

Maine Board of Licensure in Medicine Home Page



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In this issue:

WHAT EVERYONE SHOULD KNOW

- [Executive Director Honored as PFR Manager of the Year](#)
- [Board Accomplishments in 2017](#)
- [Mark S. Cooper, M.D. - In Memoriam](#)
- [Sexual Misconduct in Medicine: Unethical, Unprofessional, Incompetent, and Potentially Criminal](#)
- [Notification Requirements for Physicians and Physician Assistants](#)
- [Physicians and Physician Assistants at Risk for Discipline](#)
- [Death Certificate Changes](#)

DISCIPLINARY ACTIONS

- [Adverse Actions](#)

FOCUS ON LICENSING ISSUES

- [Opioid Epidemic](#)
- [Opioids: What to expect from your dentist](#)
- [Death by Fentanyl](#)

READERS RESPOND

- [Dana Dyer](#)
- [Stephen Parden, MD](#)
- [Dirk van Leeuwen, MD](#)

FROM THE EDITOR

- [Book Review](#)
- [Zen Reminders](#)

WHAT EVERYONE SHOULD KNOW

Dennis E. Smith, Esq., Executive Director, has been honored as the 2017 State of Maine Governor's Manager of the Year for the Department of Professional and Financial Regulation



On Tuesday December 19, 2017, at the Blaine House, Governor Paul R. LePage presented Mr. Smith with the 2017 State of Maine Governor's Manager of the Year award for the Department of Professional and Financial Regulation (PFR) in recognition of his



outstanding service to the State of Maine. PFR Commissioner Anne L. Head selected Mr. Smith for this award based upon the recommendation of the staff of the Board of Licensure in Medicine (Board).

Prior to joining the Board as Executive Director in 2015, Mr. Smith served in the U.S. Army as a JAG Corps Attorney, an Assistant District Attorney, and as an Assistant Attorney General with the Maine Office of Attorney General, in which capacity he provided legal counsel to the Board for almost a decade.

Mr. Smith has had a positive effect on the Board and Board staff during the previous three years. Mr. Smith is most proud of the personal and professional growth of the Board's staff and its support for one another and the Board. Mr. Smith believes in and encourages life/work balance, and has helped create and foster a culture of collaboration, innovation, teamwork and professional development. These changes benefit not only staff, but assist the Board in carrying out its mission of protecting the public. Some of the accomplishments that the Board staff and Board have achieved during Mr. Smith's tenure include:

- Creating the position of Complaint Coordinator
- Reclassifying the Licensure Specialist positions
- Increasing professional development of staff through trainings, courses, and seminars
- Increasing staff involvement in Board meetings
- Creating an electronic newsletter
- Revising and updating Board rules:
 - Chapter 1 (Physicians)
 - Chapter 2 (Physician Assistants)
 - Chapter 4 (Citations)
 - Chapter 21 (Controlled Substances)
- Adopting new Board rules:
 - Chapter 5 (Collaborative Drug Therapy Management)
 - Chapter 6 (Telemedicine)
- Updating the Maine Professionals Health Program (MPHP) protocols
- Updating the Board statute regarding license renewal
- Working with Maine Quality Counts to provide free Category 1 CME to meet the opioid law requirements
- Creating Re-entry to Practice Guidelines

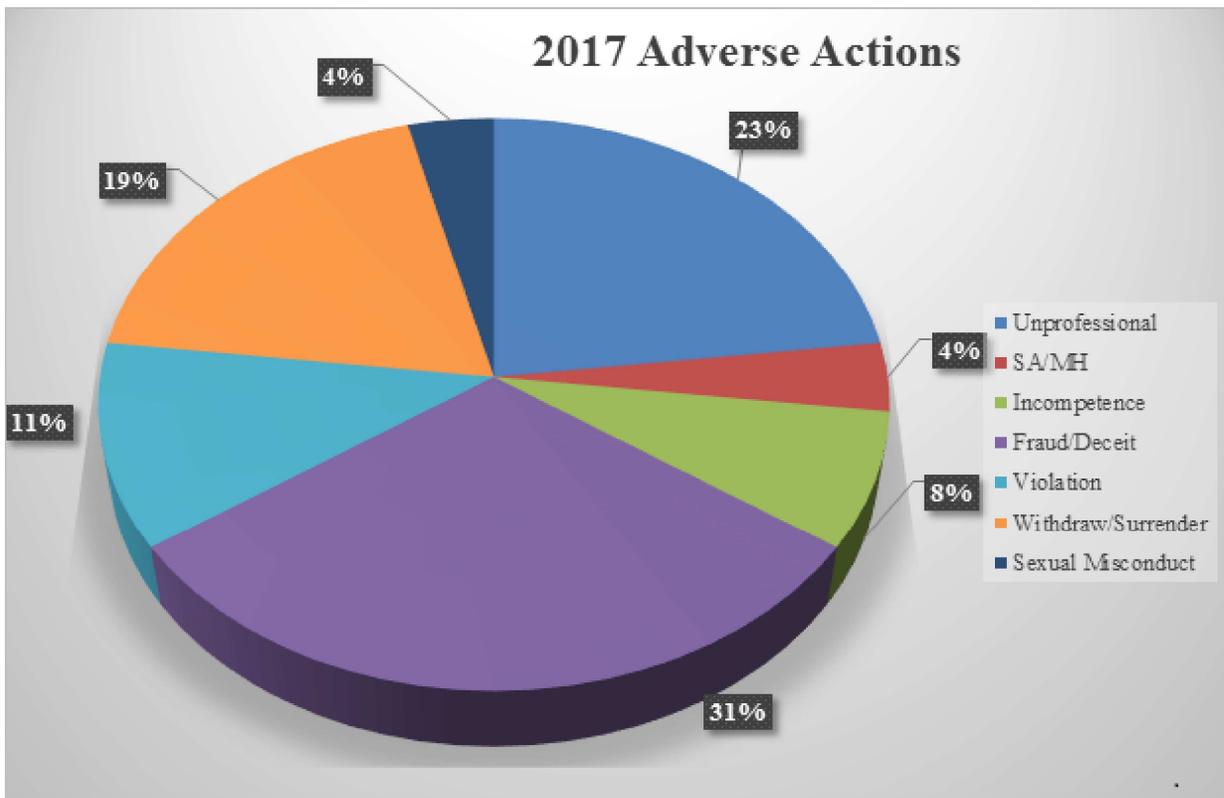
Mr. Smith is grateful to the Board staff for nominating him for this honor, and for Commissioner Head's guidance and support.

