

## Maine Board of Licensure in Medicine Home Page



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## WHAT EVERYONE SHOULD KNOW

### Important Changes

#### Important Changes to Physician/Physician Assistant License Renewal Process

On November 1, 2017, laws passed during the previous session will become effective and will change the license renewal process as follows:

- The Board will e-mail a renewal notice to your e-mail of record 60 days prior to the expiration of your license. Licensees will not receive any further notices after the 60 day renewal notice.
- **If the license is not renewed during that 60 day period, it will expire and you will not be able to practice medicine.**
- The license will remain in an expired status for 90 days, during which time you may submit a renewal application in order to re-activate your license. Any renewal granted during the 90 day period will be effective on the date that the renewal is granted and **will not be retroactive** to the date on which the license expired.
- If the license is not renewed during the 90 day period, it will automatically lapse.
- Due to the effective date of the law, this will affect licensees with license expiration dates of November 30, 2017 and later.

### **Important Changes to Physician License Renewal Fees**

On January 2, 2018, rule updates will become effective and will change the license renewal process as follows:

- All physicians, **regardless of age**, will pay the full renewal fee for renewal of an active or inactive license

### **New Emeritus License (no fee)**

On January 2, 2018, rule updates will become effective and will change the license process as follows:

- Physicians who are not actively practicing medicine may obtain an **Emeritus License** at no fee. In order to be eligible for an Emeritus License you must have a current active or inactive Maine License. Licensees can submit an application for conversion to an Emeritus License at any time.

### **Important Changes for Physicians Related to Non-Clinical Practice**

On January 2, 2018, rule updates will become effective and will change the initial and renewal processes as follows:

- In order to maintain an active license an applicant for a Maine medical license **must have practiced clinical medicine within the past two years immediately preceding the application.**
- If an applicant has not practiced clinical medicine during the two years immediately preceding the application, he/she is no longer eligible for an active license. In such circumstances, the applicant has the following options:
  - Renew in “inactive” status; or
  - Request conversion to an Emeritus license; or
  - Demonstrate current clinical competence.

### **Important Changes to CME for Physicians**

On January 2, 2018, rule updates will become effective and will change the license renewal process as follows:

- Applicants for renewal of licensure must obtain 40 Category 1 hours of CME every two years. This removes the previous requirement of Category 2 hours.

### **New Notification Requirements for Physicians**

On January 2, 2018, rule updates will become effective, and physicians must notify the Board of the following situations within 10 calendar days or be assessed an administrative fine:

- Change of Contact Information
- Criminal Arrest/Summons/Indictment/Conviction
- Change in status of employment or hospital privileges
- Disciplinary Action
- Material Change of Qualifications
- Termination of Plan of Supervision
- Change of Name (30 day notification requirement)

### **New Alternative Licensure Process for Physicians**

Effective November 1, 2017, the Board will be part of the Interstate Licensure Compact (“Compact”). The Compact offers licensees an alternative method of obtaining licensure in other Compact states. The licensee must obtain a Letter of Qualification from the state of primary residence. Once that letter is forwarded through the Compact system to another Compact state and the appropriate fees are paid the Compact state issues a license. In Maine, the Letter of Qualification and passage of the state Jurisprudence Exam will qualify physicians for permanent licensure. If you are a Maine physician wishing to use the Compact to obtain a license in another state you must meet the following conditions in order to qualify for a Letter of Qualification:

- Graduate from an accredited Medical School or school listed in the IMED database.
- Pass USMLE within 3 attempts or a predecessor exam.
- Complete graduate medical education approved by ACGME.
- Hold specialty board certification.
- Possess a full and unrestricted license to practice medicine.
- Have never been convicted or received adjudication, deferred adjudication, community supervision or deferred disposition for any offense by a court of appropriate jurisdiction.
- Have never been subjected to discipline by state, federal or foreign jurisdictions.
- Have never had a controlled substance license or permit suspended or revoked.
- Not be under active investigation by any authority.
- Have undergone a criminal background check, including fingerprinting.

### **New Law Affecting Death Certificate Certification**

This past legislative session, the Maine 128th Legislature passed a bill which will require that death certificates are completed and filed using Maine’s Electronic Death Registration System (EDRS). **After July 1, 2018 paper records, will no longer be accepted.**

Data, Research, and Vital Statistics (DRVS) would like to encourage health care providers (physician, nurse practitioner or physician assistants authorized to practice in this State) to start using the EDRS as soon as possible. Below, DRVS has provided (3) three options for health care providers to learn more about the EDRS.

