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State of Maine  
Board of Licensure in Medicine  
137 SHS, 161 Capitol Street  
Augusta, Maine 04333-0137  
Minutes of February 12, 2019

Board Members Present: Maroulla S. Gleaton, M.D., Chair; Louisa Barnhart, M.D., Secretary (excused at 2:08 p.m.); Susan Dench (excused at 4:15 p.m.); Timothy R. Fox, M.D.; Peter J. Sacchetti, M.D. (arrived at 8:31 a.m.); Michael P. Sullivan, M.D. (arrived at 8:34 a.m.); Brad E. Waddell, M.D.; Lynne M. Weinstein; Miriam Wetzel, Ph.D. (excused at 2:59 p.m.)

Board Members Absent: Christopher R. Ross, P.A.-C

Board Staff Present: Dennis E. Smith, Executive Director; Timothy E. Terranova, Assistant Executive Director; Savannah Okoronkwo, Consumer Assistance Specialist; Nikolette P. Alexander, Investigative Secretary; Maureen S. Lathrop, Administrative Assistant; Tracy Morrison, Licensing Specialist; Elena I. Crowley, Licensing Specialist

Attorney General’s Office Staff Present: Michael Miller, Assistant Attorney General

The Board met in public session except during the times listed below which were held in executive session. Executive sessions are held to consider matters which, under statute, are confidential (e.g., 1 M.R.S. § 405; 10 M.R.S. § 8003-B; 22 M.R.S. § 1711-C; 24 M.R.S. § 2510; 32 M.R.S. § 3282-A). The Board moved, seconded, and voted the following executive session times. During the public session of the meeting, actions were taken on all matters discussed during executive session.

EXECUTIVE SESSIONS

9:30 a.m. – 9:36 a.m.  
Pursuant to 10 M.R.S. § 8003-B (1) to discuss a pending complaint or investigation

9:49 a.m. – 10:22 a.m.  
Pursuant to 32 M.R.S. § 3282-A (1) to conduct an informal conference

RECESSES

9:39 a.m. – 9:49 a.m.  
Recess

10:28 a.m. – 10:32 a.m.  
Recess

12:10 p.m. – 12:43 p.m.  
Lunch

2:30 p.m. – 2:38 p.m.  
Recess
I. Call to Order

Dr. Gleaton called the meeting to order at 8:30 a.m.

A. Amendments to Agenda

At 4:25 p.m. Ms. Weinstein moved to amend a request to approve Mr. Terranova’s attendance at a leadership program onto the agenda under Executive Director’s Remarks. Dr. Sacchetti seconded the motion, which passed unanimously.

At 4:50 p.m. Dr. Sullivan moved to amend a request to approve attendance of an additional staff member and Board member at the Federation of State Medical Board’s annual meeting in April onto the agenda under Assistant Executive Director’s Report. Dr. Waddell seconded the motion, which passed unanimously.

B. Scheduled Agenda Items

1. 9:30 a.m. Informal Conference (CR18-27)

II. Licensing

A. Applications for Individual Consideration

1. Initial Applications

a. Sanjay Krishnan, M.D.

Dr. Barnhart moved to preliminarily deny Dr. Krishnan’s license application with leave to withdraw and authorize AAG Miller to negotiate a consent agreement to include probation with conditions. Ms. Dench seconded the motion, which passed unanimously.

b. Sajad Zalzala, M.D.

Ms. Weinstein moved to investigate further. Ms. Dench seconded the motion, which passed unanimously.

c. Joel Wolinsky, M.D.

Dr. Sacchetti moved to approve Dr. Wolinsky’s license application. Ms. Dench seconded the motion, which passed unanimously.

d. Robert McKay, M.D.

Dr. Sullivan moved to investigate further and request that Dr. McKay submit a practice plan for approval, with authority for approval delegated to Dr. Waddell, or
leave to withdraw his application if he does not wish to submit a plan for approval. Ms. Dench seconded the motion, which passed unanimously.

2. Reinstatement Applications

   a. David Austin, M.D.

   Ms. Dench moved to preliminarily deny Dr. Austin’s license application with leave to withdraw and authorize AAG Miller to negotiate a consent agreement to include a reprimand, civil penalty of $200.00 and probation with conditions. Dr. Sacchetti seconded the motion which passed 8-0-0-1. Dr. Barnhart was recused from the matter and left the room.

3. Renewal Applications

   a. Noreen Sholl, M.D.

   Ms. Weinstein moved to deny Dr. Sholl’s request for reconsideration of her proposed monitor and preliminarily deny her renewal application with leave to withdraw or convert to an administrative or emeritus license. Dr. Sacchetti seconded the motion, which passed unanimously.

   b. David Nagler, M.D.

   At 9:30 a.m. Ms. Dench moved to enter executive session pursuant to 10 M.R.S. § 8003-B (1). Dr. Barnhart seconded the motion, which passed unanimously.

   At 9:36 a.m. Dr. Sullivan moved to come out of executive session. Ms. Weinstein seconded the motion, which passed unanimously.

   Dr. Barnhart moved to grant Dr. Nagler’s request to renew his license while a complaint is outstanding. Ms. Dench seconded the motion, which passed unanimously.

   c. Robert Struba, M.D.

   Ms. Dench moved to withdraw the preliminary denial of Dr. Struba’s renewal application and approve conversion to an emeritus license. Ms. Weinstein seconded the motion, which passed unanimously.

4. Requests to Convert to Active Status (none)

5. Requests to Withdraw License/License Application (none)

6. Requests for Supervisory Relationships (none)
B. Other Items for Discussion

1. Plan of Supervision Length

After discussion, the Board referred the issue to a joint workgroup with the Osteopathic Board to discuss possible revisions to the Chapter 2 Rule Regarding Physician Assistants.

C. Citations and Administrative Fines

This material was provided for informational purposes. No Board action was required.

III. Consent Agreements/Resolution Documents for Review (none)

IV. Complaints

1. CR18-213

Dr. Barnhart moved to investigate further. Ms. Weinstein seconded the motion, which passed 8-0-0-1. Dr. Sacchetti was recused from the matter and left the room.

