# August 2016

MAINE BOARD OF LICENSURE IN MEDICINE BOLIM

In this issue:



# A Note from the Board Chair

Maroulla S. Gleaton M.D.

The Board of Licensure in Medicine has been extremely busy with complaints surrounding opioid prescribing. That should come as no surprise to most physicians given that every printing of the lay press is filled with news of the heroin epidemic and its horrific ramifications. Most authorities feel that narcotic overprescribing by physicians plays a role in fueling this epidemic. Recent legislation outlining restrictions/regulations on opioid prescribing by Maine physicians is designed to rein in narcotic prescribing. So the Board may well be seeing fewer complaints surrounding this issue. Time will tell.

There is another common theme in most complaints that the Board encounters, which is not so much in the news. Personal communication is the common denominator. If most of us stepped back and thought about it, we would agree. However, in our busy practicing lives of more and more patient encounters, electronic health record demands, endless workplace regulations and details, opportunities for reasonable, thoughtful, and empathetic communication often get short shrift. This situation can get physicians in trouble as leaders of the team in patient care.

Communication is first and foremost between the doctor and the patient, but it seldom stops there. More often than not it also includes guardians, family members, significant others and sometimes friends. Physicians are also required to interact appropriately with office and /or operating room staff to inspire and enable them to help and care for patients in the best possible ways. Good rapport amongst the medical team can make all the difference in critical situations.

Another aspect of problematic communication is due to the fact that the medical world has evolved into a spectrum of specialists so that people with specific ailments are segregated into specific areas with specialists, who all too often only see the patient through the lens of their own expertise. Communication among the various physicians involved in a patient's care is paramount for good, safe medical care, but often it is difficult to achieve. Although touted to do so, the electronic medical record has not solved this disintegration problem by a long shot.

Also, when patients are transferred to different care settings there needs to be personal communication with the receiving providers above and beyond filling out forms so that patients get their special needs met and receive the right care at the right time.

Most doctors get caught up on the information we have to convey, but it is critical to pay attention to the manner of that conveyance as well. We can increase the likelihood of successful communication by adjusting the tone, the pace, the vocabulary, and the way we frame important issues to suit the needs of the person we are talking to.

So pause, take an extra few seconds to consider how to deliver the message. Lay the groundwork to coordinate the patient's care with effective, empathetic communication and hopefully you will avoid a complaint to the Board of Licensure in Medicine about failed or deficient communication.

# Training in Risk Communication and Shared Decision Making

Paul Han, MD, MA, MPH

For the past 5 years, the Center for Outcomes Research and Evaluation (CORE) at Maine Medical Center (MMC) has been developing and implementing innovative medical education programs to train clinicians in risk communication and shared decision making (SDM).

1. Risk communication training program

Since 2011, CORE has administered a successful training program in risk communication skills to 2nd-year medical students at Tufts University School of Medicine (TUSM). The original training program, known as ?Risk Talk,? consisted of a 3-hour workshop integrating didactic and experiential training (role play) using standardized patients (SPs), as well as formative evaluation of students? skills using Observed Structured Clinical Examination (OSCE).*1* The program has since been integrated within a larger advanced communication skills training session for all 2nd-year TUSM students, and now consists of a 70-minute experiential training workshop. The program has been adopted at Washington University School of Medicine (WUSM), and is currently being used as a model for a new risk communication training program at the Heidelberg University School of Medicine (Germany). Our group is exploring expanding the Risk Talk program to graduate and continuing medical education settings.

CORE has also developed tools to assess clinicians? competence in risk communication. In 2011 we developed the only published observational measure of risk communication competence, the Risk Communication Content (RCC) Scale.*1* Most recently in 2015, we developed a brief 4-item version of the measure, known as the Brief Risk Information SKill (BRISK) Scale; a manuscript reporting on the scale?s reliability and validity is currently under review.