Board Accomplishments in 2017

1. Board Rules:
 - Chapter 1 Rule Regarding Physicians. The Board updated the rule to include:
 - Creating an Emeritus License
 - Requiring physicians who have not practiced clinical medicine in over 24 months to demonstrate continuing clinical competency
 - Reducing the total number of CME hours required every 2 years
 - Notification requirements
 - Chapter 21 Joint Rule regarding Use of Controlled Substances for Treatment of Pain. The Board (in conjunction with the Board of Osteopathic Licensure and State Board of Nursing) updated the rule to include:
 - Universal precautions for prescribing controlled drugs
 - Completion of CME in opioid prescribing
2. Board Statute regarding License Renewal:
 - With the assistance of PFR Commissioner Anne Head and the Governor's Office, the Board was able to update and simplify the license renewal process by amending the Board's statute to allow

notifications by email, an identified expiration date, and a 90 day period after expiration within which a licensee may reinstate his/her license without penalty by the Board.

3. License Renewal Survey:
 - At the request of the Office of Rural Health and Primary Care, the Board created a minimum data set for a survey on license renewal applications to collect workforce data regarding licensees. The data will be used by the Office of Rural Health and Primary Care to determine the areas of federal assistance each area in Maine will receive.
4. Maine Quality Counts:
 - The Board allocated \$35,000 of its funds to support educational modules related to opioid prescribing.
5. Re-entry to Practice Guidelines:
 - The Board developed practice re-entry guidelines for physicians and physician assistants who have been out of practice.
6. Updates to online licensing:
 - Updated the system to handle the changes listed above under License Renewal
 - Update to the online addendum to the uniform application for medical licensure
 - Created an online checklist so applicants can view outstanding application items
 - Change in type of references requested (personal vs. employer) and the method used to obtain them (e-mail vs. mail)
7. Electronic Newsletter – three issues emailed to licensees
8. Citizen Advocacy Center – public Board member attended annual meeting
9. Federation of State Medical Boards (FSMB) Annual Meeting – attended by staff, chair, and public Board member
10. Membership in International Association of Medical Regulatory Authorities (IAMRA)
11. Updated Maine Physicians Health Program (MPHP) Protocols
12. Board licensing and complaint statistics:
 - Licensing:
 - 794 New physician and physician assistant licenses issued
 - 3,088 renewal applications processed
 - 47.23 days on average to process most license applications
 - 58.17 days on average to process permanent license applications
 - Complaints:
 - 82 = Number of Complaints carried forward from 2016
 - 177 = Number of New Complaints filed in 2017
 - 259 = Total Number of Complaints 2017
 - 129 = Number of Complaints dismissed in 2017
 - 27 = Number of complaints resulting in adverse licensing actions in 2017
 - 83 = Number of Complaints carried forward to 2018
 - 27 = Total adverse licensing actions 2017
 - The following is a breakdown of adverse licensing actions taken in 2017
 - 6 = Unprofessional Conduct
 - 1 = Substance Abuse /Mental Health Issues (SA/MH)
 - 2 = Incompetence
 - 8 = Fraud and/or Deceit
 - 3 = Violation of Statute or Rule of the Board
 - 5 = Withdraw/Surrender While Under Investigation
 - 1 = Sexual Misconduct



Mark S. Cooper, M.D. - In Memoriam



The Board of Licensure in Medicine and staff mourn the recent passing of Mark S. Cooper, M.D., who served as the first Medical Director to the Board from 2009 to 2015. As the Board's first Medical Director, Dr. Cooper helped to forge the duties and responsibilities of the position, and added depth and a broad fund of medical knowledge to its investigations and rule making initiatives. The Board staff regularly relied upon Dr. Cooper's knowledge and guidance, while the Board greatly appreciated his review of medical records and opinions regarding medical care. Following his retirement as Medical Director, the Board recognized Dr. Cooper's significant contributions to the Board and its mission of protecting the citizens of the State of Maine by presenting him a plaque containing the following inscription:

Mark S. Cooper, M.D. ("Dr. Cooper")
 First Medical Director for the Board of Licensure in Medicine
 2009-2015

This plaque commemorates in deep appreciation your six years of dedicated service to the Maine Board of Licensure in Medicine and the citizens of the State of Maine. As the Board's first Medical Director, you set a standard of excellence for all who may follow you. The depth of your medical knowledge, professional integrity, dedication to duty, practical wisdom, and sense of humor combine to make you a role model and an exceptional member of the Board staff. It is with profound admiration, gratitude and affection that the Board of Licensure in Medicine and staff thank you and wish you well.

The Board and its staff extend their sincere condolences to Dr. Cooper's family.

Sexual Misconduct in Medicine: Unethical, Unprofessional, Incompetent, and Potentially Criminal

Dennis E. Smith, Esq., Executive Director

Introduction

Over 2000 years ago, the Greek physician and teacher Hippocrates is supposed to have authored the original “Hippocratic Oath.”¹ The original Hippocratic Oath specifically prohibited any physician from engaging in sexual misconduct:

Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves.²

While it no longer appears in the modern versions of the Hippocratic Oath, the prohibition against engaging in sexual misconduct with patients is codified in: (1) the ethical codes of various medical societies; (2) the rules of the medical licensing boards; and (3) the criminal statutes of the State of Maine.

