ALERT: Stay up to date on Maine's COVID-19 Response

Winter 2020

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FROM THE CHAIR

Precluding Complaints About Impersonal Communication

Louisa Barnhart, MD, MPH, Chair of BOLIM
Susan Dench, Public Board Member

Impersonal or ineffective communication is at the root of many complaints brought to the Board. In the midst of the COVID pandemic and attendant additional workloads, the need for communication skills becomes magnified and more important than ever.

As the groundwork for patient communication starts before you enter the room, take time to gather yourself before going in. Many complaints arise from sensitive patients, especially those with anxiety or a trauma background, who will immediately pick up on things, given their hyper-alert state. If these patients perceive any lingering negative feelings, they may well assume the feelings are aimed towards them.

Making a specific effort to lay aside personal or office issues before you enter the room can go a long way toward getting a visit off on a good footing. These first few moments of your undivided attention set the tone for a positive and productive rapport. A meditation practice called mindfulness can be useful in settling and gathering the mind for clear and positive focus.

The integration of technology with the patient visit presents another risk for a communication disconnect. Physicians are all too familiar with the tension of being pulled between taking personal time with the patient, and getting information into the electronic medical record. Best practice during this part of the visit is to connect with the patient before starting to record the session, and then let them know what you are doing when you start. The old maxim: “tell them what you’re going to tell them, tell them, and then tell them what you told them” works well.

Another best practice is being able to actually face the patient while using the computer, enabling toggling between the patient and computer. If this is an issue, administrators and IT departments should step in to ensure the technology is configured for maximum personal-patient contact. A patient can easily feel neglected and insignificant compared to the computer – in fact, the Board often hears from patients feeling abandoned by a physician they perceive to be paying more attention to the computer than to them as a patient. A physician typing on the computer with their back to the patient might not have a good resolution of medical issues, not to mention communication issues.

It’s also very helpful if staff can do medicine reconciliation and any other such tasks to reduce as much computer work as possible during the visit. Patients can be offended if some attempt to review their chart before the visit isn’t evident.

While patient communication can be a major challenge for clinicians, adhering to these best practices can increase patient satisfaction and lessen the likelihood of a complaint being filed with the Board.

WHAT EVERYONE SHOULD KNOW

OPTIONS Initiative

Mills Administration Announces “OPTIONS” Initiative to Support Maine People With Substance Use Disorder

Augusta, MAINE — To combat the disturbing rise in fatal drug overdoses exacerbated by the COVID-19 pandemic, Governor Janet Mills announced a new “OPTIONS” (Overdose Prevention Through Intensive Outreach, Naloxone and Safety) initiative. Under the initiative, mobile response teams in every Maine county will engage with communities that have high rates of drug overdoses to promote drug prevention and harm reduction strategies, connect people directly to recovery services and treatment, and distribute naloxone, the lifesaving overdose treatment.

“My Administration has taken aggressive steps to confront the opioid epidemic that has stolen the lives of thousands of people of all ages, of all backgrounds across all regions in our state. The COVID-19 pandemic has laid bare challenges in reaching people struggling with substance use disorder. We must do more to save lives and to prevent the use of dangerous substances,” **said Governor Mills**. “I want any person in Maine struggling to overcome addiction, their families, their employers, and their communities to know that help is here for them. Today, we take one more step in ensuring that every community has resources to prevent substance use disorder and fatal overdoses and create a path toward recovery.”

The OPTIONS teams will focus on populations at high risk of overdose, such as those experiencing homelessness, those who have left treatment programs, and those recently released from incarceration. Special efforts will also be made to serve survivors of prior drug overdoses, as leading addiction research indicates that assertive outreach and post-overdose engagement leads to sustained connections to recovery and reduced risk of subsequent overdoses.

> “Maine people who are struggling with substance use disorder need appropriate treatment, life-saving resources and support,” **said Dr. Jessica Pollard, Director of the DHHS Office of Behavioral Health.** “This initiative will connect them with familiar faces in their communities who know how to help in a moment of crisis and all along the path toward recovery.”

