated;
 6. using the physician/physician assistant-patient relationship to solicit a date or initiate romantic relationship;
 7. initiation by the physician/physician assistant of conversation regarding the sexual problems, preferences, or fantasies of the physician/physician assistant; and,
 8. examining the patient without verbal or written consent.

§2 SANCTIONS

If the Board finds that a licensee has engaged in sexual misconduct as defined in section 1 of these rules the licensee shall be disciplined in accordance with these rules.

1. All disciplinary sanctions under 32 M.R.S.A. § 2591-A, § 3282-A and 10 M.R.S.A. § 8003 are applicable.
2. Sexual Violations - Findings of sexual violations are egregious enough to warrant revocation of a physician/physician assistant's medical license. Boards may, at times, find that mitigating circumstances do exist and, may impose a lesser sanction.
3. Sexual Impropriety - Findings of sexual impropriety will result in harsh sanction, which may include revocation. Special consideration should be given to at least the following when determining an appropriate sanction:
 - A. patient harm;
 - B. severity of impropriety;
 - C. culpability of licensee;
 - D. psychotherapeutic relationship;
 - E. inappropriate termination of physician/physician assistant-patient relationship;
 - F. age of patient;
 - G. physical /mental capacity of patient;
 - H. number of times behavior occurred;
 - I. number of patients involved;
 - J. period of time relationship existed; and,
 - K. evaluation/assessment results.

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4. Chapter 21: USE OF CONTROLLED SUBSTANCES FOR TREATMENT OF PAIN

Summary: Chapter 21 is a joint rule of the Board of Osteopathic Licensure, the Board of Licensure in Medicine, the Board of Dental Examiners, the Board of Nursing and the Board of Podiatric Medicine to ensure adequate relief of pain to the citizens of Maine.

Rule Index

Section I: Definitions

- Section II: Joint Statement on the Treatment of Pain
- Section III: Principles of Proper Pain Management
- Section IV: Controlled Substances Contract

Section I: Definitions. As used by the Boards when evaluating practice and prescribing issues, the following terms are defined as follows:

1. **Acute pain** – Acute pain is the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It is generally time-limited.
2. **Addiction** – Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.
3. **Chronic Pain** – Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.
4. **Clinician** – An allopathic (MD) or osteopathic (DO) physician, physician assistant (PA), nurse practitioner (NP) or certified nurse midwife (CNM), dentist (DMD or DDS), or podiatrist (DPM).
5. **Pain** – An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.
6. **Physical Dependence** – Physical dependence is a state of adaptation manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.
7. **Pseudoaddiction** – the iatrogenic syndrome (medically caused) resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.
8. **Substance Abuse** – Substance abuse is the use of any substance(s) for non-therapeutic purposes of medication for purposes other than those for which it is prescribed.

9. Tolerance – Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Section II: Joint Statement on the Treatment of Pain.

The Boards recognize that principles of quality medical, dental and advanced nursing practice dictate that the people of the State of Maine have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as to reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this rule, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine, dentistry and advanced nursing. The Boards encourage clinicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All clinicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this rule has been developed to clarify the Boards' position on pain control, particularly as related to the use of controlled substances, to alleviate clinician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from clinicians' lack of knowledge about pain management. Fears of investigation or sanction by federal, state and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating clinician's responsibility. As such, the Boards will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The Boards recognize controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The Boards will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the clinician. Pain should be assessed and treated promptly and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain and treatment outcomes. Clinicians should recognize that tolerance and physical dependence

are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The Boards are obligated under the laws of the State of Maine to protect the public health and safety. The Boards recognize that the use of opioid analgesics for other than legitimate medical purposes poses a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the Boards expect that clinicians will incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

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

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

Allegations of inappropriate pain management will be evaluated on an individual basis. The Boards will not take disciplinary action against a clinician for deviating from this rule when contemporaneous medical records document reasonable cause for deviation. The clinician's conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life.

Section III: Principles of Proper Pain Management

The Boards have adopted the following criteria when evaluating the clinician's treatment of pain including the use of controlled substances. Each of these principles is essential in the treatment of patients with pain.

1. **Evaluation of the Patient** — A medical history and appropriate physical examination must be obtained, evaluated and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the

effect of the pain on physical and psychological function and history of substance abuse. It is recommended that the State's Controlled Substance Prescription Monitoring Program Database (PMP) be utilized. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. **Treatment Plan** — The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the clinician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. **Informed Consent and Agreement for Treatment** — The clinician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one clinician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse or substance dependence, the clinician should use a written agreement between clinician and patient outlining patient responsibilities, including:

- a. urine/serum medication levels screening when requested;
- b. pill count when requested;
- c. number and frequency of all prescription refills; and
- d. reasons for which drug therapy may be discontinued (e.g., violation of agreement).

4. **Periodic Review of Treatment Efficacy** — The clinician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the clinician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the clinician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. Likewise, the clinician should periodically review the course of treatment where psychoactive drugs are used for the treatment of components of chronic pain, e.g., emotional,

psychological, or psychosocial stressors, and assess the appropriateness of continued use of the current treatment plan if the patient's progress is unsatisfactory.

5. **Consultation or Referral** — The clinician should consult or refer, as necessary, for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. Chronic pain often has, as a component, emotional, psychological, or psychosocial stress. In these situations, a number of patients may benefit from psychoactive medications, as well as controlled substances for pain control. The combination of opiates with psychoactive medications, e.g., benzodiazepines, may place the patient at greater risk. The risk may be associated with drug interaction, potentiation, or abuse. In these situations, consultation with or referral to an expert in the management of such patients may be required.

6. **Medical Records** — The clinician should keep accurate and complete records to include:

- a. the medical history and appropriate physical examination;
- b. diagnostic, therapeutic and laboratory results;
- c. evaluations and consultations;
- d. treatment objectives;
- e. discussion of risks and benefits;
- f. informed consent;
- g. treatments;
- h. medications (including date, type, dosage and quantity prescribed);
- i. instructions and agreements; and
- j. periodic reviews.

Records should remain current and be maintained in an accessible manner, readily available for review.

7. **Reportable Acts** — Generally, information gained as part of the clinician/patient relationship remains confidential. However, the clinician has an obligation to deal with persons who use the clinician to perpetrate illegal acts, such as illegal acquisition or selling of drugs; this may include reporting to law enforcement. Information suggesting inappropriate or drug-seeking behavior,

should be addressed appropriately and documented. Use of the PMP is recommended.

8. Compliance With Controlled Substances Laws and Regulations — To prescribe, dispense or administer controlled substances, the clinician must be licensed or otherwise authorized and comply with applicable federal and state regulations. Clinicians are referred to the *Physicians Manual of the U.S. Drug Enforcement Administration* and any relevant documents issued by the appropriate board or agency for specific rules governing controlled substances as well as applicable state regulations.

Section IV: Controlled Substances Contract.

Suggested elements of a controlled substance contract are as follows:

1. Specifies that the clinician is the single source of controlled substances;
2. May specify the pharmacy;
3. Provides written, informed consent to release contract to local emergency departments and pharmacies;
4. If written consent is given for release to local emergency departments and/or pharmacies, consent is also being given to the other clinicians and providers such as pharmacists to report violations of the contract back to the prescribing clinician;
5. Specifies that if the clinician becomes concerned that there has been illegal activity, the clinician may notify the proper authorities;
6. Provides that if the clinician has obtained a written release, ER personnel and other providers shall report violations of the contract back to the doctor who prescribed the controlled substance(s);
7. Specifies that a violation of the contract will result in a tapering and discontinuation of the narcotics prescription;
8. Specifies that a risk of chronic narcotics treatment is physical dependence (as defined);
9. Specifies that a risk of chronic narcotics treatment is addiction (as defined);
10. Specifies that it is the responsibility of the patient to be discreet about possessing narcotics and keeping medications in an inaccessible place so that they may not be stolen;

11. If the patient violates the terms of the contract, the violation should be documented. The clinician response to the violation should be documented, as well as the rationale of and changes in the treatment plan;

12 Clinician may consider “fill only at _____ pharmacy” on the prescription form;

13. Specifies use of urine/serum medications levels screening when appropriate; and

14. Specifies use of a pill count when appropriate.

STATUTORY AUTHORITY:

- R. 2009, c. 56
- 32 MRSA §1072 and 1073(2) (Board of Dental Examiners)
- 32 MRSA §§2102(2-A) and 2153-A(1) (State Board of Nursing)
- 32 MRSA §2562 (Board of Osteopathic Licensure)
- 32 MRSA §3269(3), (7) (Board of Licensure in Medicine)
- 32 MRSA §3605-B (Board of Licensure of Podiatric Medicine)

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OTHER BOARD DOCUMENTS

5. Mission Statement of the Board

MISSION STATEMENT BOARD OF LICENSURE IN MEDICINE

The mission of the Board of Licensure in Medicine is to safeguard the health, welfare, safety and lives, of the people of Maine by ensuring that the public is served by competent, ethical and honest practitioners. To accomplish this, the Board will:

- license only qualified medical doctors and physician assistants;
- monitor the practice of medicine to insure the integrity of the profession and to maintain high professional standards and conduct;
- provide the public a forum to have complaints heard and impartially investigated;
- discipline and sanction licensees who violate the standards of conduct or whose performance is below minimum acceptable standards of proficiency;
- Undertake special projects, often in collaboration with other interested groups that both enhance the profession and meet public needs.

