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MAINE BOARD OF LICENSURE IN MEDICINE BOLIM

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Spring 2019

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Maroulla S. Gleaton, M.D.

New Guidelines for Communicating with Patients

May will mark the end of my 12th and final year as a physician member of the Board of Licensure in Medicine ("Board"). I was appointed to the Board in May 2007 by then Governor John Baldacci, and elected by the Board membership to serve as Chair since 2013. It has been a privilege to serve on the Board, which – like the medical profession – has continued to evolve. Since I first joined the Board, its systems, rules, policies, and guidelines have been continually updated to keep apace of emerging issues facing medical licensing and regulation at both the State and national levels.

During my tenure with the Board one issue of concern to patients and their family members has been repeatedly raised with the Board: professional communication – or rather the lack thereof. Like sound medical practice, professional communication is a skill that requires constant cultivation. Also, like good medical practice, professional communication is a combination of both science and art. Time and again the Board receives complaints regarding allegations of unprofessional communication by physicians or physician assistants. These complaints run the gamut: not listening; not allowing the patient to speak or cutting off a patient; not making eye contact with the patient – staring at the computer; making off-color jokes or attempts at humor in inappropriate circumstances; acting robotic – not expressing empathy; failing to communicate the results of tests; inappropriate statements or behaviors towards other medical personnel; and on and on.

The Board has tried to educate its licensees regarding this issue, including through previous articles in the Board's newsletter. In some cases, the unprofessional communication is so unacceptable that the Board imposes discipline, while in others it issues a "Letter of Guidance or Concern."

In an effort to "get the word out" to licensees regarding the importance of professional communication, the Board recently developed new guidelines entitled "Communicating with Patients." The guidelines are intended to convey the message that professional communication with patients is both a science and an art. I would encourage all licensees to review these new guidelines, which are reproduced below. They are also available on the Board's website: https://www.maine.gov/md/laws-statutes/policies.html. See From the Editor below for further reading suggestions.

As professionals and as healers, we owe it to our patients to "do no harm" in our communications with our patients.

Communicating With Patients

Guidelines from the Maine Board of Licensure in Medicine

Why Are These Guidelines Important?
Refined skills in communicating with patients have been shown in many studies to produce therapeutic benefits for patients.

It is likewise true that patients who experience satisfaction with their clinicians' sincere attempts at meaningful communication also express greater satisfaction with their medical care over-all.

A practical consequence of this attitude is the likely preclusion of complaints to the Board, and to the courts via lawsuits. A majority of Board complaints about clinicians are related to issues of communication, rather than clinical competence. (1)

The Board intends these Guidelines to enhance the artful practice of the science of medicine, as shown by this analogy to musical performance: "To become a musician . . . you need to acquire all the technical skills . . . the notes, the chords, the scales. This is the *science* of music. But when you *play* music, especially when you improvise, this is the art of music." (2)

Goals of These Guidelines
A primary goal of these Guidelines is to facilitate an increase in comfort and confidence for clinicians and patients, which then can lead to more satisfactory outcomes in terms of diagnosis and readiness to act in accordance with treatment plans.

A second goal is to increase efficiency in office visits by obtaining a good history that adds *meaning* to the information given (more on this below).

A third goal is to emphasize that, like any skill, effective communication requires practice, reflection, and refinement.

The Setting
The most effective position to assume while communicating with a patient is to sit down at the same level as the patient, in an unhurried posture, showing emotional comfort, while making easy and sustained eye contact.

Sitting in this way is itself powerful non-verbal communication. (3) It leads to a *perception* of added time with the patient (but not actual time). It also conveys an impression of caring, connection, and respect. When this impression is sincere, there is a very good chance the patient will be pleased, even gratified with the visit.

The desk, the computer, and the chair can either be aids or impediments to good communication. In general, it is better not to use a desk to separate yourself from the patient. Likewise, looking at the computer screen while talking with a patient can convey an impression of indifference to the patient as a *person*, rather than as a clinical portrait.

If necessary, given that electronic medical records are ubiquitous, place the computer such that it and the patient are in the same line of sight. This way, shifting focus from the patient to the screen can be done by simply raising and lowering the eyes.

Kinds of Questions

"Everyone nodded, nobody agreed." (4) This outcome is to be avoided at all cost.