This latest effort in the Mills Administration’s response to the opioid epidemic comes as fatal drug overdoses are rising nationally. While fatal overdoses in Maine began to rise prior to COVID-19, they have been exacerbated by the pandemic, which is making it more challenging to connect people with treatment and recovery resources.

A report released today by the Maine Office of the Attorney General determined that 132 Maine people have died from drug overdoses in the second quarter of 2020, representing a 4 percent increase over the first quarter of 2020. In total, 258 Maine people have died from drug overdoses through the first six months of 2020, representing a 27 percent increase over the last two quarters of 2019. Eight percent of the fatal overdoses in 2020 were homeless individuals. In addition to the pandemic, fatal drug overdoses in Maine are also closely linked to the emergence of dangerous and lethal opioids like the synthetic painkiller fentanyl. The Attorney General's report on overdoses indicated nearly two-thirds of overdose deaths this year are attributable to the presence of fentanyl or a fentanyl analog.

"The COVID-19 pandemic is a destabilizing and deadly time for persons in recovery across the entire country," **said Gordon Smith, Maine's Director of Opioid Response.** "We know that we cannot pave the way to recovery if we can't keep people alive. The OPTIONS initiative will provide on the ground, lifesaving support in communities across Maine to ensure that people have a chance to seek the help they need to recover from substance use disorder."

The OPTIONS initiative will also include a broad public information campaign aimed at warning about the dangers of fentanyl, encouraging treatment and recovery, reducing the stigma of substance use disorder, and emphasizing the importance of calling 911 immediately during a suspected overdose. This campaign will increase awareness of Maine's "Good Samaritan Law," signed into law by Governor Mills in May 2019, which protects someone experiencing an overdose, or who reports a suspected overdose in good faith, from prosecution for certain drug-related offenses.

The OPTIONS initiative is supported by $2.5 million in existing federal funds, including $500,000 in Coronavirus Relief Funds, through the Maine Department of Health and Human Services' Office of Behavioral Health, and will operate with assistance from the Maine Center for Disease Control and Prevention and the Maine Department of Public Safety.

To implement county-level outreach efforts under the OPTIONS initiative, the State is contracting with regional behavioral health providers and recovery centers. These organizations will mobilize response teams in collaboration with local law enforcement, emergency responders, recovery coaches and harm reduction professionals. Services are expected to begin in November.

The OPTIONS initiative builds on a number of measures implemented by the Mills Administration to address Maine's long-standing opioid epidemic, including: increasing access to treatment, opening new recovery centers and residences, training more than 300 new recovery coaches, and providing career training and employment opportunities for individuals adversely affected by the opioid epidemic.

In response to the COVID-19 pandemic, the Administration authorized recovery service providers to utilize telehealth services, increased flexibility for take-home doses of the opioid treatment methadone, and provided flexibility to needle exchange programs.

Free, confidential peer recovery support is available seven days a week, and help is only a phone call or click away. If you, a friend or a family member needs help, resources are also available by calling 211. For more urgent needs, call the state crisis line at 1-888-568-1112.

Free CE from VHA

VHA EES Provides Free, Accredited Educational Offerings to Community Providers

The Veterans Health Administration Employee Education System (VHA EES) has historically provided education and training to VA employees only. However, since the establishment of VHA TRAIN, EES has worked with various VA offices to make Veteran-focused health care training available to public health care providers in order to ensure our Nation's Veterans are receiving the same level of care whether they visit a VA facility or a seek care from a public provider. This goal was further amplified by the MISSION Act of 2018. EES is proud to be able offer timely, reliable and essential educational offerings to community providers in a variety of easily accessible and cutting-edge formats, many of which offer continuing education (CE) credits.

Clinicians interested in earning no-cost CE can click here for a catalog of courses available via the VHA TRAIN platform, and here to sign up by health care topic for email announcements when courses are added to VHA TRAIN.

In addition, VA has also established a COVID-19 training site for community providers. Click here to access COVID-19 training programs/resources offered from a variety of organizations and vetted through the VA.