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6. Statement of Principle: Telemedicine

NORTHEAST REGION STATE MEDICAL BOARDS
STATEMENT OF PRINCIPLE
September 24, 1999

MEDICAL PRACTICE ACROSS STATE LINES

Whereas: Technology allows almost instantaneous high quality transmission of images, data, text, audio, and real-time activities without regard to state boundaries; and

Whereas: Technology has expanded the capability of physicians to provide services using electronic means; and

Whereas: Medical boards, as the state regulatory authorities charged to protect the health and welfare of their citizens, must have mechanisms to appropriately monitor and discipline professionals providing services within their state boundaries;

NOW THEREFORE: The states named in this document agree in principle that:

EXCEPT FOR CONSULTATION AS DEFINED BY OUR SEVERAL STATES, PROVISION OF ALL MEDICAL SERVICES SHALL REQUIRE A FULL LICENSE IN THE STATE IN WHICH THE PATIENT ENCOUNTER WILL OCCUR.

The following states agree to and support this statement of principle:

Maine Board of Licensure in Medicine – adopted by vote of the board Oct. 12, 1999

Maine Board of Osteopathic Licensure

New Hampshire Board of Medicine

New York Board of Professional Medical Conduct

Vermont Board of Medical Practice

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7. BoardNotes Article (Fall, 1998): Self/Family Prescribing

PHYSICIAN HEAL THYSELF? THY FAMILY? Editorial comment by Judy Burk, M.D., board member

Medical boards, on occasion, review instances of self-prescribing and instances of prescribing for family members. These come to the attention of regulatory boards through reports from pharmacists, friends, relatives, colleagues, and as incidental information while reviewing material pertinent to unrelated complaints. As a member of such a board, I have observed that considerable confusion reigns about whether or not these practices are acceptable.

Prescribing for self or immediate family is legal in Maine. This includes Schedule II, III, and IV substances. *It does not necessarily follow that doing so is good medicine.*

By way of contrast, in Massachusetts, prescribing schedule II-IV medications for immediate family members is illegal, except in an emergency. The statute defines "immediate family members" as spouse or equivalent, parent, child, sibling, parent-in-law, brother/sister-in-law, son/daughter-in-law, stepparent, stepchild, step-sibling, or any other person permanently residing in the same residence as the physician.

When reviewing instances of self-prescribing or prescribing for family members, as a board member, I will be seeking to decide whether the physician's conduct was unethical, unprofessional or incompetent.

Controlled Substances - Self or Family Members

Section 8.19 of the **Code of Ethics** of the American Medical Association states that *"It is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members."* It follows that medical boards may find such practices unacceptable (unprofessional, incompetent or both) and might sanction the licensee, except if "emergency conditions" exist.

Non-controlled Substances - Family Members

Here medical boards seek to determine competency. Was an appropriate history taken, examination done, differential diagnosis considered? Were there appropriate records containing adequate documentation? Was appropriate follow-up arranged? Was consultation sought if indicated? In short, a board would hold the physician to the same standard of care expected if the patient were not a family member. As a board member I would have concerns about a physician providing care to a family member for a problem outside the physician's area of expertise.

In addition to issues of competency, I would be concerned about boundary violations, especially sexual boundary violations. In general, physicians should not provide care for family members around sexually charged concerns or problems requiring examination of breasts, genitalia or rectum.

As a member of a medical board I would also be concerned about a physician providing mental health care to a family member. Arguably, the necessary objectivity would be impossible if the treating physician was a family member. In general, physicians should not treat family members for mental illness.

Noncontrolled Substances - Self

A medical board should be concerned about a physician providing care for him or herself. Meeting competency standards would be very hard such as those outlined above, although theoretically possible. Objectivity would obviously be difficult. The potential for "bad medicine" would be high. Except in very routine, or conversely, emergent situations, I, as a board member, would wish to discourage self-prescribing.

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8. BoardNotes Article (Spring 2000): Communications

POOR COMMUNICATIONS OFTEN RESULT IN PATIENT COMPLAINTS TO THE BOARD

By Kimberly K. Gooch, M.D.
Member of Board

As a relatively new member of the Board of Licensure in Medicine, I have been struck by the number of complaints that arise from simple failures in communication. Although these complaints may not rise to a level requiring Board discipline, the time, energy, and emotional distress involved in dealing with this type of complaint could be prevented. Risk management people have been telling us this all along. Therefore, I'd like to present some tips from my perspective as a Board member.

1. **Watch the front.** Your office staff is well trained at keeping you on time and saving you from dealing with nonclinical issues. Sometimes after multiple encounters with staff, a patient lodges a complaint just to get your attention. Most of the time, you could solve the problem in less than five minutes if you knew about it. Be sure that your employees know when to refer an issue to you, and take responsibility for it. It's like asking to speak to the manager.
2. **Count to ten.** If you find yourself angry with something that a patient or co-worker has said, think before you talk. We have all made unintentionally naive comments. In all likelihood, no one meant to question your ability or intentions, but are just requesting your opinion about a consultation, or something on the Internet, or a medical advice column. Do not abruptly dismiss the person, or make a sarcastic or condescending remark. Be diplomatic.
3. **Remember the old honey/vinegar adage.** It takes no more effort to be nice than to be rude, dismissive, or rushed. Remember to deliver information in a confidential setting, and be careful with the type of information that staff or family members relay to patients. Many persons who lodge a complaint with the Board expect to cause you the humiliation that you have caused them. Treat others as you expect to be treated.
4. **Get a life.** If your life is a mess, eventually it will affect your relationships with patients. Chronic personal problems, substance abuse, or unresolved issues in your past should be addressed by you before they result in a complaint to the Board. There are many resources available to assist you. Call if you'd like to get help.
5. **Respect respect.** Physicians year after year maintain their high ranking in public opinion polls. This translates into a high tolerance for your behavior. People realize that you work long hours, may have had little sleep, and deal with a lot of stress. This always puts you in an

advantageous position, so, don't push it. Definitely avoid arrogance.

The Board's purpose is to ensure that the public receives competent and professional care from its physician licensees. I believe that the quality of Maine's physicians is high and that we all would rank our relationships with patients as one of the best things about our work. We strive for perfection in our communications. With awareness and effort, we should at least decrease the number of these communication complaints, if not see them disappear entirely.

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9. BoardNotes Article (Winter 2000): Opioid Prescription Techniques Caution

DIVERSION OF OPIOID ANALGESICS **OXYCONTIN - STREET VALUE \$1 MG**

The Board of Licensure in Medicine has become increasingly aware of a major problem in the state of Maine. Many licensees received a letter from Jay P. McCloskey, the U.S. Attorney, concerning the diversion of opioid analgesics from legitimate to illegitimate use. Currently Oxycontin tablets are bringing in a dollar per milligram on the street. Other opioids are similarly priced.

The Board recognizes that physicians owe their obligation to the patient. The Board has promulgated rules designed to ensure that no patient will have to suffer because of an inability to obtain adequate pain relief. Relevant features of the rules are:

- The patient must be fully **evaluated** with a complete history, physical, and diagnostic assessment.
- A **treatment plan** should be developed for their specific problem.
- Consideration should be given to **treatment modalities** other than or in addition to controlled substance.
- **Documentation** is essential for supporting the reason for controlled substance prescribing. Every prescription should be clearly documented in the patient record.

To address the conflict between adequate prescribing for pain and diversion of drugs for illicit use, the Board makes the following recommendations to our licensees:

- 1 Physicians could obtain special prescription pads for the writing of opioids and other scheduled substances (schedule 2, 3, 4) prescriptions. These pads, which can be obtained for a nominal amount, are blue in color and when subjected to copying turn white and have the word "VOID" appear

across the copy. Use of these special prescription pads will make the copying and reusing of prescriptions much more difficult.

- 2 Physicians might write out the quantity and strength of medication rather than using numerals. Pharmacists have found prescriptions for 25 or 40 tablets changed to 250 or 400 tablets, or strength being similarly altered.
- 3 Physicians should consider writing on their prescriptions which pharmacy the patient has selected. "Fill only at..." will alert another pharmacy should the prescription appear there.
- 4 It may be feasible, depending on your practice location, to fax your prescription to the selected pharmacy. The pharmacist will then be able to compare the fax with the prescription handed in, so that any changes can be noted.
- 5 If you work with PA's or NP's do not pre-sign prescription pads and give them to these practitioners.

