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MAINE BOARD OF LICENSURE IN MEDICINE BOLIM

Summer 2019

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In this issue:

WHAT EVERYONE SHOULD KNOW

Alzheimer's Disease Detection

Alzheimer's Disease affects an estimated 5.8 million Americans. Early detection of Alzheimer's is critical to:

- Initiating beneficial treatments
- Allowing patient and family time for future planning
- Establishing medical and personal care services coordination

In 2019, the Alzheimer's Association issued a report, including a special report on *Alzheimer's Detection in the Primary Care Setting: Connecting Patients and Physicians.* A copy of that report is available online at: https://www.alz.org/media/Documents/alzheimers-facts-and-figures-2019-r.pdf.

The report provides information regarding the ways in which primary care providers can use the Annual Wellness Visit to assess patients for Alzheimer's.

Alzheimer's Association Medicare Annual Wellness Visit Recommendations for Primary Care Providers

The Alzheimer's Association released guidance to help health care providers detect cognitive impairment (memory and thinking problems) as part of the Medicare Annual Wellness Visit. Those recommendations can be found online at: https://www.alzheimersanddementia.com/article/S1552-5260(12)02501-0/pdf.

In developing the recommendations, the Alzheimer's Association convened a group of experts to survey the current literature and build consensus around an effective, practical, and easy process. In addition to the range of tools identified, the recommendations suggest questions to include in the required Health Risk Assessments that patients must provide for the visit. The recommendations also include tools that are available in multiple languages and are unaffected by education levels and different cultural backgrounds.

Since January 2011, an Annual Wellness Visit has been available for all seniors who are Medicare eligible. The benefit was added in the Affordable Care Act (health care reform law); its purpose is to detect illness early and to forestall its development. Checking for cognitive impairment is part of the visit. During the visit, providers can use the recommended tools to assess patients' responses as well as to evaluate family members' information. These tests, along with vital patient history, self-reported concerns, and clinician observations are the first steps in determining the need for further evaluation.

As baby boomers turn 65 years old, they advance into an age of greater risk for developing Alzheimer's. The Medicare Annual Wellness Visit could increase timely diagnosis of Alzheimer's and allow patients and their families to adjust current lifestyles, engage in learning about care and support, and plan for the future.

For additional information on Cognitive Assessment at the Medicare Annual Wellness Visit https://alz.org/professionals/healthcare-professionals/cognitive-assessment

Responsible Opioid Prescribing: A Balanced Approach Peter Sacchetti, MD

Maine and the rest of the United States are in the midst of an opioid crisis. In response to this crisis in 2016, the United States Centers for Disease Control and Prevention (CDC) issued the *CDC Guideline for Prescribing Opioids for Chronic Pain*. https://www.cdc.gov/drugoverdose/prescribing/guideline.html

This guideline, while well intended, resulted in some clinicians abruptly reducing or discontinuing opioids in patients who had been on them for years, and who might need them just to function on a daily basis. In April 2019, the CDC issued the following letter (attached below) clarifying the intent of the guideline. The letter states in part:

> The Guideline does not endorse mandated or abrupt dose reduction or discontinuationas these actions can result in patient harm. The Guideline includes recommendations for clinicians to work with patients to taper or reduce dosages only when patient harm outweighs patient benefit of opioid therapy.

A recent article in the *Journal of the American Medical Association* (JAMA), entitled "Limits on Opioid Prescribing Leave Patients with Chronic Pain Vulnerable" deals with the 2016 CDC Guideline, the April 2019 CDC letter of clarification, and the need for a balanced approach to opioid prescribing (1).

The Board encourages clinicians who prescribe opioids to review the April 2019 letter from the CDC and the JAMA article, and to reflect upon whether they are taking a balanced approach.

Footnotes

(1) JAMA (June 4, 2019) 321:21

CDC

The following link will take you to a PDF copy of the April 2019 CDC Letter.

Prescribing for Colleagues, Friends, Family, or Self: A Professional Quagmire

The December 2016 issue of the Board's newsletter included an article regarding the ethical implications of prescribing for self, friends, or family. The American Medical Association's Code of Medical Ethics discourages physicians from treating themselves, friends, or family due to concerns about professional objectivity, patient autonomy, informed consent, and treating issues beyond their experience and training. The same issues may arise when prescribing for colleagues. The following article by Drs. Makrides

and Ascanio chronicles their experience with this issue and the impact it had upon them and their medical licenses. The Board wishes to express gratitude to Dr. Makrides and Ascanio for their acceptance of responsibility, and their leadership in educating other physicians regarding this very important issue.