2. CR18-217

Dr. Barnhart moved to dismiss the complaint. Dr. Sullivan seconded the motion, which passed 8-0-0-1. Dr. Sacchetti was recused from the matter and left the room.

**MOTION:** The patient was successfully treated for addiction for several years. The patient was switched to a cheaper form of therapy. There was not good communication between the patient and the physician regarding the patient’s level of dissatisfaction. There were significant financial issues and the patient chose to change providers. A review of the charts reveals excellent care.

3. CR18-252

Dr. Sullivan moved to investigate further. Dr. Fox seconded the motion, which passed 8-0-0-1. Dr. Sacchetti was recused from the matter and left the room.

4. CR17-54

Dr. Barnhart moved to authorize AAG Miller to offer a revised consent agreement. Ms. Weinstein seconded the motion, which passed unanimously.

5. CR18-276

Dr. Barnhart moved to investigate further. Dr. Fox seconded the motion, which passed unanimously.
6. CR18-242

Dr. Sacchetti moved to dismiss the complaint. Dr. Fox seconded the motion, which passed unanimously.

**MOTION:** A patient complains of an orthopedic physician’s inaccurate documentation of her visit with him. The patient was initially treated in the emergency department for a hand fracture and promptly seen in consultation the following day by the physician. X-rays were reviewed showing minimal displacement and the plan was to leave the hand splinted with follow up imaging. To document the encounter, the physician used a note template which included a portion of the exam that had not occurred and reference the wrong type of splint. The patient, having read the note, made the physician aware of the mistakes. The physician apologized to the patient and edited his note accordingly.

7. CR18-228

Dr. Sullivan moved to dismiss the complaint. Dr. Waddell seconded the motion, which passed 7-0-0-2. Dr. Barnhart and Dr. Gleaton were recused from the matter and left the room.

**MOTION:** The Board initiated this complaint following receipt of information from the Office of Inspector General Department of Health and Human Services regarding the physician’s termination from its Immunization Program. The physician responded and provided a history of her participation in the program, including communications and efforts at compliance. Following review, the Board found no violation of its statutes or rules.

8. CR18-229

Dr. Sullivan moved to investigate further. Ms. Dench seconded the motion, which passed unanimously.

9. CR18-230

Dr. Sullivan moved to investigate further. Ms. Dench seconded the motion, which passed unanimously.

10. CR18-231

Dr. Sullivan moved to dismiss the complaint. Ms. Dench seconded the motion, which passed unanimously.

**MOTION:** The patient asserts that he has been denied adequate medical treatment and pain management for chronic pain associated with an eye injury. Review of information and medical records reveals that appropriate care was provided.
11. CR18-233

Ms. Dench moved to dismiss the complaint. Dr. Sullivan seconded the motion, which passed 8-1.

**MOTION:** A patient complains the provider failed to treat her pain with medication she was previously prescribed. The patient made many requests for tramadol and the provider explains that this medical practice does not support opioid medications for this particular type of pain. The provider has referred the patient to several other practices including chiropractic, neurosurgery, pain management, physical therapy, and rheumatology. The supervising physician has additionally reviewed the records and supports the course of treatment suggested. Professional care was provided.

12. CR18-235

Ms. Weinstein moved to dismiss the complaint. Dr. Sullivan seconded the motion, which passed unanimously.

**MOTION:** A patient complains of the care she received, phone calls not being responded to and alleges the physician violated HIPAA by returning a phone call to her husband, who was listed as an emergency contact.

Review of the records reveal findings that the patient’s imaging was discussed with the patient by a skilled registered nurse offering a follow up plan. When the practice discovered the patient’s desire to speak to the physician, several appointments were made available to the patient for that week. The patient made the appointment, but then cancelled as she had done previously.

The patient’s husband was contacted only after he made a concerned phone call to the practice and for the physician to establish whether the patient needed emergent care requiring immediate intervention. The patient’s medical needs and care plan were not discussed.

Reasonable care and follow up offered with the practice repeatedly attempting to accommodate the patient.

13. CR18-237

Dr. Waddell moved to investigate further. Ms. Dench seconded the motion, which passed 8-0-0-1. Dr. Sullivan was recused from the matter and left the room.

14. CR18-240

Dr. Sacchetti moved to dismiss the complaint. Dr. Wetzel seconded the motion, which passed unanimously.
MOTION: A patient’s mother complains about the medical care her eleven-year-old son received from his new pediatrician. The mother felt the pediatrician’s recommendations of focused office visits for the child’s two unrelated chronic illnesses in addition to a yearly well-child visit were excessive, inconvenient and fraudulent. Review of the records reveals appropriate, reasonable care and recommendations. There was evidence that the physician’s practice took additional steps to accommodate the family.

15. CR18-243

Dr. Wetzel moved to dismiss the complaint. Ms. Weinstein seconded the motion, which passed unanimously.

MOTION: A patient complains he was falsely accused of threatening behavior. The medical record of the patient’s visit on July 17, 2017 reveals that he spoke of specific plans for violent behavior against a certain group of people and in a later phone call he again became belligerent and repeatedly expressed violent intent against the physician and office staff. The physician was correct to alert the local police. The physician arranged for proper care of the patient as he transitioned to another provider.

16. CR18-254

Dr. Sullivan moved to dismiss the complaint. Ms. Dench seconded the motion, which passed unanimously.

MOTION: A patient complains of inadequate evaluation and treatment of left hip pain by the physician following a fall. Review of the medical records and physician’s response reveals adequate care was provided.

17. CR18-261

Dr. Wetzel moved to request that the physician convert his license to inactive status within five days, summarily suspend his license if he declines, and authorize AAG Miller to negotiate a consent agreement for voluntary surrender of his license. Dr. Sullivan seconded the motion, which passed unanimously.

18. CR18-264

Dr. Wetzel moved to dismiss the complaint. Dr. Sullivan seconded the motion, which passed unanimously.