1. Try on your own [https://gatewaytest.maine.gov/evrs\\_mirror\\_web/logon.aspx](https://gatewaytest.maine.gov/evrs_mirror_web/logon.aspx) The URL is a link to the web-based system used for training and is a mirror of the functionality in the production database currently in use. The cases created in the training site are not real cases. Health care providers may create and certify death cases to become familiar with the online system. DRVS has created generic usernames and passwords to use in the training site. The username is always “Cert” as the first name and the first four letters of the county of your primary practice. Example: “Cert.Aroo” or “Cert.Knox”, etc. Usernames are case sensitive. The password is Train2017. Once you become comfortable with the application, please contact the Application Support Desk at 1-888-

664-9491 (opt. 7) for an enrollment and disclosure form. You will be provided with a permanent user name, password and the link to the production site.

2. E-Learning Tool - <http://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/edrs/edrs-training/index.html> The URL is a link to the online training module that has been created for health care providers. The training module demonstrates how to complete the medical certification information required by health care providers for the completion of a death certificate. The training module has been designed so health care providers may complete at their convenience. After completion of the training, health care providers will need to complete the post test to gain access to the production database. Successful completion of the post test will generate an email to EDRS staff to enroll you as a user.
3. On-Site Training - A series of on site trainings will be offered by DRVS and held throughout the state over the next few months. On-site trainings may be organized through health care facilities in your area. Training schedules will be announced when finalized.

Thank you in advance for your cooperation and commitment to improving death reporting.

## License and Registration Reminders

**Attention Physicians and Physician Assistants!** Updating your contact information with the Board can save you time and money. Important Board documents (license renewal notifications, complaint notifications, electronic newsletters, licenses) are sent to the last address (mailing/email) you provide to the Board. Failure to update your contact information can result in your not receiving these important notifications, which may have an impact upon your license. You can review and update your contact information online anytime by visiting the Board's website: <http://www.maine.gov/md/online-services/services.html>.

**Attention Physician Assistants!** It is your responsibility to ensure that your license application and registration are properly filed with the Board and that you have both a license and registration prior to rendering any medical services in the State of Maine. Physician assistants who do not ensure that they have both a license and registration face possible disciplinary action and sanction by the Board. For information regarding physician assistant licensure and registration, visit the Board's website: <http://www.maine.gov/md/licensure/physician-assistants.html>.

**Attention Physicians!** Physicians who do not ensure that their physician assistants have both a license and registration also face possible disciplinary action and sanction by the Board.

## DISCIPLINARY ACTIONS

### Adverse Actions

#### **Malathy Sundaram, MD License #MD16273**

Date: August 8, 2017

Action: Consent Agreement - The agreement requires that: Dr. Sundaram obtain a Clinical Competence Assessment from The Center for Personalized Education for Physicians (CPEP), and comply with all resulting recommendations, including, if necessary, implementing an educational or educational intervention program, and practice monitoring; and reimburse Board costs in the amount of \$8,479.

Basis: Engaging in conduct that evidenced a lack of ability or fitness to discharge the duty owed to a

patient or the general public, or that evidenced a lack of knowledge to apply principles or skills to carry out her medical practice, and for unprofessional conduct.

**Catherine Crute, MD License #MD12111**

Date: August 8, 2017

Action: Consent Agreement - The Board imposed a reprimand, a \$1,000 civil penalty, and a probation of at least three months during which Dr. Crute is required to notify all former patients regarding how they may access their medical records.

Basis: Unprofessional conduct for her failure to comply with professional standards related to patient access to medical records.

**Francisco Baraona, MD License #MD19439**

Date: June 13, 2017

Action: Acceptance of Dr. Baraona's request to withdraw his Maine medical license while under investigation.

**Frederick A. van Mourik, MD License #MD123840**

Date: January 30, 2017

Action: Acceptance of Dr. van Mourik's request to surrender his Maine medical license while under investigation.

