Spring 2021 Newsletter

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In this issue:

FROM THE CHAIR

Letter from The Chair

Louisa Barnhart, MD, MPH, and Chair of BOLIM

One of the ways the Board protects the public is to take every complaint seriously. Many of these turn out to be communication issues. For example, a tired, overly busy, stressed doctor makes an offhand comment to the wrong patient, especially a previously traumatized, hyper-alert patient also stressed by attending the appointment who is offended or misinterprets the remark. These situations are common. Sometimes, if there is a sudden change in the visit tone, you can ask if there has been a miscommunication. Sometimes, staff may notice negative remarks after the visit. Try to clear these up right away. Those few minutes are much less trouble than a Board complaint.

Another common communication issue is too much communication through staff. When the issue requires multiple calls or there is disagreement about a telephone request despite staff discussion, either call the patient yourself or set up an acute visit.

The Board is working on a series of continuing medical education modules to address communication with patients.

A Board complaint can be very stressful, contribute to burnout, and be costly. So the best advice to prevent complaints is to communicate compassion. Pause a moment and collect yourself before you see a patient. Allow the first few moments of the interview to focus on interpersonal connection. This is a critical few minutes to get the interview going in the right direction. However, if communication is not going well, ask the patient to pause with you, and take a deep breath. Acknowledge that the conversation is not going well. Try reflective listening: "I heard you say this . . . is that what you meant"? Consider stating you need to agree to disagree. Also, if the patient has needs you feel you can't meet, consider ways you can help the patient seek to fill those needs.

Certain patients' goals are not congruent with the physician's goals. These discussions can become rather heated. First, take a deep breath and pause. Quietly state that agreement is not possible. Document carefully what the disagreement concerned and how you attempted to resolve it. Attaching a statement of staff observations can be helpful later. Sometimes having a staff member join you in the room can deescalate the patient and give you a moment to collect yourself and observe your countertransference (your reaction to the patient). This is especially valuable if the patient or their family is threatening you. Not all discussions can end amicably, but if the physician can stay calm it rarely becomes a Board complaint.

In today's time-constrained practice it may be difficult for some patients to be sufficiently organized to express their concerns in a time appropriate fashion. Giving patients several minutes of freedom to explain their concern without interruption is very valuable to the patient. Then helping them focus on the recent past by using your hands to signal an interruption or saying, "I really need to know about . . ." Patients who are tangential need to repeat this process over and over with frequent firm but caring redirection. Encouraging patients to bring a list of concerns helps the physician to know the extent of issues and helps the patient not to forget important issues. If a person consistently struggles to be efficient, a staff member might help the patient organize a problem list. Not all of the communication that happens in the office has to be directly with the physician.*

A Note on Licensing Complications

Physicians need to be aware of potential complications if the license renewal happens to fall during the complaint process. The license is pended instead of being renewed. Notice is sent out indicating the physician is still allowed to practice on this pended license. Part of the resolution of the complaint is to renew the license. At times other entities such as insurance companies, computer systems, and specialty boards will not accept this pended license. The physician may request having the license reviewed in light of the seriousness of the case. Many licenses can be renewed despite having an open complaint. File a formal request to renew the license due to hardship. The matter will then be presented at the next Board meeting. It's important to communicate concerns and difficulty to Board staff.

* For more on communication issues see below the Introduction to Adverse Actions, a Public Member's note on apology in Board News and the citation in From the Editor.

WHAT EVERYONE SHOULD KNOW

Scam Alert!

Dennis E. Smith, Esq., Executive Director of BOLIM

On March 4, 2021, I received a call from a physician working in Downeast Maine indicating that he was returning my call. The physician's practice had received a call from someone who identified himself as "Darren Smith from the Board of Medicine." I informed the physician that no one from the Board – including me - had attempted to contact him and that scammers have been attempting to obtain personnel information from licensees by pretending to be calling from the Board. Scammers who obtain personnel information such as date of birth, social security number, and home address can use that information to commit identity theft and cause significant financial problems for the victim.

If you receive a suspicious call, you should not share any personal information over the phone or by email. Licensees who think they may be a victim of a scam or attempted fraud should contact the Consumer Protection Division of the Office of the Attorney General toll-free at 800-436-2131 (TTY 711) or online at: https://www.maine.gov/ag/consumer/complaints/.