MOTION: A patient asserts that the physician performed an unnecessary test. The physician explained that the referral was for evaluation of the patient’s asthma and allergies, and the asthma evaluation was conducted while allergy testing had to be deferred because the patient had taken allergy medication which precluded allergy testing that day. Review of information and medical records reveals that appropriate care was provided.
19. CR18-279

Dr. Waddell moved to dismiss the complaint. Ms. Dench seconded the motion, which passed unanimously.

**MOTION:** A patient complains about the care he received from his gastroenterologist. The patient felt the physician did not follow up with him in a timely manner. The patient’s clinical course was complicated by several emergency room visits for medical and behavioral health comorbidities. Review of the emergency room, primary care, psychiatric hospital and medical/surgical gastroenterology records reveals appropriate care. The physician interacted with the patient’s primary care physician to attempt to coordinate care and reached out to a Mission Office to gain the patient social support.

20. CR18-199

Dr. Sullivan moved to table the complaint. Ms. Weinstein seconded the motion, which passed 7-0-0-1. Dr. Fox was recused from the matter and left the room.

21. CR18-249

Dr. Waddell moved to investigate further. Ms. Weinstein seconded the motion, which passed unanimously.

22. CR18-257

Ms. Dench moved to dismiss the complaint. Dr. Sacchetti seconded the motion, which passed 7-0-0-1. Dr. Sullivan was recused from the matter and left the room.

**MOTION:** A patient complains about the care he received from his primary care physician even though the physician had not seen the patient since his moving to Florida in 2008. Even though the physician’s practice was closed to new patients, she accommodated him by agreeing to resume his care. Review of the records reveals appropriate medical care, but a lack of meaningful communication between the physician’s nurse and the patient. However, through mutual discussion, the physician and the patient resolved the miscommunication amicably.

23. Intentionally left blank

24. Intentionally left blank

25. Intentionally left blank

V. Assessment and Direction
26. AD18-203

Dr. Sullivan moved to close the matter with no further action. Dr. Sacchetti seconded the motion, which passed unanimously.

27. AD18-277

Dr. Waddell moved to close the matter with no further action. Dr. Sacchetti seconded the motion, which passed unanimously.

28. AD18-281

Dr. Sacchetti moved to issue a complaint (CR19-28). Ms. Dench seconded the motion, which passed unanimously.

29. AD18-286

Dr. Sullivan moved to close the matter with no further action. Dr. Waddell seconded the motion, which passed unanimously.

30. AD19-1

Dr. Sullivan moved to close the matter with no further action. Dr. Sacchetti seconded the motion, which passed unanimously.

31. AD19-2

Dr. Sacchetti moved to close the matter with no further action. Ms. Weinstein seconded the motion, which passed unanimously.

32. Intentionally left blank

33. Intentionally left blank

34. Pending Adjudicatory Hearings and Informal Conferences Report

This material was provided for informational purposes. No Board action was required.

35. Consumer Assistance Specialist Feedback

This material was provided for informational purposes. No Board action was required.

36. Other Items for Discussion (none)
VI. Informal Conference

A. CR18-27

At 9:49 a.m. Ms. Weinstein moved to enter executive session pursuant to 32 M.R.S. 3282-A (1). Ms. Dench seconded the motion, which passed 8-0-0-1. Dr. Fox was recused from the matter and left the room.

At 10:22 a.m. Dr. Waddell moved to come out of executive session. Dr. Sacchetti seconded the motion, which passed 8-0-0-1. Dr. Fox was recused from the matter and left the room.

Ms. Dench moved to dismiss the complaint. Dr. Waddell seconded the motion, which passed unanimously.

MOTION: The complaint was initiated by the Board following receipt of an anonymous complaint filed against the physician based upon a social media posting by the physician, which implicated the AMA Code of Medical Ethics principle “Professionalism in the Use of Social Media.” The physician responded to the complaint, including his intent behind the posting. The Board met with the physician in an informal conference to discuss medical ethics and professionalism in the use of social media. Following the informal conference, the Board voted to dismiss the complaint.

VII. Minutes for Approval

Ms. Dench moved to approve the minutes of the January 8, 2019 meeting. Ms. Weinstein seconded the motion, which passed 6-0-1-0 with Dr. Sacchetti abstaining.

VIII. Board Orders & Consent Agreement Monitoring

A. Board Orders

1. CR17-139 Paul M. Willette, M.D. [Appendix A]

   Dr. Sullivan moved to approve the Decision and Order. Ms. Weinstein seconded the motion, which passed 5-0-1-1 with Dr. Sacchetti abstaining. Dr. Waddell was recused from the matter and left the room.

B. Monitoring Reports

1. Cathleen G. London, M.D.

   This material was presented for informational purposes. No Board action was required.
2. G. Paul Savidge, M.D.

Ms. Weinstein moved to deny the proposed monitor and offer an amendment to the consent agreement. Dr. Sacchetti seconded the motion, which passed unanimously.

3. Ronald D. Oldfield, P.A.

Dr. Waddell moved to table the matter. Ms. Dench seconded the motion, which passed unanimously.

4. Donald B. Shea, M.D.

Dr. Waddell moved to not approve the updated pain protocol submitted by Dr. Shea and direct him to follow the original pain protocol. Dr. Shea may propose a new pain protocol for approval. Dr. Fox seconded the motion, which passed unanimously.

5. David B. Robsinon, M.D.

Dr. Waddell moved to terminate Dr. Robinson’s probation. Dr. Sacchetti seconded the motion, which passed unanimously.

6. Mark E. Cieniawski, M.D.

Dr. Sullivan moved to contact Dr. Cieniawski regarding concerns identified by his practice monitor. Dr. Waddell seconded the motion, which passed unanimously.

7. Karyn Tocci, M.D.

This material was presented for informational purposes. No Board action was required.

IX. Adjudicatory Hearing (none)

X. Remarks of Chair

A. Chaperones

The Board discussed chaperones and a program being used in Canada to train chaperones. Board staff will gather additional information regarding the program.

B. Transparency, Disclosure, and Collaboration

The Board discussed concerns that hospitals and private entities are not reporting all actions taken against licensees and how that may impact receipt of mandated reports in Maine.
XI. Remarks of Executive Director

A. Board Elections

Mr. Smith discussed the election of the chair and secretary.