Typically when patients encounter their clinician they want to "begin the story" of their problem, their illness, their suffering. This can be facilitated with an *open question* such as "What's happening; what's going on?" Some patients may be reluctant at first and will need gentle prodding; don't be in a hurry. Once the story has been told, the clinician can ask, "How can I help?"

On the other hand, clinicians often want to hear "the chief complaint," and fear the patient's story will take too long to tell. Research shows this fear, in almost all cases, is unfounded. On average, telling the story takes approximately 150 seconds (two and a half minutes). However, given the pressure of time (and perhaps a reluctance to give up control), there is an urge to interrupt the patient with a question, which can leave the patient feeling cut-off and that the clinician is not really interested in the background and context of the problem, which might prove to be essential for a correct diagnosis.

How a question is framed will affect the answer offered.

Sometimes starting a question with "Why . . . ?" can sound critical or inquisitorial, and therefore should be avoided. Patients can be expected to *describe* rather than to interpret, or explain. The latter is the clinician's job.

Likewise, *closed questions* that require a specific answer (a Q & A list of symptoms aimed at Yes or No answers) leave little room for qualification or explanation, and when asked in rapid succession can be so taxing as to preclude precision in response. This is especially important to keep in mind when the patient is feeling vulnerable due to anxiety or pain.

Leading questions: "Did you then take the pills as prescribed?" is a leading question. This form can introduce bias and be misleading. Objectivity (accuracy and precision) is compromised by leading questions.

After discussing a medical situation, asking a patient "Do you understand?" can actually be threatening. Admitting a lack of understanding can feel like exposing ignorance – nobody wants to do that. So, that form of question might well elicit a nod of agreement, when there is no agreement.

With all these caveats, what is left? Open questions (i.e., "What did you do then?") that allow the patient to tell the story of the problem, followed by requests for clarification and elaboration, followed by the "teach back" technique; that is, asking the patient to express a personal understanding of the conversation, along with desires, and expectations. This form of question does not carry the same threat potential that comes with "Do you understand?"

Kinds of Listening

Consider this anecdote from an astute physician: A wise senior partner told me when I was starting, "You will know the diagnosis within a minute of entering the room. Restrain

yourself from triumphantly announcing it. Instead, sit down and listen to the story. Even examine him/her whether you need to or not. He/she has come less for the diagnosis than to be seen and heard. And who knows, you might find out that your first impression was wrong."

There is a useful distinction between two kinds of listening:

1. Keenly focused attention with regard to the technical/medical concerns of the listener: like recording post-surgical details. This is related to a closed Q & A list of questions.
2. Empathetic attention with the aim of assuming the speaker's perspective: like identifying with a character in a novel or a movie. This is related to the open narrative type of question.

In the first kind of listening, if what is heard does not fit within what is already known and familiar, it may sometimes be discounted or ignored.

The second kind of listening is deliberately drawn to anomaly, to the descriptive details and explanations that make the speaker unique as a person who is also a patient, or make the situation unique because *this* person is in it. (The anecdote above is about this kind of listening.)

Failure to recognize the anomalous (unique) patient can usually be traced to the clinician's skills and style of listening. Luckily, the skills of empathetic understanding can be improved simply and without cost (except in terms of time set aside for the purpose). Start by engaging a partner who is willing to sit with you and explain something of personal importance. Attend to what is offered and do not interrupt except to clarify your understanding of a word or expression. At certain junctures, ask to paraphrase in your own words what you believe you have heard. Repeat until the speaker can certify your understanding by saying something like "Yes; that is what I mean. You understand."

This exercise takes time because first impressions or first interpretations are often only partially correct. They need refinement to capture subtlety; that is, to become accurate and precise. Accuracy and precision in understanding what a patient is saying can be more than helpful in diagnostics and treatment planning.

If a good scientific clinician is one who seeks, acquires, interprets, and understands all data relevant to diagnosing and treating a given condition, and if empathetic understanding offers access to more of these data that would otherwise be unavailable, then the clinician who has developed skills of empathetic understanding is a better scientific clinician, as well as a more adaptable one. Just as important, the clinician who listens empathetically conveys that she/he cares about the patient.

Kinds of Explanation

It is important to distinguish between two useful but distinct kinds of explanation. The first is *scientific* explanation, which is making a case for why certain events are the way

they are and for predicting future events. The second is *semantic* explanation, which by contrast is making the meaning of something clear to the listener. Semantic explanation is like translation or paraphrase, using different words and terms until the intended meaning is revealed and understood.