Communication of Sympathy or Benevolence

Recently, the Board of Licensure in Medicine reviewed a complaint filed against a licensee by the relative of a patient who alleged that the licensee performed a procedure that caused unnecessary pain and suffering. While the licensee responded to the complaint, they did not express sympathy or empathy for the patient or the patient's relative. Responses to complaints are, in general, shared with the persons who file the complaints. Overly legalistic and defensive responses that do not contain expressions of sympathy or convey

empathy come across as both sterile and uncaring – something that is incongruent with the practice of medicine. In contrast, responses that do include expressions of sympathy convey the sense that the licensees care about the impact of the incident on the patient or the patient's relative – regardless of whether or not they are at fault.

The law in Maine specifically permits health care providers to express sympathy and benevolence to patients and their relatives or representatives without having such expressions used in evidence of an admission of liability in any civil action for professional negligence (i.e. a medical malpractice suit). 24 M.R.S. § 2907 provides:

> **§2907. Communications of sympathy or benevolence**
> **1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.
> A. "Relative" means an alleged victim's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half brother, half sister or spouse's parents. "Relative" includes these relationships that are created as a result of adoption. In addition, "relative" includes any person who has a domestic partner relationship with an alleged victim. As used in this paragraph, "domestic partner" is a person who has registered as a domestic partner pursuant to Title 22, section 2710.
> B. "Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under an advance directive or any person recognized in law or custom as a person's agent.
> C. "Unanticipated outcome" means the outcome of a medical treatment or procedure that differs from an expected result.
> **2. Evidence of admissions.** 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.

The Board encourages its licensees to educate themselves regarding this provision of law, and reflect upon the way in which they can avail themselves of this law in responding to patient concerns as well as responding to complaints filed against them with the Board.

ADVERSE ACTIONS

Adverse Actions

In 2019 the Board reviewed 335 complaints – an average of about 27.9 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" 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.

Simon Paul Roy, M.D. License #MD23754 (Date of Action 10/16/2020)
On October 16, 2020, the Board accepted Dr. Roy's request to withdraw his pending application for a Maine medical license and while under investigation for allegations of unprofessional conduct and incompetence.

Calvin P. Fuhrmann, M.D. License #MD14675 (Date of Action 10/16/2020)
On October 16, 2020, Dr. Fuhrmann entered into a First Amendment to Consent Agreement effective September 10, 2019, inserting paragraphs 12(c), 12(d), and 12(e). Within thirty (30) days from the effective date of the First Amendment, Dr. Fuhrmann shall begin participating in and maintain enrollment in a Controlled Substances Stewardship ("CSS") Program that shall include case reviews by an interdisciplinary committee. Dr. Fuhrmann shall also engage a Board approved licensed physician as Preceptor ("Preceptor"). The Preceptor shall implement the recommendations and address the educational needs identified in the CPEP Assessment Report and submit monthly written reports to the Board.

David R. Austin, M.D. License #MD12867 (Date of Action 10/15/2020)
On October 15, 2020, Dr. Austin's Maine Medical License was immediately and automatically suspended pursuant to paragraph 13(c)(1) of Dr. Austin's March 12, 2019 Consent Agreement for Reinstatement of License, which suspension shall continue so long as determined by the Board in its sole discretion.

Sherry L. Hill, M.D. License #MD23320 (Date of Action 10/15/2020)
On October 15, 2020, the Board accepted Dr. Hill's request to voluntarily surrender her Maine medical license to the Maine Board of Licensure in Medicine while under investigation for allegations of unprofessional conduct, substance misuse, and disciplinary action taken by the Tennessee Board of Medical Examiners.