The Ethical Codes

The ethical codes of the American Medical Association (AMA), the American Academy of Physician Assistants (AAPA), and the American Psychiatric Association (APA) make sexual misconduct with current patients (and key third parties) unethical. The AMA *Code of Medical Ethics* specifically states that romantic or sexual interactions between physicians and patients or key third parties (spouses, partners, parents, guardians, surrogates) within a current patient-physician relationship are unethical.³ In addition, the AMA *Code of Medical Ethics* states that sexual or romantic relationships with former patients are unethical “if the physician uses or exploits trust, knowledge, emotions, or influence derived” from the previous patient-physician relationship or would “foreseeably harm” the former patient.⁴ Similarly, the AAPA *Guidelines for Ethical Conduct for the Physician Assistant Profession* provides:

Such relationships generally are unethical because of the PA’s position of authority and the inherent imbalance of knowledge, expertise, and status. Issues such as dependence, trust, transference, and inequalities of power may lead to increased vulnerability on the part of the current or former patients or key third parties.

The APA *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* recognizes that the “inherent inequality in the doctor-patient relationship may lead to exploitation of the patient [and therefore] [s]exual activity with a **current or former** patient is unethical.”

The Medical Boards’ Joint Rule

The Board of Licensure in Medicine and the Board of Osteopathic Licensure have a joint rule prohibiting sexual misconduct by physicians and physician assistants with patients.⁵ Joint Board Rule Chapter 10 makes sexual misconduct with patients “incompetence” and “unprofessional conduct” and grounds for revocation of a physician’s or physician assistant’s license. Like the codes of ethics mentioned above, the Chapter 10 rule recognizes that sexual misconduct “exploits” the patient-physician/physician assistant relationship, and constitutes an extreme breach of trust. **It does NOT matter whether the sexual misconduct was suggested or initiated or consented to by the patient.** Sexual misconduct may be verbal or physical, and includes gestures or expressions with sexual connotation. Examples of sexual misconduct identified in the rule include sexual intercourse; kissing; any touching of a body part for any purpose other than appropriate examination, treatment, or comfort; offering drugs in exchange for sexual favors; examination or touching of genitals without the use of gloves; and using the patient-physician/physician assistant relationship to solicit a date or initiate a romantic relationship. The Boards are in the process of updating the Chapter 10 Rule to include sexual misconduct with “key third parties” – which is unethical under the AMA and AAPA ethical codes - as a basis for revocation of licensure.

Maine Criminal Statutes

Maine laws criminalize certain types of physician sexual misconduct with patients. Psychiatrists who engage in a sexual act with a current patient commit the crime of gross sexual assault (rape) punishable by up to five years' incarceration.⁶ Psychiatrists who engage in unlawful sexual contact with a patient commit the crime of unlawful sexual contact, which can be punishable by up to five years' incarceration.⁷ In addition to the criminal penalties, psychiatrists who are convicted of either of these crimes must register as a sex offender under Maine's Sex Offender Registration and Notification Act of 2013.⁸

Conclusion

There is a reason that ethical codes, rules, and laws prohibit sexual misconduct by physicians and physician assistants. Patients seeking care may be physically, mentally, and emotionally compromised and extremely vulnerable. The physician/physician assistant-patient relationship is built upon trust and the fundamental principle that the physician/physician assistant will place the physical, mental, and emotional health of the patient before all else. Physicians and physician assistants who engage in sexual misconduct with patients violate that trust, undermine that fundamental principle, harm patients, and denigrate their professions.

1. https://www.nlm.nih.gov/hmd/greek/greek_oath.html
2. Ibid.
3. <https://www.ama-assn.org/delivering-care/code-medical-ethics-patient-physician-relationships>
Opinions 9.1.1 & 9.1.2.
4. Ibid.
5. <http://www.maine.gov/md/laws-statutes/rules-statutes.html>
6. 17-A M.R.S. § 253(2)(I) <http://legislature.maine.gov/statutes/17-A/title17-Asec253.html>.
7. 17-A M.R.S. §§ 255-A(1)(U) & (V) <http://legislature.maine.gov/statutes/17-A/title17-Asec255-A.html>.
8. 34-A M.R.S. Chapter 17 <http://www.mainelegislature.org/legis/statutes/34-a/title34-Asec11273.html>.

Notification Requirements for Physicians and Physician Assistants

As you are aware, the updated Chapter 1 rule, Rule Regarding Physicians, became effective on December 23, 2017. One of the new sections of that rule includes notification requirements for physicians. While these may be new for physicians, the notification requirements have been in effect for physician assistants since July 2016. Failure to provide the required notifications can lead to citations (administrative fines) or disciplinary action.

With one exception (item #7), the following notifications must be provided to the Board within ten (10) calendar days of their occurrence:

1. **Change of Contact Information.** The Board continues to have to track down its licensees in order to communicate with them. It is vital that the Board have current contact information, including phone and e-mail. Please remember that under Maine law licensees must provide two addresses, home and work. If a licensee fails to provide two addresses, the licensee's home address will become his/her public contact address.
2. **Criminal Arrest/Summons/Indictment/Conviction.** This is a change from the previous rule where this only had to be provided at renewal.
3. **Change in Status of Employment or Hospital Privileges.** This has been a source of great concern for licensees. The notification requirement is not meant to include things such as retirement or changing of jobs, unless they are due to an investigation or action by the employer/facility. However, this does not relieve a licensee of the obligation to notify the Board of his/her change of contact information within ten days.
4. **Disciplinary Action.** Any disciplinary action taken by any licensing authority must be reported.
5. **Material Change.** Any material change in qualifications or the information and responses provided to the Board in the licensee's most recent application must be submitted to the Board. For example, a licensee reported national board certification on his/her application, but it has expired and has not been renewed.