An explanation can be *satisfactory* (to the clinician) from a formal (scientific) point of view, while at the same time failing to be *satisfying* from the patient's point of view. Another way to put this point is that while a medical explanation of risks and benefits associated with treatment options can be scientifically sound, the listener may find it to be unintelligible, and therefore not useful as information upon which to grant or withhold consent, or even to comprehend what to expect, or what to do.

Self-Evaluation

Be aware of the "Lake Wobegon Effect": a town where "all the children are above average."

There is a common tendency for clinicians to overestimate their communicative effectiveness. It is helpful to be aware of one's personal style and when it may not be working. "Inappropriate humor" can be particularly damaging to relations with patients and their families.

Self-review of interpersonal behavior, often with the help of a colleague (especially including nurses) takes a bit of humility, but it can be enormously helpful. Nurses have more frequent incidental interaction with patients who might reveal to them misunderstandings, particular needs, and reactions. Nurses can be a rich source of information about how to communicate with individual patients, and to interpret their non-verbal signs.

Extension to Other Persons and Situations

While these Guidelines have been focused on clinician-patient interactions, they can with similar benefit be applied to conversations with colleagues, nurses, other staff members, patients' families and advocates, and even, should it come to that, with Board members.

Plenty of research shows that a higher quality of communication skills and effort leads to higher quality in patient outcomes, and interpersonal relations generally.

Footnotes

1. Competent clinical decision-making is not, by itself, enough. Interpersonal and communications skills are one of the six areas in which clinicians-in-training need to demonstrate competence as identified by the Accreditation Council for Graduate Medical Education (ACGME).
2. Danielle Ofri, MD. What Patients Say, What Doctors Hear. Beacon Press, 2017.
3. Nonverbal communication (e.g., body language and facial expressions) occurs throughout a patient encounter. Clinicians are trained to observe and evaluate patients' nonverbal cues. A clinician's nonverbal cues can convey to the patient a sense of attention or caring or a sense of impatience and indifference.

4. Ian McEwan. Amsterdam. Doubleday, 1999.

Recent Response to the Opioid Epidemic

Maine and the United States are still in the throes of an opioid epidemic. At least 1,630 people in Maine have died from a drug overdose in the last five years, including 418 deaths in 2017 alone – more than one death per day. Much has been done to combat this epidemic, including mandatory PMP checks, dosage limits, and mandatory continuing medical education regarding opioid prescribing. Prescriptions for opioids in Maine have dropped significantly. Yet more needs to be done.

Governor Janet T. Mills appointed Gordon Smith, Esq. to serve as the Director of Opioid Response for the State of Maine. In addition, on February 6, 2019, Governor Mills issued an *Executive Order To Implement Immediate Responses to Maine's Opioid Epidemic*. A copy of that Executive Order is available on the Governor's website: https://www.maine.gov/governor/mills/official_documents.

The Executive Order outlines Mr. Smith's authority and responsibilities as the Director of Opioid Response, including:

- Identifying non-tax based financial resources such as grants to fund programs to prevent and treat substance use disorder.
- Using available funds to purchase doses of Naloxone for distribution to hospitals, needle exchange programs, public health districts, and peer recovery centers.
- Encouraging clinicians who prescribe more than 100 morphine milligram equivalents (MME) or other potentially combination of dangerous drugs to co-prescribe Naloxone.
- Developing an Overdose Map with geomapping technology to identify overdose hotspots and provide real-time data sharing.
- Integrating Medication Assisted Therapy (MAT) into the criminal justice system.
- Designing a MAT plan as part of a larger system of a "hub" of clinical care and "spokes" of supportive services.

At its most recent meeting on March 12, 2019, Mr. Smith addressed the Board regarding his new position as the Director of Opioid Response, Governor Mills' Executive Order, and some of the initiatives he intends to implement. To assist in the continued efforts to combat the opioid epidemic in Maine, the Board strongly encourages any licensees who prescribe more than 100 morphine milligram equivalents (MME) or other potentially dangerous combination of drugs to co-prescribe Naloxone.