2. Risk communication e-learning module

In 2014, CORE developed an e-learning module, ?Risk Talk Online,? designed to provide didactic training on the principles of risk communication. The program integrated content from the workshop-based risk communication program, as well as professionally produced video recordings of an exemplary risk communication conversation between a physician and a patient, to facilitate observational learning. At TUSM, the e-learning module has been used in a ?flipped classroom? approach, in which students view the module prior to the in-person advanced communication skills workshop, and classroom time is devoted to experiential training using role play. The program has been well-received by students and is currently also being used at WUSM, and its effectiveness in improving students? risk communication knowledge is reported in a forthcoming publication.*2*

3. Shared decision making training program

Through a grant from the Picker-Gold Foundation in 2015, CORE developed and pilot-tested a training program in SDM at the Graduate Medical Education level. The program was implemented among 4 residency programs at MMC: Family Medicine, Internal Medicine,

Obstetrics/Gynecology, and Urology. The SDM training program consists of didactic training provided through educational in-services, as well as an e-learning module developed by collaborators at the Dartmouth Institute. The program also integrates experiential learning, provided either through direct clinical observation by faculty or through OSCEs conducted in a clinical simulation laboratory setting with standardized patients. In 2016, this work will be extended to more residency programs at MMC (General Surgery, Pediatrics, Psychiatry), and a ?train the trainer? faculty development toolkit will be developed and implemented to facilitate further dissemination of the program.

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1. Han PK, Joekes K, Elwyn G, et al. Development and evaluation of a risk communication curriculum for medical students. Patient Educ Couns. 2014;94:43-9.

2. Han PK, Piccirillo J, Gutheil C, et al. Development and evaluation of an online risk communication teaching program for medical students. Med Sci Educ. 2016;(in press).

# Introduction to Staff

**New Consumer Assistance Specialist, Savannah Okoronkwo**

Savannah is a Maine native, born and raised in Windsor, Maine. She graduated from Erskine Academy and went on to work for Maine State Government for a number of years before coming to the Board of Licensure in Medicine (BOLIM). Prior to coming to the Board, Savannah worked at the Department of Health and Human Services shortly after completing high school. For two years, Savannah worked for Child Support Enforcement and then moved on to the Office of Substance Abuse and Mental Health Services where she worked from 2009-2016. Savannah is very passionate about this field and believes it is where she wants to eventually further her education. Savannah enjoys spending time with her family, and she and her husband, Emmanuel, who is a native of Nigeria, live in China with their twenty- month old daughter Natania. As the Consumer Assistance Specialist, Savannah is the primary point of contact for the public regarding BOLIM complaints and the Board?s investigative process. Savannah can be reached by email at Savannah.Okoronkwo@maine.gov and by phone at 287-3608.

**Investigative Secretary, Katie Feliciano**
Katie has lived in Maine her whole life. She spent her early elementary school years on the coast in Phippsburg and graduated from Messalonskee High School in Oakland. Katie later completed additional education in Lewiston/Auburn and she is currently taking courses through the University of Maine at Augusta. Katie enjoys travelling to visit friends and family across the country, from New Mexico to New York. She resides in Lewiston with her boyfriend and their cat, Dinah, and enjoys creating art including painting, sketching and photography. As the Board?s investigative secretary, Katie is responsible for processing all complaints received by the Board, including sending out initial complaint notifications, obtaining medical records, and issuing notices of informal conferences and adjudicatory hearings. She is also the point of contact for licensees and their legal counsel. Katie can be reached by email at Katie.Feliciano@maine.gov and by phone at (207) 287-3625.

**Complaint Coordinator, Julie Best**
Julie was born in Maine, has a daughter and a son, and currently lives in Windsor with her family. Julie studied Biology and Business in Florida, and returned to Maine after her first child was born. She came to the Board of Medicine after working many years with the Maine Department of Labor assisting job seekers and employers. Julie was hired at the Board of Medicine 2 years ago and started as the Board?s Consumer Assistant. Currently, as the Board?s Complaint Coordinator, she is responsible for supervising the Complaint Unit and for monitoring licensee?s on probation. Julie finds her position at the Board of Medicine to be interesting and enjoys working with licensees, complainants and her Board of Medicine team. Julie is a nature lover and prefers to spend her time outside exploring and hiking with her family and her dog. Julie may be reached by email at Julie.A.Best@maine.gov and by phone at 207-287-6931 with questions about licensee monitoring or the Board?s complaint process.