In addition, the Federal Bureau of Investigation (FBI) provides the following tips about how to avoid becoming a victim of a scam:

How to avoid being victimized by impostors posing as regulators

The FBI lists four best practices for licensees to avoid becoming a victim of an extortion scheme like this one:

- Use official websites and official phone numbers to independently verify the authenticity of communications from alleged law enforcement or medical board officials.
- Independently contact those boards or law enforcement agencies to confirm the identity of the person(s) contacting the provider.
- Do not provide personal identifying information (Social Security Number, date of birth, or financial information) in response to suspicious emails, phone calls, or letters and do not provide professional information (medical license number, NPI number, or DEA license number).
- Be wary of any request for money or other forms of payment regarding supposed criminal investigations by alleged law enforcement agencies or regulatory entities.

For more information visit this link to the FBI's website: https://professionallicensingreport.org/fbi-impostors-posing-as-regulators-threaten-medical-licensees-nationwide-with-license-suspension/.

Staggering Data on Opioid Prescribing

The NEJM Journal Watch: Hospital Medicine (January 15, 2021) has published an article on multisite studies from eight countries on "Postdischarge Opioids After Surgery: U.S. vs. the World." The study shows overwhelming prescribing differences between the U.S. and the other countries following appendectomy, cholecystectomy, or inguinal hernia repair. These findings include:

- Ninety-one percent of U.S. patients were prescribed opioids, compared with 5% of non-U.S. patients.
- The mean number of pills prescribed in the U.S. was 23, compared with 1 in other countries.
- Eighty-three percent of U.S. patients without pain were prescribed opioids, compared with 9% of non-U.S. patients without pain in other countries.

The author, Andrew S. Parsons, MD, MPH, suggests these staggering data should push an investigation of the opioid prescribing culture in U.S. medical practice.

The Continuing Opioid Crisis

The Office of Attorney General (OAG) and the Office of Chief Medical Examiner have released figures demonstrating that drug overdose deaths slightly decreased in the third quarter of 2020, though the total year-to-date deaths is on pace to significantly exceed those in 2019. Attorney General Aaron M. Frey says that the numbers are still too high and serve as evidence of the opioid epidemic's continued force as a public health crisis.

The report compiled by Dr. Marcella Sorg and Dr. Kiley Daley of the University of Maine's Margaret Chase Smith Policy Center, showed that 122 deaths were caused by drugs in the third quarter of 2020. This is a 7% decrease from the second quarter of 2020. The 380 deaths caused by drugs in the first three quarters of 2020 represent a 24% increase over the previous three-quarter period, April through December 2019, which had a total of 306. Eighty-three % of deaths were caused by at least one opioid, frequently nonpharmaceutical fentanyl, and 81% of deaths were caused by two or more drugs.

The report notes that these increases are comparable to increases being seen nationally, which are "likely due at least in part to the effects of the covid-19 pandemic and related mitigation measures: isolation, avoidance of or difficulty accessing medical services, and alterations in the illicit drug supply."

The report included the following overall patterns of note:

- Most (81%) drug deaths were caused by two or more drugs. The average cause of death involved 3 drugs.
- The vast majority of overdoses (83%) were caused by at least one opioid, including both pharmaceutical and illicit (nonpharmaceutical) opioid drugs.
- Fentanyl (and/or its analogs) caused 65% of deaths, usually in combination with other drugs, down slightly in proportion from 68% in 2019.

- Heroin/morphine caused 12% of deaths, usually in combination with other drugs, down slightly in proportion from 16% in 2019.
- Cocaine or crack caused 25% of deaths, usually in combination with other drugs, down slightly in proportion from 29% in 2019. However, the 3rd quarter total of cocaine deaths, 19 (20%) represents an approximately 50% drop from the 1st and 2nd quarter totals of 38 (40%) and 37 (39%) respectively.
- Methamphetamine caused 16% of deaths, usually in combination with other drugs, up slightly in proportion from 12% in 2019.
- Pharmaceutical opioid deaths caused 26% of deaths, almost all in combination with other drugs, similar to the proportion as in 2019 (25%).
- Mitragynine (Kratom) appeared as a cause of death in 14 cases, 4% of deaths. This represents an increase over 2019 when there were 10 (3%).