No, It's Not Illegal But . . . : Treatment of Family, Friends, and Self

It is likely that during your medical training one of the core themes drilled into you was that you will have specialized training and that you are there to help people. That impetus, to help people, is precisely why many of us went to medical school in the first place. If you finished medical school and residency before 2000, it is unlikely that you received any formal training in the ethics of treating and prescribing to family member or friends. You just did it to help. Period.

Your brother-in-law came down with something over the Thanksgiving weekend, you helped, including prescribing if indicated. Your colleague was leaving on a trip and was concerned about not sleeping while traveling, you helped, and prescribed sleep medication. Your son/daughter was away at school and needed medication, you helped, and prescribed. You became so caught up in the ever increasing tasks and responsibilities related to being a physician that you wrote your own prescriptions. Do these scenarios sound familiar? They should. These scenarios describe us and they describe many of you.

Please don't click out of this newsletter or turn the page. This issue – prescribing for family/friends/self is something all of us need to address – and need to address NOW. We are both in the middle of Board complaints involving this issue that would not necessarily have been on anyone's radar a decade ago. We both now know, and embrace, that it is imperative for all of us to change these behaviors immediately.

As soon as these issues were brought to our attention, we began a campaign, along with risk management, to educate our peers. We have together and separately, addressed 225 physicians and multiple additional mid-level providers, with an additional grand rounds presentation already planned for 7/11/19 at Maine Medical Center and internal education for providers and staff alike. Here are some of the reactions received at the outset to our presentation:

- You have got to be kidding
- Not doing so is arrogant and withholds care and treatment
- Who is pushing this agenda
- If this is so critically important, why have we not heard this before
- No one in medical school ever addressed this
- No CME ever addressed this
- Don't we have more important things to discuss
- It's not illegal

You would be correct to state that there is no law against treating family, friends, or self – HOWEVER-- the Maine Board of Licensure in Medicine follows the AMA Guidelines, which specifically speak to when you should generally NOT treat family, friends, and self, what the exceptions are, and what to do if you do treat. Also, because of the importance of this issue, your applications for licensure and re-licensure in Maine contain questions about this issue that you should recognize and answer truthfully. Each of these subjects is addressed below:

AMA Guidelines: Opinion 8.19 reads, in relevant part:

> **Physicians generally should not treat themselves or members of their immediate families.**

The importance of this guideline is borne out by the following underlying rationales:

1. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered.
2. Concerns about patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family.
3. Physicians may feel obligated to provide care for immediate family members, including prescribing, even if they feel uncomfortable doing so and may not otherwise provide the same care for other patients.

Exceptions: It is not always inappropriate to treat family, friends or self.

1. In emergency or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves, family, or friends until another physician becomes available.
2. In addition, while physicians should not serve as the primary or regular care doctors for family, friends, or self, there are situations where routine care is acceptable for short-term, minor problems.
    - For example, it may be appropriate to treat a family member for a UTI while traveling in a foreign country, but it would not be appropriate to routinely treat the same family member for UTIs that may be recurrent or non-acute.
3. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances (including sleep aids, cough syrup, valium, etc.) for themselves, colleagues, or family.

If you treat family, friends, or self, you must treat as you would with any other patient:

1. Anyone for whom you prescribe should be assessed.
2. All care provided, including assessment and particularly, prescribing, should be documented as you would with any other patient.

3. All care provided should be communicated with the patient's PCP or relevant specialist.
4. Whether you should charge for the visit is not as clear but the norm would be to do so, in accordance with charges for any other patient.

Licensure application questions:

There have recently been several relevant questions on your applications for licensure and re-licensure but you need to read the entire questions carefully, as they change.