B. Legislation

Mr. Smith discussed pending legislation.

C. Draft Guideline – Talking with Patients

Dr. Sullivan moved to approve a new guideline, Talking with Patients, as amended. Dr. Sacchetti seconded the motion, which passed unanimously.

D. Maine Medical Association Wellness Summit

This material was presented for informational purposes. No Board action was required.

E. FSMB Draft Report for Comment Regarding Resolution 18-3

This material was presented for informational purposes. No Board action was required.

F. Leadership Program

Ms. Weinstein moved to approve Mr. Terranova’s attendance at a leadership program at Harvard in July. Dr. Sacchetti seconded the motion, which passed unanimously.

XII. Assistant Executive Director’s Report

Mr. Terranova reported that staff will be contacting all licensees with an administrative license to notify them of the change in license prefix from AL to MDA. New licenses will be issued this month.

A. Complaint Status Report

As of February 1, 2019, there are ninety complaints outstanding. Twenty complaints were opened during the month of January and fifteen were closed.

B. FARB Meeting

This material was presented for informational purposes. No Board action was required.

C. Compact Update

This material was presented for informational purposes. No Board action was required.
D. Licensing Feedback

This material was presented for informational purposes. No Board action was required.

E. FSMB Annual Meeting

Dr. Sullivan moved to approve the attendance of Lynne Weinstein and Elena Crowley at the FSMB annual meeting in Fort Worth in April. Dr. Sacchetti seconded the motion, which passed unanimously.

XIII. Medical Director’s Report (none)

XIV. Remarks of Assistant Attorney General (none)

XV. Rulemaking (none)

XVI. Policy Review

A. Draft Duties and Election of Officers policy

This matter was tabled.

B. Board Secretary Duties Policy

Dr. Sullivan moved to approve amendments to the Board Secretary Duties policy. Dr. Fox seconded the motion, which passed unanimously.

XVII. Requests for Guidance (none)

XVIII. Standing Committee Reports

A. Licensure and CME Committee

1. Licensing Status Report [Appendix B]

This material was presented for informational purposes. No Board action was required.

XIX. Board Correspondence (none)

XX. FSMB Material

A. Final Call for Resolutions

This material was presented for informational purposes. No Board action was required.
XXI. FYI

This material was presented for informational purposes. No Board action was required.

XXII. Other Business (none)

XXIII. Adjournment 4:48 p.m.

At 4:48 p.m. Dr. Waddell moved to adjourn the meeting. Dr. Sullivan seconded the motion, which passed unanimously.

Respectfully submitted,

Maureen S. Lathrop
Administrative Assistant
STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE

In Re: Paul M. Willette, M.D. )
Complaint No. CR17-139 )

DEcision AND ORDER

I. PROCEDURAL HISTORY

Pursuant to the authority found in 10 M.R.S. Section 8003(5) and 32 M.R.S. Sections 3269 and 3282-A, the Maine Board of Licensure in Medicine ("Board") met in public session at its offices in Augusta, Maine, on January 8, 2019. The purpose of the meeting was to determine whether to affirm the preliminary denial of the application for renewal of licensure of Paul M. Willette, M.D. ("Licensee").

On March 7, 2018, a Notice of Adjudicatory Hearing was issued setting the hearing in this matter for April 10, 2018. On March 14, 2018, an Amended Notice of Adjudicatory Hearing was issued rescheduling the hearing for May 8, 2018. The Licensee was not responsive to efforts to schedule a telephonic prehearing conference. On April 6, 2018, a Scheduling Order was issued setting deadlines for the filing of witness lists and exhibits. On April 11, 2018, the Licensee requested a 90-day continuance of the hearing date to consult with an attorney and to attempt to resolve an issue pending before the New Mexico Medical Board. On April 18, 2018, the Licensee agreed in writing not to practice medicine in Maine until the outcome of this proceeding. On April 19, 2018, the Licensee's request to continue the hearing was granted.

On September 7, 2018, an Amended Notice of Continued Adjudicatory Hearing was issued setting the hearing date for October 9, 2018. The Licensee again did not respond to communications seeking to schedule a telephonic prehearing conference. On September 16, 2018, a Scheduling Order was issued setting new deadlines for the submission of exhibits and witness lists.
On September 21, 2018, a Continuance Order was issued granting the Licensee’s second continuance request on the basis of his recent retention of counsel who was unavailable on October 9, 2018.

On November 16, 2018, a Notice of Continued Adjudicatory Hearing was issued rescheduling the hearing in this matter for January 8, 2019. On December 3, 2018, a telephonic prehearing conference was held, attended by Christopher Taintor, Esq., attorney for the Licensee, and Michael Miller, Esq., Assistant Attorney General. A Conference Order was issued on December 3, 2018, setting new deadlines for the submission of witness lists and exhibits.

On December 13, 2018, Attorney Taintor withdrew from his representation of the Licensee. On January 2, 2019, the State submitted its opening statement pursuant to the deadline in the December 3 Conference Order. On January 4, 2019, four days prior to the rescheduled hearing date, the Licensee filed a request to stay the proceeding. The basis of the request was that he continued to have an unresolved appeal involving the New Mexico Medical Board and he had agreed not to practice under his Maine license while the present matter was pending. The State objected. On January 6, 2019, the Licensee filed further information related to his request, primarily disputing the underlying facts related to the New Mexico Medical Board decision and the actions of Augusta University Medical Center. On January 6, 2018, an Order Denying Continuance Request was issued, denying the Licensee’s third continuance request on the basis that the preliminary denial had been issued nearly 15 months prior, the matter had been scheduled for hearing nine months prior but had twice been continued at the Licensee’s request, and the Licensee had not participated in the prehearing process. On January 8, 2019, the day of the hearing, the Licensee filed another request for a stay of the proceedings, which was denied.