# The License Renewal Process

The Board receives many calls from licensees about the renewal process. This article will address three of the most common questions/concerns.

**I did not receive notice that my renewal was due.**

The Board sends all correspondence to the most recently designated contact address provided to it by an applicant or licensee. If the applicant?s or licensee?s designated contact address

changes, and the applicant or licensee does not update the Board with the new one, all correspondence ? including renewal notices ? will go to the old designated contact address. Therefore, it is critically important for applicants and licensees to provide the Board with any changes to their designated contact address. Those who fail to do so will not receive a renewal notification and risk having their license expire, be administratively suspended, and lapse. Here?s how the renewal notification process works.

The Board sends out renewal notices to licensees sixty days in advance of their license expiration date. The renewal notices are sent to the most recent address provided to the Board by the licensee. On July 1st the Board sent 298 notices to licensees whose licenses expire on August 31st. If history holds, between thirty and 50 of these notices will be returned to the Board because the licensee?s address has not been updated.

Licensees who do not renew their license prior to the expiration date are sent a second notice informing them that their licensee has expired, but that they can renew their license within the next thirty days with a $100 late fee. The Board sends these notices to the most recent address provided by the licensee, even if the original sixty day notice letter was returned. The Board sent 67 of this type of notice on July 1st for licenses that expired June 30th.

Licensees who still don?t renew their license are sent a third notice that their license has been administratively suspended and they may no longer practice medicine in Maine, but they can still renew their licensee for thirty more days with a $100 late fee. These notices are sent certified and are again sent to the most recent address provided by the licensee. The Board sent 32 of these notices on July 1st at a cost of $6.46 per letter. Almost every one of these letters will be returned to the Board ?unclaimed.?

Finally, if the license is still not renewed after sixty days the license lapses and a fourth notice is sent, again to the same address, indicating that the license has lapsed and must be reinstated if the licensee decides to practice in Maine again.

In all, the Board will spend about $2,000 this year on postage to licensees who have not updated their addresses.

When you apply for a license, and each time you renew that license, you are reminded to update your contact address. In addition, you are requested to specify to which address, home or business, the Board is to send correspondence. The Board will use the address that you designate. If your contact address changes, and you do not update the Board about that change, you will not receive your renewal notices. There are many different reasons licensees do not update their addresses between the renewal cycles. The most common reaction from licensees that their license has lapsed is amazement that they have to inform the Board of their contact address change. The most common problem with non-updated

contact addresses involves employment. Many licensees designate that all Board correspondence be sent to their place of employment. This is problematic for many licensees who change employment, as many employers do not forward mail to former employees.

The second most common problem is with new licensees. New licensees provide out of state addresses when they are applying for licensure, and then fail to update the address after they receive the license and start working in Maine.

All applicants and licensees of the Board are required to notify the Board when they change their name, address, phone number or email from the one most recently provided. Those applicants and licensees who fail to provide this updated information risk not receiving important information such as renewal notices, complaint and investigation notices or requests for additional information. You can update your name and contact information online at the Board?s website: https://www1.maine.gov/cgi-bin/online/licensing/begin.pl?Board_number=376

**Do I need to take the jurisprudence exam?**

When renewing online the system will automatically prompt you to take the exam if necessary. You will not be able to proceed with the renewal until a valid exam is on file in the system. The Board expects the licensee to take the exam every other renewal cycle, or approximately every four years. For example:

- Your renewal date is 7/31/16 and you last took the exam on 7/30/12. You are completing your renewal this year on 7/20/16. It has been less than four years, so do you need to take the exam? Answer ? Yes. The exam is due every four years or every other renewal cycle. This is actually a common question and complaint. Just take the exam.
- I was licensed in September 2013, renewed in July 2014 and am renewing again in July 2016. I originally took the exam in September 2013, so do I need to take the exam again? Answer ? No. You took the exam less than three years ago. Even though you are going through your second renewal cycle, so you do not need to take the exam. However, if you took the exam more than three years ago, you may be asked to complete the exam.
- I have an inactive license. Do I need to take the exam? Answer ? Yes/No. If you are completing the renewal online and you are prompted to take the exam you must take the exam. If you are one of the few renewing on paper, you do not need to take the exam at renewal, but you will need to take it prior to returning to active practice.
- I don?t have an email address and renew on paper. How do I know when to take the exam? Answer ? Once your renewal application is received your license will be placed in a pended status and a copy of the exam will be sent to you.