## FOCUS ON LICENSING ISSUES

### The Challenge of Establishing Clinical Competence

**Margaret Duhamel, M.D., Medical Director, Maine Board of Licensure in Medicine**

BOLIM recently approved "Re-entry to Practice Guidelines" for physicians and physician assistants who choose to take a break from the practice of medicine and allow their licenses to lapse for a period of two or more years. They are required to demonstrate current clinical competency prior to the full reinstatement of their licenses. Clinicians contemplating time away from clinical practice are encouraged to read the guidelines as it may alert them to issues they should consider.

The Rationale for These Guidelines

State medical boards are accountable to the public to assure their licensees maintain a level of competence that is consistent with current professional knowledge and practice. Competency, as defined by the Federation of State Medical Boards is: possessing the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of professional physician practice while adhering to professional ethical standards. (1)

In order to ensure that medical professionals are well trained and competent, medical boards have strict criteria for initial licensure. But when it comes to license renewal, completing the minimum required continuing medical education (CME) has been the most often used method of demonstrating the maintenance of competence. Although CME is important in keeping medical knowledge current, it alone cannot verify competence.

Hospitals also play a role in ensuring current competence. Retaining medical staff privileges often requires clinical peer review and assessments of professionalism and interpersonal functioning. In addition, most hospitals require national board certification as part of granting privileges and employment. Many states, including Maine, do not require board certification as a condition for licensure.

In fact, a law was recently enacted by the Legislature to explicitly prohibit the Board of Licensure in Medicine (BOLIM) and the Board of Osteopathic Licensure (BOL) from requiring national board certification as a condition of licensure or re-licensure. However, national board certification is another way in which to attempt to establish competence, though by itself it does not verify it.

Other efforts are underway to ensure current competence and satisfy the public's expectation that clinicians be held to high performance standards. For example, national specialty boards have enacted Maintenance of Certification (MOC) programs with the intention of assessing ongoing competence in both cognitive expertise and performance in practice. Unfortunately, there have been issues with cost and time expenditure, and questions about the effectiveness of the requirements that have created controversy about some MOC programs. Approximately 85% of the nation's physicians possess a certification from one of the national medical specialty boards. However, the large majority of older physicians who possess certificates that are not time limited, are not participating in MOC (2), making the effort to verify competence even more difficult among this group.

Many medical boards now require clinicians who are renewing or reinstating their license to report if they have not been clinically active for a given period of time because there is evidence that clinical skills degrade as a result of lack of practice. Some physicians maintain an active license (by paying the fee and reporting CME), but do not practice clinical medicine for a substantial period of time. Yet, these physicians have a license, and could restart clinical practice at any time even after a long absence. This creates concern about the competency of the clinical care, and therefore the safety of the patients. This is especially risky when a physician is in private practice and does not have hospital privileges, and is therefore somewhat isolated from peer review. Medical boards now often require clinicians who have been out of clinical practice to take written exams, or attend assessment or remediation programs to identify any gaps in medical knowledge or skills, and to remediate them. Some hospitals have created residency programs specifically to retrain physicians. These requirements are not meant to be demeaning or punitive, but are designed to assure continued competence in order to ensure safe patient care. BOLIM recently approved "Re-entry to Practice Guidelines" for physicians and physician assistants who choose to take a break from the practice of medicine and allow their licenses to lapse for a period of two or more years. They are required to demonstrate current clinical competency prior to the full reinstatement of their licenses. Clinicians contemplating time away from clinical practice are encouraged to read the guidelines as it may alert them to issues that they may have not considered.

Cognitive ability is not the only indicator of competence, but it is certainly a very important factor. Several variables can affect cognition, including health and mental health status, medications, nutrition, genetics, lifestyle choices, and aging. The majority of these variables can affect clinicians at any time in their career and it is imperative that clinicians seek out the appropriate care when they are experiencing physical or emotional problems, as these may unknowingly affect their clinical abilities. There is also evidence that people with mild cognitive impairment demonstrate a lack of insight about their impairments (3). Thus, physicians and physician assistants are required to report to the Board a clinician who is displaying signs of incompetence. Having that clinician assessed and treated can be the best outcome for everyone involved if it gets the clinician back to good health and able to practice safely again.