The State bears the burden to prove by a preponderance of the evidence any alleged violation that would form the basis of denial of renewal of licensure or of discipline.
A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Louisa Barnhart, M.D.; Susan Dench, Public Member; Timothy Fox, M.D.; Christopher Ross, P.A.-C.; Michael Sullivan, M.D.; Lynn M. Weinstein, Public Member; Miriam Wetzel, Ph.D., Public Member; and Maroulla Gleeton, M.D., Chair. The Licensee was not present at the hearing.\(^1\) Michael Miller, Esq., Assistant Attorney General, represented the State of Maine. Rebekah Smith, Esq., served as Hearing Officer. The hearing was held in accordance with the requirements of the Maine Administrative Procedure Act, 5 M.R.S. Section 9051 to Section 9064.

State Exhibits #1 to #24 were admitted without objection. The admitted exhibits are identified as follows:

- State Exhibit #1: Amended Notice of Adjudicatory Hearing dated September 7, 2018
- State Exhibit #2: ALMS Licensing Information
- State Exhibit #3: April 19, 2018, Continuance Order
- State Exhibit #4: August 24, 2016, New Mexico Medical Board Notice of Summary Suspension
- State Exhibit #5: October 25, 2016, Colorado Medical Board Order of Suspension
- State Exhibit #6: January 13, 2017, Letter of Suspension of Clinical Privileges from Augusta University Medical Center
- State Exhibit #7: Memorandum regarding Administrative Leave from Augusta University signed January 18, 2017
- State Exhibit #8: January 26, 2017, Transcript of Proceedings before the New Mexico Medical Board
- State Exhibit #9: January 27, 2017, Transcript of Proceedings before the New Mexico Medical Board
- State Exhibit #10: March 28, 2017, Memorandum from Medical College of Georgia at Augusta University regarding Termination
- State Exhibit #11: March 30, 2017, Memorandum to Board from Margaret Duhamel, M.D., Medical Director
- State Exhibit #12: April 10, 2017, New Mexico Board Decision and Order
- State Exhibit #13: May 1, 2017, Renewal Application
- State Exhibit #14: June 29, 2017, Board Complaint CR17-139
- State Exhibit #15: July 17, 2017, Letter upholding Termination from Augusta University Medical Center
- State Exhibit #16: August 16, 2017, Licensee Communication to Board Staff
- State Exhibit #17: August 25, 2017, Licensee Letter to Board Staff

\(^1\) The Licensee is not presently in the military service within the meaning of the Servicemembers Civil Relief Act. (State Exh. #24.)
The Board took notice of its statutes and rules and confirmed that no participating member had any conflict of interest or bias that would prevent him or her from rendering an impartial decision in this matter. The State presented Margaret Duhamel, M.D., former Medical Director for the Board, as a witness. The State made a closing argument. The Board then deliberated and made the following findings of fact and conclusions of law by a preponderance of the credible evidence regarding the allegations against the Licensee.

II. FINDINGS OF FACTS

Paul M. Willette, M.D., was first licensed to practice medicine in Maine in July 2010. (State Exh. #2.) His most recent license expired on April 30, 2017, but remained active because he filed a timely application for renewal, pending the final resolution of this matter by the Board. (State Exh. #2.)

On August 25, 2016, the New Mexico Medical Board summarily suspended the Licensee’s license to practice medicine on the basis that he posed a clear and immediate danger to the public health and safety. (State Exh. #4.) The summary suspension was based upon evidence that showed that the Licensee, while working as an emergency room physician, failed and/or refused to make himself available in a timely and safe manner to provide adequate emergency medical care to patients; while working as an emergency room physician, he failed and/or refused to examine one or more patients in a timely and safe manner when requested; created medical records falsely reflecting that he had examined and rendered medical care to patients when he had not done so, thereby placing patients’ health and safety at risk; and on one or more occasions, while working
alongside fellow healthcare professionals, he engaged in disruptive behavior that interfered with the orderly conduct of patient care activities, for example by slapping a nurse’s hand in anger while an emergency medical procedure was being performed on a patient in November 2014. (State Exh. #4.)

On September 9, 2016, the Colorado Medical Board had ordered the Licensee to complete an evaluation with the Colorado Physician Health Program ("CPHP") due to the board's conclusion that it had reasonable cause to believe that the Licensee was unable to practice with reasonable skill and safety to patients because of a condition. (State Exh. #5.) The Colorado Medical Board order required the Licensee to contact CPHP by September 14, 2016, and schedule an initial intake appointment by October 21, 2016. (State Exh. #6.) The order further required the Licensee to appear for all appointments with CPHP; provide any information requested by CPHP; schedule timely appointments as requested by CPHP; and otherwise cooperate fully with CPHP. (State Exh. #6.) On October 25, 2016, the Colorado Medical Board summarily suspended the Licensee's license to practice medicine because the Licensee had failed to comply with an order of the board. (State Exh. #5.) The Licensee had not contacted CPHP as of October 25, 2016, nor had he appeared at CPHP for an initial intake appointment or submitted to an examination by CPHP. (State Exh. #5.) The order suspended the Licensee's license until the Licensee provided adequate confirmation of his compliance with the September 9, 2016, order. (State Exh. #5.)

On January 11, 2017, the Augusta University Medical Center issued a memorandum for the record indicating that after a review of recent rotation and ad hoc evaluations, as well as a number of interviews of the Licensee’s faculty instructors, it was placing the Licensee on administrative leave. (State Exh. #7.) Augusta University Medical Center’s Accreditation Council for Graduate Medical Examination had concluded that the Licensee had deficiencies including but not limited to: patient care and medical knowledge (extensive deficiencies in core procedural skills appropriate to
his level of training, deficiencies in judgment with regard to patient care, and critical failures with potential patient harm; learning and improvement (inability or unwillingness to listen to instructors and co-workers with regard to medical knowledge, procedural skills, and overall conduct; lack of insight into deficiencies; and unwillingness to consider other points of view); professionalism (inappropriate living situation, dishonesty in multiple circumstances, inappropriate interactions with fellow learners, inappropriate self-care, and inappropriate use of hospital facilities); and interpersonal and communication skills (poor interactions with physician and nursing staff, aggressive behavior towards fellow learners, and inability or unwillingness to listen to instructors and co-workers with regard to patient care and safety). (State Exh. #7.) The memorandum noted that the Licensee had been offered information regarding an employee assistance program and had been advised that a full investigation would be undertaken. (State Exh. #7.) The Licensee was instructed to clear all belongings from the hospital and campus and not to appear at the hospital or attempt to assume any duties related to his fellowship. (State Exh. #7.)