Amanda E. Buzzell, P.A. License #PA1384 (Date of Action 09/14/2020)
On September 14, 2020, the Board and Ms. Buzzell entered into a Consent Agreement imposing a license probation of at least one (1) year for engaging in unprofessional conduct with the following conditions: 1) Ms. Buzzell must complete a continuing medical education course within four (4) months on the subject of medical recordkeeping; 2) Ms. Buzzell must engage in cognitive behavioral therapy for at least twelve (12) sessions conducted by a Board approved licensed psychologist or psychiatrist, with quarterly reports submitted to the Board; and 3) Ms. Buzzell must engage a Board approved physician mentor who will review at least 10% of Ms. Buzzell's patient charts monthly and submit quarterly reports to the Board.

David R. Austin, M.D. License #MD12867 (Date of Action 08/14/2020)
On August 14, 2020, the parties entered into a First Amendment to the March 12, 2019 Consent Agreement resolving a new patient complaint and addressing consent agreement compliance issues. The Board imposed a Warning for sexual impropriety and engaging in unprofessional conduct and imposed a requirement that Dr. Austin complete continuing medical education courses within four (4) months for: 1) medical ethics and professional boundaries; 2) disruptive physicians; and 3) medical recordkeeping. Dr. Austin must also engage in psychotherapy with a Board approved licensed psychologist or psychiatrist with quarterly written reports to the Board confirming his participation and compliance for at least one (1) year. In addition, upon a Board vote following a report of noncompliance with any requirement contained in the Consent Agreement, as amended, Dr. Austin's license to practice medicine shall be immediately suspended.

Peter A. Leighton, M.D. License #MD17305 (Date of Action 07/16/2020)
On July 16, 2020, the Board and Dr. Leighton entered into a Consent Agreement pursuant to which the Board issued a Warning to Dr. Leighton for unprofessional conduct for a medication dosing error.

LICENSING ISSUES

Changes to Physician Assistant Licensure

LD1660 was enacted into law as emergency legislation and made several changes to PA licensure. These include:

- Eliminating the requirement of physicians to delegate medical tasks to physician assistants
- Eliminating registration requirements for physician assistants (including fees)
- Eliminating the requirement of plans of supervision
- Creating a requirement for scope of practice/employment notifications in certain circumstances
- Creating a requirement for collaborative agreements in certain circumstances
- Creating a requirement for practice agreements in certain circumstances

It is important to note that Executive Order 16 temporarily postpones the requirement for a collaborative practice agreement or a practice agreement during the COVID-19 declared emergency for those physician assistants who are providing healthcare in response to COVID-19 (we are reading this EO broadly to include support of others who are doing so). So, the Board is not requiring collaborative agreements or practice agreements to be in place at this time.

However, the Board has been working diligently on updating both the Chapter 2 rule and the licensing database system (ALMS). The changes to ALMS are almost complete. Although they will **not** be required until the end of the declared emergency, PAs will soon find

the system asking them for appropriate forms during the application and renewal processes. In general, these will be broken into 2 major groups, more or fewer than 4,000 clinical hours since graduation.

- PAs with **fewer than 4,000** clinical hours will be notified they need to provide either a Scope of Practice Agreement or a Collaborative Agreement. A Scope of Practice Agreement or, Uniform Notice of Employment, is used when the PA works in a health care facility or physician group practice that has a system of privileging and credentialing. A Collaborative Agreement is required when the PA works in a setting that is **not** a health care facility or physician group practice.
- PAs with **more than 4,000** clinical hours will be notified they need a Scope of Practice Agreement if they are the principal clinical provider without a physician partner or they own and/or operate an independent practice. Physician Assistants with more than 4,000 clinical hours working in any other setting do not need to submit any forms.

All PAs are reminded of the need to notify the Board of any change in home or work addresses and contact information within 10 days. These changes can be made by logging into your profile on our website at www.maine.gov/md.

As part of this project two other major changes will be taking place.

1. The Physician Assistant Non-clinical ("PAN") designation will be eliminated. For those PAs currently in a PAN status one of two changes will occur.
   1. If you are in active PAN status and have had that status for less than 24 months you will be transitioned to active PA status.
   2. If you are in inactive PAN status or have been in PAN status for more than 2 years, you will be transitioned to inactive PA status.
2. If you were licensed in Maine after January 1, 2018 you will be identified as having fewer than 4,000 clinical hours. Each PA affected by this change will receive an e-mail indicating what steps to take if they believe they have more than 4,000 clinical hours. Proof of clinical hours could include, but is not limited to, work schedules, pay stubs, or a statement from an employer or employers.