The aging of the nation's physician population has become an area of concern and controversy. It is well documented that performance on virtually all cognitive measures declines with age. Although studies have shown that cognitive dysfunction is not limited to older physicians, there is significant variability in the degree of cognitive decline, especially after age 70. Efforts at creating age specific cognitive testing have been labelled by some as discriminatory, but because of the large variability in cognitive function at the older age range, the situation cannot be ignored. Again it is not age alone that determines cognitive function, but older age brings the increased risk for health problems, especially neurodegenerative disorders which may account for some of this large variability. BOLIM handled one case of a psychiatrist who maintained an active license and had an independent solo practice while likely experiencing the onset

of microvascular dementia. That case highlights that the reactive process, where issues are discovered only after a complaint is made, may not be in the public's best interest. A proactive process whereby clinicians' competence is regularly assessed is more sensible, be it with MOC requirements, peer review or mandatory physical and cognitive exams, etc. (4)

BOLIM has also dealt with several cases of physicians who change their scope of practice without obtaining all of the necessary retraining or certification. These physicians may have been fully competent in their area of primary training, but without proper retraining, have exposed themselves to situations they were not prepared for and not only endangered patients, but made themselves vulnerable to malpractice claims and the possibility of board disciplinary action. Assuming you can jump into family practice after a career in surgery may be presumptive and/or irresponsible. Physicians considering changing or expanding their areas of practice have a professional and ethical duty to put their patients' best interests before their own and only offer treatments to patients that they are able to provide competently.(5)

Developing realistic and practical methods to evaluate and demonstrate clinicians' competence is an ongoing challenge for medical boards and will continue to evolve. (6) It is important that clinicians embrace these efforts in the spirit in which they are intended.

1. [http://www.fsmb.org/Media/Default/PDF/FSMB/Foundation/mol\\_report\\_of\\_bod\\_on\\_contd\\_competenc](http://www.fsmb.org/Media/Default/PDF/FSMB/Foundation/mol_report_of_bod_on_contd_competenc)
2. <https://www.abim.org/news/physicians-enroll-in-ABIM-MOC-program-in-record-numbers.aspx>
3. <http://dx.doi.org/10.3389/fnagi.2016.00120>
4. [http://www.fsphp.org/sites/default/files/pdfs/fsphp\\_spring\\_2017\\_issue\\_interactive.pdf](http://www.fsphp.org/sites/default/files/pdfs/fsphp_spring_2017_issue_interactive.pdf) (p.11 Physicians Health News)
5. [https://www.fsmb.org/Media/Default/PDF/BRD\\_RPT\\_16-1\\_Ethics\\_Practice\\_Drift.pdf](https://www.fsmb.org/Media/Default/PDF/BRD_RPT_16-1_Ethics_Practice_Drift.pdf)
6. <http://journalofethics.ama-assn.org/2016/10/pfor1-1610.html>

## **How About You -- Compassion Fatigue? Cynicism? Physician Wellness: What can be done?**

**Lani Graham, M.D., MPH Director, Maine Professionals Health Program**

Surveys assessing physician wellness and most other medical professionals are quite alarming. The majority of physicians appear to be neither well nor happy. Symptoms of depression and anxiety are rising. Job satisfaction is falling. Medical literature increasingly identifies "burn-out" as a common occurrence. The causes of this situation are multifactorial, but can largely be traced to a health care system in constant upheaval, both in terms of the methods of health care delivery (ever changing models of care, electronic record requirements, barriers to obtaining care for patients) and the way physicians are currently employed (hospital dominance). Physicians are experiencing larger workloads, less autonomy, difficulty balancing life and work, and uncertainty regarding the meaning of what they do.

The consequences of this situation are clear and go well beyond simple job dissatisfaction. Stress and depression will show themselves in poor patient care as a result of increased medical errors, lack of professionalism in dealing with patients and colleagues, and patients' failure to adhere to medical recommendations. Personal consequences for physician health are also substantial.

Physicians experience compassion fatigue, cynicism, depersonalization and often a general loss of interest in life. In an effort to self-treat, a stressed physician may develop a substance use disorder, which in turn can adversely affect patient care. Divorce rates are higher among physicians than the general public. Worst of all, it has long been known that suicide among physicians is more than double the rate of the general public and for female physicians it is four times that rate. Sadly, physicians are less likely to seek

help for mental health disturbances: only 26% of affected physicians will seek help compared to 40% of the general public. Physicians do not like to admit to health problems of any kind. We are caretakers, not those who require care. And the stigma surrounding mental health problems worsens the situation.

The purpose of this article is to provide readers with a better understanding of this problem as well as to explain the two-sided nature of an effective response.