**How does CME work?**

You need to obtain 100 hours of CME every renewal cycle (new licensees may have their initial CME obligation prorated). At least 40 must be Category I and the remaining sixty can be either Category I or Category II.
**It is important to note that the CME requirement is based on your renewal cycle. It is not:**

- **Based on the calendar year; nor is it**
- **Based on your specialty Board cycle.**

We often hear from licensees who have not completed their CME requirement because they only follow the timing requirements of their specialty Board and insist that the Board should change its requirements to mirror those of private entities. That is not feasible.

Although the Board will work with licensees who have not completed their CME requirements, the Board will not renew the license until all requirements have been met. This delay should be avoided, as it can lead to awkward questions from employers and various difficulties with insurers.

# Opiate Dosages for Chronic Pain and/or Addiction

BOLIM?s April newsletter outlined the opioid epidemic in Maine, summarized the highlights of Maine?s new law regarding prescribing opioids, and announced BOLIM?s plan to introduce updated rules for prescribing controlled substances for pain.

As dates for compliance with the new law approach, clinicians will face the challenge of tapering the opiate dosages for chronic pain patients who do not clearly meet the exclusion criteria for dose limits. This may cause patients to become anxious, upset and frustrated. Therefore, it is important for clinicians to recognize their patients? fears of possible uncontrolled pain and withdrawal, and work with them collaboratively. The new law does not prohibit clinician?s from prescribing controlled drugs, and should not be a reason to

simply stop prescribing, as this may lead to complaints of abandonment or uncompassionate care due to inappropriately fast tapers leading to withdrawal or uncontrolled pain. Patients who are addicted to prescription opioids or even those who are opioid tolerant and in pain, may feel compelled to seek out illegal drugs, which may result in overdose and death. It is also important for clinicians to distinguish between patients who are addicted to opioids, with or without chronic pain, and those who may be physically dependent on opioids as the treatment needs can be quite different.

Many clinicians find it gratifying to treat patients who are suffering from addiction and help empower them to make positive changes in their lives. The Drug Addiction Treatment Act of 2000 (DATA 2000), greatly expanded access to treatment for addiction by allowing qualified physicians (MD, DO) to offer office based medication assisted treatment (MAT). Buprenorphine offers safe and effective treatment for both long term maintenance as well as medically supervised withdrawal from opioids. MAT with buprenorphine is most effective in combination with counseling services, which can include behavioral therapy and self- help programs. (1) Buprenorphine has properties that make it ideal for helping patients who are addicted to opioids, but it is important to understand the pharmacology in order to avoid unintended consequences.

Buprenorphine is a semi-synthetic opioid which acts as a partial agonist at the mu opioid receptor and an antagonist at the kappa receptor. It has very high affinity and low intrinsic activity at the mu receptor and will readily displace morphine, methadone, and other full opioid agonists from the receptor. In doing so, it can deter addicts from using other opioids by blocking their activity. However, because of its low intrinsic activity at the mu receptor, its effects are not linear with increasing doses; it exhibits a ceiling on its agonist effects, so is not considered a powerful anesthetic. One consequence of the ceiling effect is that an overdose of buprenorphine is less likely to cause fatal respiratory depression than might a full mu opioid agonist. But its agonist effects are often enough to help addicts ?feel normal.?

For patients who are physically dependent and taking regular doses of opioids, buprenorphine?s antagonist properties can cause acute withdrawal. In this situation, buprenorphine can displace enough of the full agonist opioid from the mu receptors, yet not provide the equivalent degree of receptor activation, leading to the onset of withdrawal, and maybe pain if that co-morbidity exists. Also because of the high affinity of buprenorphine for the opioid receptor, adequate pain control might be hard to achieve in a patient on buprenorphine maintenance who needs emergent surgery or who has acute trauma.

