**New Laws:**

The first session of the 122nd Legislature established a number of important new laws which became effective September 17, 2005.

Ch. 24, PL 2005 allows a physician to serve as the IME for a disputed claim, even though the physician has examined the employee during the previous 52 weeks for an insurance claim, if agreed by the parties to the claim.

Ch. 94 Resolves, 2005 Reminds professional associations and practitioners that agents of patients appointed through a power of attorney are entitled to the same information as the patient, and that HIPPA does not apply to protected health information given to principals or their agents.

Ch. 99 PL 2005 authorizes PAs and certified NPs to submit sworn testimony in workers compensation proceedings.

Ch. 162, PL. 2005 updated the medical practice act:

- PAs shall be disciplined under the same statute as MDs;
- The post graduate training requirement will become 36 months for medical school graduates after 2004. Physicians in Maine residency programs with unrestricted program endorsement are eligible for license after 24 months;
- Physicians over age 70 who maintain an active license will pay a biennial registration fee. No fee has yet been established by the Board.

Ch. 221 PL 2005 requires more specific information reporting from hospitals and other providers regarding adverse credentialing actions. This will assist the Board to act timely to review.

Ch. 359 PL 2005 permits APRNs to complete the medical certification of death.

Ch. 363 PL 2005 establishes a waiver of ACGME accredited postgraduate training requirements for foreign medical graduates in some instances. Rules for implementation will be adopted.

Ch. 376 PL 2005 Allows the MD to express sympathy for outcomes without it being used in malpractice litigation. This is an important tool for physicians to strengthen patient communication.

The RULES OF THE BOARD were revised and adopted effective August 22, 2005.

**Chapter 1 PHYSICIANS**

- New license type: Volunteer with a significantly reduced registration fee. The physician may not practice for any financial compensation.
- New License type: 100 Day Emergency status.
- Confirmed the requirement of the State written examination before licensure.
- Updated Category 1 CME point values per ACCME determination in 2000. Refer to the Rule on our website or the CME Bulletin included with your renewal for details.
- Allows CME requirement attestation at renewal, and post renewal audit.

(continued on next page)
New Laws: (continued)

**Chapter 2 PHYSICIAN ASSISTANTS**
- Requires that PAs take the State written examination before licensure.
- Requires biennial renewal of all supervision agreements.

**Chapter 3 PHYSICIANS WHO DELEGATE MEDICAL ACTS TO APRNs**
- Requires biennial renewal of all supervision agreements
- May now request authority to delegate prescribing schedule II to APRNs.
- Requires on site identification and name tag for APRNs under medical delegation.

The Federal Drug Enforcement Administration (DEA) has clarified its position that you **MAY NOT** write prescriptions for schedule II to be filled at a later time. They confirmed that there is no limit on the amount of drugs which can be prescribed at one time, and that the prescriber must follow any Medical Board protocol. The Board urges you to read its Chapter 10 Rule regarding pain management. See the full DEA decision at [http://www.DEA.gov](http://www.DEA.gov).

**Physician Assistants: New changes to Chapter 2 Rules.**

Physician Assistants: New changes to Chapter 2 Rules.
Certificates of Registrations are now required to be renewed every two years along with the renewal of your physician assistant license. The cost is $50 per registration with a cap of $250. This process will begin with the March 31, 2006 renewal cycle.

**Medicare Prescription Drug Plans**

Medicare Prescription Drug Plans will be available to Medicare recipients beginning January 1, 2006. A recent survey by the Kaiser Family Foundation found that 68% of seniors would be somewhat to very likely to turn to their physicians for help in deciding whether to enroll in a program. If you are unable to help your patients choose an appropriate program there are two places they can be referred for assistance. The first is 1-800 MEDICARE (1-800-633-4227), which will connect people directly to Medicare. In addition each of the Maine Areas on Aging has Medicare Prescription Drug Coverage Specialists to help people understand and enroll in the Medicare plans. Calling 1-877-ELDERS1 (1-877-353-3771) will connect people with the specialist in their area. Please keep these resources in mind as your patients ask you help in deciphering this new Medicare benefit.

**Confidentiality Requirements: What you should know.**

Recently, the Board has seen an increase in licensees, who are the subject of a complaint, sending copies of the complaints and/or their responses to other physicians and entities, such as hospitals or health systems. This action is not appropriate. Pursuant to Title 10 M.R.S.A. §8003-B all complaints and investigative records and materials are confidential until the conclusion of the investigation. In addition, Title 24 M.R.S.A. §2510 (1) designates as confidential any reports, information or records received or developed by the Board during an investigation. Title 24 M.R.S.A. §2510 (3) prohibits a person who receives such information from disclosing it. This prohibition continues even when the complaint is dismissed or otherwise completed. Title 24 M.R.S.A. §2510 (4) makes it a Class E crime to disclose this information. In addition, inappropriate disclosure of this information may result in disciplinary action against your license. All complaint materials should be kept strictly confidential and responses should be sent only to the Board. If you store information regarding a complaint in a patient’s medical chart, you must make sure that this information is not included when records are sent to other practitioners.

\[^1\text{A Class E crime is punishable by a fine of up to $1,000 and six (6) months incarceration}\]
FROM THE BOLIM FILES:

This section is meant to be educational for licensees. Cases are based on actual Board of Licensure in Medicine (BOLIM) complaints.