The full report from Dr. Sorg and Dr. Daley is reproduced below and can be found at: https://www.maine.gov/ag/news/article.shtml?id=3933388.

Maine Drug Death Report

Prescribing for Colleagues, Friends, and Family: A Professional Quagmire Introduction

Dennis E. Smith, Esq., Executive Director of BOLIM

The December 2016 issue of the Board's newsletter (https://www.maine.gov/md/sites/maine.gov.md/files/inline-files/December-2016.pdf) and the Summer 2019 issue of the Board's newsletter (https://www.maine.gov/md/sites/maine.gov.md/files/inline-files/2019summer_0.pdf) included articles regarding the ethical implications of prescribing for self or family. (The 2019 article is reprinted below.) The American Medical Association's *Code of Medical Ethics* discourages physicians from treating themselves or family due to concerns about professional objectivity, patient autonomy, informed consent, and treating issues beyond their experience and training. **The same issues may arise when prescribing for colleagues.**

Recently, the Board reviewed a complaint that involved a physician who prescribed antibiotics and hydroxychloroquine to a physician colleague. The physician was reported to the Board by a pharmacist technician who was concerned that the physician's conduct was unethical – and would unnecessarily impact the availability of hydroxychloroquine for immune-compromised patients.

Licensees are reminded that prescribing for friends or colleagues may be unethical and may lead to disciplinary action.

The following article is reprinted from a previous issue.

Prescribing for or Treating Self or Family: A Professional Quagmire (Updated April 22, 2019)

Dennis E. Smith, Esq., Executive Director of BOLIM

It is not illegal for physicians or physician assistants to prescribe drugs for themselves or their family members. Federal and Maine law do not specifically prohibit this practice, even for controlled drugs. However, while not illegal, prescribing drugs for oneself or one's family members may be unethical, unprofessional, or incompetent, and grounds for discipline by the Board.

Ethical Issues

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. Principle 1.2.1 of *The Code of Ethics of the American Medical Association* generally discourages physicians from treating themselves or family members for the following reasons:

- Professional objectivity may be compromised.
- Personal feelings may unduly influence a physician's professional medical judgment.
- Physicians may fail to probe sensitive areas when taking medical histories or fail to perform intimate parts of physical examinations.
- Patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination, particularly when the patient is a minor child who may not feel free to refuse treatment.
- Physicians may be inclined to try and treat problems beyond their medical expertise and training.
- Patients may feel uncomfortable receiving care from a family member.

- Physicians may feel obligated to provide care to family even if they feel uncomfortable doing so.

Principle 1.2.1 identifies two "limited circumstances" where self-treatment or treatment of family members may be appropriate: (1) in emergency settings or an isolated setting where there is no other qualified physician available; and (2) for “short-term, minor problems.” Principle 1.2.1 imposes the following responsibilities on physicians who do treat family members:

- Document treatment or care provided and convey relevant information to the patient’s primary care physician.
- Recognize that if tensions develop in the professional relationship (e.g., a negative medical outcome), they may be carried over into the family member’s personal relationship with the physician.
- Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.
- Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

Professionalism and Competency Issues

Beyond the ethical issues, physicians or physician assistants who prescribe for, or treat themselves or family members risk engaging in unprofessional or incompetent behavior. Examples include:

- Failing to obtain informed consent.
- Failing to perform an appropriate medical history and examination.
- Failing to create and maintain appropriate medical records.
- Failing to refer for specialty consultation.
- Failing to provide for follow-up care.
- Practicing beyond medical training and/or specialty.
- Violating the Board’s Sexual Misconduct Rule (prohibiting romantic/sexual relationships between physicians/physician assistants and patients).
- Prescribing potentially addicting controlled drugs.

Unprofessional and/or incompetent behavior constitute grounds for disciplining a physician’s or physician assistant’s license. Discipline could include public censure, civil monetary penalties, probation, limitation or restrictions on ability to practice, license suspension, or license revocation. Any disciplinary action is reportable to the National Practitioner Data Bank and the Federation of State Medical Boards, and can have significant collateral consequences and result in reciprocal disciplinary action by other jurisdictions.