Social Media and Medicine

The Merriam-Webster Dictionary defines "social media" as "forms of electronic communication (such as websites for social networking and microblogging) through which users create online communities to share information, ideas, personal messages, and other content (such as videos)." (1) It includes Facebook, LinkedIn, Twitter, Instagram,

Snapchat, Pinterest, and the list goes on. Reduced to their simplest forms, social media sites are electronic bulletin boards where anyone can “write” or “post” a message. Social media differ from most other forms of communication: once the communication is posted, the message leaves the control of the author and can go virtually anywhere and be viewed by almost anyone. When the message is positive and professional, it can be a good thing. When the message is negative or unprofessional, it can be a bad thing - especially if the author is also a physician or physician assistant.

Recently, the Board has received a number of complaints about licensees posting negative or unprofessional messages using social media. When filing their complaints about licensee communications on social media, complainants have provided the Board with a copy of the social media posting(s) by the licensee. *The Code of Medical Ethics of the American Medical Association* Principle 2.3.2 is entitled *Professionalism in the Use of Social Media* and imposes an ethical responsibility upon licensees to consider a number of factors when using social media. One of those factors is as follows:

> They must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine the public trust in the medical profession.

Recognizing this issue, the Board recently enacted guidelines regarding *Medical Professionalism and Social Media*, which are available on the Board’s website: https://www.maine.gov/md/laws-statutes/policies.html.

When considering whether or not to post a message on social media, ask yourself these questions:

1. If I put the message on a giant poster and put it in the lobby of my medical practice or the hospital or clinic where I work, how would it be viewed by patients, colleagues, administrators and others?
2. Would the posting have any tendency to reflect negatively upon the medical profession or undermine the public trust in the medical profession?
3. Would I want the Board to see it?

Footnotes

1. https://www.merriam-webster.com/dictionary/social%20media

New Rules

Seeking Comments on Proposed Sexual Misconduct Rule

The Board of Licensure in Medicine and the Board of Osteopathic Licensure propose to repeal and replace a joint rule regarding sexual misconduct. The proposed rule defines terms, including the new term "key third parties"; defines sexual misconduct by physicians and physician assistants; sets forth the range of sanctions applicable to violations of the

rule; and identifies the factors the Boards should consider in imposing sanctions. Comments are due by Friday, April 12, 2019 at 4:30 p.m. The complete document can be found on our website at www.maine.gov/md

Seeking Comments on Proposed Office Based Treatment of Opioid Use Disorder Rule

The Board of Licensure in Medicine, State Board of Nursing, and Board of Osteopathic Licensure propose to adopt a new joint rule regarding office based treatment of opioid use disorder. The proposed rule defines terms; establishes minimum requirements for qualified clinicians to prescribe, and in limited circumstances, dispense approved medications to individuals requiring and seeking treatment for opioid use disorder; establishes requirements for prescriptions for approved medications; establishes principles for proper office based treatment for opioid use disorder; establishes requirements for clinical care and management; and establishes additional requirements for pregnant patients and adolescent patients. Comments are due by Friday, April 12, 2019 at 4:30 p.m. The complete document can be found on our website at www.maine.gov/md

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 and Physician Assistants!

All licensees with an active license, except for Emeritus status, must complete 3 hours of opioid CME reach renewal cycle. The Board has partnered with Quality Counts to provide free CME on their website https://qclearninglab.org/course-cat/caring-for-me/

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.

ADVERSE ACTIONS

David R. Austin, M.D. License #MD12867 (Date of Action 03/12/19)
On March 12, 2019, Dr. Austin entered into a Consent Agreement for Reinstatement of Licensure with the Board. The Board action was based upon misrepresentations made in obtaining a license, substance misuse, unprofessional conduct, and reentry to clinical practice. The Board imposed a reprimand for misrepresentations made in obtaining a license, a $200.00 civil penalty, and probation for a period of not less than (5) years with conditions, including maintenance and compliance with a monitoring agreement requirements with the Maine Professionals Health Program, engaging a Physician Practice Monitor, and reporting requirements.

Phillip J. Din, M.D. License #MD18293 (Date of Action 03/12/19)
On March 12, 2019, Dr. Din entered into a Consent Agreement with the Board for misrepresentation in obtaining a license and engaging in unprofessional conduct. The Board imposed a reprimand for misrepresentation on his application to renew his license and unprofessional conduct related to his prescribing of controlled substances to family members, a $1,000.00 civil penalty, a license condition that Dr. Din shall not prescribe any medications to self, family or household members, and a requirement that Dr. Din complete an in-person continuing medical education course on the subject of professional ethics pre-approved by the Board within six (6) months.