6. Termination of Plan of Supervision. Both the physician assistant and the physician are responsible for notifying the Board within ten days.
7. Change of Name (Physician Only) – (30 day notice). Name changes must be provided within thirty (30) calendar days, along with a copy of the pertinent legal document. Although this specific notification was not included in the physician assistant rule, a change of name would be considered a material change in the information provided to the Board and notification must be made. In light of the longer notification period contained in the physician rule, the Board will accept as timely name change notifications by physician assistants in compliance with the 30 days allowed for physicians.
8. Change in Status of emergency, temporary, camp and educational licenses/certificates (Physician Only). The forgoing licenses are issued for the licensee to work at a specific location. The Board must be notified of the termination of employment from the specific location for which the license was issued.
9. Change of Primary Supervising Physician (Physician Assistant Only). A change in primary supervising physician must be reported by submitting the approved form.
10. Death/Departure of a Supervising Physician (Physician Assistant Only). The death or permanent/long-term departure from the practice location of a supervising physician must be reported.
11. Failure to pass the NCCPA Examination (Physician Assistant Only). Failure to pass the NCCPA examination must be reported.

These notification requirements comprise important events in the professional life of a licensee. The notifications are important for the Board to have timely information, which will help the Board with its mission to protect the citizens of Maine. The Board thanks all licensees for their assistance in fulfilling that mission.

Physicians and Physician Assistants at Risk for Discipline

The Board's statute requires that before a physician assistant may render medical services, he/she must have both a license and a certificate of registration on file with the Board. The certificate of registration is separate and distinct from the plan of supervision, which is the document that delegates medical services to the physician assistant and defines his/her scope of practice. The certificate of registration is vital for identifying and linking the supervising physician and the physician assistant in the Board's licensing system.

Recently, the Board has had a number of physicians and physician assistants who have been working together for months without submitting an application for a certificate of registration or the plan of supervision to the Board.

In almost all instances, the oversight is blamed on the practice administration. This is not an acceptable excuse. Physicians and physician assistants have a professional responsibility for ensuring that a certificate of registration has been issued. The Board has been disciplining both the physician assistant and the primary supervising physician for a failure to do so. The discipline is reported to the National Practitioner Data Base and remains in the licensee's file forever. Verifying that a certificate of registration has been issued is quick and easy. Physicians and physician assistants can check this by utilizing the Board's website and performing a search of the physician assistant's online license profile at:

<https://www.pfr.maine.gov/ALMSOnline/ALMSQuery/SearchIndividual.aspx?Board=376>.

If the online licensing profile does not show a supervisory relationship between the physician and physician assistant, then there is no certificate of registration on file and the physician and physician assistant should immediately contact the Board.

Practicing without a certificate of registration is tantamount to practicing without a license. Prior to the physician assistant rendering any medical services, the **physician and physician assistant** must ensure that the supervisory relationship has been registered with and approved by the Board. There is no acceptable excuse for abdicating this responsibility to others.

If you have questions about your supervisory relationship, or if it has been approved, Board staff is happy to help.

New Law Affecting Death Certificate Certification

This past legislative session, the Maine 128th Legislature passed a bill which will require that death certificates are completed and filed using Maine's Electronic Death Registration System (EDRS). **After July 1, 2018 paper records, will no longer be accepted.**

Data, Research, and Vital Statistics (DRVS) would like to encourage health care providers (physician, nurse practitioner or physician assistants authorized to practice in this State) to start using the EDRS as soon as possible. Below, DRVS has provided (3) three options for health care providers to learn more about the EDRS.

1. Try on your own https://gatewaytest.maine.gov/evrs_mirror_web/logon.aspx The URL is a link to the web-based system used for training and is a mirror of the functionality in the production database currently in use. The cases created in the training site are not real cases. Health care providers may create and certify death cases to become familiar with the online system. DRVS has created generic usernames and passwords to use in the training site. The username is always "Cert" as the first name and the first four letters of the county of your primary practice. Example: "Cert.Aroo" or "Cert.Knox", etc. Usernames are case sensitive. The password is Train2017. Once you become comfortable with the application, please contact the Application Support Desk at 1-888-664-9491 (opt. 7) for an enrollment and disclosure form. You will be provided with a permanent user name, password and the link to the production site.
2. E-Learning Tool - <http://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/edrs/edrs-training/index.html> The URL is a link to the online training module that has been created for health care providers. The training module demonstrates how to complete the medical certification information required by health care providers for the completion of a death certificate. The training module has been designed so health care providers may complete at their convenience. After completion of the training, health care providers will need to complete the post test to gain access to the production database. Successful completion of the post test will generate an email to EDRS staff to enroll you as a user.
3. On-Site Training - A series of on site trainings will be offered by DRVS and held throughout the state over the next few months. On-site trainings may be organized through health care facilities in your area. Training schedules will be announced when finalized.

Thank you in advance for your cooperation and commitment to improving death reporting.

DISCIPLINARY ACTIONS

Adverse Actions

Thomas J. Keating, MD License #MD11930

Date of action 2/13/2018

On February 13, 2018, the Board entered into a Consent Agreement with Dr. Keating based on concerns that he may have a mental or physical condition that impairs his ability to provide safe patient care. The Board imposed a license probation for a period of a least one (1) year during which Dr. Keating will continue monitoring and treatment with certain medical providers and the Medical Professionals Health Program, each providing reports to the Board. In addition, prior to engaging in the practice of medicine, Dr. Keating must engage a physician practice monitor, who will submit quarterly reports to the Board.