It is the Board's hope that these voluntary actions undertaken by Maine's physicians will help stem this disturbing tide of drug diversion. If you have any questions regarding these suggestions please feel free to contact The Board of Licensure in Medicine at (207) 287-3601

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10. BoardNotes article (Spring 2006): New Tools to Combat Prescription Drug Diversion in Maine

THE PROBLEM

Diversion of prescription opiates is a serious and growing problem in Maine. Data from the State Medical Examiner's office indicates the alarming fact that accidental overdose due to opiates has been rising for a decade. About 80-85% of these are due to opiates, either alone or in combination. Nearly all accidental deaths (94%) are caused by at least one prescription drug.

Effective treatment for opiate addiction includes replacement therapies such as methadone and buprenorphine, both of which can also be diverted. The majority (about 60%) of deaths involving methadone are due to the pill form, which is prescribed for pain.

THE SOLUTION

The Board recognizes that physicians are frequently asked to undertake the difficult task of managing pain, while recognizing addiction and preventing diversion. Two new tools are available to Maine physicians to assist in providing help to those legitimately in need. **The Maine Office of Substance Abuse (OSA)** now provides a **Prescription Monitoring Program** which provides all Maine physicians with two types of reports. Solicited reports will be provided when a registered clinician queries the data base online to obtain an immediate report on all schedules II, III and IV prescription medications dispensed to the patient and how the patient paid for these medications. Unsolicited "threshold" reports will be sent to physicians who have prescribed for a patient whose profile exceeds threshold indicators that suggest a possible problem with prescription medications. These threshold reports are generated quarterly. There are many ways this data will assist providers in making better medical decisions. Certainly this information will assist physicians in decreasing diversion of prescription opiates. Counsel to the Maine Medical Association has put together privacy guidelines for the physician re: disclosure of information obtained from the PMP reports.

2012 UPDATE

Maine's Prescription Monitoring Program (PMP)
Improving healthcare & protecting communities

Maine's Prescription Monitoring Program is a tool that can help prevent misuse and abuse of prescription drugs and enhances overall patient care.

What is the Prescription Monitoring Program?

Maine's Prescription Monitoring Program (PMP) is a secure online database that is used to improve public health. Registered healthcare providers are able to review their patient's prescription history of controlled medications before prescribing any new or additional medications.

Why should a Healthcare providers use PMP?

The PMP allows healthcare providers to increase safety measures to ensure patients are getting the highest standard of care.

The PMP also facilitates integration of a patient's medical team in looking for issues that might affect a patient, such as how medicines interact, possible misuse, multiple prescriptions for the same drug and other potential concerns.

The PMP can help a medical provider to determine if a patient should be referred for substance abuse evaluation and treatment.

The PMP can lead to a reduction in prescription drug overdoses and provides an opportunity to educate patients on the dangers of prescription drug misuse and abuse.

With approval from prescribers, clinical support staff (nurses, medical assistants, etc.) can also access the PMP.

Did you know?

In the United States.....

- 100 people die from drug overdoses every day
- Drug overdose death rates have more than tripled since 1990
- Nearly three out of four prescription drug overdoses are caused by prescription painkillers

In Maine.....

- In 2010, there were 167 drug overdose deaths
- Over 10 % of our youth have taken prescription drugs not prescribed to them
- More people died from drug overdose than car crashes in 2008, 2009 and 2010

Sign up to be a data requester, assistance is available.

Contact the Prescription Monitoring Program Coordinator for a brief training and/or to register as a data requester.

Patricia Lapera 207-287-3363 or patricia.lapera@maine.gov

Also, for more information about Maine's PMP, go to the website at: www.maine.gov/pmp or contact the Maine Office of Substance Abuse at 287-2595.

The Board strongly recommends that you register and use this tool.

www.maine.gov/pmp

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11. Board Brochure: The Consumer's Guide to Licensing, Regulation and Discipline of Physicians in Maine

Consumer's Guide

To the Licensing, Regulating & Disciplining of Physicians in Maine

Maine Boards of Medical &

Osteopathic Licensure

"For the protection of the health, safety and welfare of the public"

Contact Us:

Board of Licensure in Medicine

137 State House Station, Augusta ME 04333; Phone (207) 287-3601;

Fax (207) 287-6590

TTY/TB: 1-800-437-1220

<http://www.maine.gov/md/>

Board of Osteopathic Licensure

142 State House Station, Augusta ME 04333 Phone (207) 287-2480;

Fax (207) 287-3015

TTY/TB: 1-800-437-1220

<http://www.maine.gov/osteo/>

Consumer Assistant

Phone (207) 287-3608 or

Toll Free in Maine (888) 365-9964

TTY/TB: 1-800-437-1220

Other Professional Licensing Boards

Dept. of Professional & Financial Regulation

Licensing & Enforcement Division

Phone (207) 624-8603; Fax (207) 624-8637

Board vs. Malpractice:

- Differences between disciplinary and malpractice actions are significant.
- Boards may discipline a licensee for incompetence, but cannot provide money to the complainant to pay for any harm that was done.
- In a malpractice action in a court, a judge or a jury may award money damages to the complainant if the physician is found to be negligent

Locate Physicians, Administrative, Licensing, & Disciplinary Information:

Online at:

MD <http://www.maine.gov/md/>

DO <http://www.maine.gov/osteo/>

By Contacting the Consumer Assistant Toll Free in Maine at (888) 365-9964

Some Grounds for Discipline:

- Alcohol/Substance Abuse
- Conviction of a Crime
- Fraud & deceit in obtaining a license
- Inappropriate Prescribing
- Incompetence or Unprofessional Conduct
- Violation of Law, Rule, or Board Order

Possible Results of a Complaint:

1. Closure with no action
2. Closure with a Letter of Guidance (non-disciplinary)
3. Disciplinary Action which may include:
 - Warning; censure; reprimand;
 - Fine; education; specific conditions of
 - Probation; Consent Agreement;
 - Suspension; or loss of license.

The Boards Cannot Help With:

- Other Health Care Professionals (e.g. RN, LCSW, DDS, DMD, PT)
- Hospitals, Clinics, or Nursing Homes
- **Medical Malpractice**
- Billing or Fee Disputes

How to File a Complaint:

Anyone may file a complaint. It must be in writing or by e-mail. Either a letter or a complaint form may be used. Forms are available online or by calling.

The Consumer Assistant, (888) 365-9964, is available to answer questions and guide you through the process

Board History:

For over 100 years, it has been Maine law that a physician must be licensed to practice medicine in our State. Through licensure, the State ensures that all practicing physicians have an appropriate level of education and training and that they abide by recognized standards of professional conduct.

Board Functions:

Protect the public by:

- Licensing Physicians & Physician Assistants
- Investigating Complaints, Providing Guidance, or Imposing Discipline
- Providing information to the Public

Licensure Qualifications:

- Education and Training requirements
- Comprehensive written examination
- Good professional ethics and practices
- Renewal of license every two years including participation in Continuing Medical Education (CME)
- Verification of all information provided to ensure credentials

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12. INFORMED CONSENT WHITE PAPER

INFORMED CONSENT

Guidelines from the Maine Board of Licensure in Medicine¹

Obtaining and recording informed consent before major diagnostic, therapeutic, and invasive procedures is a physician's professional and legal obligation. Patients have the legal right to grant or withhold informed consent, either personally or through lawful representatives.

The term "informed consent" first appeared in an *amicus curiae* brief filed by the American College of Surgeons in the case of *Salgo v. Leland Stanford University* in 1957.² While not all physicians and not all patients desire to be involved in a shared decision making process, prevailing negligence law and the legal right to self-determination now require some documentation of informed consent for most major treatments and procedures. Physicians therefore have a legal motivation for obtaining and recording informed consent for major treatments and procedures, subject to recognized legal exceptions such as in providing emergency medical care to incapacitated patients. In addition to this

¹ Title 32 M.R.S.A. § 3269(3) authorizes the Board to "license and set standards of practice for physicians and surgeon practicing medicine in Maine." However, nothing in this document is intended to affect the definition of "informed consent" for civil medical malpractice actions as defined by Title 24 M.R.S.A. § 2905.

² 154 *Cal.App.2d* 564.

legal motivation, the Board believes physicians ought to be motivated by a commitment to the ethical value of patient self-determination, or personal autonomy. Therefore, the Board offers these guidelines for physicians practicing in Maine.

The Goal

The goal of offering these guidelines is to help physicians move beyond a limited consent model that emphasizes primarily the physician's legal obligation to disclose information and the patient's legal right to make independent decisions. The Board advocates a different model that emphasizes communication and encourages a certain kind of transaction between patient and physician. The norms that govern such transactions are clarity, relevance, accuracy, and sincerity. There is no standard form, nor any uniform procedure that will fit all cases calling for informed consent in this model, but there is an underlying ethical obligation to make it possible for the patient and the physician to participate together in a transaction that takes into account the norms of clarity, relevance, accuracy, and sincerity.