Conclusion

Practicing medicine or rendering medical services in Maine is a privilege, not a right. The Board confers that privilege when it issues a license. That privilege may be lost or restricted if physicians or physician assistants self-prescribe/self-treat or prescribe for or treat family members. While it may seem convenient to provide medical care to oneself and/or family members, physicians and physician assistants who do so risk engaging in unethical and unprofessional behavior that may have a detrimental impact upon their licenses.

Rural Medical Access Program

The Rural Medical Access Program (RMAP) helps to ensure that doctors who deliver babies are available in rural and underserved communities. Rural Health and Primary Care works with the State Bureau of Insurance to coordinate and oversee application, eligibility, and administration of the RMAP. The funds for the program come from assessments that every physician pays. A surcharge on their premiums is collected by their insurer and transferred to the State Bureau of Insurance, which provides a rebate for physicians providing OB/GYN and pre-natal care in underserved areas. Funds are awarded to those physicians who meet eligibility requirements and total at least $5,000 per physician.

To be eligible, physicians must have:

1. Performed Deliveries and/or provided prenatal care in Maine between the dates of July 1 and December 31, 2020.
2. Carried malpractice insurance for prenatal care and/or obstetrical services; and
3. Maintained a caseload of MaineCare patients (10% at minimum) and practiced at least 50% of the time in a Primary Care Health Professional Shortage Area or Medically Underserved Area or Population (https://data.hrsa.gov/tools/shortage-area/hpsa-find) or maintained a caseload of MaineCare patients (50% visits minimum) and practiced in a Primary Care Analysis Area having a population of under 20,000 people.

You can access the application and the application cover letter for the 2021 RMAP at the Maine Rural Health and Primary Care Program website. **Complete applications are due back to the Maine Rural Health and Primary Care Program by 5/3/2021.**

Please feel free to contact Erica Dyer, erica.dyer@maine.gov, if you have any questions or concerns.

ADVERSE ACTIONS

Adverse Actions

In 2020 the Board reviewed 303 complaints and investigative reports – an average of 25 per meeting. While the number of complaints received by the Board remains consistently large, the number of complaints that result in adverse action is quite small. In most cases, the conduct resulting in adverse action is egregious or repeated or both.

The majority of complaints received by the Board continue to center around patient dissatisfaction with the communication of the physician/physician assistant. Patients who feel that they were not listened to, ignored, or disrespected (talked down to) are more likely to file a complaint with the Board than patients who may believe their treatment was not optimal but have a good relationship with their physician/physician assistant. The Board developed guidelines entitled “Communication with Patients” (recently published in the *Journal of Medical Regulation* and reproduced in this issue of BOLIM), which licensees are encouraged to review: https://www.maine.gov/md/sites/maine.gov.md/files/inline-files/COMM_WITH_PTS.pdf.

The Board’s complaint process is relatively straight-forward. FAQs about the complaint process are available on the Board’s website: https://www.maine.gov/md/complaint/discipline-faq. Brochures regarding the complaint process are also available on the Board’s website: https://www.maine.gov/md/resources/forms. Upon receipt of a complaint, it is forwarded to the licensee for a written response and a copy of the medical records. In general, the licensee’s response is shared with the complainant, who may submit a reply. The Board reviews the complaint file once completed, and may take any of the following actions:

- Dismiss
- Dismiss and issue a letter of guidance
- Further investigate
- Invite the licensee to an informal conference
- Schedule an adjudicatory hearing

The following adverse actions are being reported for the purpose of educating licensees regarding ethical and/or legal issues that can lead to discipline, and to inform licensees of any limitations or restrictions imposed upon scope of practice.

Calvin P. Fuhrmann, M.D. License #MD14675 (Date of Action 02/17/2021)
On February 17, 2021, Dr. Fuhrmann entered into a Second Amendment to the September 10, 2019 Consent Agreement with the Board, as amended by the First Amendment dated October 16, 2020, deleting paragraph 12(d) and inserting new paragraphs 12(f) and 12(g) which limits Dr. Fuhrmann's license to practice medicine to providing addiction treatment to patients as a Medication-Assisted Treatment provider, requires his identified supervisor to submit written reports to the Board, and requires Dr. Fuhrmann to complete forty (40) hours of continuing medical education regarding buprenorphine product prescribing and/or treatment of substance use disorders within 3 months. The Second Amendment to Consent Agreement terminated the suspension of Dr. Fuhrmann's license to practice medicine for non-compliance with paragraph 12(c) of the Consent Agreement, as amended. All other terms of the Consent Agreement, as amended, remain in effect.