Michael S. Berry, MD License #MD17153

Date of action 2/13/2018

On February 13, 2018, the Board entered into a Consent Agreement with Dr. Berry for unprofessional conduct and misuse of alcohol, drugs or other substances that may result in the licensee performing services in a manner that endangers the health or safety of patients. The Board imposed terms and conditions, including that Dr.

Berry must comply with all requirements of and maintain a monitoring agreement with the Maine Medical Professionals Health Program, or an equivalent program, for a period of at least five (5) years.

Michael England, MD License# MD12298

Date of action 01/09/2018

On January 9, 2018, the Board approved Dr. England's request to withdraw his license while under investigation.

Ronald D. Oldfield, PA License #PAN564

Date of action 01/09/2018

On January 9, 2018, Mr. Oldfield entered into a Consent Agreement with the Board for unprofessional conduct related to engaging in sexually harassing conduct with a medical assistant. Mr. Oldfield was placed on probation for a period of at least one (1) year, during which he is required to attend a disruptive providers course, obtain an evaluation from the Maine Medical Professionals Health Program and comply with any recommended treatment or monitoring, and engage in mental health therapy.

Phillip L. Saunders, MD License #MD17225

Date of action 12/12/20178

On December 12, 2017, Dr. Saunders entered into a Consent Agreement with the Board. Dr. Saunders agreed to the immediate surrender of his Maine medical license. The Board found that Dr. Saunders engaged in misrepresentation in obtaining renewal of his license, engaged in unprofessional conduct, and engaged in misuse of alcohol, drugs, or other substances that may result in performing services in a manner that endangers the health or safety of patients, following disciplinary action taken by the Alabama Medical Board.

William P. Carter, III, MD License #MD19156

Date of action 12/12/2017

On December 12, 2017, Dr. Carter entered into a Consent Agreement with the Board for unprofessional conduct following disciplinary action taken by the New Hampshire Board of Medicine. Dr. Carter was placed on probation for a period of at least six (6) months, during which he is required to engage a Board approved physician practice monitor who will review patient charts and provide monthly reports to the Board.

Stanley Dwayne Roberts, MD License #MD20054

Date of action 11/20/2017

On November 20, 2017, The Board issued a Decision and Order following an adjudicatory hearing held on October 10, 2017. The Board found that: 1) Dr. Roberts engaged in misrepresentation in obtaining his license by not informing the Board of the investigation of his actions by the Utah Department of Commerce Division of Occupational and Professional Licensing ("UDOPL"); 2) Dr. Roberts had engaged in the misuse of substances that could have resulted in his performing services in a manner that endangered the health or safety of patients; 3) that Dr. Roberts engaged in unprofessional conduct by treating family members in a non-emergency and non-isolated setting without documenting the treatment provided; 4) that Dr. Roberts was subjected to discipline by UDOPL for self-prescribing and prescribing to family members without following appropriate protocols; and 5) that Dr. Roberts failed to respond to the Board complaint as required by law. Pursuant to the Decision and Order, the Board revoked Dr. Robert's license to practice medicine.

David Robinson, MD License #MD18360

Date of action 11/20/2017

On November 20, 2017, Dr. Robinson entered into a Consent Agreement with the Board. Dr. Robinson was issued a reprimand for failing to disclose information required on an application to renew his Maine medical license and for engaging in unprofessional conduct. Dr. Robinson was placed on probation for at least one (1) year, required to participate in treatment, required to comply with the terms of his October 28, 2016 Iowa Medical Board Order, and must pay a civil penalty of one thousand (\$1000) dollars.

Reinaldo O. de los Heros, MD License #MD17206

Date of action 10/31/2017

On October 31, 2017, Dr. de los Heros entered into a Consent Agreement with the Board for the permanent

revocation of his license to practice medicine. The Board found that Dr. de los Heros engaged in fraud, deceit or misrepresentation in connection with service rendered within the scope of his license, engaged in incompetence, engaged in unprofessional conduct, and violated a Board consent agreement and conditions of probation.

John G. Costa, MD License #MD10758

Date of action 10/10/2017

On October 10, 2017, the Board of Licensure in Medicine voted to accept Dr. Costa's request to withdraw his application to renew his license while under investigation.

Donald B. Shea, MD License #MD18015

Date of action 10/10/2017

On October 10, 2017, the Board entered into a Consent Agreement with Dr. Shea issuing a censure for engaging in fraud, deceit, or misrepresentation in connection with services rendered, for misuse of alcohol, drugs, or other substances that may result in performing services in a manner that endangers the health or safety of patients, and for unprofessional conduct. Dr. Shea may not prescribe to himself or family members. Dr. Shea must immediately cease practicing medicine should he in the course of receiving medical treatment receive or take any opiate except buprenorphine for the period of such treatment. Dr. Shea was also issued a license probation for at least five (5) years subject to terms outlined in the consent agreement including entering into a monitoring agreement with the Maine Physicians Health Program, requiring an immediate suspension of his license upon a confirmed positive toxicology test result for alcohol or any drug not known to be prescribed to him, imposing certain notification requirements, and requiring that Dr. Shea engage a Board approved physician practice monitor for at least six (6) months who will submit monthly reports to the Board.

Jessica L. Cyr, PA License #PA1331

Date of action 10/10/2017

On October 10, 2017, the Board issued a Decision and Order imposing a Warning on Ms. Cyr's license as discipline for three violations. The Board found that: 1) Ms. Cyr violated Board statutes by rendering medical services without a certificate of registration from August 2015 through May 5, 2016; 2) Ms. Cyr violated Board rules by practicing as a physician assistant without approval by the Board of the primary supervising physician and without obtaining a certificate of registration from August 2015 to May 5, 2016; and 3) Ms. Cyr violated Board rules by failing to provide the required notification of a change in her supervising physician within 14 days of the effective date of the change on September 30, 2015, August 4, 2015, and January 15, 2016.