First of all, physicians have a clear responsibility to be aware of their own health status, which includes mental as well as physical health. It is axiomatic that you cannot take care of others if you are not in good health, and, as with all health problems, the earlier care is sought, the more likely it is that treatment will be effective. Here are some questions that physicians should consider:

- Do you have a primary care physician whom you see for preventive care?
- Are you getting enough sleep each night without the use of sleep aids?
- Do you take time for exercise to stay strong and not just for stress relief?
- Are you maintaining a healthy weight and eating nutritious food?
- Is losing your temper at work rare for you?
- Do you have a well-balanced personal and professional life?
- Do you feel relaxed and comfortable at home?
- Do you find meaning and satisfaction in your work?
- Are feelings of hopelessness, anxiety or depression rare for you?
- Do you use all your vacation days?

If you answered “no” to any of these questions, it would be wise to assess your own health and reach out for some of the resources mentioned at the end of this article.

However, institutions have a big role to play in creating a work environment that is supportive and healthy. It is very unlikely that until the health of medical professionals is valued and tracked using standard metrics by institutions, with appropriate corrective action taken based on what is learned, that there will be any significant improvement in this abysmal situation. It would not be out of place for the Joint Commission to set some standards for at least tracking the wellness of medical personnel and acting on findings. But in the absence of clear-cut accountability standards there are actions that any institution can take and many have begun this process. The Mayo Clinic has been particularly active in moving forward on the health of medical professionals, dating back to 2007. Below are some actions that are being taken around the country as well as in Maine:

- Openly acknowledge the importance of physician health to patient care and the responsibility of the institution to be part of improving the situation
- Back up the acknowledgement with sustained actions (more than “lip service”)
- Make it clear that seeking care for stress or depression is encouraged and admired
- Engage physician leaders in developing strategies for encouraging health
- Support the training of physician leaders in participatory styles of leadership that encourages the sharing of opinions and demonstrates respect and dignity
- Initiate a process of regularly, and anonymously, tracking physician health through a standardized survey (there are a number of tools in use now to do this—anonymity is vital to assuring honest answers)
- Encourage physicians to act on the results of their own survey which can be compared to national data
- Obtain and analyze aggregate data through the surveys that will allow institutions to identify changes leading to clear changes in the work environment
- Promote flexibility in work schedules to enhance work/life integration
- Provide resources and teach skills on site than can reduce stress and promote self-care



- Develop a protocol for responding to individuals who appear stressed that can result in confidential supportive interventions that will be early and sustained over time.

On that subject, the Medical Professionals Health Program (MPHP) now assists medical professionals who may be struggling with stress or depression and who do not have substance use disorders. That assistance can be as simple as providing a list of resources, including treatment providers who are familiar with helping medical professionals. Or it might result in a referral to an out of state program. Please contact anyone at MPHP (623-9266) for further information about how we can help or to get additional resources.

Consult resources listed below for further information:

<http://www.ismanet.org/doctoryourspirit/>

<https://www.mededwebs.com/well-being-index>

<http://jamanetwork.com/pdfaccess.ashx?url=/data/journals/jama/o/>

<http://dx.doi.org/10.1016/j.jmayocp.2016.10.004>

Epstein, R. M., et al. Doing something about physician burnout. *The Lancet*, Vol. 388, No. 10057, 2216-2217.

## **Aging Physicians - A New Challenge for Medical Regulators**

**Dennis E. Smith, Esq. Executive Director, Maine Board of Licensure in Medicine**

*The Board of Licensure in Medicine encourages readers to offer suggestions for best ways to respond to the issues identified in this article. The Board has an obligation to generate policy addressing these issues, and would be appreciative of readers' reflections and recommendations.*

The Federation of State Medical Boards (FSMB) recently published the 2016 census of actively licensed physicians in the United States.<sup>(1)</sup> The census shows that the number of physicians over age 60 who still practice medicine continues to grow. Today 29.3% of actively licensed physicians in the U.S. are age 60 or older. In comparison, according to FSMB data regarding Maine physicians, 30.9% of Maine physicians are ages 60 and older.