On January 13, 2017, Augusta University Medical Center, Children’s Hospital of Georgia, and its affiliated AUMA practice sites suspended the privileges of the Licensee to practice medicine and surgery. (State Exh. #6.) The action was taken to ensure the safety of patients. (State Exh. #6.) The suspension of the Licensee’s clinical privileges extended to his access to electronic medical records and badge access to hospital facilities and clinics. (State Exh. #6.)

On January 26 and 27, 2017, a hearing, presided over by a hearing officer, was held with regard to the New Mexico Medical Board’s summary suspension of the Licensee’s medical license. (State Exhs. #8 & #9.) The hearing lasted over a day and a half. (State Exhs. #8 and #9.) Five witnesses testified. (State Exhs. #8 and #9.) The Prosecution offered 29 exhibits that were admitted and the Licensee offered 22 exhibits that were admitted. (State Exhs. #8 and #9.) The hearing officer noted that the Licensee appeared shaky and nervous at the hearing. (State Exh. #8.) The
testimony regarding the Licensee's lapses in the practice of medicine was very significant. (State Exhs. #8 and #9.) Testimony indicated that there were 12 patient and family complaints filed with the Community Hospital Corporation, the managing company for Union County General Hospital in Clayton, New Mexico, at which the Licensee had worked from July 2014 to September 2, 2015. (State Exhs. #8 & #12.) Tammy Chavez, Chief Operating Officer/Chief Nursing Officer/Chief Compliance Officer in Risk Management with Community Hospital Corporation, reviewed 104 of the Licensee's patient records in her investigation. (State Exh. #12.) On more than 50 occasions the Licensee did not respond within 30 minutes of being contacted when he was the physician on call. (State Exh. #8.) The Licensee sometimes did not respond at all to pages when he was the physician on call. (State Exhs. #8 & #12.) An external peer review of the Licensee's medical records concluded that the Licensee was clearly providing substandard and unacceptable medical care. (State Exhs. #8 & #12.) The Licensee had created records of seeing patients that he had not actually seen and, in one instance, spoke to a patient from a doorway but documented that he had conducted a patient examination. (State Exh. #8.) The review of one patient chart by the outside peer review organization concluded that the Licensee gave orders over the telephone for an emergency room patient although a more appropriate course of treatment would have included immediate aggressive diuresis and intubation for respiratory support within the first hour and within the next hour if no improvement in oxygenation, then specialty consultation and preparation for immediate transfer to a higher level of care. (State Exh. #12.) The patient was transferred six hours later upon his wife's insistence; the patient later died. (State Exh. #12.) Four witnesses provided statements to Ms. Chavez that the Licensee had slapped a nurse's hand during a procedure in the operating room for not passing instruments fast enough. (State Exh. #8.) A female nurse reported to Ms. Chavez that she was uncomfortable working with the Licensee; she felt that he was harassing her. (State Exh. #8.) The nurse reported to Ms. Chavez that after the Licensee no longer had
worked at the hospital, in the middle of the night, he was hiding in the bushes outside the hospital, and when she exited the hospital, he called her name, jumped out of the bushes with 50 dozen roses, pushed them at her chest, hugged her, and put his face close to hers, which made her very uncomfortable. (State Exh. #8.) The Licensee informed Ms. Chavez that although he was married, he was in love with the nurse he had accosted. (State Exh. #8.)

Shortly after the January hearing dates in New Mexico had passed, Dr. Margaret Duhamel, then Medical Director for the Board, tried to reach the Licensee by leaving two or three messages but the Licensee did not respond to Dr. Duhamel’s messages. (Testimony of Duhamel.)

On March 28, 2017, the Medical College of Georgia at Augusta University issued a letter to the Licensee indicating that the Clinical Competence Committee’s recommendation to terminate his clinical privileges, a recommendation supported by the Trauma, Surgical Critical Care faculty, had been forwarded to the Chair of the Department. (State Exh. #10.)

On March 30, 2017, Dr. Duhamel received a phone call from the Licensee that she memorialized in a memorandum to the Board. (Testimony of Duhamel; State Exh. #11.) The Licensee told Dr. Duhamel that he was waiting to hear the decision of the New Mexico Medical Board regarding his license. (State Exh. #11.) The Licensee informed Dr. Duhamel that he was undertaking a critical care fellowship in Augusta, Georgia, which had seven months left, but which was on hold pending resolution of the New Mexico situation. (State Exh. #11.) The Licensee made these representations to Dr. Duhamel even though almost two months prior the Medical University of Georgia had placed the Licensee on administrative leave for reasons unrelated to the situation with the New Mexico Medical Board and two days prior had issued a letter to him informing him that it was being recommended that his clinical privileges be completely terminated. (State Exhs. #6 & #10.) The Licensee complained to Dr. Duhamel that the complaint in New Mexico had been filed in retaliation for several issues; he maintained that he had left Union County General Hospital
in good standing; and he argued that the New Mexico Medical Board had just taken reports from the hospital and, without adequate proof, summarily suspended his license. (State Exh. #11.) The Licensee expressed frustration about understaffing at Union County General Hospital. (State Exh. #11.) He denied the hospital’s allegation that he made sexual advances toward a hospital staff member, stating that he gave her flowers after her husband died, in contrast to the explanation he gave Ms. Chavez. (State Exh. #11.) Dr. Duhamel noted that the Licensee was interested in retaining his Maine medical license because his son attended college in Maine and he wanted to keep open the option of practicing in Maine. (State Exh. #11.) Dr. Duhamel perceived that the Licensee was very nervous, spoke quickly, made it hard for her to participate in the conversation, and often went off topic in answering her questions. (Testimony of Duhamel.) Dr. Duhamel was concerned that the Licensee was very disorganized in his thinking and was possibly manic. (Testimony of Duhamel.)