If you have questions about these changes we urge you to reach out to Board staff.

HEALTH & WELLNESS

Stigma and the Myth of the Uber Clinician: A reminder from the Board in a time of urgency

"Maximum effort." "Failure is not an option." "Give until it hurts." "Walk it off." "Give 110%." "You can sleep when you're dead." "No pain no gain." "Pain is weakness leaving the body."

Do any of these phrases sound familiar to you? If so, are they part of your everyday vocabulary and approach to medical practice? Hopefully not. If they are, then you are placing an enormous burden upon yourself, and on many people around you.

There appears to be a tension between, on the one hand, the duty of a clinician to care for, to take responsibility for patients, and on the other hand, taking time away from performing that duty for personal reasons. The former is construed as professional dependability, while the latter is often seen as being selfish or self-indulgent, or even weak.

One very effective way of resolving this tension is to realize that the best way to perform the duty of care for others is to realize that keeping good care of yourself makes you a better caregiver for others. Being responsible for your own well-being makes for better clarity, more strength, and a positive stability of approach in being responsible for others. This line of reasoning shows that self-care can lead to the opposites of selfishness, self-indulgence, or weakness. **It shows that being as awake as possible is a prerequisite to providing care for others who trust you and depend on you.**

This reminder is especially important for clinicians in the midst of coping with a pandemic, which can sometimes demand what seems like heroic efforts.

Consider: if you can't take care of yourself, how can you take care of others? If you can't have sympathy for yourself, how can you have sympathy for others? If you don't get enough rest, how can you continue to provide good patient care? If you don't provide your body and mind with good nutrition, how can you convince patients to do so?

There are studies that show physicians sometimes fail to avail themselves of the necessary health care they provide others in order to avoid "looking weak." This is nothing new to medicine, but it should shock the conscience. Practicing medicine is a service to humanity. Dimming the humanity of those who practice medicine by neglecting self-care is a disservice to patients and the profession, reflects an unwarranted fear of stigma, and perpetuates the myth of the Uber Clinician. We encourage clinicians to rethink the basis of such avoidance.

Seeking help – for whatever reason – does not make a clinician unprofessional or incompetent, nor does it place their license at risk. On the contrary, it demonstrates insight, personal responsibility, and strength of character. The Board encourages all licensees to reflect upon the ways in which they can care for themselves with the same spirit and dedication that they demonstrate in caring for their patients. You and your patients will be the better for it.

Clinician Health & Wellness: Now More Than Ever

Support Services for Clinicians and First Responders

Many studies have shown that stress adversely impacts the mental and physical health of clinicians. These stresses have been increased by the COVID-19 Pandemic. The Board urges clinicians to be aware of and avail themselves of assistance through the Maine Medical Professionals Health Program (https://www.mainemphp.org/) or their facilities' employee assistance programs. In addition, clinicians should be aware that the Maine Association of Psychiatric Physicians has teamed with the Maine Department of Health and Human Services to create Frontline WarmLine, a new volunteer phone support service for clinicians to manage the stress of serving on the front lines of the fight against COVID-19.

The FrontLine Warmline serves health care professionals, such as physicians, nurses, and counselors, as well as emergency medical services personnel, law enforcement, and others who are directly responding to the pandemic in Maine. The line is staffed by volunteer professionals activated through Maine Responds, including licensed psychiatrists, psychologists, therapists, social workers, and nurse practitioners, who can help callers deal with anxiety, irritability, stress, poor sleep, grief, worry, and if needed, connect them with additional supports.

The FrontLine WarmLine is available to clinicians and first responders from 8 am to 8 pm, 7 days a week by calling **(207) 221-8196 or 866-367-4440.** Text capability will be added soon.