During the previous several years, a number of articles have appeared in medical and regulatory journals regarding the aging of physicians and its potential impact upon physical and cognitive abilities, and, therefore, clinical competency and patient safety. Studies have shown that cognitive intelligence is comprised of crystalized intelligence and fluid intelligence. Both are required in medicine in order to appropriately and safely diagnose and treat patients. However, while crystalized intelligence is generally preserved with age, fluid intelligence is more susceptible to decline with age. Crystalized intelligence is composed of cumulative information acquired during one's lifetime, including medical knowledge, training and experience. Crystalized intelligence allows physicians to recognize patterns in making diagnoses and perform familiar clinical tasks. Fluid intelligence is the ability to reason: to process information, analyze it, and solve new and complex problems. As fluid intelligence declines, complex and urgent problems become more difficult to solve. While older physicians bring a breadth of experience and wisdom to patient care, studies have shown that they do not perform as well as younger physicians on knowledge tests or with patient examination and record keeping.

The issue of aging physicians and its potential effect on patient safety raises a number of difficult questions:

- Is there an age at which a physician should no longer practice clinical medicine?

- Should physicians have mandatory retirement ages as do other professions such as airline pilots, air traffic controllers, and FBI agents?
- Since studies have shown a decline in cognitive abilities for all persons after age 50, should physicians undergo cognitive evaluation and testing and, if so, at what age?

One of the major challenges in answering these questions is the fact that aging, by itself, does not affect all physicians in the same way. Some physicians experience less physical and cognitive decline than others – and vice versa. However, the same could be said for airline pilots, air traffic controllers and FBI agents, yet those professionals face mandatory retirement ages regardless of physical and cognitive ability. In addition, airline pilots are required to undergo regular assessments of their mental and physical health, which reflects a “proactive” approach to ensuring current competency and the safety of the public. In contrast, with limited exceptions, licensing and regulatory agencies employ a “reactive” approach with regard to physician assessment. The Maine Board of Licensure in Medicine (Board) may open an investigation regarding a physician’s competency based upon a patient complaint or a report by a health care provider or healthcare entity that has concerns regarding a physician’s ability to competently care for patients. Upon receipt of such a report, in some circumstances the Board directs the reported physician to undergo a cognitive evaluation.

Because of the potential for significant patient harm, some entities are advocating for and, in some cases, taking a more “proactive” approach to this issue. In 2015 the Council on Medical Education (CME) of the American Medical Association (AMA) issued a report which stated that a physician has a “professional duty to continually assess his or her own physical and mental health” and called for the development of formal “guidelines/standards for monitoring and assessing” aging physicians’ competency.<sup>(2)</sup> In 2016 the American College of Surgeons (ACS) issued a statement recognizing the fact that surgeons “are not immune to age-related decline in physical and cognitive skills,” and supporting the “objective assessment of fitness” of an aging surgeon in lieu of a mandatory retirement age.<sup>(3)</sup> The ACS statement recommended that “starting at age 65-70, surgeons undergo voluntary and confidential baseline physical examination and visual testing by their personal physician,” encouraged surgeons to “voluntarily assess their neurocognitive function using confidential online tools,” and reminded them to disclose any concerning findings. This proactive approach by the AMA and the ACS relies primarily upon voluntary action by physicians. However, physicians who are already cognitively impaired are less likely to recognize the need for an evaluation or to self-limit their practice. In addition, studies have shown that a significant percentage of physicians who are aware of a colleague’s competency issues do not report them to the relevant authorities. In addition, a 2017 article in the Journal of the American Medical Association Surgery recommended that “the most promising and feasible next step is to move from voluntary to mandatory programs to assess the wellness and competence of physicians at a certain age.”<sup>(4)</sup>

More and more hospital systems are already mandating that physicians undergo health and cognitive screenings upon reaching a certain age. The University of Virginia Health System requires physicians to undergo a physical and mental screening upon reaching the age of 70, and upon reaching the age of 75 to undergo the screening every 2 years. Other hospital systems that have imposed similar requirements include: Driscoll Children’s Hospital in Texas, Stanford Hospitals and Clinics in California, Cooper University Health Care in New Jersey, and the University of Pittsburgh Medical Center Health Care System. Opponents of the screenings assert that they are unnecessary and discriminatory. Proponents of the screening argue that they verify the physicians’ health and competency and act to allay any concerns of patient advocates.