The Board is concerned here with major diagnostic, therapeutic, and invasive procedures, and not so much with routine decisions about minor medical problems. In certain cases, physicians may simply explain that they see many people with a particular problem and regularly with success treat the problem in a particular way, then ask if the patient has any questions about the problem or the treatment. In these cases, if the patient makes statements or asks questions indicating discomfort, lack of understanding, or continuing uncertainty, then the following guidelines apply.

Shared Decision Making

The primary value of documented informed consent is that it represents the existence of a relationship between physician and patient that is based upon, or at least includes, an element of shared decision making. Shared decision making for the patient is not the same as mere acquiescence, or compliance based on partial or slanted information, or indifference due to habit or apathy, nor is it the same as conformity to custom – such as the custom of “following doctor’s orders.”

Shared decision making is a process for reaching a shared conclusion through informed judgment. Such a process is an educational ideal in the field of medical care, as it is throughout most institutions in a democratic society. The heart of the matter is the control of information: to the extent information about a problem can be shared, decisions about potential solutions can be shared. Physicians have privileged access to medical information through their education, experience, and expertise. This privilege carries with it the duty to disclose *clearly* such information as is *relevant* and is supported by *accurate* scientific information in a *sincere* manner for consideration by the patient. Furthermore, this duty is itself governed by the physician’s fiduciary obligation to protect the patient’s best interests.

Generally, physicians control the medically relevant information patients need in order to ask the questions they may want to ask but might not be able to

formulate on their own. Successfully sharing that information is a matter of 1) the physician's willingness to do so, and 2) the physician's ability to apply the skills of communication required to do so. It is also a matter of 3) the patient's willingness to participate in the process, and 4) the patient's ability to understand the information, apply it to his or her situation, and then express a reasoned judgment based on the relevant medical information as well as on personal values, wishes, and goals. If there is any doubt about the patient's ability in this regard, the physician should arrange an evaluation of the patient's capacity by a qualified colleague.

The physician personally initiates the process of informing the patient by presenting the medically reasonable options relevant to the patient's condition. The medical reasonableness of these options is tied to the available and reliable evidence base of expected benefit and risk for each alternative. The physician's judgment about these options should be free of personal self-interest, and religious, political, racial, and gender bias.

The Board encourages physicians to remind patients of their right to have someone with them (an advocate of some kind) during these discussions, as patients can be overwhelmed, frightened, and confused when confronting an important medical decision.

Skills for Eliciting Informed Consent

By far the most important skill is **empathetic listening**, which is the capacity for acquiring objective knowledge about the perspective taken by another person. It is a way of listening that requires temporary suspension of one's personal point of view while trying to assume another's point of view. It is a means for gathering data. It is not synonymous with being compassionate or sympathetic, even though its mere presence can have a beneficial effect. The primary purpose of empathy in this sense is to become well informed about the patient's point of view. It is important for the physician to find out what and how much the patient already knows and what more the patient wishes or needs to know, and to what extent the patient desires to participate in the decision making process. In disclosing medical information the physician can err in two ways – excess and deficiency. Empathetic understanding can help guard against going wrong in either of these ways.

Next is skill in **disclosing and explaining**. In trying to establish the basis for shared decision making, the physician discloses medical information relevant to the case at hand, and provides explanations of what that information means, in language that is intelligible to the patient.

It is important to distinguish between two useful but distinct kinds of explanation. The first is *scientific* explanation, which is making a case for why certain events are the way they are and for predicting future events. The second is *semantic* explanation, which by contrast is making the meaning of something clear to the listener. Semantic explanation is like translation or paraphrase, using different words and terms until the intended meaning is revealed and understood.

An explanation can be *satisfactory* from a formal (scientific) point of view, while at the same time failing to be *satisfying* from the patient's point of view. Another way to put this point is that while a medical explanation of risks and

benefits associated with treatment options can be scientifically sound, the listener may find it to be unintelligible, and therefore not useful as information upon which to grant or withhold consent. Informed consent depends on the physician's success in providing both kinds of explanation.

Third is **framing**. Anything that can be said, can be said another way. Decisions are often influenced by the way alternatives are presented. For example, the outcome statistics for 100 middle-aged men undergoing surgery for lung cancer can be described as "90 survive the surgery . . . and of those 90, 34 are alive at the end of 5 years." An alternative way of expressing (framing) the same results might be: "10 die from surgery. . . and 66 more die within 5 years." Typically, for a patient choosing between surgery and radiation, surgery appears much less attractive when described using mortality rather than survival statistics. The difference between 10% mortality (for surgery) and 0% mortality (for radiation) is more impressive than the difference between 90% survival (for surgery) and 100% survival (for radiation). A physician may knowingly or unwittingly nudge a patient toward one option simply by the way the range of options is described, or framed. (Note that 5-year mortality statistics for radiation only have not been mentioned.)

Definition of Informed Consent

In conclusion, the Board recommends the following definition of informed consent be adopted and applied by Maine physicians.

Informed consent for treatment has been obtained when: 1) the physician has disclosed and explained *to the patient's satisfaction* the process used to arrive at the medically reasonable and recommended intervention(s), which is based on reliable evidence of expected benefit and risk of each alternative, and which is free of any impermissible bias; 2) the patient, who has demonstrated capacity, has been given ample opportunity to ask questions about the process and the recommended intervention(s), *to the extent the patient wishes*, all questions then having been answered *to the patient's satisfaction*; and 3) the patient gives consent in writing to major intervention(s) agreed to jointly with the physician.

Nota bene:

Obtaining informed consent is the physician's personal responsibility. This responsibility cannot be *wholly* delegated. Other medical staff (PA's, NP's, Physicians in training and others) may usefully participate in the process, but no amount of shared videos, questionnaires, and pamphlets can substitute *entirely* for personal communicative transaction with the responsible physician. Finally, proof of informed consent cannot be reduced merely to a signature on a form. A note from the physician about the process of gaining that signature should be attached to the form.

When a Physician Assistant, with proper delegation, performs a diagnostic, therapeutic, or invasive procedure for which the standard of care indicates informed consent is required, the Board expects the Physician Assistant to take the same actions as are described in this document for the physician.

Approved: March 2011

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OTHER IMPORTANT INFORMATION

13. Brochure: Maine Medical Professionals Health Program, 2010

MEDICAL PROFESSIONALS HEALTH PROGRAM

A Program of the
Maine Medical Association

PROGRAM OVERVIEW

The complexity of contemporary medicine and health care requires today's medical professional to be healthy and well balanced. Medical professionals are subject to high degrees of stress, both personally and professionally. This stress can impair one's ability to maintain a healthy balance and can result in addictive behaviors and psychiatric or medical disorders. The potential for impairment is universal and no one is immune from the dangers of alcohol or other drug use. The Medical Professionals Health Program is available to assist and advocate for a number of healthcare professionals including:

Physicians, M.D. / D.O.

Physician Assistants

Nurses

Dentists

Dental Hygienists

Denturists

Pharmacists

For more information contact the
Medical Professionals Health Program

(207) 623-9266

mphp@mainemed.com

The Medical Professionals Health Program offers non-disciplinary, voluntary participation under protocols developed with the Maine Board of Licensure in Medicine, the Maine Board of Osteopathic Licensure, the Maine Board of Dental Examiners, the Maine Board of Pharmacy, and the Maine State Board of Nursing.

Signs and Symptoms of Impairment

The following behavioral changes may be indications that someone may be impaired:

Changes in Work Habits – Conflicts with Colleagues, absenteeism/lateness, increased patient complaints, neglect of patients or duties, appointments/schedules disorganized, decreased productivity, misses work or frequently is tardy because of illness or oversleeping; doesn't keep scheduled appointments; assignments are late and work is unacceptably inaccurate. Narcotic inventory counts are consistently off, going back into the pharmacy after hours.

Changes in Behavior - Has become more irritable, defensive, jealous, easily angered, depressed, or moody and these behaviors affect work and relationships at work; more withdrawn socially or professionally, alcohol on breath, unexplained weight change, anxiety .

Change in Personal Care - Personal hygiene is deteriorating.

Changes in Prescribing Practices - Writing prescriptions for narcotics, stimulants or sedatives for self or office staff, requesting prescriptions for narcotics, stimulants or sedatives from colleagues, diverting patient's narcotics, stimulants or sedatives for self use.

MEDICAL PROFESSIONALS HEALTH PROGRAM

Phone: 207 - 623 - 9266
Fax: 207 - 430 - 8386
E-mail: mphp@mainemed.com
20 Pelton Hill Road
P.O. Box 69
Manchester, Maine 04351-0069

PURPOSE AND GOAL

Mission

The Medical Professionals Health Program, a program of the Maine Medical Association, assists medical professionals of Maine by providing confidential, compassionate assistance and advocacy. Our clinical professionals and committee members help participants with diagnosed substance use disorders. Although we do not provide evaluation or treatment, we help participants better understand the treatment and recovery process and help implement strategies for return to safe practice.