Buprenorphine can produce euphoria, especially if injected. It can cause physical dependence although it appears to do so to a lesser degree than do full opioids. It must be tapered off slowly and full termination can be difficult. Some patients may require long term

administration of buprenorphine. Side effects are similar to full opioids. Overdose is possible at high dose if taken with other respiratory depressants like alcohol or benzodiazepines.

Buprenorphine can be abused, particularly by people who do not have an opioid dependency. Naloxone is added to buprenorphine (Suboxone) to decrease the likelihood of diversion and misuse of the combination drug product. Buprenorphine has poor GI bioavailability but good sublingual bioavailability. Naloxone has poor GI and sublingual bioavailability. Thus, if the combination tablet is taken as directed sublingually, the patient gets a primarily weak opioid effect, but if an individual dissolves and injects it IV, the antagonistic effects of the naloxone predominates. As with any prescription opioid, clinicians should monitor patients closely for signs of diversion or misuse, especially if buprenorphine alone is used.

Subutex (buprenorphine alone), Suboxone (buprenorphine plus naloxone, 4:1), and Probuphine (the first buprenorphine implant for the maintenance treatment of opioid dependence) are the only Schedule III drugs approved by the FDA for use in office-based treatment of opioid addiction by clinicians. In order to prescribe these medications for the treatment of addiction, clinicians must apply for a DATA 2000 or X waiver from the DEA. To qualify, clinicians must hold a state license and a schedule III DEA registration. They must also complete at least 8 hours of approved training in the treatment of opioid addiction, or have other qualifications, like certification in addiction medicine, and must attest that they can provide or refer patients to necessary, concurrent psychosocial services. The Substance Abuse and Mental Health Services Administration (SAMHSA) web site http://www.samhsa.gov/medication-assisted-treatment, has all necessary information on CME courses, waiver forms and physician support services . In addition to these requirements, DATA limits the number of patients that a physician is permitted to treat at any one time to 30 in the first year after obtaining a waiver. If they wish to treat more than 30 patients after the first year, they must file an application with the DEA to extend his or her waivered capacity to the new limit of 275 patients which takes effect August 8, 2016. The previous limit was 100 patients.

Waivered physicians are not permitted to delegate the prescribing of buprenorphine for the treatment of addiction to nurse practitioners or physician assistants, but on July 22, 2016, the Comprehensive Addiction and Recovery Act of 2016 (S.524 CARA ) was signed into law and will allow PAs and NPs to obtain their own waivers to treat addiction with buprenorphine. (4) Rules regarding this are pending from DHHS, so stay tuned for more information.

There is an exemption, known as the three day rule, that allows non-waivered physicians to administer (but not prescribe) narcotic drugs, such as buprenorphine, to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient?s referral for addiction treatment, under the following conditions: 1) not more than one day?s

medication may be administered or given to a patient at one time; 2) this treatment may not be carried out for more than 72 hours; and 3) this 72-hour period cannot be renewed or extended. Details can be found at http://www.deadiversion.usdoj.gov/drugreg/faq.htm.

A patient with an opioid dependency who is admitted to a hospital for a primary medical problem other than opioid dependency, such as myocardial infarction, may be administered opioid agonist medications such as methadone and buprenorphine to prevent opioid withdrawal that would complicate the primary medical problem. It is good practice, however, for the admitting physician to consult with the patient's substance misuse treatment provider, when possible, to obtain treatment history.

DEA record keeping requirements for office-based treatment of opioid dependency go beyond the Schedule III record keeping requirements. According to DEA, clinicians must keep records (including an inventory that accounts for amounts received and amounts dispensed) for all controlled substances and shall not store and dispense controlled substances that are the result of filled patient prescriptions. (5)

The FDA has approved Buprenex (injectable formulation of buprenorphine) and Butrans (transderm patch) to treat pain, but not opioid dependence. Suboxone, Subutex and Probuphine are FDA-approved to treat opioid dependence but not to treat pain. Thus, any prescription use of Suboxone and Subutex to treat pain is considered ?off-label,? an unapproved but not illegal use of these medications. (6) In some areas of Maine, clinicians use buprenorphine for short term treatment of moderate acute pain. In these cases, knowledge of the pharmacokinetics of buprenorphine is important, the documented rational for use must be very clear, and it is recommended to label the prescription for acute pain.