Ronald D. Oldfield, P.A. License #PA564 (Date of Action 03/12/19)
On March 12, 2019 the Board reviewed Dr. Oldfield's compliance with his Consent Agreement and his request to terminate the remaining probation requirement related to mental health therapy. Following its review, the Board voted to terminate that probation requirement. Dr. Oldfield has completed the requirements of his probation and the January 9, 2018 Consent Agreement with the Board.

G. Paul Savidge, M.D. License #MD8503 (Date of Action 03/12/19)
On March 12, 2019, the parties entered into a First Amendment to the Consent Agreement effective October 9, 2018, amending paragraph 11(c)(5) to clarify the requirements related to the Physician Practice Monitor.

Malathy Sundaram, M.D. License #MD16273 (Date of Action 03/12/19)
On March 12, 2019, the Board reviewed information and determined that Dr. Sundaram had taken all action necessary to come into compliance with the August 8, 2017 Consent Agreement and reinstated her license from suspended to active status.

Michael A. Weicker, M.D. License #TD161119 (Date of Action 03/12/19)
On March 12, 2019, Dr. Weicker entered into a Consent Agreement with the Board for unprofessional conduct. The Board imposed a reprimand for inadequate medical record documentation. Dr. Weicker shall complete an in-person continuing medical education course on medical recordkeeping pre-approved by the Board within six (6) months. Prior

to submitting an application to the Board for any Maine medical license, Dr. Weicker shall undergo a neurological examination.

Zakia D. Bell, M.D. License #MD21775 (Date of Action 2/18/19)
On January 8, 2019, the Board preliminarily denied Dr. Bell's application for a Maine medical license which denial became final on February 18, 2019. The basis for the denial of Dr. Bell's license was based upon failure to take and pass the State of Maine Jurisprudence Examination in order to qualify for licensure, and for representing that she met Maine licensure requirements on a 2017 emergency license application.

Paul M. Willette, M.D. License #MD18545 (Date of Action 2/12/2019)
On February 12, 2019, the Board issued a Decision and Order following an Adjudicatory Hearing that was held on January 8, 2019. The Board upheld the preliminary denial of Dr. Willette's application for renewal of his Maine medical license based on the following statutory violations: 1) fraud in seeking to obtain a renewal of his Maine medical license; 2) incompetence by engaging in conduct that evidenced a lack of ability to discharge the duty owed by the licensee to the patient; 3) incompetence by engaging in conduct that evidenced a lack of knowledge and an ability to apply the principles or skills to carry out the practice of medicine; 4) engaging in unprofessional conduct by violating standards of professional behavior, including engaging in disruptive behavior; and 5) disciplinary action imposed by medical boards in Colorado and New Mexico for conduct which constituted grounds for discipline in Maine.

Janice A. King, P.A. License #PAN1698 (Date of Action 2/1/19)
On February 1, 2019, the Board accepted Ms. King’s request to withdraw her application to renew her Maine physician assistant license while under investigation.

Cathleen G. London, M.D. License #MD20645 (Date of Action 1/8/19)
On January 8, 2019, the parties entered into a First Amendment to the Consent Agreement effective August 14, 2018, amending paragraph 38(c)(5) to permit monitoring of Dr. London's compliance with prescribing and medical recordkeeping standards to be conducted by an interdisciplinary team ("IDT").

Daniel Bobker, M.D. License #MD13940 (Date of Action 1/8/19)
On January 8, 2019, Dr. Bobker entered into a Consent Agreement with the Board. The Board imposed a reprimand for in engaging in deceit or misrepresentation in connection with issuing prescriptions of olanzapine, misuse of non-controlled substances that may result in performing services in a manner that endangers the health or safety of patients, and for unprofessional conduct. Dr. Bobker shall not prescribe to self, family or household members. The Board imposed a license probation for at least (5) years with several reporting requirements and conditions including that he maintain his monitoring agreement with the MPHP, and prior to engaging in the active practice of clinical medicine participation in Board approved ongoing psychiatric care with a psychiatrist and cognitive behavioral therapy for insomnia with a qualified licensed psychologist or other provider. Dr. Bobker shall undergo a neuropsychological evaluation between January 1, 2020 and June 1, 2020. Dr. Bobker must practice in a setting with at least one other licensed

physician and engage a Board approved physician monitor. The Consent Agreement provides for the immediate suspension of Dr. Bobker's license to practice medicine under certain circumstances.