Stephanie A. Graves, PA License #PA1274

Date of action 09/12/2017

On September 12, 2017, the Board entered into a Consent Agreement with Ms. Graves for engaging in conduct that evidences a lack of fitness to discharge the duty owed by the licensee to a client or patient or the general public, or that evidences a lack of knowledge or inability to apply principles to carry out the practice for which the licensee is licensed, and for engaging in unprofessional conduct. The Board imposed a period of probation for at least two (2) years, during which she is subject to conditions including the requirement that she engage a physician practice monitor who will review all of Ms. Graves's patient charts to verify accuracy of the medical record documentation within two (2) days of the patient encounter. The physician practice monitor will provide monthly reports to the Board confirming accuracy of Ms. Graves's medical record documentation. Ms. Graves may not render any medical services in the absence of the physician practice monitor unless an alternate physician practice monitor is approved by the Board Chair or Board Secretary.

FOCUS ON LICENSING ISSUES

The Opiod Epidemic

The Board's April 2016 newsletter contained an article on prescription drug abuse in the U.S. and Maine, and highlighted several efforts to combat it. Since that time, federal and state agencies have taken significant steps

toward reversing the epidemic. For its part, the Board - in conjunction with the Board of Nursing and Board of Osteopathic Licensure - has updated the joint Chapter 21 rule regarding the use of controlled substances for the treatment of pain. That updated rule can be found on the Board's website: <http://www.maine.gov/md/laws-statutes/rules-statutes.html>. The updated rule is just "one piece of the puzzle." As the following article by Dr. Polly Nichols, DDS points out, other health care practitioners hold pieces of the puzzle and can contribute towards ending the epidemic. Moreover, communication and coordination between and among health care practitioners regarding the care and treatment of their patients will help to ensure safe and effective pain care.

Opioids: What to expect from your dentist

coastaljournal.com/2017/12/26/opioids-expect-dentist/

By Polly Nichols, DDS Special to the Coastal Journal

I enjoy writing this column, especially when it can be fun, as well as educational. This time, however, there is no way to put a lighthearted spin on the subject.

Most people are aware of the disheartening problem of opioid addiction in our beautiful state and the rest of the nation. It is a current topic in the media. I feel like it is important to let you know how this epidemic is affecting you and your dentist. Many solutions are being offered, some by the Maine Legislature. As a dentist, I want to be a part of the solution.

First, a few facts to illustrate how critical the opioid addiction situation is in Maine.

Maine leads the nation in per capita prescriptions for long-acting opioids. In 2015, 272 Mainers died from opioid/heroin overdoses. This number increased 40 percent in 2016 when 376 deaths occurred – 313 of which involved opioids, not heroin.

These numbers are higher than annual car fatalities in Maine. There were more opioid/heroin overdose deaths in 2016 than deaths from homicide for the past 10 years in Maine. Also in 2016, one out of every 11 babies born in Maine was drug affected. That means that every day in 2016, three drug affected babies were born in our state.

A quote from the April 21, 2016 New England Journal of Medicine summarized the situation this way: "We know of no other medication routinely used for a nonfatal condition that kills patients so frequently."

How did we get here?

As is often the case, we believed a story that sounded too good to be true. Because the medical community is sworn to uphold life and minimize pain where possible, we are eager for ways to improve patients' quality of life. So, when news of a class of effective, safe, long-term pain medications broke in the 1990s, the medical world was ready to believe it.

The too-good-to-be-true story included these three lies: Opioids are more effective than over the counter pain relievers such as ibuprofen and acetaminophen. Opioids have no ceiling dose - in other words - you can take as much as you need - there is no maximum dose. Opioids have a less than 1 percent risk of addiction.

Sad experience and scientific research have proven otherwise.

Our state legislature has acted rapidly to enact measures within the medical/dental community to increase awareness of the problem, educate practitioners on reliable alternatives to opioid pain management, and in making an effort to reduce the number of opioid prescriptions written.

Dentists are a piece of this solution because as members of the medical profession we also believed the too-good-to-be true story and got into the habit of prescribing a few opioids after most surgical procedures. The post-surgical pain was managed with the opioid prescription, but here is the problem: Prescriptions get filled, and there are often left-over tablets that are not needed for the intended pain relief.

To illustrate the magnitude of the left-over pill problem we will consider wisdom teeth. In the U.S., about 10 million wisdom teeth are removed annually in approximately 3.5 million surgeries. On average, 20 tablets of opioid medication are prescribed per surgery for a total of 70 million tablets. Statistically, only eight of those tablets are used by the patient for post-operative pain control. That leaves 42 MILLION opioid tablets vulnerable to misuse and abuse.

And that is just the wisdom tooth piece of the puzzle!

The good news is, we as dentists and patients can be a lot smarter and safer. Quality research has determined that opioids are NOT more effective in controlling pain than over-the-counter pain medications. This information is penetrating the dental practice world rapidly and is reducing the number and size of opioid prescriptions written by dentists.

When I was exposed to this research almost two years ago, I immediately stopped writing opioid prescriptions. I now give over-the-counter medication prior to the surgical procedure and give very specific instructions for the use of over-the-counter pain medications for post-surgical pain control.

As many dentists do, I call my surgical patients to follow up on their progress. What I have learned from these follow-up conversations is that patients are doing just as well with the new protocol of over-the-counter pain medication.

I have written exactly one opioid prescription in the last two years. In the past, I may have written 100 opioid prescriptions in a two-year period.

The Maine State Legislature has enacted laws to limit access to opioid prescriptions. In the past, a dentist or physician could prescribe opioids by using a prescription pad and simply writing down the necessary information. Now, a dentist needs to look up every patient prescription history, if an opioid or benzodiazepine prescription is required.

