Understanding Your Patient

This is the first in a series of articles which provide a general overview of techniques to assist you in understanding your patient using Cognitive Behavioral Therapy. In our next newsletter some techniques to apply CBT in the treatment of non-cancer based pain will be summarized.

Cognitive Behavioral Therapy (CBT) is a tool that can be very helpful in the management of chronic pain problems (Pain 127, 2007, p 276, Turner et al). As such, it is a preferable alternative to chronic opioid management. This is the first in a series of articles which may assist physicians in the understanding CBT and how it may be of use as a non pharmacologic option in a number of clinical situations.

For example, you spill a glass of milk. Right away a little quick thought crosses your mind. Contrast the emotional response of, “You stupid jerk!” to “That was careless.” CBT teaches the patient to bring these thoughts under scrutiny. When the patient modifies their thoughts to be more neutral, the mood improves. CBT is as effective as antidepressants when assigned in random fashion in studies. However, the relapse rate is far lower than antidepressants when therapy is withdrawn.

These quick little thoughts are called automatic thoughts. In dysfunctional persons they are primarily judgmental and negative in character, but everyone has automatic thoughts. The first step is to catch one of these thoughts yourself and notice how the mood that follows is related to the thought. Consider your thoughts when certain patients show up on the schedule. Contrast the mood generated by saying, “I can’t stand her/him!” versus “This is going to be difficult.” Or, “I’ll do the best I can with this patient.” The first task is just to notice that you don’t have to ignore these thoughts and that they affect your mood. It is helpful to ask the patient what is going through their mind. Consider your thoughts when certain patients show up on the schedule. Contrast the mood generated by saying, “I can’t stand her/him!” versus “This is going to be difficult.” Or, “I’ll do the best I can with this patient.” The first task is just to notice that you don’t have to ignore these thoughts and that they affect your mood. It is helpful to ask the patient what is going through their mind.

When there is an obvious severe self-judgment, help the patient modify during the visit to a more neutral appraisal of him/herself. You could say, “My, that’s being harsh with yourself, what would be a kinder way to put that?” Other therapies and advanced CBT identify core beliefs that cause a person to judge themselves harshly, but the patient will feel better to just start modifying these automatic thoughts no matter what their source.

A common set of automatic thoughts follows your suggestion to ask for more testing after an abnormal test result. When the patient looks anxious and distressed, ask what is going through their mind. You might get, “I can’t stand waiting for the test,” or “This means I’m dying,” or “I can’t afford more tests.” Your response will be very different in each situation; the automatic thought guides your next move. When the automatic thought contains extreme states like can’t stand, always, never, should there is generally catastrophization present. This is one of the common categories of automatic thoughts.

Automatic thoughts fall into certain categories or thought distortions and certain patterns are common in different psychiatric illnesses. It is helpful to identify the typical pattern used by the patient and help them address how they are doing every visit. Anxious patients tend to catastrophize, socially anxious patients focus on others negative judgment of them, paranoid patients jump to conclusions, depressed patients filter out all positive input. By learning these patterns and teaching our patients to look out for them, the session with the patient takes on a whole new meaning.
How Your Licensing And Renewal Fees Are Used

The Maine Board of Licensure in Medicine reports current licenses of over 5,500 allopathic physicians, and over 600 physician assistants. Registration from these licensees provides $1.8 million operational revenue for the Board each year. All Board functions, including licensing, complaint investigations, administrative hearings and licensee discipline/monitoring are funded entirely from these fees; no general tax funds are used to operate the board.

There are nine board members: six physicians and three public members. Board member compensation (set by statute over 20 years ago) is so minimal that members effectively work for less than minimum wage. Members consider their extensive time commitment a significant way to "give back" to the profession.

The Board members and staff make every effort to be efficient in using funds provided by licensees. An effort is made to recover the direct costs of investigations when a cause for discipline is found. Neither staff nor board has received a salary increase in the past four years. None are anticipated in the coming fiscal year.

Because of ever increasing costs, the Board made the difficult decision last winter to raise fees for physician renewal. Disciplinary fees go to the general fund, and are not available for Board expenses. For the first time in 12 years the fee to renew licenses was increased, effective April 2012, to $500 every other year. Your license renewal fees are still among the lowest in the region.

Proposed Changes to the Physician Assistant Rule

After over two years in the making, the Board will issue for public comment this fall some significant revisions to the Board Rule — Chapter 2 — relating to physician assistants. The proposed changes will bring the rules which give direction to PAs up to date. The Physician Assistant Advisory Committee was instrumental in analyzing the need for change and proposed the recommended changes. Significant items that are addressed include:

- Establishing a Citation ($200) for failure to have a Plan of Supervision immediately available for inspection.
- CME changes to allow NCCPA certification to meet biennial CME requirements at renewal.
- Establishing that a PA may own the practice, with special provisions.

These rules, once they have gone through the public comment process and are officially adopted, have the effect of law, and are enforceable by the Board and by the courts.