Daniel Bobker, M.D. License #MD13940 (Date of Action 1/8/19)
On January 8, 2019, the Board terminated Dr. Bobker's September 10, 2019, Interim Suspension, pursuant to which he agreed to refrain from practicing medicine in Maine until the Board investigation was resolved.

Mia H. Marietta, M.D. License #MD18931 (Date of Action 11/13/18)
On November 13, 2018, Dr. Marietta entered into a Consent Agreement with the Board for engaging in unprofessional conduct, violation of Board rules, and misrepresentation in obtaining a license. The Board imposed a practice limitation limiting medical surgical practice to minor outpatient office-based procedures involving local anesthesia only with no sedation. In addition, Dr. Marietta is subject to a period of probation of at least one year. Prior to Dr. Marietta engaging in any practice in Maine or providing health care to Maine patients, she must first obtain Board approval of a practice plan for oversight and mentorship.

Heather M. Sneff, M.D. License #MD18391 (Date of Action 11/13/18)
On November 13, 2018, Dr. Sneff entered into a Consent Agreement with the Board for engaging in unprofessional conduct. The Board imposed a warning for unprofessional conduct associated with medical recordkeeping, a $1,000 civil penalty, and a requirement that Dr. Sneff have an approved medical recordkeeping plan prior to providing any health care services in the State of Maine or pursuant to her Maine license.

Robin E. Locke, M.D. License #MD18128 (Date of Action 11/13/18)
On November 13, 2018, Dr. Locke entered into a Consent Agreement with the Board for the immediate voluntary surrender of her Maine medical license for engaging in unprofessional conduct, engaging in fraud, deceit or misrepresentation in connection with a service rendered, and substance misuse that may result in the licensee performing services in a manner that endangers the health or safety of patients.

Karyn Tocci, M.D. License #AL91006 (Date of Action 11/13/18)
On November 13, 2018, Dr. Tocci entered into a Consent Agreement with the Board for violation of a Board statute, failure to respond to a Board subpoena, and failure to respond timely to Board complaint notification. The consent agreement requires that Dr. Tocci engage in mental health therapy with a Board approved psychiatrist or psychologist.

Michael S. Zahra, M.D. License #MD21482 (Date of Action 11/13/18)
On November 13, 2018, Dr. Zahra entered into a Consent Agreement for licensure with the Board. Dr. Zahra must maintain and comply with all requirements of his August 3, 2017 five-year monitoring contract with the Missouri Physicians Health Program and enroll in the Maine Professionals Health Program with coordinated monitoring. In addition, the Board imposed a $500 civil penalty.

William P. Carter, III, M.D. License #MD19156 (Date of Action 11/13/18)
On November 13, 2018 the Board reviewed Dr. Carter's compliance with his consent agreement. Following its review, the Board voted to terminate Dr. Carter's December 12, 2017 Consent Agreement with the Board.

LICENSING ISSUES

License Application Update

The Board recently updated its license applications to emphasize the importance of current health and wellness. The updated applications:

- Strongly encourage taking steps when necessary to establish and maintain health and wellness.
- Specifically identify the Medical Professionals Health Program ("MPHP") as a resource. More information about the MPHP can be found at: https://www.mainemphp.org/.
- Inquire only about current fitness of an applicant to practice safely.
- Assure that any information provided will be treated confidentially.

HEALTH AND WELLNESS

Health and Wellness

Physician and physician assistant health and wellness is a major topic in medicine. It permeates all levels of medicine: physician assistant schools; medical schools; training and residency programs; and experienced practitioners – operating alone or within healthcare systems. The importance of maintaining health and wellness has been recognized by the American Medical Association and the Federation of State Medical Boards ("FSMB"). The FSMB, of which the Maine Board of Licensure in Medicine is a member, created a Workgroup on Physician Wellness and Burnout ("Workgroup"). In April 2018 the FSMB adopted as policy a report from the Workgroup on Physician Wellness and Burnout, which is available on the FSMB website: http://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf.