Richard F. Klonoski, M.D. License #MD16052 (Date of Action 02/09/2021)
On February 9, 2021, the Board accepted Dr. Klonoski's request to allow his Maine physician license to expire while under investigation for allegations of unprofessional conduct.

Malathy Sundaram, M.D. License #MD16273 (Date of Action 1/27/21)
Dr. Sundaram failed to renew her Maine medical license while under investigation for allegations of fraud, deceit or misrepresentation in connection with services rendered under her medical license, unprofessional conduct, incompetency, failure to timely respond to a complaint, and failure to produce upon request documents in her control concerning a pending complaint or proceeding or any matter under investigation by the Board of Licensure in Medicine. As a result of Dr. Sundaram allowing her license to expire while under investigation, the Board reported her non-renewal of licensure while under investigation to the National Practitioner Data Bank and the Federation of State Medical Boards and notified Dr. Sundaram regarding these reports.

Morris S. Minton Jr., M.D. License #MDE21968 (Date of Action 12/22/2020)
The Board accepted Dr. Minton's request to permanently convert his Maine medical license to emeritus status, a non-clinical license, while under investigation for allegations of unprofessional conduct.

Scott T. Roethle, M.D. License #MD22779 (Date of Action 12/11/2020)
On December 11, 2020, Dr. Roethle entered into a consent agreement for failing to conform to minimal standard of acceptable and prevailing practice when he prescribed medication to a patient via telehealth without establishing an appropriate physician-patient

relationship. The consent agreement imposed a warning, $1,000 civil penalty, probation for at least six (6) months, and limits Dr. Roethle's practice for Maine patients to his specialty of anesthesiology.

Sarah P. Greven-Chaousis PA License #PA1109 (Date of Action 12/11/2020)
On December 11, 2020, Ms. Greven-Chaousis entered into a consent agreement for licensure with the Board of Licensure in Medicine for issues related to substance misuse. The consent agreement imposed a period of probation for at least one (1) year with conditions, including enrollment and compliance with the Medical Professionals Health Program, participation in an IOP program, obtaining a psychopharmacology evaluation, and continuing psychotherapy.

LICENSING ISSUES

COVID-19 Emergency Licenses

On March 20, 2020, the Governor issued Executive Order 16 (EO-16), creating "an emergency Maine license" free of cost or fee "to assist in the health care response to COVID-19." Following the issuance of EO-16 the Board created an application form for a "COVID-19 Emergency License," which authorizes physicians and physician assistants who are licensed in good standing in another state and who have no disciplinary or adverse action in the past ten years involving loss of license, probation, restriction or limitation, and who seek immediate licensure to assist in the health care response to COVID-19, to be issued an emergency Maine license that shall remain valid during the state of emergency.

Since that time, the Board staff have received, processed, and issued over 850 COVID-19 Emergency Licenses to physicians and physician assistants. This increased the Board's pool of licensees by over 13% with vast majority of these licensees indicating that they would provide support through telemedicine.

As the pandemic appears to be turning a corner with lower daily rates of persons testing positive for COVID-19 and more vaccines being administered, the Board would like to take this opportunity to thank these clinicians for their willingness to serve Maine patients during this difficult time.

In addition, the Board would like to remind these clinicians their COVID-19 Emergency Licenses will expire at the end of the declared emergency in Maine. The Board urges these clinicians to start planning for the continuity of care of their Maine patients following the end of the declared emergency. This can be accomplished either by referring Maine patients to other clinicians or by applying for and obtaining a permanent Maine medical license. The Board takes patient safety seriously and failure to ensure that Maine patients are provided with the appropriate continuity of care can result in complaints of abandonment.

Information regarding how to apply for a permanent Maine medical license is available on the Board's website: https://www.maine.gov/md/licensure. Obtaining a Maine license takes time, an average of 49 days from receipt of the application. If a clinician with a COVID-19 Emergency License chooses to apply for a Maine license, they should not wait until the end of the declared emergency and submit the application now.

Board staff is ready, willing, and able to assist any applicant for licensure!