The Board encourages everyone with an interest to provide comments during the comment process. All written comments will be accepted. At this time it is unclear whether a public hearing will to be held.
The Board has invested in a number of major projects, using both cash and extensive staff time. Those projects include:

- The addition of a part time medical director.
- Extensive educational and policy work related to opioid prescription and use, based on the work of public committees related to legislation and the LePage administration task forces.
- $70,000 annual financial sponsorship of the Medical Professionals Health Program (MPHP). This equates to about $20 per licensee.
- $45,000 annual sponsorship of Schedule II Rx education with the Maine Medical Association.
- Outreach/education to citizens and licenses.
- Work with other state medical boards to improve and speed multi-state licensing.
- Active in leadership of the Federation of State Medical Boards of the United States (FSMB).
- Extensive IT upgrade for online licensing, renewal, and improved complaint tracking.

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**Fiscal Year 2012 Budget**

**Revenues:**

- Applications: $281,500
- Renewals: 1,313,200
- Physician Assistant fees: 99,200
- Miscellaneous Fees: 49,900

**Total:** $1,743,800

**Expenses:**

- Operations: $358,450
- Staff payroll: 894,230
- Board compensation: 19,000
- Information Systems: 396,820
- Physician Health Program and Rx education contracts: 116,990
- Investigations Hearings/ expert reviews: 62,760
- Legislative takings: 20,000

**Total Expenses** $1,868,250

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In addition to budgeted expense demands, some $20-$45,000 is taken annually by the legislature to fund general tax fund shortfalls.

If you have any questions please feel free to contact the Board's Executive Director, Randal C. Manning, MBA, CMBE, at 207 287-3605 or randal.c.manning@maine.gov

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**Communication Makes a Difference**

The majority of complaints received by the Board include some aspect of communication. In many cases, it is a lack of clear communication that is directly responsible for the complaint. Communication is often a casualty as healthcare moves away from small, individual, and often personalized medicine into larger health systems. Many of these systems introduce layers of communication between licensees and patients. However, regardless of the system and your status within the system (contractor, employee, independent, etc.) you are responsible for the communication between your office and the people you treat.

The Board recently reviewed a case that illustrates the danger of failing to communicate well within a system.

A medical assistant complained to the practice that Patient A had acted inappropriately in the exam room while the licensee was not present. The complaint was reviewed by the practice administrator, the office manager, and the medical director. After review, but without speaking to the patient, they determined that Patient A should be discharged from the practice. The licensee, Patient A’s primary care provider, was not part of this process, but was presented the discharge letter to sign. Patient A complained of the discharge to the practice and the medical director responded in writing by apologizing to Patient A for causing undue stress and telling him that the termination letter would be removed from his medical record. The medical director told the Board the letter was meant to be conciliatory, but “did not intend to suggest the practice made the incorrect decision…” Patient A interpreted the letter to say that he had been wrongly terminated from the practice and that the licensee was responsible since the letter the licensee signed was being removed from the file. Patient A then filed a complaint against the licensee with the Board.

After review, both the licensee and the health system determined that their communication with the patient was poor and needed to be improved. From failure to speak with the patient about the incident prior to discharge, to sending the patient conflicting information about the discharge, both the licensee and the system failed the patient. In this case, the licensee accepted responsibility for the system’s decision and apologized to the patient for the poor communication.

Regardless of the size of the practice or system you work in, it is your responsibility to make sure that all your patients receive clear communications. Make sure you know what the process is for every interaction between your patient and your practice. Make sure the process involves you directly and, if there is a problem with a patient, make sure you communicated directly with the patient. Taking the time to speak with an upset patient may be the difference between a satisfied patient and a complaint before the Board.
Meetings are held on the following dates at 8:00 am:

Questions? Contact the Board Office at: 207 287-3601

Notify the Board of Business and Home Address Changes Immediately

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 address.

To verify that the Board has your correct addresses on file, visit either of the following sites:
www.maine.gov/md or www.docboard.org/me/me_home.htm and click on “Find a Licensee” in the lower left. If the address is incorrect, simply send a signed note with changes to the Board or submit the new information online at:
www.maine.gov/online/doclicensing/

Confidential Help Available

Confidential professional help for substance abuse is available by calling 207 623-9266.

For more information, visit the MPHP website at www.mainemed.com/health/index.php or send an email to mphp@mainemed.com

2013 Meeting Schedule

Meetings are held the second Tuesday of the month convening at 9:00 a.m. Sub-committees (except for PA Advisory Committee) meet prior to the start of the meeting at scheduled times.

Medical Board Meetings
January 8       July 9
February 12    August 13
March 12       September 10
April 9        October 8
May 14         November 12
June 11        December 10

PA Advisory Committee Meetings
Meetings are held on the following dates at 8:00 am:
March 5        September 3
June 4         December 3

Questions? Contact the Board Office at:  207 287-3601