Patient?s being treated for opioid addiction with Suboxone who develop conditions causing acute pain may find it difficult to get the care they need because clinician?s may feel wary of prescribing opioids in these patients. Yet they deserve a full evaluation and treatment of their pain. Prompt consultation with a pain or addiction specialist may be prudent.

The SAMHSA-funded Physician Clinical Support System (PCSS-B) is designed to assist practicing physicians incorporate buprenorphine treatment of prescription opioid and heroin dependent patients into their practices. Physicians may use this resource for assistance in obtaining a mentor for beginning an office-based practice. The PCSS-B service is available at no cost to interested physicians and staff at http://pcssmat.org. Physicians can also join the SAMHSA Buprenorphine Clinical Discussion WebBoard to ask and discuss questions on the clinical use of buprenorphine.

Concern about the lack of access to treatment for opioid addiction and the need for education on the compassionate tapering of patients on high dose opioids has led to quick

action by Maine Quality Counts (https://www.mainequalitycounts.org) and the Maine Medical Association (https://www.mainemed.com) to try to get more clinician?s trained in these areas, and anyone interested is encouraged to check their websites. Quality Counts has weekly live webinars that often address these issues and can be accessed on their website for viewing at any time.

(1) http://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine
(2) http://www.naabt.org/30_patient_limit.cfm
(3) https://www.federalregister.gov/articles/2016/07/08/2016-16120/medication-assisted-treatment-for-opioid-use-disorders
http://www.asam.org/magazine/read/article/2016/07/06/summary-of-the-major-components-of-the-hhs-final-rule-which-will-be-effective-on-august-5-2016
(4) S.524 Comprehensive Addiction and Recovery Act of 2016
https://www.govtrack.us/congress/bills/114/s524
https://www.govtrack.us/congress/bills/114/s524/text
(5) Clinical Guidelines For The Use Of Buprenorphine In The Treatment Of Opioid Addiction
http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf
(6) http://pcssmat.org/wp-content/uploads/2014/02/PCSS-MATGuidanceOff-label-bup-for-pain.Gordon.pdf

# From the Executive Director?s Desk

**Maine Medical Boards Adopt Joint Rule for Physician Assistants**

Background
The Maine Board of Licensure in Medicine and the Board of Osteopathic Licensure have adopted ?Chapter 2 Joint Rule Regarding Physician Assistants.? The joint rule implements Public Law 2015, Chapter 242, as amended, which was designed to eliminate the dual licensure of physician assistants in Maine. Prior to that law change, physician assistants were required to be licensed and registered with each board if they provided medical services under the delegation of an allopathic physician and an osteopathic physician. The new law eliminates this requirement and allows a physician assistant to practice under an allopathic or osteopathic physician when licensed and registered with either board. Prior to the enactment of the Chapter 2 Joint Rule, each board had its own rules regarding physician

assistants, which were not identical. The Chapter 2 Joint Rule eliminates this discontinuity, and creates uniform:

- Definitions
- Qualifications for licensure
- Requirements for registration
- Applications for licensure and registration
- Fees
- Scope of practice
- Standards for physician supervision of physician assistants
- Standards for written plans of supervision
- Notification requirements
- Identification requirements
- CME requirements

Important Points

Here are some of the important aspects of the Chapter 2 Joint Rule:

- Physician assistants will be licensed with only one board
- Physician assistants who are currently licensed by both boards will need to select the board with which they want to continue to be licensed
- Physician assistants require both a license and a registration in order to render medical services
- Physician assistants may prescribe Schedule II-V drugs so long as the prescribing authority is specifically delegated in the written plan of supervision
- Physicians are responsible for the prescribing practices of the physician assistants under their supervision
- Physician assistants must notify the boards in writing within 10 calendar days of any of the following:
    - Change of primary supervising physician
    - Termination of the plan of supervision
    - Change of contact information
    - Death/Departure of supervising physician
    - Failure to pass NCCPA exam
    - Criminal arrest/summons/indictment/conviction
    - Change in employment or hospital privileges
    - Disciplinary action
    - Material change in any answers to questions on applications

The Chapter 2 Joint Rule is available on the boards? websites:
http://www.maine.gov/md/
http://www.maine.gov/osteo/

As of 8/1/16 the Federal Drug Enforcement Administration (DEA) has removed the schedule restrictions from all Federal DEA registrations for PA?s in the State of Maine.
PAs desiring to add drug schedules to their Federal DEA registrations should do so by using the DEA web site: www.deadiversion.usdoj.gov PLEASE DO NOT TO CALL THE BOSTON DEA OFFICE. The DEA will update registrations as quickly as possible, but will need a few days to process the request.