COVID-19 Vaccine Information for Retired Licensees

The Board has received questions from retired licensees regarding their ability to administer the vaccines needed to control the COVID-19 pandemic. The Board appreciates the efforts of retired licensees to volunteer their services. There are a number of state and federal laws that may permit retired licensees to administer vaccinations. The following information is intended for retired licensees who may want to administer the COVID-19 vaccine, but should not be considered as legal advice:

1. Maine Governor Janet Mills issued an Executive Order (EO-16) that permits the Board to issue a COVID-19 Emergency License to qualified retired licensees. EO-16, which can be found at https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/EO-16.pdf, states:

   > All physicians, physician assistants, and nurses who have retired in good standing in this State within two years of the date of this Order and who have no disciplinary or adverse action in the past ten years involving loss of license, probation, restriction, or limitation with no outstanding complaints or open investigations shall have their licenses immediately reactivated upon request and such license shall remain valid during the state of emergency. License application fees for licenses issued pursuant to this paragraph are waived.

   If a retired licensee meets the requirements of EO-16, they can be issued a COVID-19 Emergency License, which enables them to not only administer vaccines but to practice medicine.

2. If the retired licensee does not qualify for a COVID-19 Emergency License, they may administer vaccines if delegated that authority by a licensed physician. The Board's statute, which can be found at http://legislature.maine.gov/statutes/32/title32sec3270-A.html, allows licensed physicians to delegate to staff and employees the ability to perform vaccinations – so that a physician licensed in Maine could delegate to a retired licensee the ability to perform vaccinations. Physicians delegating the authority to administer vaccines to retired licensees are legally responsible for any acts delegated and for appropriate supervision and control.

3. The federal government has issued a 5th amendment to the Federal Prep Act, which can be found at https://www.phe.gov/Preparedness/legal/prepact/Pages/COVID-Amendment5.aspx, and which states:

> (f) Any healthcare professional or other individual who holds an active license or certification permitting the person to prescribe, dispense, or administer vaccines under the law of any State as of the effective date of this amendment, or as authorized under section V(d) of this Declaration, who prescribes, dispenses, or administers COVID-19 vaccines that are Covered Countermeasures under section VI of this Declaration in any jurisdiction where the PREP Act applies, other than the State in which the license or certification is held, in association with a COVID-19 vaccination effort by a federal, State, local, Tribal, or territorial authority or by an institution in the State in which the COVID-19 vaccine covered countermeasure is administered, so long as the license or certification of the healthcare professional has not been suspended or restricted by any licensing authority, surrendered while under suspension, discipline or investigation by a licensing authority or surrendered following an arrest, and the individual is not on the List of Excluded Individuals/Entities maintained by the Office of the Inspector General, subject to:
>
> > (i) documentation of completion of the Centers for Disease Control and Prevention COVID-19 (CDC) Vaccine Training Modules1 and, for healthcare providers who are not currently practicing, documentation of an observation period by a currently practicing healthcare professional adequately experienced in vaccination who confirms competency of the healthcare provider in preparation and administration of the particular COVID-19 vaccine(s) to be administered; and
>
> (g) Any physician, advanced practice registered nurse, registered nurse, or practical nurse who has held an active license or certification to prescribe, dispense, or administer vaccines under the law of any State within the last five years, which is inactive, expired or lapsed, who prescribes, dispenses, or administers COVID-19 vaccines that are Covered Countermeasures under section VI of this Declaration in any jurisdiction where the PREP Act applies in association with a COVID-19 vaccination effort by a federal, State, local, tribal or territorial authority or by an institution in which the COVID-19 vaccine covered countermeasure is administered, so long as the license or certification was active and in good standing prior to the date it went inactive, expired or lapsed and was not revoked by the licensing authority, surrendered while under suspension, discipline, or investigation by a licensing authority or surrendered following an arrest, and the individual is not on the List of Excluded Individuals/Entities maintained by the Office of the Inspector General, subject to (i) documentation of completion of the Centers for Disease Control and Prevention COVID-19 Vaccine Training Modules and (ii) documentation of an observation period by a currently practicing healthcare professional adequately experienced in vaccination who confirms competency of the healthcare provider in preparation and administration of the particular COVID-19 vaccine(s) to be administered.

In addition, to the foregoing laws, the Governor's Office and Maine Legislature are currently working on enacting an emergency State law regarding the permitted delegation of the administration of COVID-19 vaccinations.