The policy highlights the following:

- Features and Consequences of Burnout
- Factors Contributing to Burnout
- Challenges and Barriers to Addressing Barriers
- Recommendations

Here are ways in which the Board supports physician and physician assistant health and wellness:

- Amending its license applications to:
    - Encourage applicants/licensees to obtain appropriate medical assistance when needed.
    - Specifically refer to the Medical Professionals Health Program as a resource.
    - Delete questions that do not pertain to current medical health and current ability to practice safely.
    - Assure the confidentiality of medical information disclosed.
- Providing on-going financial support for the Medical Professionals Health Program.
- Developing protocols for the operation of the Medical Professionals Health Program.

The Board encourages clinicians to address their healthcare needs, including regular visits to a primary care provider. We must take care of ourselves so we can continue to take care of others.

Kidness in the Curriculum (AAMC Link)

https://news.aamc.org/medical-education/article/putting-kindness-curriculum/

FROM THE EDITOR

Book Note

Advice for Future Corpses (and Those Who Love Them)
Sallie Tisdale. *Advice for Future Corpses (and Those Who Love Them): A Practical Perspective on Death and Dying*. N.Y.: Touchstone, 2018. Pp. 240. $25.99.

Sallie Tisdale's thirty-years of nursing and her talent for writing clear and compelling prose combine to make this book a practical and graceful guide for talking candidly about death and dying.

Tisdale intertwines her personal experiences, practical medical advice, clinical descriptions, and literature. Her tone is conversational; her understanding deep. She demystifies the processes of death and grief, making them less scary.

Her experiences as a palliative nurse make Tisdale a singularly qualified counselor of corpses-to-be, and allow her to illuminate the various dull, occasionally absurd practicalities of dying, while acknowledging "the strange undeniable fact that the presence of death can be joyful."

Her personal commitment is clear. "I wear my bias on my sleeve. I believe in palliative care for anyone with a serious illness, and I know that palliative care can provide the support needed for a good death. Yet palliative care receives a laughably tiny fraction of the money spent on medical care."

The body of the book is about preparation for dying, the process itself, disposal of corpses, and bereavement. Four short appendices offer advice about a "death plan," organ and tissue donation, assisted dying, and advance directives.

This is a book that can be shared with dying patients and their families to enhance communication about vital issues and decision-making near the end of life.

Further Reading on Communicating...

The Effecct of Physician Behavior on the Collection of Data. Howard B. Beckman, M.D. and Richard M. Frankel, Ph.D. Annals of Internal Medicine Vol. 101; No. 5 Nov. 1984.

Speaking and Interruptions During Primary Care Office Visits. Donna R. Rhoades, Ph.D.; Kay F. McFarland, M.D.; W. Holmes Finch, MEd; Andrew O. Johnson. Fam Med 2001;33 (7):528-32.

Questioning a Taboo: Physicians' Interruptions During Interactions With Patients. Larry B. Mauksch, M.Ed. JAMA. 2017;317(10):1021-1022.

Danielle Ofri, M.D. *What Patients Say, What Doctors Hear*. Boston: Beacon Press, 2017. Pp. 242. $24.95.

BOARD NEWS

The Board Welcomes a New Medical Director

On March 4, 2019, Dr. Gregory A. Kelly, M.D. joined the Board's staff as its new Medical Director. Dr. Kelly is a graduate of Vanderbilt University and Duke University School of Medicine. Dr. Kelly performed his residency training at Duke University Medical Center and The Milton S. Hershey medical Center. Prior to moving to Maine, Dr. Kelly served as an Assistant Professor of Surgery at Hershey Medical Center, Pennsylvania State University Medical School. Dr. Kelly practiced general surgery in the State of Maine for 40 years, including serving as Chief of the Department of Surgery at Mid Coast Hospital. The Board and its staff warmly welcome Dr. Kelly and look forward to working with him.

The Board Welcomes a New Physician Member

On December 26, 2018, former Governor LePage appointed Timothy Fox, M.D. to the Board of Licensure in Medicine. Dr. Fox is a graduate of the University at Buffalo, School of Medicine and Biomedical Sciences, and specializes in Emergency Medicine in which medical specialty he is also certified by the American Board of Emergency Medicine. Dr. Fox has practiced Emergency Medicine for 16 years, and serves as Chief of Emergency Medicine and Associate Vice-President of Medical Affairs at

LincolnHealth. In addition, Dr. Fox serves as the Chair of the Emergency Medicine Workgroup at MaineHealth. The Board and its staff warmly welcome Dr. Fox and look forward to working with him.

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Credits