Services Offered

The MPHP provides the following confidential services:

- Initial interview and screening;
- Recovery monitoring and documentation;
- Referral for evaluation and treatment;
- Networking opportunities with colleagues in recovery;
- Advocacy to those seeking re-licensure, credentialing;
- Speaking at grand rounds and conferences.

Who does the MPHP consider impaired?

The Medical Professionals Health Program helps professionals who suffer from alcohol or chemical dependency. The Medical Professionals Health Program and the Medical Professionals Health Committee are advocates for colleagues whose health problems may compromise their professional and personal lives and the lives of their patients.

How are Participants Referred?

Anyone with a concern and desire to help a family member, colleague or friend can make a referral. The MPHP also accepts self-referrals as well as anonymous calls. The MPHP is a voluntary program and does not mandate participation, but we are glad to assist anyone interested in exploring referral options. Our clinical staff is prepared to discuss the process of referral and enrollment in addition to diagnosis and recovery options. It is in the best interest of participants, both personally and professionally, that treatment begins as soon as possible.

How does the MPHP help Medical professionals?

The Medical Professionals Health Program assists medical professionals in developing strategies for treatment, helping them return to successful professional careers. **The MPHP does not make diagnoses or provide treatment.** The MPHP clinical staff and committee members act as advocates for their impaired colleagues, providing compassionate, comprehensive and confidential assistance.

PROGRAM & STAFF

The MPHP has a professional, compassionate **clinical and administrative staff** that is experienced and trained to manage the recovery process from initial contact and case management through to graduation.

The **Medical Professionals Health Committee** is made up of many dedicated healthcare professionals representing the diversity of our participants – medicine, dentistry, osteopathy, pharmacy and nursing. For more information and a listing of Medical Professionals Health Program Staff and Committee members, visit our website at

<http://www.mainemed.com/health/team.php>

The Medical Professionals Health Program serves medical professionals across the state of Maine. The program is funded through a variety of sources - state licensing boards, professional associations, medical staffs and malpractice carriers. Participant fees also account for a significant portion of the operating budget.

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14. FSMB Ethics Committee's Report (Excerpts)

Federation of State Medical Boards Report of the Special Committee on Professional Conduct and Ethics

Table of Contents:

- Section I Introduction and Charge
- Section II Enhancing Medical Board Authority
- Section III Disruptive Behavior
- Section IV Internet Prescribing
- Section V Sale of Goods from Physician Offices
- Section VI Recommendations
- Section VII Bibliography

Section III.

Managing Complaints of Disruptive Behavior in Physicians

Complaints alleging disruptive behavior in physicians present a distinct challenge to medical boards. The Committee therefore developed recommendations to assist boards in recognizing physician behavior that may negatively affect patient safety and/or create a hostile practice environment, thereby adversely affecting the quality of patient care.

While disruptive behavior may not, in and of itself, constitute a clear violation of the medical practice act, the effects of this behavior have serious implications on the quality of patient care and patient safety. Patterns of disruptive behavior can have a deleterious impact on patient care and can result in errors in clinical judgment and performance. Additionally, the increased anxiety and intimidation associated with a disruptive physician's behavior may severely compromise the effectiveness of the health care team providing patient care by increasing the level of workplace stress and creating an environment in which errors are more likely to occur.

A. Definitions

For the purposes of this report, the following terms are defined:

Disruptive behavior in physicians – aberrant behavior manifested through personal interaction with physicians, hospital personnel, health care professionals, patients, family members, or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care.

Behavioral sentinel events – episodes of inappropriate or problematic behavior which indicate concerns about the physician's level of functioning and suggest potential for adversely affecting patient safety and welfare.

Characteristics of physicians exhibiting disruptive behavior (behavioral sentinel events) may include, but are not limited to:

1. Profane or disrespectful language
2. Demeaning or intimidating behavior
3. Sexual comments or innuendo
4. Inappropriate touching, sexual or otherwise
5. Racial or ethnic jokes

6. Outbursts of rage or violent behavior
7. Throwing instruments or charts or other objects
8. Inappropriately criticizing health care professionals in front of patients or other staff
9. Boundary violations with staff, patients, surrogates or key third parties
10. Comments that undermine a patient's trust in a physician or hospital
11. Inappropriate chart notes
12. Unethical or dishonest behavior
13. Difficulty working collaboratively with others
14. Repeated failure to respond to calls
15. Inappropriate arguments with patients, family, staff, and other physicians
16. Resistance to recommended corrective action
17. Poor hygiene, slovenliness

Hostile environment – an environment which is intimidating, adverse or offensive to the patient and/or any individual working in that environment and which may interfere with patient care.

Impaired physician program (IPP) – may be synonymous with “physician health program” and refers to a program approved by the state medical board and charged with the management of physicians who are in need of evaluation and/or treatment.

B. Statement of the Problem

Disruptive behavior in physicians creates a hostile environment that interferes with the physician/patient relationship in the following manner(s):

1. The physician's inappropriate behaviors or emotional outbursts shift the physician's focus from the patient, which can result in errors in clinical judgment and performance.
 2. Physician's emotional outbursts or other inappropriate behavior can increase apprehension and anxiety of the physician's patients as well as other patients who may witness such outbursts and inappropriate behavior.
 3. Decreased effectiveness of the entire health team. Peers, nurses, allied health professionals, and other members of the health care team may be intimidated and anxious causing a loss of their clinical focus and productivity thereby increasing the propensity for medical errors.
 4. Decrease in effective communications among the health care team.
- Disruptive behavior in physicians is often a symptom of underlying pathology. The differential diagnosis should include (1) addiction (2) stress (3) psychiatric disorders (e.g. bipolar disorder) or (4) personality disorders (e.g. narcissism). Personality disorders appear to contribute to the majority of referrals for disruptive behavior. Physicians impaired due to disruptive behavior may be effectively treated, without or concurrent with punitive action. Physician health programs may be an appropriate vehicle for evaluation and treatment if such programs incorporate the elements set forth in the Report of the Ad Hoc Committee on Physician Impairment (HOD 1995).

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15. Guidelines Regarding Disciplines Reportable to the National Practitioner Data Bank (NPDB) and the Federation of State Medical Board's Disciplinary Database

NPBD HELPLINE: 1-800-767-6732

a. Reporting Adverse Licensure Actions

State Medical and Dental Licensing Boards must report adverse actions to the Data Bank within 30 days from the date an adverse licensure action was taken. State Medical and Dental Boards must report to the Data Bank certain disciplinary actions related to professional competence or conduct taken against the licenses of physicians or dentists. Such licensure actions include revocation, suspension, censure, reprimand, probation, and surrender. State Medical and Dental Boards must also report **revisions** to adverse licensure actions, such as reinstatement of a license.

b. Federation of State Medical Boards Disciplinary Database

This is a database of all prejudicial actions taken by every medical licensing board in the United States. A private database, it is available to participating medical boards and to other health care providers by subscription. Report to this database is made no later than 60 days after a board prejudicial action is taken. Rapid reporting is encouraged. Actions are reported to other boards within 48 hours.

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16. AMA Code of Medical Ethics (Excerpts)

For a complete list of Opinions see the American Medical Association Council of Ethical and Judicial Affairs, Code of Medical Ethics. Or visit the AMA website at www.ama-assn.org

American Medical Association Principles of Medical Ethics, June 2001

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principles of Medical Ethics

- I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
- VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
- IX. A physician shall support access to medical care for all people.

Adopted by the AMA's House of Delegates June 17, 2001

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E-7.01 Records of Physicians: Availability of Information to Other Physicians.

The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. A physician who formerly treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient. Proper authorization for the use of records must be granted by the patient. Medical reports should not be withheld because of an unpaid bill for medical services. (IV) Issued prior to April 1977.

E-7.02 Records of Physicians: Information and Patients.

Notes made in treating a patient are primarily for the physician's own use and constitute his or her personal property. However, on request of the patient a physician should provide a copy or a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient.

Most states have enacted statutes that authorize patient access to medical records. These statutes vary in scope and mechanism for permitting patients to review or copy medical records. Access to mental health records, particularly, may be limited by statute or regulation. A physician should become familiar with the applicable laws, rules, or regulations on patient access to medical records.

The record is a confidential document involving the patient-physician relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community. Medical reports should not be withheld because of an unpaid bill for medical services. Physicians may charge a reasonable fee for copying medical records. (IV) Issued prior to April 1977; Updated June 1994.

E-7.04 Sale of a Medical Practice.

A physician or the estate of a deceased physician may sell the elements that comprise his or her practice, such as furniture, fixtures, equipment, office leasehold, and goodwill. In the sale of a medical practice, the purchaser is buying not only furniture and fixtures, but also goodwill, i.e., the opportunity to take over the patients of the seller. A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation, matriculation, or other reasons. Therefore, the transfer of records of patients is subject to the following:

- (1) The physician (or the estate) must ensure that all medical records are transferred to another physician or entity who is held to the same standards of confidentiality and is lawfully permitted to act as custodian of the records.
 - (2) All active patients should be notified that the physician (or the estate) is transferring the practice to another physician or entity who will retain custody of their records and that at their written request, within a reasonable time as specified in the notice, the records (or copies) will be sent to another physician or entity of their choice.
 - (3) A reasonable charge may be made for the cost of locating, duplicating, and mailing records. (IV) Issued July 1983; Updated June 2000.