Governor Mills' Office has a website specifically regarding COVID-19 Response, https://www.maine.gov/covid19/maine-helps, which identifies various ways in retired licensees can support the response to the COVID-19 pandemic, including registering with "Maine Responds": https://maineresponds.org/.

Amended Executive Order Ends Automatic License Extensions

On February 24, 2021 Governor Mills issued an amendment to Executive Order 16 (EO-16). The amendment repeals a section of the original EO-16 that required Board staff to automatically extend physician and physician assistant licenses that were scheduled to expire during the declared state of civil emergency until 30 days after the expiration of the declared emergency. All licensees affected by the original EO-16 who have not renewed their licenses must do so on or before March 31, 2021 or their licenses will expire.

Since March 2020, approximately 450 licensees have not submitted renewal applications when their licenses were due to expire. As directed by EO-16, Board staff automatically extended those licenses. However, they will now expire on March 31, 2021, unless a renewal application is submitted on or before that date. Renewal applications can be submitted using our online licensing system at https://licensing.web.maine.gov/cgi-bin/online/licensing/begin.pl?board_number=376.

All licensees affected by this change have been individually contacted by Board staff and informed they need to renew their license by March 31, 2021, or they will no longer be able to practice medicine or render medical services. These licensees are still responsible for meeting their CME requirements and paying the appropriate fees. In addition, despite the extended renewal date, moving forward these licenses will revert to their normal renewal date associated with licensees' month and year of birth.

The overwhelming majority of the Board's licensees did not take advantage of EO-16 and continued to submit timely renewals. The Board is grateful to these licensees because the renewal fees are necessary to help fund the Board's operations. Licensees who renewed their licenses on or before their regularly scheduled expiration do not need to do anything until they receive a renewal notice from the Board staff.

FROM THE EDITOR

Guidelines Publication Notice

The *Journal of Medical Regulation* has published "Communicating with Patients: Guidelines from the Maine Board of Licensure in Medicine." The article is available online at: https://meridian.allenpress.com/jmr/issue/106/4

BOARD NEWS

2020 Annual Reports

Each year Board staff prepares reports of activities that have happened during the past year. The attached Annual Report (PDF) includes 2 sections:

- Licensing
- Complaints and Investigations

Is it O.K. to say "I'm sorry"?

Miriam S. Wetzel, Ph.D., Public Member of BOLIM

From an early age we are taught to apologize, especially if we are responsible for actions that result in an undesirable outcome. As we get older, moral and ethical sensibilities prompt us to do so. But for many physicians and other health care providers, there is underlying concern that an expression of regret or an apology will be seen as an admission of guilt and can trigger a formal complaint to a hospital personnel department or the Board of Licensure in Medicine, or end up in an expensive malpractice case.

On the other hand, there is recognition that a sincere apology or expression of concern can let the patient know that the health care provider truly cares about the impact of the incident on the patient[1] and wants to provide only the best care. This can go a long way toward building a sense of trust that can enhance the therapeutic value of the patient-physician relationship, even if it does not reduce complaints.

Apology Laws

Currently, 39 states, including Maine, have passed laws that allow doctors to apologize to patients, when a mistake occurs, without an expression of sympathy or apology being used against them in court.[2] In Maine, 24 M.R.S.§2907 states:

> "In any civil action for professional negligence or in any arbitration proceeding related to such civil action, any statement, affirmation, gesture or conduct expressing apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence that is made by a health care practitioner or health care provider or an employee of a health care practitioner or health care provider to the alleged victim, a relative of the alleged victim or a representative of the alleged victim and that relates to the discomfort, pain, suffering, injury or death of the alleged victim as the result of the unanticipated outcome is inadmissible as evidence of an admission of liability or as evidence of an admission against interest. Nothing in this section prohibits the admissibility of a statement of fault.

Lawmakers, medical professionals and laypeople who supported the development of these laws intended that they would reduce malpractice lawsuits and encourage more open communication about errors between health care providers and patients. In addition, such laws could permit doctors to show their humanity freely, and restore dignity to the relationship with injured patients.[3] Certainly, they could help to raise awareness of how important a simple expression of regret can be when treatment results in an unintended consequence.