The Board recognizes that for a significant number of physicians, practicing medicine is not just an occupation; it is their calling and identity. It takes years of hard work and commitment to complete medical education and training. Physicians who have been caring for patients for many years have provided an invaluable service to the community, and continue to do so – especially in rural areas. However, experience has shown that some older physicians continue to practice beyond the time when it

is safe to do so. Recently, the Board had three cases where older physicians were investigated for issues related to competency and professionalism. Each of the cases shared the following commonalities:

- The physicians were age 80 or older
- The physicians were in solo practice
- The physicians failed to create and maintain adequate medical records

Significantly, studies have shown that physicians in solo practice are more likely to score lower on knowledge-based examinations and that older physicians' have more problems with medical record documentation. Other risk factors for predicting substandard performance include: lack of board certification, general practice, and practice outside of the scope of the physician's training. For example, the Board dealt with a complaint involving a physician OB-GYN, who towards the end of his career attempted to practice as a general family physician, including prescribing opiates. As a result of unprofessional practice and substandard medical record keeping, the physician was disciplined and his license restricted.

The Board is aware of the aging of Maine physicians and the issues surrounding it. The Board's mission is to protect the public, and it is studying this issue and ways to be more "proactive" in identifying physicians whose physical and/or cognitive abilities may pose a risk to the delivery of safe patient care. Recently, the Board adopted new guidelines for physician re-entry to medical practice.<sup>(5)</sup> The new guidelines identify the steps that physicians should take in order to return to medical practice, including older physicians who may have previously retired. In addition, the Board is considering whether or not a physical and mental health screening would be appropriate when physicians reach a certain age. Like the AMA and ACS, the Board encourages all physicians to continually assess their physical and mental health and report to the Board physicians who may be impaired, incompetent or unprofessional. The Board also encourages physicians to be cognizant of the effects that age may have on themselves and their colleagues and their ability to safely practice medicine. Physicians take an oath at the beginning of their medical practice to "do no harm." That oath should remain paramount – even into the twilight years of practice.

1. Young A, Chaudhry HJ, Pei X, Arnhart K, Dugan M, Snyder G. *A Census of Actively Licensed Physicians in the United States, 2016*. *Journal of Medical Regulation*, Vol. 103, No. 2:7-21, 2016. Available at <https://www.fsmb.org/Media/Default/PDF/Census/2016census.pdf>.
2. American Medical Association, *Competency and the Aging Physician, Report 5 of the Council on Medical Education (A-15)*. Chicago, IL: AMA, 2015. Available at <https://www.cppph.org/wp-content/uploads/2016/02/AMA-Council-on-Medical-Education-Aging-Physician-Report-2015.pdf>.
3. American College of Surgeons Board of Governors Physician Competency and Health Workgroup, Statement on the Aging Surgeon, *Bull Am Coll Surg* 2016, 101(1): 42-43. Available at <https://www.facs.org/about-ac/s/statements/80-aging-surgeon>.
4. Dellinger E P, Pellegrini C, Gallagher T, *The Aging Physician and the Medical Profession, A Review*, *JAMA Surg*. doi: 10.1001, 2017. Available at <https://www.ncbi.nlm.nih.gov/pubmed/28724142>.
5. <http://www.maine.gov/md/laws-statutes/policies.html>

## NEW PHYSICIAN BOARD MEMBER

### New Board Member, Michael Sullivan, MD



Michael Sullivan, M.D. is board certified in Family Medicine and practices both Hospitalist Medicine and Emergency Medicine at Northern Maine Medical Center. Dr.



Sullivan has also held several teaching, administrative, and quality positions at Northern Maine Medical Center as well as other hospitals and universities.

Dr. Sullivan is a native of Illinois but has called Maine home since 2003. He is married and has two teenage children.

## OPPORTUNITIES

### **New Medical Reserve Corps Units in Maine!**

September is *National Preparedness Month*-a suiting designation this year considering the tremendous response we have recently seen following a busy hurricane season in the Atlantic, Caribbean and Gulf of Mexico. In the spirit of preparedness, Maine has recently added six new *Medical Reserve Corps* units to our Public Health landscape (bringing the total number of units to eight across the state-one for each of Maine's Public Health Districts).

The Medical Reserve Corps is a federal program that supports building local teams of volunteers to aid in public health initiatives and respond as needed during disasters or public health emergencies. MRC members register with the state as volunteers ([www.MaineResponds.org](http://www.MaineResponds.org)) and meet, train, exercise and deploy with their local unit. In the event of a statewide crisis these teams can be folded into the larger response.