If you are a renewing physician and have prescribed for yourself, family, or friends during the two years since you last renewed your license, you must answer yes to questions like the ones below and explain your answers. You will likely be asked to produce patient records for prescriptions you wrote. For example:

- Have you furnished prescription drugs to or written a prescription for anyone without having a legitimate physician-patient relationship? Note: this would include prescriptions written for yourself.
- Have you been found in any civil, administrative, or criminal proceeding to have prescribed any controlled substances for yourself or family/household member?

Answering these questions incorrectly, whether you intend to or not, can result in adverse consequence by the Board of Licensure in Medicine.

Where we are and where we need to go from here:

We would like you to think about prescribing for self, family and friends in light of two points: 1) the opioid crisis; and 2) potential problems inherent in prescribing for family/friends/self.

Regarding the first point, even if feel you have good boundaries because you are not prescribing opioids, or even controlled substances, to self, family, or friends, remember this: In the climate of our current opioid crisis (and it is a crisis), all prescription medication has street currency, like never before, and thus has to be considered in the abstract as potential proxy for opioids. This includes stimulants, anti-depressants, and other medications.

Regarding the second point, we all consider ourselves to be professionals, capable of independent, objective, and incorruptible judgment. However, as noted in a previous newsletter, in the press of business at any given moment, if you are prescribing to family/friends/self:

- you may feel pressured to prescribe where you would not otherwise;
- you may not ask all the questions you normally would ask of your patient;
- you may not receive candid answers because of a close relationship;
- you may not have/ask about relevant information about allergies/drug interactions;

- physician and patient may be uncomfortable/unwilling to complete an examination that you otherwise would perform;
- you may try to treat problems beyond your expertise as a favor, the patient may be reluctant to decline treatment, you may feel obligated to provide or continue care even when you are uncomfortable doing so;
- you may not go through the informed consent process because of the relationship to the patient;
- you may not undertake an assessment as you normally would;
- you may not create the record as you normally would;
- you may not refer the patient out as you normally would; and
- you may not provide for follow up care as you normally would.

All of these points are particularly salient where physicians have increasing responsibilities and decreasing time. The shortcut and time saver may be to write the prescription but that can no longer be our choice.

We know that the norms of prescribing for self/family/friends persisted for many decades. We also know that we are practicing in a different climate and that these norms must change. We are happy to report that during our presentations, there typically came a time, usually during the question and answer portion, where the light came on for many providers. That is a good step in the transition that we all must make.

So what do we do? Just like when any new paradigm changes our medical decision making, there must be a paradigm shift here that flips the script, focusing not on what prescription the patient might need but on who the patient is in relation to you. Begin with the premise of only prescribing for patients. Period. Then, if the question of prescribing for a non-patient arises, you can ask whether this situation is an exception for which you may prescribe. Ask yourself, is this an emergency, are we otherwise isolated from care, is this for a limited time, etc. If yes, then know that you will perform an assessment as you would for any other patient, document as you would for any other patient, and communicate the results as you would for any other patient.

Coming full circle, back to where we began, we believe that in the end, this paradigm shift will do more to accomplish the core theme of helping people that is at the heart of our profession. As we are all adjusting (quickly) to this reality, we encourage you to talk about this issue with your colleagues, risk managers, and with those for whom you may have prescribed in the past, including family and friends. We all need to be educated about this issue and we sincerely hope that this article has been useful to you. We welcome any questions on the subject and believe that through honest and supportive dialogue about this subject we will make an enormously positive contribution to the health of our communities.

Robert S. Ascanio, M.D.
John C. Makrides, M.D.

Post Script: The Board dismissed the complaints it initiated against Drs. Makrides and Ascanio based upon their acceptance of responsibility, completion of continuing medical education, and willingness to educate other physicians regarding this ethical issue.

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

The following adverse actions are being reported for the purpose of educating licensees regarding ethical and/or legal issues that can lead to discipline, and to inform licensees of any limitations or restrictions imposed upon scope of practice.

Marc C. DeBell, M.D. License #MD20244 (Date of Action 06/12/19)
On June 12, 2019, Dr. DeBell entered into a Consent Agreement with the Board arising out of conduct resulting in disciplinary action by the Massachusetts Board of Registration in Medicine. The Board imposed a requirement that Dr. DeBell enter into and remain compliant with a substance misuse monitoring agreement for a period of not less than five (5) years and to notify the Board upon certain events.