The website providing the history is the Prescription Monitoring Program website. This website provides information about who else has prescribed for the patient, where and when the patient has filled prescriptions and how the prescriptions were paid for. Obviously, this information gives the prescriber a good idea of the patient's pattern of use and whether or not an additional prescription is warranted.

The other hurdle that prescribers must clear is the requirement that all opioid prescriptions must be transmitted electronically to the pharmacy. This is a costly and time-consuming process for dentists as there are annual or monthly fees for the software required to send these prescriptions electronically. As a result of these challenges, many general dentists are choosing not to prescribe opioids. In our office, in the rare event that an opioid prescription is needed, we coordinate with the patient's physician to prescribe the medication.

The new law has an insightful provision that all patients filling an opioid prescription should be aware of. For example, if a prescription is for 10 tablets, and the patient knows that they will probably only use five, they can request the pharmacist to fill the prescription only for the five tablets. If this is done, the balance of the prescription is void. If additional tablets are needed, the patient must contact the prescriber for a second prescription.

Efforts to curb opioid abuse in Maine appear to be meeting with some early successes. For example, the number of opioid prescriptions filled in Maine decreased 21.5 percent from 2013 to 2016. The national average reduction for the same period was 14.6 percent. While year-end statistics are not yet available, midyear statistics on overdose deaths in Maine indicate that the 40 percent increase in opioid-related deaths has been stopped.

There is something you can do to help, as well. Please do not come to your dental appointments and request opioid pain relief. You can expect that your dentist will be very reluctant to give you an opioid prescription if you do ask. Additionally, some general dentists will not be able to legally prescribe opioids for you because they have not met the electronic prescribing requirement.

What you should expect from your general dentist is quality pain management with over-the-counter medications taken according to specific protocols. You can also expect, or request, an analgesic prior to your procedure. In the rare event that an opioid is required, if your general dentist does not prescribe opioids, they can help you coordinate with your physician to obtain them. We each have an opportunity to be part of the solution, let's work together!

Polly Nichols, DDS., practices dentistry at Topsham Dental Arts along with her brother, Gregory Sprague, D.D.S., and her father, J. Howard Sprague, D.D.S. Topsham Dental Arts is located at 37 Foreside Road. For more information, call 798-6700 or visit topshamdentalarts.com.

Death by Fentanyl

An addiction specialist explains the role of synthetic opioids in the current epidemic.

The story can be found at:

<http://news.harvard.edu/gazette/story/2017/06/mass-general-hospital-addiction-specialist-explains-fentanyl-threat/>

READERS RESPOND

Dana Dyer, retired airline captain and former Board member

I have read with interest recent discussions regarding when or if it is appropriate to have a mandatory retirement age for a physician or surgeon. As a retired airline captain with experience flying international routes for a major airline and as a former public member of the Maine Board of Licensure in Medicine I have an opinion regarding factors to be considered. This decision is not a simple go or no-go decision.

As a point of reference, the skills of a pilot in command are under constant observation and subject to an annual proficiency check for flight competence including a comprehensive oral exam to demonstrate aircraft knowledge. In addition, every 6 months the medical certificate of a pilot in command must be renewed. Any given flight crew can and should be prepared for a no-notice *en route* flight check by an Air Carrier Inspector. Finally, the operation of your aircraft domestically is under constant observation by Air Traffic Control.

It is my opinion the following 4 factors should be included in evaluating physician or surgeon suitability for continued licensure:

1. Periodic evaluation for demonstrated physical ability.
2. Periodic evaluation for demonstrated knowledge and mental competency.
3. Consideration for the maximum duration of required or allowed duty periods and required rest or off duty periods.
4. Consideration for how much duty time is permitted on the back-side of the clock, i.e. a graveyard shift.

The regulations for pilot duty cycles are found in *Federal Air Regulations* 117. It is complex in application of duty cycles due to time zone changes. The simplest explanation is the underlying limits are based on the time of day or night and the length of a duty period.

The current "age 65 law" regarding mandatory pilot retirement was signed by President Bush on December 13, 2007. At that time the airlines were allowed to implement the law; however, officially it did not go into effect until July 15, 2009. A great deal of argument has taken place for and against the age 65 law.

The political and competitive aspects of a mandatory age based retirement system for pilots include but are not necessarily limited to the following issues:

1. During the Clinton administration commuter airlines became subject to the age 60 rule. This created a domino effect: older commuter pilots were forced to retire, there already was a shortage of pilots, and the major airlines were offering a more attractive work and pay environment. The commuter airlines needed help to relieve their pilot shortages and Senator Murkowski (R-AK) proposed raising the airline pilot retirement age to 65. This was approved by the United States Congress and became known as the age 65 law.
2. Due to economic factors including bankruptcy by airlines such as United Airlines, Inc., older pilots wanted to fly longer in order to recoup financial losses that reduced their projected retirement income.
3. A more complex economic and political factor was created by foreign airlines. The United States is a member of the International Civil Aviation Organization (ICAO). As a member state we recognize the aviation rules of carriers from foreign states. ICAO members began flying aircraft into the United States with cockpit crew members who could be 65 years old. This is perceived as a competitive disadvantage to United States carriers because the foreign carriers have a less restrictive work rule. Currently there is consideration to once again change the work rule, this time to increase the mandatory retirement age to 67.
4. Another socio-economic factor is related to the union seniority list. Cockpit flying responsibilities are controlled by seniority. Raising the retirement age from age 60 to age 65 introduced 5 years of promotion stagnation for junior pilots. This stagnation caused a loss of promotion opportunity for those junior pilots. This in turn reduced their income and decreased their investment in retirement benefits.