All of Maine's MRC units are actively recruiting volunteers. Although medical professionals are the target audience for these teams, a background in healthcare is not a prerequisite to volunteer with MRC. There are countless volunteer roles needed to support an organized response to a public health emergency. What is important is that volunteers are registered with Maine Responds and join one of Maine's MRC units *before* disaster strikes.

For more information about the local Medical Reserve Corps unit in your region please contact State Coordinator Jared McCannell at [jared.mccannell@maine.gov](mailto:jared.mccannell@maine.gov) or visit [www.maineresponds.org](http://www.maineresponds.org) to register as a Public Health volunteer with the State of Maine.

### **Vacant Seat on The Board of Pesticides Control**

The Board of Pesticides Control (BPC) is Maine's lead agency for pesticide oversight. The BPC is attached to the Maine Department of Agriculture, Conservation and Forestry for administrative and staffing purposes. Policy decisions are made by a seven-member, public board.

BPC currently has a vacant seat. The seat must be filled by a representative of the medical community and was previously held by Carol Eckert MD, who served for 30 years.

The Board meets 9 times per year with a normal meeting taking 3-4 hours.

If you are interested, please contact Peggy Lamb at [peggy.lamb@maine.gov](mailto:peggy.lamb@maine.gov)

### **School Bus Driver Fitness Determination**

## **Repeal and replacement of Chapter 81: Uniform School Bus Standards for Pupil Transportation in Maine**

The enacted new regulations that replaced Chapter 81: Uniform School Bus Standards for Pupil Transportation in Maine and became effective on 9/16/17 can be found on the following link:

<http://maine.gov/doe/transportation/laws/index.html>

In order to provide increased clarity and durability to its regulations relating to student transportation, the Department broke the existing Chapter 81 into six shorter regulations, Chapters 81-86. Most of the language of the former Chapter 81, with the exception of specifications, remains; however, minor changes to existing regulatory language were made in order to modernize the regulations with technical, language, and process updates to make it easier for all to understand and use. The enacted new rules include the following updates:

- Chapter 81 School Transportation Safety identifies uniform safety requirements that include student riding safety practices training, school bus driver entry-level training, transportation employee in-service safety training, prohibitions, school bus daily inspections, contracts, year-end transportation reports, and records retention.
- Chapter 82 School Bus Driver Fitness Determination retains the requirement of an annual physical and adapts to federal changes by moving to use of the U.S. Department of Transportation Federal Motor Carrier Safety Administration Medical Examination Report Form and National Registry of Certified Medical Examiners. Please note annual physical renewal date will remain the same.
- Chapter 83 School Transportation Operations Program establishes requirements for access to transportation operations software made available by the Department at no cost to public schools, including public charter schools, and private schools approved for the receipt of public funds.
- Chapter 84 School Bus Refurbishment Program contains requirements derived from the existing Memorandum of Understanding between the Department and the Maine Military Authority for participation in the School Bus Refurbishment Program.
- Chapter 85 School Bus Purchase Program retains most of the language while modernizing the regulation with technical, language, and process updates.
- Chapter 86 Maine Uniform School Bus Specifications updates school bus specifications to align with both state and federal standards by adopting, with exceptions, the National School Transportation Specifications and Procedures 2015 as enacted by the National Congress on School Transportation.

Questions should be directed to Pat Hinckley, Transportation and Facilities Administration, at [pat.hinckley@maine.gov](mailto:pat.hinckley@maine.gov).

## **FROM THE EDITOR**

### **Book Review**

Jessica Nutik Zitter. *Extreme Measures: Finding a Better Path To The End Of Life*. New York: Avery, 2017. 352 pp. \$27.00

Haider Warraich. *Modern Death: How Medicine Changed The End Of Life*. New York: St. Martin's Press, 2017. 336 pp. \$26.99

These two notable books on conundrums at the end of life were reviewed by Jerald Winakur in the "Advanced Illness & End-Of-Life Care" issue of *Health Affairs* (Vol. 36: No. 7, July 2017). Dr. Winakur is a clinical professor of medicine and an associate faculty member at the Center for Medical Humanities and Ethics at UT Health Science Center San Antonio.

The full review can be found at <http://content.healthaffairs.org/content/36/7/1343.full>

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**Credits**

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