# Adverse Actions

**Jack L. Flippo, M.D. License #MD21015 (Date of action June 16, 2016)** On June 16, 2016, the Board entered into a Consent Agreement for licensure with Dr. Flippo based upon disciplinary action taken by theNorth Carolina Medical Board. The Consent Agreement requires Dr. Flippo to comply with all terms and conditions of a December 2, 2015 North Carolina Medical Board Consent Order, a monitoring contract with the North Carolina Physicians Health Program, and a monitoring contract with the Maine Medical Professionals Health Program.

**James Grossman, PA-C License #PA44 (Date of action June 16, 2016)** On June 16, 2016, the Board entered into a Consent Agreement with Mr. Grossman finding that Mr. Grossman had engaged in incompetence and unprofessional conduct for prescribing scheduled drugs on several occasions to a person who was not his patient. The Board imposed a reprimand, a civil penalty of one thousand dollars ($1,000.00), and a license probation for at least ten (10) months which includes requirements that Mr. Grossman attend an in-person continuing medical education course of not less than twenty (20) hours on the subject of professional boundaries, attend an in-person continuing medical education course of not less than six (6) hours on the subject of prescribing opioids and the use of universal precautions, and chart reviews.

**Robert S. LaMorgese, M.D. License #MD19083 (Date of action June 16, 2016)** On June 16, 2016, the Board issued a Decision and Order following an adjudicatory hearing held on May

10, 2016. The Board found that because Dr. La Morgese had not actively engaged in the practice of medicine since early 2014, he engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to patients and imposed a period of probation for six (6) months during which Dr. LaMorgese agrees to retain a Board approved practice monitor and to obtain a neurological evaluation by a Board approved neurologist. In addition, if Dr. LaMorgese reactivates his DEA registration, he must complete an in-person continuing medical education course of at least eight (8) hours on the topic of prescribing opioids.

**James F. McGuckin, M.D. License #MD19821 (Date of action May 10, 2016)** On May 10, 2016, the Board entered into a Consent Agreement with Dr. McGuckin imposing discipline resulting from disciplinary action taken by the State of Washington Medical Quality Assurance Commission in October 2015. The Consent Agreement requires that Dr. McGuckin comply with all requirements imposed by the State of Washington Medical Quality Assurance Commission Order, and specifies that he shall not perform angioplasty and stenting procedures of the venous system for CCSVI or multiple sclerosis patients in the State of Maine.

**Edison P. McDaniels, II, M.D. License #MD19821 (Date of action May, 10, 2016)** On May 10, 2016, the Board entered into a Consent Agreement with Dr. McDaniels imposing a warning and a civil penalty of one thousand dollars ($1,000.00) for misrepresentation in obtaining a license, i. e., for his failure to disclose all malpractice settlements on his license applications.

**Sharon Marble, M.D. License #MD16567 (Date of action April 12, 2016)** On April 12, 2016, the Board entered into a cConsent aAgreement with Dr. Marble based upon the Board finding that Dr. Marble engaged in incompetence and unprofessional conduct by having a romantic relationship with a patient/former patient for whom she had provided mental health treatment. The Board imposed a censure, a license probation for five years, a fifteen hundred dollar ($1,500.00) civil penalty, and requirements that Dr. Marble enroll in a Board approved medical ethics/ professional boundaries course within nine months, terminate her relationship with the former client, and obtain a substance abuse evaluation. In addition, Dr. Marble?s license to practice medicine is limited to the practice of administrative medicine for at least two years.