 - (9) Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.
- (IV, V) Issued June 1994.

E-8.062 Sale of Non-Health-Related Goods from Physicians' Offices.

The sale of non-health-related goods by physicians presents a conflict of interest and threatens to erode the primary obligation of physicians to serve the

interests of their patients before their own. Furthermore this activity risks placing undue pressure on the patient and risks demeaning the practice of medicine.

Physicians should not sell non-health-related goods from their offices or other treatment settings, with the exception noted below.

Physicians may sell low-cost non-health-related goods from their offices for the benefit of community organizations, provided that

- (1) the goods in question are low-cost;
- (2) the physician takes no share in profit from their sale;
- (3) such sales are not a regular part of the physician's business;
- (4) sales are conducted in a dignified manner; and
- (5) sales are conducted in such a way as to assure that patients are not pressured into making purchases. (I, II) Issued June 1998 based on the report, "Sale of Non-health-related Goods from Physicians' Offices," adopted December 1997.

E-8.063 Sale of Health-Related Products from Physicians' Offices

"Health-related products" are any products that, according to the manufacturer or distributor, benefit health. "Selling" refers to the activity of dispensing items that are provided from the physician's office in exchange for money and also includes the activity of endorsing a product that the patient may order or purchase elsewhere that results in direct remuneration for the physician. This Opinion does not apply to the sale of prescription items which is already addressed in Opinion 8.03, Conflicts of Interest: Guidelines.

Physicians who engage in in-office sales practices should be aware of the related guidelines presented in Opinion 8.062, Sale of Non-Health-Related Goods from Physicians' Offices; Opinion 8.03, Conflicts of Interest: Guidelines; Opinion 8.032, Conflicts of Interest: Health Facility Ownership by a Physician; Opinion 3.01, Nonscientific Practitioners; Opinion 8.20, Invalid Medical Treatment; as well as the Reports from which these Opinions are extracted.

In-office sale of health-related products by physicians presents a financial conflict of interest, risks placing undue pressure on the patient, and threatens to erode patient trust and undermine the primary obligation of physicians to serve the interests of their patients before their own.

- (1) Physicians who choose to sell health-related products from their offices should not sell any health-related products whose claims of benefit lack scientific validity. When judging the efficacy of a product, physicians should rely on peer-reviewed literature and other unbiased scientific sources that review evidence in a sound, systematic, and reliable fashion.
- (2) Because of the risk of patient exploitation and the potential to demean the profession of medicine, physicians who choose to sell health-related products from their offices must take steps to minimize their financial conflicts of interest. The following guidelines apply:
 - (a) In general, physicians should limit sales to products that serve the immediate and pressing needs of their patients. For example, if traveling to the closest pharmacy would in some way jeopardize the welfare of the patient (e.g., forcing a patient with a broken leg to travel to a local

pharmacy for crutches), then it may be appropriate to provide the product from the physician's office. These conditions are explained in more detail in the Council's Opinion 8.03, Conflicts of Interest: Guidelines, and are analogous to situations that constitute exceptions to the permissibility of self-referral.

- (b) Physicians may distribute other health-related products to their patients free of charge or at cost, in order to make useful products readily available to their patients. When health-related products are offered free or at cost, it helps to ensure removal of the elements of personal gain and financial conflicts of interest that may interfere, or appear to interfere, with the physician's independent medical judgment.
- (3) Physicians must disclose fully the nature of their financial arrangement with a manufacturer or supplier to sell health-related products. Disclosure includes informing patients of financial interests as well as about the availability of the product or other equivalent products elsewhere. Disclosure can be accomplished through face-to-face communication or by posting an easily understandable written notification in a prominent location that is accessible by all patients in the office. In addition, physicians should, upon request, provide patients with understandable literature that relies on scientific standards in addressing the risks, benefits and limits of knowledge regarding the health-related product.
- (4) Physicians should not participate in exclusive distributorships of health-related products which are available only through physicians' offices. Physicians should encourage manufacturers to make products of established benefit more fairly and more widely accessible to patients than exclusive distribution mechanisms allow. (II) Issued December 1999 based on the report, "Sale of Health-Related Products from Physicians' Offices," adopted June 1999.

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17. Board Policy Regarding AMA Code of Medical Ethics

POLICY: It is the policy of the Board of Licensure in Medicine that the American Medical Association's Code of Medical Ethics, most recent edition of *Current Opinions with Annotations*, is one of the primary sources in defining ethical physician and physician assistant behavior.

Effective Date: February 13, 2001

Revised Date:

History: The Board has, for at least the past 14 years, relied on the guidance provided by this document as a definitive source of clearly stated ethical medical performance and behavior.

RELEVANT MAINE STATUTES

All copyrights and other rights to statutory text are reserved by the State of Maine. Refer to the current [Maine Revised Statutes Annotated](#) and supplements for certified text.

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18. Mandatory Reporting Requirements

24 MRSA § 2505. Committee Reports and Physician Reports

Any professional competence committee within this State and any physician licensed to practice or otherwise lawfully practicing within this State shall, and any other person may, report the relevant facts to the appropriate board relating to the acts of any physician in this State if, in the opinion of the committee, physician or other person, the committee or individual has reasonable knowledge of acts of the physician amounting to gross or repeated medical malpractice, habitual drunkenness, addiction to the use of drugs or professional incompetence. The failure of any such professional competence committee or any such physician to report as required is a civil violation for which a fine of not more than \$1,000 may be adjudged. [1977, c. 492, § 3 (new).]

Except for specific protocols developed by a board pursuant to Title 32, section 1073, 2596-A or 3298, a physician, dentist or committee is not responsible for reporting misuse of alcohol or drugs or professional incompetence or malpractice as a result of physical or mental infirmity or by the misuse of alcohol or drugs discovered by the physician, dentist or committee as a result of participation or membership in a professional review committee or with respect to any information acquired concerning misuse of alcohol or drugs or professional incompetence or malpractice as a result of physical or mental infirmity or by the misuse of alcohol or drugs, as long as

that information is reported to the professional review committee. Nothing in this section may prohibit an impaired physician or dentist from seeking alternative forms of treatment. [1997, c. 107, §3 (amd).]

§2506. Provider, entity and carrier reports

A health care provider or health care entity shall, within 60 days, report in writing to the disciplined practitioner's board or authority the name of any licensed, certified or registered employee or person privileged by the provider or entity whose employment or privileges have been revoked, suspended, limited or terminated or who resigned while under investigation or to avoid investigation for reasons related to clinical competence or unprofessional conduct, together with pertinent information relating to that action. Pertinent information includes: a description of the adverse action; the name of the practitioner involved; the date, the location and a description of the event or events giving rise to the adverse action; and identification of the complainant giving rise to the adverse action. Upon written request, the following information must be released to the board or authority within 20 days of receipt of the request: the names of the patients whose care by the disciplined practitioner gave rise to the adverse action; medical records relating to the event or events giving rise to the adverse action; written statements signed or prepared by any witness or complainant to the event; and related correspondence between the practitioner and the provider or entity. The report must include situations in which employment or privileges have been revoked, suspended, limited or otherwise adversely affected by action of the health care practitioner while the health care practitioner was the subject of disciplinary proceedings, and it also must include situations where employment or privileges have been revoked, suspended, limited or otherwise adversely affected by act of the health care practitioner in return for the health care provider's or health care entity's terminating such proceeding. Any reversal, modification or change of action reported pursuant to this section must be reported immediately to the practitioner's board or authority, together with a brief statement of the reasons for that reversal, modification or change. If the adverse action requiring a report as a result of a reversal, modification or change of action consists of the revocation, suspension or limitation of clinical privileges of a physician, physician assistant or advanced practice registered nurse by a health care provider or health care entity for reasons relating to clinical competence or unprofessional conduct and is taken pursuant to medical staff bylaws or other credentialing and privileging policies, whether or not the practitioner is employed by that health care provider or entity, then the provider or entity shall include in its initial report to the disciplined practitioner's licensing board or authority the names of all patients whose care by the disciplined practitioner gave rise to the adverse action. The failure of any health care provider or health care entity to report as required is a civil violation for which a fine of not more than \$5,000 may be adjudged. [2005, c. 397, Pt. C, §15 (AMD); 2005, c. 397, Pt. C, §16 (AFF).]

Carriers providing managed care plans are subject to the reporting requirements of this section when they take adverse actions against a practitioner's credentials or employment for reasons related to clinical competence or unprofessional

conduct that may adversely affect the health or welfare of the patient. [1997, c. 271, §3 (NEW).]