Medical Apology Momentum

From 2005 until 2015 or 2016, there was an awareness of the need to take a close look at litigation involving medical care, which resulted in an active presence of commentary and opinion on the Internet. In 2005, Doug Wojcieszak, a health care consultant, founded *SorryWorks.net*,[4] and added the concept of "full disclosure" to the interaction of patients and medical caregivers who were engaged in malpractice suits. For the medical caregiver, this meant immediately informing the patient and his or her family of what went wrong, expressing concern, and laying out the next steps in the patient's care. For the patient it meant a clearer understanding of the problem and a speedier resolution of a claim. Whatever we may think of the validity and usefulness of this for-profit service, it is still available on the Internet and apparently thriving.

In 2006, Hilary Rodham Clinton and Barack Obama, who were senators at the time, supported the National Medical Error Disclosure and Compensation (MEDIC) bill, citing evidence from the University of Michigan that showed dramatic reduction in annual litigation costs, average time to resolution of claims and fewer claims and lawsuits. While all of these benefits may not have been realized as hoped for, this was important enough to the medical community to be reported in the *New England Journal of Medicine*.[5] They remain important issues today.

Caps on Damages

To mitigate escalating damages awarded in some jurisdictions, over 25 states have enacted laws that place a cap on monetary awards in medical liability actions. These caps vary widely in amount from $250,000 in California to $1.75 million in Nebraska, of which qualified health care providers are only liable for $500,000. In Maine, there is a cap of $400,000 on noneconomic damages in wrongful death actions, set in 1999.[6]

Laws protecting physicians and other health care providers from punitive legal consequences have the potential for positive results for both patients and practitioners. They can encourage open communication; promote timely reporting and investigation of errors. and ensure that the same criteria are applied in all cases.[7] Less financial and legal pressure may allow the physician to think more candidly and objectively about what happened, and to seek help if needed to improve skills or to ameliorate the anxiety the experience can generate. The ultimate aim is to avoid the same mistake in the future.

Laws Are Not Always Enough

Not everybody sees value in the laws that have evolved to allow a health care provider to say, "I'm sorry" without fear of having this statement used in court as admission of guilt. Writing in the *Canadian Medical Journal*, authors McLennan, Rich, and Truog recognize the trend toward openness in apologizing for adverse medical events, but they are skeptical of the idea that laws will lead to improvement in patients' experiences.[8] Nevertheless, since the passage of the Northwest Territories' Apology Act in 2013, most Canadian provinces and territories, except Québec and Yukon, have adopted "apology legislation."[9]

Essential Elements of a Genuine Apology

Sometimes an apology will fall short of expectations. It may not be comprehensive enough to satisfy the complainant or may seem contrived to make the medical provider appear less blameworthy. To be effective, it must sound sincere and authentic to the aggrieved person. "I'm sorry you feel that way" can be termed a "pseudo apology" because it focuses the blame on the patient. Better wording might be, "I'm sorry this has happened." There are many forms of "scapegoat" apologies, which put the blame on staff or on the patient's failure to make their wishes known in a timely or unambiguous manner, or on circumstances of scheduling or work overload. The most believable and satisfying apologies include a statement of what the person has learned and how he or she plans to avoid the mistake in the future.

Aaron Lazare, MD, Chancellor of the University of Massachusetts and retired professor of the Psychiatry Department, has written extensively on the subject of apology.[10] David Nyberg, Ph.D., offers these essential elements of a genuine apology based on Lazare's writings:

1. frank acknowledgement of the offense;
2. clear explanation of what happened and why it happened;
3. sincere expression of various attitudes such as remorse, shame, humility;
4. realistic offer of adequate reparations.

A Communication Issue

It is clear that communication issues play an important role in any discussion of apologies. Attention to clear communication with patients could often avoid the need for an apology. As pointed out by Dr. David Nyberg in a recent issue of the *Journal of Medical Regulation*, the majority of Board complaints about clinicians are related to issues of communication, rather than clinical competence.[11]

So, is it O.K. to say, "I'm sorry"?

If you are a health care provider who practices in Maine, or in any of the other 39 states, Washington, DC, or in Canadian provinces and territories that have passed apology laws, there is legal protection from having an expression of benevolence, such as "I'm sorry" used against you in court. Beyond that, it is a matter of heart and conscience. What is the right thing to do? It may be reassuring to know that in considering complaints, the Maine Board of Licensure takes note of, and values a sincere apology.

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