For more information about the "Frontline WarmLine" program visit: https://www.maine.gov/tools/whatsnew/index.php?topic=DHS%20Press%20Releases&id=2417012&v=dhhs_article_2020

FROM THE EDITOR

What Constitutes Effective Team Communication After an Error?

The following link to the *AMA Journal of Ethics* provides a commentary on a case of a surgical complication and examines how transparency in communication, cooperative disclosure, and working collaboratively to restore an injured patient's health support clinicians' common purpose, long-standing work relationships, and collegiality.

https://journalofethics.ama-assn.org/article/what-constitutes-effective-team-communication-after-error/2020-04

BOARD NEWS

Joint Collaboration

Did you know that the Board of Licensure in Medicine collaborates with other licensing boards in Maine? One example of such collaboration is the adoption of joint rules, which creates uniform standards for a number of licensing boards. Here are a few examples:

1. Chapter 5 Rules for Collaborative Drug Therapy Management (Board of Licensure in Medicine and Board of Pharmacy)
2. Chapter 6 Telemedicine Standards of Practice (Board of Licensure in Medicine and Board of Osteopathic Licensure)
3. Chapter 12 Office Based Treatment of Opioid Use Disorder (Board of Licensure in Medicine, Board of Osteopathic Licensure, Board of Nursing)
4. Chapter 21 Use of Controlled Substances for Treatment of Pain (Board of Licensure in Medicine, Board of Osteopathic Licensure, Board of Nursing, Board of Podiatric Medicine)

On the national level, the Board of Licensure in Medicine is a member of the Federation of State Medical Boards (FSMB), which annually participates in the Tri-Regulator Symposium involving the National Association of Boards of Pharmacy (NABP) and the National Council of State Boards of Nursing (NCSBN). The symposium facilitates the exchange of information and ideas among agencies licensing and regulating physicians, physician assistants, pharmacists, and nurses.

Joint Accreditation

Similarly, other organizations and associations have taken steps towards collaboration among health care professionals. The Accreditation Council for Continuing Medical Education (ACCME) is promoting joint accreditation of continuing education for myriad health care professionals. (https://www.jointaccreditation.org). One health care facility in Maine that is pursuing joint accreditation is Maine Medical Center (MMC).

MMC is pursuing Joint Accreditation as a major initiative to improve patient care through enhanced interprofessional education. The mantra "education by the team, for the team" aligns with its strategic focus on team-based care, which has demonstrated better patient outcomes. Joint Accreditation brings together nine certifying bodies: physicians, nurses, pharmacists, physician assistants, dentists, psychologists, social workers, optometrists, and dieticians. MMC will hear the decision on its application this December. If MMC is successful, participants in interprofessional education will then begin receiving Interprofessional Continuing Education credit, recognized by all of the certifying bodies. MMC hopes this initiative will be a more efficient and significant time-saver for practicing clinicians.

The Board expresses its support for organizations and associations that promote inter-professional and inter-disciplinary collaboration such as joint accreditation.

Informed Consent and Telehealth

Lynne Weinstein, Public Board Member

The COVID-19 epidemic poses new challenges and opportunities for health care professionals and patients alike. In addition, the COVID-19 emergency has led to the relaxing of telehealth rules to allow for voice-only (e.g., phone) patient encounters. Recently, while attempting to schedule a COVID-19 test telephonically, I had an experience related to informed consent and telehealth.

Prior to COVID-19, calling a health care professional to arrange an appointment was not in and of itself billed to patients – after all, it was just a phone call. Imagine my surprise when I received a bill in the amount of $37.00 simply for calling to set up a test. Fortunately, this story has a happy ending.

When I contacted the health care professional's office and explained the situation, I learned that I should have been informed at the beginning of the telephone call that I was going to be billed for the call and that my consent was required to do so. Since I was not informed about the billing and did not consent to it, the office cancelled the bill.

The Board encourages licensees to obtain informed consent to patient care and billing for any services that are provided via telehealth – including any services provided by voice-only technology.

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Credit

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Commemorating 200 Years of Statehood