On April 10, 2017, the New Mexico Medical Board issued a Decision and Order, adopting the February 27, 2017, recommended decision of the hearing officer, which concluded that the prosecution had proven by a wealth of evidence that the Licensee failed to respond to the emergency room on numerous occasions within 30 minutes and that the Licensee on numerous occasions failed to examine one or more patients in violation of New Mexico law; that the Licensee failed to meet the standard of care to numerous patients in violation of New Mexico law and the Code of Ethics for Emergency Physicians; the Licensee created false medical records in violation of New Mexico law; the Licensee failed to adhere to regulations regarding the prescribing of controlled substances in violation of New Mexico law; the Licensee injudiciously prescribed controlled substances to at least one patient in a manner that deviated from the standard of care in violation of New Mexico law; and that the Licensee failed to maintain complete, accurate, and legible medical records in violation of New Mexico law. (State Exh. #12.) The New Mexico
Medical Board also concluded that the prosecution had proven by a preponderance of the evidence that the Licensee engaged in disruptive behavior in violation of New Mexico law and that the Licensee failed to communicate with patients and/or their families in violation of New Mexico law. (State Exh. #12.) The New Mexico Medical Board concluded that the Licensee did not rebut the prosecution's evidence. (State Exh. #12.) The Board revoked the Licensee's license to practice medicine in the State of New Mexico. (State Exh. #12.) The Board also ordered that before the Licensee was eligible to apply for licensure in the State of New Mexico, the Licensee had to prove clinical competency by providing the board with an evaluation by the Center for Personalized Education for Physicians or similar approved competency evaluation and demonstrate his psychological competency to practice medicine by providing the Board with a neuropsychological evaluation. (State Exh. #12.)

On May 1, 2017, the Licensee submitted a renewal application to the Maine Board of Licensure in Medicine. (State Exh. #13.) The Licensee responded "yes" to the question of whether he had ever had any licensing authority deny his application or take any disciplinary action against him. (State Exh. #13.) The Licensee's explanation was as follows: "New Mexico [M]edical Board revoked my medical license but it was not based on professional competence or conduct which could adversely [effect] the health or welfare of patients. Rather it was based on a recommendation of the New Mexico Hearing Officer which is under appeal. Colorado Medical Board suspended my license based on New Mexico." (State Exh. #13.) With regard to the suspension of his privileges at the Augusta University Medical Center, the Licensee reported that he was on unpaid leave from his Critical Care Fellowship pending his appeal of the New Mexico Medical Board decision. (State Exh. #13.)

In fact, the New Mexico Medical Board's Decision and Order was based on professional competence and conduct that the New Mexico Medical Board found continued to pose a "clear and
immediate danger to the public health and safety of the community” after a fully contested administrative hearing in which the Licensee participated. (State Exh. #12.) In addition, the Colorado Medical Board’s suspension of the Licensee’s license was due to his failure to comply with a Board order, not because of the decision of the New Mexico Medical Board. (State Exh. #12.) Further, the suspension of the Licensee’s privileges at Augusta University Medical Center was not related to the allegations against the Licensee in New Mexico but instead was directly related to patient safety at the hospital and a multitude of educational, practice, and conduct issues; in fact, Augusta University Medical Center staff complained that the Licensee had not told them about the New Mexico Medical Board proceeding. (State Exh. #6; Testimony of Duhamel.) The Licensee’s privileges at Augusta University Medical Center were not slated to be restored once the New Mexico appeal had been concluded. (State Exh. #6.) Moreover, by the time the Licensee filed his renewal application in Maine, the Augusta University Medical Center had issued him a letter indicating that it was being recommended that his privileges be terminated. (State Exh. #15.)

On June 29, 2017, the Board issued a letter to the Licensee indicating that it had voted to initiate a complaint against him. (State Exh. #14.)

On July 17, 2017, the Dean of the Medical College of Georgia at Augusta University issued a letter to the Licensee indicating that after careful consideration, he was upholding the recommendation to terminate the Licensee from the department of Surgery and the Surgical Critical Care Fellowship at Augusta University. (State Exh. #15.) The letter informed the Licensee of his right to appeal the decision to the President of Augusta University. (State Exh. #15.)

On August 16, 2017, the Licensee issued a “self report” to the Board indicating that the New Mexico Medical Board’s Decision and Order was based on unsubstantiated allegations; alleging that the New Mexico hearing officer did not do an investigation to determine the validity or credibility of the charges or the credibility of the individuals making the charges; and asserting that
a thorough investigation by the New Mexico Medical Board would have resulted in a conclusion that the allegations against him were false. (State Exh. #16.) He noted that he had appealed the decision of the New Mexico Medical Board. (State Exh. #16.) The Licensee disclosed that he had been terminated from his fellowship at Augusta University Medical Center on July 17, 2017, but noted that he had appealed the termination. (State Exh. #16.) Finally, the Licensee stated that he was unaware that the Colorado Medical Board was trying to contact him before it took action against him and since he had never worked in Colorado, he was focusing his appeal efforts on the New Mexico matter. (State Exh. #16.) The Licensee reported that he was “actively trying to complete” his surgical critical care fellowship at Augusta University (even though his privileges had been terminated a month prior) and wished to work with the Board to retain his Maine license. (State Exh. #16.)

On August 20, 2017, the Dr. Steve Holsten, Director of the Surgical Critical Care Fellowship at Augusta University Medical Center confirmed to Dr. Duhamel that the Licensee had been terminated; he subsequently provided the Board a copy of the termination notice. (State Exh. #18.) Augusta University Medical Center was not willing to share any further information without a release from the Licensee, although Dr. Holsten did inform Dr. Duhamel that the Augusta University Medical Center staff had a lot of concerns about the Licensee, including that he had been living in a call room at the hospital against policy and took a significant amount of time to move out after he was discovered, his evaluations had gone downhill over his tenure, he exhibited significant clinical deficiencies, and he had not informed them of the New Mexico Medical Board proceedings. (Testimony of Duhamel.)