Marc J. Gorayeb, M.D. License #MD15841 (Date of Action 6/11/19)
On June 11, 2019, the Board issued a Decision and Order following an Adjudicatory Hearing held on May 14, 2019. The Board denied Dr. Gorayeb's application for renewal of his Maine medical license based on having not been engaged in active clinical medicine during the 24 months preceding his application and not otherwise demonstrating continuing clinical competency as required for renewal of his license in accordance with Board rules. In addition, the Board imposed $,1,672.50 in costs to be paid within four (4) months of the effective date of the Decision and Order.

Donald B. Shea, M.D. License #MD13940 (Date of Action 06/12/19)
On June 12, 2019, Dr. Shea entered into a Third Amendment to Consent Agreement effective October 10, 2017 with the Board amending paragraph 15(d) to add additional substances to the conditions of probation.

Miguel West, M.D. License #MD21343 (Date of Action 06/12/19)
On June 12, 2019, Dr. West entered into a Consent Agreement with the Board converting his license to an Administrative license limited to the practice of administrative medicine and agreeing that he will not apply for any license in Maine that authorizes the clinical practice of medicine.

Mark E. Cieniawski, M.D. License #MD13544 (Date of Action 04/09/19)
On April 9, 2019, the Board reviewed Dr. Cieniawski's compliance with his Consent Agreement. Following its review, the Board voted to terminate Dr. Cieniawski's April 11, 2017 Consent Agreement with the Board.

LICENSING ISSUES

Licensing Updates

The Board has moved more of its Initial Applications online. Previously, only applications for a permanent license could be submitted using the Uniform Application (UA) process online. Beginning June 3, 2019, the Board expanded the use of the UA to include initial applications for:

- Permanent;
- Emergency;
- Administrative;
- Consultative Telemedicine;
- Youth Camp; and
- Educational Certificates.

The use of the UA, which is hosted by the Federation of State Medical Boards (FSMB), allows applications to be downloaded directly into the Board's licensing system. Once the application is downloaded, the applicant receives an automatic e-mail describing the next steps. This reduces the turnaround time for both applicants and staff.

In addition, the UA is accepted by 27 state medical and osteopathic boards and 6 boards that license physician assistants.

A New Question on the Renewal Application Form

If you renewed your license recently, you will have noticed a new question on the application. For those of you who have not renewed your license in the past few months, you will find a new question when you complete the application. The question reads:

> Have you been examined/evaluated by your primary health care provider within the past 24 months?

There are three possible answers; Yes, No, or Decline to Answer. But, why ask the question? There is growing evidence that competence is strongly related to physician/physician assistant health and wellness. During illness, especially a chronic condition or major illness, competence can decrease. If the physician/physician assistant is not seeking help for the condition, the effects can be magnified, putting patients at risk.

Fortunately, this decrease in competency is often easily remedied. Once the condition is addressed, the level of competency returns. An important piece of maintaining health and wellness is establishing a relationship with a primary health care provider who provides regular and ongoing care. This type of relationship can often draw attention to health issues before they become major or chronic and keep you at a steady level of competence

This voluntary survey question is designed to provide the Board information as it studies how physician/physician assistant health and wellness affects patient care, and what education the Board can provide to licensees regarding this important issue.

A Pilot Program for CME Reporting

The Maine Board of Licensure in Medicine is pleased to announce that we will be participating in a pilot program with the Accreditation Council for Continuing Medical Education (ACCME) that will allow licensed physicians to have their continuing medical education (CME) credits conveniently and securely shared directly between participating accredited educational providers and the Board. We expect that reporting of your participation could begin by the middle of August 2019, and we will share the list of the participating providers when it is finalized.

Once the program has gone live, when you attend an accredited CME activity offered by one of the participating educational providers, you may be asked to provide your name, Maine license number or national provider identifier (NPI), and the day and month of your birth. Providing this information allows the educational provider to automatically verify and share your participation in the accredited CME activity with the Board. Our goal is to move to a model where we are able to verify our licensees' fulfillment of all CME requirements with minimal action by the licensee. This goal is motivated by a desire to reduce and simplify regulatory burdens on our licensees.

Of course, you may choose not to use this system and to retain your own CME records if you wish, just as you do now.

HEALTH AND WELLNESS

Take Time to Think

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 who operate 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").