SECTION HISTORY

1977, c. 492, §3 (NEW). 1985, c. 804, §§6,22 (AMD). 1989, c. 462, §1 (AMD). 1997, c. 271, §3 (AMD). 1997, c. 697, §5 (AMD). 2005, c. 221, §1 (AMD). 2005, c. 397, §C15 (AMD). 2005, c. 397, §C16 (AFF)

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19. Patients' Rights to Personal Medical Records

22 MRSA (Chapter 401 -) §1711 A - C:

Patient access to hospital medical records - 22 MRSA § 1711

If a patient of an institution licensed as a hospital by the State, after discharge from such institution, makes written request for copies of the patient's medical records, the copies must, if available, be made available to the patient within a reasonable time unless, in the opinion of the hospital, it would be detrimental to the health of the patient to obtain the records. If the hospital is of the opinion that release of the records to the patient would be detrimental to the health of the patient, the hospital shall advise the patient that copies of the records will be made available to the patient's authorized representative upon presentation of a proper authorization signed by the patient. The hospital may exclude from the copies of medical records released any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration.

If an authorized representative for a patient requests, in writing, that a hospital provide the authorized representative with a copy of the patient's medical records and presents a proper authorization from the patient for the release of the information, copies must be provided to the authorized representative within a reasonable time.

A written request or authorization for release of medical records under this section satisfies the requirements of section 1711-C, subsection 3.

A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem may submit to a hospital health care information that corrects or clarifies the patient's treatment record, which must be retained with the medical record by the hospital. If the hospital adds to the medical record a statement in response to the submitted correction or clarification, the hospital shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem.

Reasonable costs incurred by the hospital in making and providing copies of medical records and additions to medical records must be borne by the requesting person and the hospital may require payment prior to responding to

the request. The charge for copies of records may not exceed \$10 for the first page and 35¢ for each additional page.

Release of a patient's medical records to a person other than the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem is governed by section 1711-C.

Fees charged for records - 22 MRSA § 1711-A

Whenever a health care practitioner defined in section 1711-B furnishes requested copies of a patient's treatment record or a medical report or an addition to a treatment record or medical report to the patient or the patient's authorized representative, the charge for the copies or the report may not exceed the reasonable costs incurred by the health care practitioner in making and providing the copies or the report. The charge for copies of records may not exceed \$10 for the first page and 35¢ for each additional page.

Patient access to treatment records; health care practitioners Access - 22 MRSA § 1711-B (2)

Upon written authorization executed in accordance with section 1711-C, subsection 3, a health care practitioner shall release copies of all treatment records of a patient or a narrative containing all relevant information in the treatment records to the patient. The health care practitioner may exclude from the copies of treatment records released any personal notes that are not directly related to the patient's past or future treatment and any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. The copies or narrative must be released to the designated person within a reasonable time.

If the practitioner believes that release of the records to the patient is detrimental to the health of the patient, the practitioner shall advise the patient that copies of the treatment records or a narrative containing all relevant information in the treatment records will be made available to the patient's authorized representative upon presentation of a written authorization signed by the patient. The copies or narrative must be released to the authorized representative within a reasonable time.

Except as provided in subsection 3, release of a patient's treatment records to a person other than the patient is governed by section 1711-C.

Person receiving the records - 22 MRSA § 1711-B (3)

Except as otherwise provided in this section, the copies or narrative specified in subsection 2 must be released to:

- A. The person who is the subject of the treatment record, if that person is 18 years of age or older and mentally competent;
- B. The parent, guardian ad litem or legal guardian of the person who is the subject of the record if the person is a minor, or the legal guardian if the person who is the subject of the record is mentally incompetent;
- C. The designee of a durable health care power of attorney executed by the person who is the subject of the record, at such time as the power of attorney is in effect; or

D. The agent, guardian or surrogate pursuant to the Uniform Health-care Decisions Act.

Corrections and clarifications of treatment records - 22 MRSA § 1711-B (3-A)

A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem may submit to a health care practitioner health care information that corrects or clarifies the patient's treatment record, which must be retained with the treatment record by the health care practitioner. If the health care practitioner adds to the treatment record a statement in response to the submitted correction or clarification, the health care practitioner shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem.

Minors - 22 MRSA § 1711-B (4)

This section does not affect the right of minors to have their treatment records treated confidentially pursuant to the provisions of, chapter 260.

HIV test - 22 MRSA § 1711-B (5)

Release of information regarding the HIV infection status of a patient is governed by Title 5, section 19203-D.

Retention of records - 22 MRSA § 1711-B (5)

This section does not alter the existing law or ethical obligations of a health care practitioner with respect to retaining treatment records.

Patient Records; Destruction of certain images limited - 22 MRSA §1721

A hospital licensed pursuant to chapter 405 or a health care practitioner as defined in section 1711-C, subsection 1, paragraph F may not destroy an image of a patient recorded using x rays, magnetic resonance imaging or computerized tomography without the consent of the patient.

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20. Disciplinary Proceedings and Sanctions

Disciplinary proceedings and sanctions - 32 MRSA §3282-A (1)

The board shall investigate a complaint, on its own motion or upon receipt of a written complaint filed with the board, regarding noncompliance with or violation of this chapter or any rules adopted by the board.

The board shall notify the licensee of the content of a complaint filed against the licensee as soon as possible, but not later than 60 days after receipt of this information. The licensee shall respond within 30 days. The board shall share the licensee's response with the complainant, unless the board determines that it would be detrimental to the health of the complainant to obtain the response. If the licensee's response to the complaint satisfies the board that the complaint does not merit further investigation or action, the matter may be dismissed, with notice of the dismissal to the complainant, if any.

If, in the opinion of the board, the factual basis of the complaint is or may be true and the complaint is of sufficient gravity to warrant further action, the board may request an informal conference with the licensee. The board shall provide the licensee with adequate notice of the conference and the issues to be discussed. The complainant may attend and may be accompanied by up to 2 individuals, including legal counsel. The conference must be conducted in executive session of the board, pursuant to Title 1, section 405, unless otherwise requested by the licensee. Before the board decides what action to take at the conference or as a result of the conference, the board shall give the complainant a reasonable opportunity to speak. Statements made at the conference may not be introduced at a subsequent formal hearing unless all parties consent. The complainant, the licensee or either of their representatives shall maintain the confidentiality of the conference.

When a complaint has been filed against a licensee and the licensee moves or has moved to another state, the board may report to the appropriate licensing board in that state the complaint that has been filed, other complaints in the physician's record on which action was taken and disciplinary actions of the board with respect to that physician.

When an individual applies for a license under this chapter, the board may investigate the professional record of that individual, including professional records that the individual may have as a licensee in other states. The board may deny a license or authorize a restricted license based on the record of the applicant in other states.

If the board finds that the factual basis of the complaint is true and is of sufficient gravity to warrant further action, it may take any of the following actions it determines appropriate.

- A. With the consent of the licensee, the board may enter into a consent agreement that fixes the period and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the licensee. A consent agreement may be used to terminate a complaint investigation, if entered into by the board, the licensee and the Attorney General's office.
- B. In consideration for acceptance of a voluntary surrender of the license, the board may negotiate stipulations, including terms and conditions for reinstatement, that ensure protection of the public health and safety and serve to rehabilitate or educate the licensee. These stipulations may be set forth only in a consent agreement signed by the board, the licensee and the Attorney General's office.
- C. If the board concludes that modification or nonrenewal of the license is in order, the board shall hold an adjudicatory hearing in accordance with Title 5, chapter 375, subchapter IV.
- D. If the board concludes that suspension or revocation of the license is in order, the board shall file a complaint in the District Court in accordance with Title 4, chapter 5.

The board shall require a licensee to notify all patients of the licensee of a probation or stipulation under which the licensee is practicing as a result of board disciplinary action. This requirement does not apply to a physician participating in

an alcohol or drug treatment program pursuant to Title 24, section 2505, a physician who retires following charges made or complaints investigated by the board or a physician under the care of a professional and whose medical practices and services are not reduced, restricted or prohibited by the disciplinary action.

Grounds for discipline - 32 MRSA §3282-A (2)

The board may suspend or revoke a license pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, restrict, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

- A. The practice of fraud or deceit in obtaining a license under this chapter or in connection with service rendered within the scope of the license issued;
- B. Habitual substance abuse that has resulted or is foreseeably likely to result in the licensee performing services in a manner that endangers the health or safety of patients;
- C. A professional diagnosis of a mental or physical condition that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients;
- D. Aiding or abetting the practice of medicine by an individual who is not licensed under this chapter and who claims to be legally licensed;
- E. Incompetence in the practice for which the licensee is licensed. A licensee is considered incompetent in the practice if the licensee has:
 - 1. Engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public; or
 - 2. Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed;
- F. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed;
- G. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or relates directly to the practice for which the licensee is licensed, or conviction of a crime for which incarceration for one year or more may be imposed;
- H. A violation of this chapter or a rule adopted by the board;
 - I. Engaging in false, misleading or deceptive advertising;
- J. Prescribing narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes;
- K. Failure to report to the secretary of the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee;

- L. Failure to comply with the requirements of Title 24, section 2905-A; or
- M. Revocation, suspension or restriction of a license to practice medicine or other disciplinary action; denial of an application for a license; or surrender of a license to practice medicine following the institution of disciplinary action by another state or a territory of the United States or a foreign country if the conduct resulting in the disciplinary or other action involving the license would, if committed in this State, constitute grounds for discipline under the laws or rules of this State.