In 2000, former Federal Air Surgeon, Jon Jordan, wrote "...how to solve the problem of deterioration in performance with aging and its impact on aviation safety is an enigma. I only wish I knew the answer." An extensive report is available here: <http://transportation.gov/content/faa's-age-60-commercial-pilot-rule>

I have observed a deterioration in pilot performance and ability brought on with aging. Further I have observed that over time long-term duty cycles on the back-side of the clock have a noticeable negative impact on pilot performance.

I recommend the Board consider and evaluate the impact of aging and duty cycles on continuing licensure of older physicians and surgeons.

Stephen Parden, M.D.

Dear Sir:

I am 67 practicing as a locum tenens surgeon with 13 state licenses working about 200 days per year. I plan to practice to age 75 at least. I am board certified obtaining about 50 to 100 hours per year of class I CME and try to attend the ACS Clinical Congress every few years.

I think that you can get more work out of an old workhorse like me than two of the younger surgeons. So keeping us around is really good for patients and the other physicians. While I no longer have as much information on the tip of my tongue, I know how to get the information off of the internet quickly. I would put the breadth of my experience up against young surgeons. While young surgeons can be great surgeons with great clinical skills, sometimes it takes an old guy like me to figure out how to care for the complex patient in the simplest, safest manner. We older physicians are an asset. I must tell you that I have mastered most of the EMR's, and have templates that make it easy for me fill in information that I type myself.

I also fear losing this ability. I welcome some sort of testing; however, I am acutely aware that age discrimination exists and the prejudice towards we older individuals produces bias, especially in academics. My advice is to have testing based on what should be common knowledge that every surgeon (or physician specialty in particular) should know, that is normalized by testing every age group. In other words, if the younger age groups cannot pass it, then it should not be used against we older individuals. I think this capability should fall at least two standard deviations within the average. Testing straight knowledge is biased against we older individuals. Some hot shot academic may know the entire textbook, but his clinical capabilities, interpersonal skills, and

surgical skills may not be even adequate outside academia. I would have to think more deeply about the subject to come up with some really good suggestions.

Stephen Parden, M.D., FACS

Dirk van Leeuwen, M.D., Ph.D.

Dear Dennis,

Interesting topic that you addressed.

Interesting that in the USA compared to certain other countries “the freedom to practice at a higher age” is relatively open and I see here many more aging physicians than in some other countries. But slowly worldwide mandatory age-based retirement seems to disappear.

Yes, I remember my very distinguished and decorated physician professor/ friend who always asked me to warn him if I thought he should stop practicing. Frankly, he should not have practiced to age 80 but to 76 or so. But to tell him, probably some more objective distance is required, sometimes it can be too complex if it involves long time associates and friends. Letting it go usually requires less investment in time and emotional energy than starting a discussion here. So should places have a more independent counseling service for this?

For some it is the reward and inspiration derived from caring for patients that keeps them going and thriving mentally and physically. For others the financial incentives supplementing retirement benefits can be major. For again others trying to select “the currents in the cake” by during business hours doing financially rewarding procedures but not being able or willing to provide nightly attendance to the complications they created during business hours and or even to try to hide such event . . .? So the considerations include the ethics of business practice and for the hospitals the lack of being able to provide certain procedures and the associated loss of revenue (facility fees) that create complex dilemmas and conflicts of interest. I noted that “retired colleague” whose complications or referrals for complex cases regularly arrived, resulting in the patient undergoing one or more extra endoscopies. How do we deal with this?

Can we better define the high-risk physicians? You indicated age > 80, and ability to adjust to digital environment. A colleague in one city just had his contract not renewed (age 63) because getting his notes completed and signed appeared to have become too much . . .

A continuous list of overdue notes -- it can be aging, it can also be chaotic practice at a much younger age.

Defining a list of red flags? In a time when pressure is already increasing and burnout threatens many?

You may want to consider a special advisory board for this including some aging physicians . . .

I am 66, retired from “regular academic practice,” doing a locum in Maine right now; the income helps me to teach for the Human Resources for Health Program in Rwanda (3-4 months a year), while studying clinical ethics as well.

The work keeps me going, and I enjoy it, but for how long, ha ha . . .

Thanks for bringing up this point,

Happy holidays and good 2018,

Dirk

FROM THE EDITOR

Book Review

Victoria Sweet. *Slow Medicine: The Way to Healing*. N.Y.: Riverhead Books, 2017.

Dr. Sweet has written a subtle and insightful memoir about how she learned to be a doctor practicing both fast and slow medicine. Fast medicine is based on the machine model of the human body, and the doctor as mechanic. Slow medicine is based on the plant model, and the doctor as gardener who does this and that with the plant and with the garden to help the plant flourish. The book's many engaging stories of experiences with doctors, nurses, patients, and administrators in some ways parallel the psychologist Daniel Kahneman's theories in his book, *Thinking Fast and Slow*, about how humans make decisions in conditions of uncertainty.

Dr. Sweet was for more than 20 years a physician at San Francisco's Laguna Honda Hospital, the subject of her first book, *God's Hotel*. She is also a prizewinning historian with a Ph.D. in history and social medicine.

Zen reminders

In thinking, keep to the simple. In conflict, be fair and generous. In governing, don't try to control. In work, do what you enjoy. In family life, be completely present. *Tao Te Ching*

When hungry, eat your rice; when tired, close your eyes. Fools may laugh at me, but wise men will know what I mean. *Lin-Chi*

If you cannot find the truth right where you are, where do you expect to find it? *Dogen*

When you can do nothing, what can you do? *Zen koan*

Do not seek to follow in the footsteps of the wise. Seek what they sought. *Basho*

How refreshing, the whinny of a packhorse unloaded of everything. *Zen saying*

Editor-in-Chief David Nyberg, Ph.D. Graphic Design Ann Casady

Credits

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