One of the leading causes of physician and physician assistant burnout is the sheer number and complexity of patients. There just isn't enough time. According to Dr. Danielle Ofri, M.D., that includes, at times, not enough time to think. In her essay in the *New England Journal of Medicine*, "Perchance to Think,"(1) Dr. Ofri, an Internist who practices in New York, reflects upon her experience in medical school and the contrast of that experience with the complexities of modern medical care, including the lack of time during patient visits to synthesize the information and develop a plan of treatment.

> I found myself pining for those medical-school Saturdays in the library – endless hours to read and think. Nothing but me, knowledge, and silence, facing off in a battle of concentration. How I hated those study sessions then, and how I would have given my left adrenal for a few minutes of that now. But a gazillion EMR fields were demanding attention. Three more charts were waiting in my box. The patient still had two MRI reports and an EGD for me to review, plus a question about PSA testing. His adrenal insufficiency was swamped by my cerebral insufficiency.

How many of you have felt this way on any given day? Dr. Ofri goes on to describe how she took extra time after work hours to think about all of the information, refamiliarize herself with some of the medical issues, and develop a plan for the patient – and how important doing so is to a clinician's sense of well-being. Take a moment to read Dr. Ofri's essay, and think about the ways in which you might be able to enhance your own well being.

Footnotes

(1) n engl j med 380;13 nejm.org March 28, 2019

FROM THE EDITOR

Another Good Book

Leana Wen, M.D. and Joshua Kosowski, M.D. *When Doctors Don't Listen: How to Avoid Misdiagnoses and Unnecessary Tests.* New York: St. Martin's Press, 2012.

All doctors are taught the art (and value) of obtaining a thorough medical history from their patients. Increasingly, though, many doctors are paying less attention to these stories of illness, of suffering. Algorithms and clinical pathways, time constraints, fear of misdiagnosing a serious illness, and an increased reliance on technology have often reduced conversations between physicians and patients into brief interrogations.

Drs. Wen and Kosowsky use tales of patients treated in the emergency room to illustrate sound and efficient suggestions for improving the achievement of differential and working diagnoses while minimizing speculative testing.

More on Communicating with Patients

We offer a link to this article as a continuation of the theme of communicating with patients established in the Spring issue with the publication of the Board's guidelines, "Communicating with Patients." (Available on the Board's website.)

Note that a free, one-time registration is required in order to view the entire article and all other content on the Medscape site. Free registration is offered when the link is opened.

The article is: Arthur L. Caplan. Doctors Must Give Life-or-Death News in Person, Not by Telemedicine - Medscape - Apr 01, 2019.
https://www.medscape.com/viewarticle/910938

BOARD NEWS

Federation of State Medical Boards 2019 Annual Meeting

Board Members and staff had the opportunity to attend the Federation of State Medical Boards (FSMB) Annual Meeting in April. FSMB represents the 70 state medical and osteopathic regulatory boards within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

Topics at this year's meeting included sessions on:

- Competence, including looking at wisdom, judgment, and compassion in addition to technical knowledge and skills proficiency;
- Sexual boundary violations, and how to investigate them and if corrective action can be taken. There are now data showing that in cases where a violation has occurred, chaperones are not an effective preventative measure and that the only way to ensure patient safety is to restrict the physician from treating that portion of the population;

- The United Kingdom's revalidation program, how it is working, and data from the first revalidation cycle;
- Artificial Intelligence and its role in complementing health care services;
- Opioid Prescribing;
- Physician health and wellness; and
- The late-career physician.

In addition to numerous sessions, the annual meeting provides an opportunity for Board members and staff to meet with their counterparts from across the US and beyond. Problems and solutions common to all regulatory boards were discussed and shared.

At the conclusion of the meeting, Maroulla Gleaton, MD, Chair of the Maine Board of Licensure in Medicine, was elected to the FSMB Nominating Committee. In addition to the Nominating Committee, Dr. Gleaton sits on the FSMB Sexual Boundaries Workgroup and was invited to join a committee for the United States Medical Licensing Examination (USMLE). Filling these roles gives the Board representation at the national policy level and we are excited to have Dr. Gleaton share her expertise and insights.

Editor-in-Chief David Nyberg, Ph.D. Graphic Design Ann Casady

Credits