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21. Authority of the Board to Take Emergency Actions, Including Mandating Medical/Psychiatric/Substance Abuse Evaluations

Emergency action - 32 MRSA §3286

Upon its own motion or upon complaint, the board, in the interests of public health, safety and welfare, shall treat as an emergency a complaint or allegation that an individual licensed under this chapter is or may be unable to practice medicine with reasonable skill and safety to patients by reason of mental illness, alcohol intemperance, excessive use of drugs, narcotics or as a result of a mental or physical condition interfering with the competent practice of medicine. In enforcing this paragraph, the board may compel a physician to submit to a mental or physical examination by physicians designated by it. Failure of a physician to submit to this examination when directed constitutes an admission of the allegations against the physician, unless the failure was due to circumstances beyond the physician's control, upon which a final order of disciplinary action may be entered without the taking of testimony or presentation of evidence. A physician affected under this paragraph must, at reasonable intervals, be afforded an opportunity to demonstrate that the physician can resume the competent practice of medicine with reasonable skill and safety to patients.

For the purpose of this chapter, by practicing or by making and filing a biennial license to practice medicine in this State, every physician licensed under this chapter who accepts the privilege to practice medicine in this State is deemed to have given consent to a mental or physical examination when directed in writing by the board and to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the grounds that the testimony or reports constitute a privileged communication.

Injunctions must issue immediately to enjoin the practice of medicine by an individual licensed to practice under this chapter when that individual's continued practice will or may cause irreparable damage to the public health or safety prior to the time proceedings under this chapter could be instituted and completed. In a petition for injunction pursuant to this section, there must be set forth with particularity the facts that make it appear that irreparable damage to the public health or safety will or may occur prior to the time proceedings under this chapter could be instituted and completed. The petition must be filed in the name of the board on behalf of the State.

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22. Disciplines, Letters of Guidance, Data Banks

10 MRSA § 8003. Departmental organization; duties

5. Authority of bureaus, offices, boards or commissions.

A-1. For each violation of applicable laws, rules or conditions of licensure or registration, the bureau, office, board or commission may take one or more of the following actions:

- (1) Issue warnings, censures or reprimands to a licensee or registrant. Each warning, censure and reprimand issued must be based upon violations of different applicable laws, rules or conditions of licensure or must be based upon separate instances of actionable conduct or activity;
 - (2) Suspend a license or registration for up to 90 days for each violation of applicable laws, rules and conditions of licensure or registration or for instance of actionable conduct or activity. Suspensions may be set to run concurrently or consecutively and, in total, may not exceed one year. Execution of all or any portion of a term of suspension may be stayed pending successful completion of conditions of probation, although the suspension remains part of the licensee's or registrant's record;
 - (3) Impose civil penalties of up to \$1,500 for each violation of applicable laws, rules and conditions of licensure or registration or for instances of actionable conduct or activity; and
 - (4) Impose conditions of probation upon an applicant, licensee or registrant. Probation may run for such time period as the bureau, office, board or commission determines appropriate. Probation may include conditions such as: additional continuing education; medical, psychiatric or mental health consultations or evaluations; mandatory professional or occupational supervision of the applicant, licensee or registrant; and other conditions as the bureau, office, board or commission determines appropriate. Costs incurred in the performance of terms of probation are borne by the applicant, licensee or registrant. Failure to comply with the conditions of probation is a ground for disciplinary action against a licensee or registrant. [1995, c. 502, Pt. H, §10 (amd).]
- B. The bureau, office, board or commission may execute a consent agreement that resolves a complaint or investigation without further proceedings. Consent agreements may be entered into only with the consent of: the applicant, licensee or registrant; the

bureau, office, board or commission; and the Department of the Attorney General. Any remedy, penalty or fine that is otherwise available by law, even if only in the jurisdiction of the District Court, may be achieved by consent agreement, including long-term suspension and permanent revocation of a professional or occupational license or registration. A consent agreement is not subject to review or appeal, and may be modified only by a writing executed by all parties to the original consent agreement. A consent agreement is enforceable by an action in Superior Court. [1995, c. 502, Pt. H, §10 (amd); 1999, c. 547, Pt. B, §78 (amd); §80 (aff).]

C. The bureau, office, board or commission may:

- (1) Require all applicants for license or registration renewal to have responded under oath to all inquiries set forth on renewal forms;
- (2) Require applicants for license or registration renewal to present proof of satisfactory completion of continuing professional or occupational education in accordance with each bureau's, office's, board's or commission's rules. Failure to comply with the continuing education rules may, in the bureau's, office's, board's or commission's discretion, result in a decision to deny license or registration renewal or may result in a decision to enter into a consent agreement and probation setting forth terms and conditions to correct the licensee's or registrant's failure to complete continuing education. Terms and conditions of a consent agreement may include requiring completion of increased hours of continuing education, civil penalties, suspension and other terms as the bureau, office, board, commission, the licensee or registrant and the Department of the Attorney General determine appropriate. Notwithstanding any contrary provision set forth in a bureau's, office's, board's or commission's governing law, continuing education requirements may coincide with the license or registration renewal period;
- (3) Refuse to renew a license or registration when the bureau, office, board or commission finds a licensee or registrant to be in noncompliance with a bureau, office, board or commission order or consent agreement;
- (4) Allow licensees or registrants to hold inactive status licenses or registrations in accordance with each bureau's, office's, board's or commission's rules. The fee for an inactive license or registration may not exceed the statutory fee cap established for the bureau's, office's, board's or commission's license or registration renewal set forth in its governing law; or

(5) Delegate to staff the authority to review and approve applications for licensure pursuant to procedures and criteria established by rule. Rules developed pursuant to this subparagraph are routine technical rules as described in Title 5, chapter 375, subchapter II-A. [1999, c. 386, Pt. B, §4 (amd).]

- D. The bureau, office, board or commission may require surrender of licenses and registrations. In order for a licensee's or registrant's surrender of a license or registration to be effective, a surrender must first be accepted by vote of the bureau, office, board or commission. Bureaus, offices, boards and commissions may refuse to accept surrender of licenses and registrations if the licensee or registrant is under investigation or is the subject of a pending complaint or proceeding, unless a consent agreement is first entered into pursuant to this chapter. [1995, c. 502, Pt. H, §10 (amd).]
- E. The bureau, office, board or commission may issue letters of guidance or concern to a licensee or registrant. Letters of guidance or concern may be used to educate, reinforce knowledge regarding legal or professional obligations and express concern over action or inaction by the licensee or registrant that does not rise to the level of misconduct sufficient to merit disciplinary action. The issuance of a letter of guidance or concern is not a formal proceeding and does not constitute an adverse disciplinary action of any form. Notwithstanding any other provision of law, letters of guidance or concern are not confidential. The bureau, office, board or commission may place letters of guidance or concern, together with any underlying complaint, report and investigation materials, in a licensee's or registrant's file for a specified amount of time, not to exceed 10 years. Any letters, complaints and materials placed on file may be accessed and considered by the bureau, office, board or commission in any subsequent action commenced against the licensee or registrant within the specified time frame. Complaints, reports and investigation materials placed on file are only confidential to the extent that confidentiality is required pursuant to Title 24, chapter 21, the Maine Health Security Act. [1999, c. 386, Pt. B, §5 (amd).]
- F. A bureau, office, board or commission may establish, by rule, procedures for licensees in another state to be licensed in this State by written agreement with another state, by entering into written licensing compacts with other states or by any other method of license recognition considered appropriate that ensures the health, safety and welfare of the public. Rules adopted pursuant to this paragraph are routine technical rules

pursuant to Title 5, chapter 375, subchapter II-A. [1999, c. 687, Pt. C, §7 (new).]

The jurisdiction to suspend occupational and professional licenses conferred by this subsection is concurrent with that of the District Court. Civil penalties must be paid to the Treasurer of State.

Any nonconsensual disciplinary action taken under authority of this subsection may be imposed only after a hearing conforming to the requirements of Title 5, chapter 375, subchapter IV, and is subject to judicial review exclusively in the District Court in accordance with Title 5, chapter 375, subchapter VII, substituting the term "District Court" for "Superior Court," notwithstanding any other provision of law.

10. National disciplinary record system. Within the limits of available revenues, all bureaus, offices, boards or commissions internal or affiliated with the department shall join or subscribe to a national disciplinary record system used to track interstate movement of regulated professionals who have been the subject of discipline by state boards, commissions or agencies and report disciplinary actions taken within this State to that system.