A standardized and well-defined approach to managing an office practice is essential in this day and age. Uniform office policies or "systems", enable all who work in a physician's office to understand and conform to these standards, thereby improving patient care. How the immense amount of information received in an office on a daily basis is received, reviewed, recorded, and acted upon is vital to good patient care. Reviewing all aspects of how office personnel and physicians deal with this information is an important part of caring for patients. It has been shown that greater than 35% of medical malpractice lawsuits are directly associated with substandard systems within the office setting. The Board of Medicine hears one to three complaints each month that stem from poor office management.

Written policies that define such diverse areas as scheduling, managing incoming calls, reviewing test results, and the physician's charting of office visits are examples of systems that are very helpful. There are many sources of information that can assist with developing guidelines for a practice, including malpractice insurance carriers, medical societies, and private risk management consultants. It may take some time to fully implement these systems, but the improvement in patient care, along with potential time and financial savings makes it well worth the commitment, as demonstrated by the following cases seen by the BOLIM.

Dr. A. prescribed increasing amounts of narcotics over time to a patient with a history of drug abuse and a diagnosis of chronic costochondritis. Several notes by the physician outlined her concerns about possible drug abuse; however, there was no continuity or follow-up plan from note to note. At the same time, the actual prescriptions were poorly charted in several different ways, making it difficult to follow the drug amounts over time and the frequency of refills. A note from a pain consultant, that Dr. A. had referred the patient to, pointed out that this patient was likely abusing medication and recommended further action to cut back on narcotics. No mention of the consultant's note was seen in the progress notes and there was no indication that these recommendations were noted by Dr. A. Finally, no pain contract was present. Pain contracts are another example of a system that should be used regularly for appropriate patients, creating a well-outlined process that makes monitoring uniform and easy to follow.

Dr. B. saw a 70 year old man for shortness of breath and ordered several studies, one of which was an echocardiogram showing a poor ejection fraction. At the next office visit, five months later, no mention was made about the echocardiogram and there was no indication that the patient was asked about his dyspnea. Thus a study performed in the past was never acted upon. Eighteen months later, the patient was hospitalized with acute congestive heart failure, did poorly over several months, and died. The lack of a problem list in the chart contributed to the lack of continuity, and an ultimately serious problem was forgotten.

A patient brought a complaint to the Board about Dr. C, who she felt had overlooked the diagnosis of a rotator cuff tear from not listening to her continued symptoms. Dr. C. had thorough electronic records documenting a complete exam at each and every visit. The patient was seen four times over eleven months and according to the records, had four pelvic exams, four breast exams and four full skin exams. None of the three subsequent visits necessitated more than a focused localized exam of the shoulder. If all the other exams were performed, which of course they weren't, they would have been inappropriate. What actually DID occur became difficult, even to Dr. C. to figure out. Physicians are ultimately responsible for what is in their patients' records and for utilizing new systems appropriately.

These actual cases point out that systems, if properly used, are invaluable in ensuring that problems are dealt with in a continuum, thereby improving patient care, outcomes, and satisfaction.

DID YOU KNOW??

Why do consumers file complaints against physicians?

The most common complaint consumers have is not about fees or quality of care, but is related to the conduct of a physician — lack of attention or disinterest on the part of the physician (or even the staff), rudeness or failure to provide medical records when requested. When a beloved relative dies, apparent lack of sensitivity and communication issues often result in complaints. These are all areas where a physician's efforts to improve may result in fewer complaints being filed and less headaches for physicians.

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Many people experience problems at renewal time because they have neglected to notify the Board of an address change. To prevent delays or even loss of license due to lapse, notify the Board immediately of any change in your mailing address.

REMEMBER THE CONTACT ADDRESS AND PHONE NUMBER YOU INDICATE ON YOUR RENEWAL, “AS YOUR PREFERRED CONTACT ADDRESS”, WILL BE POSTED ON THE BOARD’S WEBSITE.

Check out our website at [http://www.docboard.org/me/me_home.htm](http://www.docboard.org/me/me_home.htm) to verify that the Board has your correct mailing address on file. If the address is incorrect, simply send a signed note with changes to the Board.

Committee on Physician Health Confidential professional help for substance abuse is available by contacting Dr. David J. Simmons at 622-3374 or 623-9266.