On October 24, 2017, the Board issued a Notice of Preliminary Denial to the Licensee informing him of its decision to preliminary deny his application for renewal of his Maine medical license. (State Exh. #19.) The Licensee filed a timely notice of appeal. (Administrative File.)
III. GOVERNING STATUTES AND RULES

1. The Board’s sole purpose is to protect the public health and welfare. 10 M.R.S. § 8008.

2. The Board may refuse to renew a license if the licensee engaged in the practice of fraud, deceit, or misrepresentation in obtaining a license or in connection with service rendered within the scope of the license issued. 32 M.R.S. § 3282-A(2)(A).

3. The Board may refuse to renew a license if the licensee exhibited incompetence by engaging in conduct that evidenced a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public. 32 M.R.S. § 3282-A(2)(E)(1).

4. The Board may refuse to renew a license if the licensee exhibited incompetence by engaging in conduct that evidenced a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed. 32 M.R.S. § 3282-A(2)(E)(2).

5. The Board may refuse to renew a license if the licensee engaged in unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if he or she violated a standard of professional behavior, including engaging in disruptive behavior, that has been established in the practice for which the licensee is licensed. "Disruptive behavior" means aberrant behavior that interferes with or is likely to interfere with the delivery of care. 32 M.R.S. § 3282-A(2)(F).

6. The Board may refuse to renew a license if the licensee was subjected to revocation, suspension, or restriction of a license to practice medicine by another state for conduct that would constitute grounds for discipline under Maine laws if committed in the State of Maine. 32 M.R.S. § 3282-A(2)(M).

IV. CONCLUSIONS OF LAW

The Board, considering the above facts and those alluded to in the record but not referred to
herein and in light of its sole purpose of protecting the public health and welfare, concluded that it had jurisdiction over the Licensee and found that he had committed the following statutory violations:

1. By unanimous vote, the Licensee engaged in fraud in seeking to obtain a renewal of his license in Maine by intentionally distorting the nature and status of the allegations against him with the New Mexico Medical Board and the Colorado Medical Board and the status of his clinical privileges at Augusta University Medical Center in his March 30, 2017, phone conversation with Dr. Duhamel, and his May 1, 2017, application for renewal of licensure, subjecting him to discipline pursuant to 32 M.R.S. Section 3282-A(2)(A).

2. By unanimous vote, the Licensee exhibited incompetence by engaging in conduct that evidenced a lack of ability to discharge the duty owed by the licensee to a patient by not seeing emergency room patients in a timely manner or at all, not conducting thorough examinations, not documenting examinations, and not providing appropriate care to an emergency room patient who subsequently died, subjecting him to discipline pursuant to 32 M.R.S. Section 3282-A(2)(E)(1).

3. By unanimous vote, exhibited incompetence by engaging in conduct that evidenced a lack of knowledge and an inability to apply the principles or skills to carry out the practice of medicine by his failure to accept responsibility for the failures in the care he provided when he blamed his actions on understaffing and by the multitude of patient care problems documented in the New Mexico Medical Board Decision and Order, subjecting him to discipline pursuant to 32 M.R.S. Section 3282-A(2)(E)(2).

4. By unanimous vote, the Licensee engaged in unprofessional conduct by violating standards of professional behavior that have been established in the practice of medicine, including engaging in disruptive behavior, by exhibiting inappropriate behavior with co-workers,
slapping a nurse’s hand during an operating room procedure, not coming to the hospital when called for emergency care, sleeping in the hospital as if it were a residence against policy, and not appearing for an examination ordered by the Colorado Medical Board, subjecting him to discipline pursuant to 32 M.R.S. Section 3282-A(2)(F).

5. By unanimous vote, the Licensee was subjected to discipline in Colorado and New Mexico for his unprofessional conduct and incompetence, which constituted conduct that would have provided grounds for discipline if committed in Maine, subjecting him to discipline pursuant to 32 M.R.S. Section 3282-A(2)(M).

As a sanction for the above violations, by a vote of seven to one, the Board upheld the preliminary denial of the Licensee’s application for renewal of licensure.

Dated: 2/12/19, 2019

[Signature]
Maroula Gleatón, M.D., Chair
State of Maine Board of Licensure in Medicine

V. APPEAL RIGHTS

Pursuant to the provisions of 10 M.R.S. Section 8003(5) and 5 M.R.S. Section 11002(3), any party that appeals this Decision and Order must file a Petition for Review in the Superior Court within 30 days of receipt of this Order. The petition shall specify the person seeking review, the manner in which they are aggrieved, and the final agency action which they wish reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought, and a demand for relief. Copies of the Petition for Review shall be served by certified mail, return receipt requested, upon the State of Maine Board of Licensure in Medicine, all parties to the agency proceedings, and the Attorney General.
BOARD OF LICENSURE IN MEDICINE

DATE: FEBRUARY 1, 2019
TO: BOARD MEMBERS
CC: TIMOTHY TERRANOVA
RE: LICENSING STATUS REPORT AND LISTS

The following information is included:

A summary of all new licenses granted in January 2019 by license type (66);
A list of all individuals granted a new license in January 2019 by license type;
A summary of all pending applications by license type (140);
A list of online vs. paper renewals in January 2019 by license type (91.43%);
The number of licenses expired January 31, 2019 (35)
The number of licenses lapsed for date 10/31/2018 (39); and
The list of licenses withdrawn in January 2019 (6).

In addition, the overall licensing statistics include:

The number of active MD licenses (not including EC) February 1, 2019 (6,148);
The number of active MD licenses with a Maine address (not including EC) on February 1, 2019 (3458);
The number of active PA/PAN licenses on February 1, 2019 (890);
The number of active PA/PAN licenses with a Maine address on February 1, 2019 (803); and
The number of licenses pending renewal on February 1, 2019 (46).

We look forward to your feedback.
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**SUBTOTAL:**

1 + 4 + 49 + 6 + 2 + 3 + 1 = 66

### SUMMARY BY LICENSE STATUS

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