**Donald B. Shea, M.D. License #MD18015 (Date of action April 12, 2016)** On April 12, 2016, the Board entered into an interim consent agreement with Dr. Shea providing for the immediate suspension of his license to practice medicine after acknowledging that existing evidence could provide a basis for the Board to conclude that the continued licensure of Dr. Shea as a physician would place the health and physical safety of the public in immediate jeopardy. The suspension of Dr. Shea?s license shall continue until a pending complaint alleging that Dr. Shea misused alcohol, drugs or other substances that has resulted or may

result in the licensee performing services in a manner that endangers the health or safety of patients, engaged in the practice of fraud, deceit or misrepresentation in connection with service rendered within the scope of the license issued, and engaged unprofessional conduct is resolved.

**William Silber, M.D. License #MD12320 (Date of action April 8, 2016)** On April 8, 2016 Dr. William Silber requested to withdraw his application for renewal of licensure while under investigation. On April 12, 2016, the Board approved his request to withdraw. Should he decide to apply again for a Maine license in the future, he will be required to meet all licensure requirements in effect at the time of application and the Board may consider whether any grounds exist to deny the application, including grounds for denial that may arise out of the conduct that gave rise to the investigation.

**Charles D. Clemetson, M.D. License #MD13808 (Date of action March 9, 2016)** On March 9, 2016, the Board issued a Decision and Order following an adjudicatory hearing that was held on February 9, 2016. The Board found that Dr. Clemetson engaged in misrepresentation in connection with the practice of medicine by requesting Board approval of an individual as his Board ordered practice monitor while knowing that he was unlikely to continue working with that individual, and by not subsequently informing the Board that he had ceased using that individual as a monitor after just one meeting. The Board also found that Dr. Clemetson had engaged in unprofessional conduct by violating a standard of professional behavior in the practice of medicine by practicing without a practice monitor for a period of 31 months after being ordered not to do so, by not communicating the status of his practice monitor, and by falsely representing that he was using an electronic records system to the Board. Finally the Board found that Dr. Clemetson had failed to comply with the conditions of probation imposed pursuant to the July 11, 2013 Decision and Order. The Board imposed a censure, and a license probation for five years. Dr. Clemetson must close his private practice within 90 days, and is limited to practicing in a setting with other physicians and with a Board approved practice monitor who will report to the Board.

**Ajitpal S. Dhaliwal, M.D. License #MD20397 (Date of action March 8, 2016)** On March 8, 2016, the Board entered into a Consent Agreement with Dr. Dhaliwal based upon the Board concluding that Dr. Dhaliwal engaged in misuse of alcohol, drugs or other substances in a manner that may result in performing services in a manner that endangers the health or safety of patients, and unprofessional conduct The Consent Agreement requires that Dr. Dhaliwal be subject to a two year license probation with conditions that include compliance with and participation in an agreement with the New York Committee for Physician Health that includes toxicology monitoring and abstinence from any non-prescribed substances.

**Brandon W. Chan, M.D. License #MD20448 (Date of action March 8, 2016)** On March 8, 2016, the Board entered into a Consent Agreement with Dr. Chan based upon the Board

concluding that Dr. Chan engaged in unprofessional conduct and misrepresentation in obtaining a license by failing to report an existing complaint against him in another state on his application and failing to timely respond to a complaint notification sent by the Board. The Consent Agreement imposes a warning, a civil penalty in the amount of fiftenn hundred dollars ($1,500) and requires Dr. Chan to notify the Board within ten days of any change to his contact information or the commencement of practice in Maine.

**Ron Mark, M.D. License #MD18634 (Date of action March 8, 2016)** On March 8, 2016, the Board entered into a Consent Agreement with Dr. Mark based upon the Board concluding that Dr. Mark engaged in unprofessional conduct and misrepresentation by failing to disclose pending medical malpractice claims, medical malpractice settlements, and disciplinary complaints and action on applications for license renewal. The Consent Agreement imposes a reprimand, and a civil penalty in the amount of three thousand dollars ($3,000).

# Online Renewal Notification Option

**To E or not to E?**

The Board is considering changing the way it notifies its licensees it is time to renew their licenses. As shown in the 2015 Annual statistics, 96% of licensees are renewing their licenses online. Currently the Board sends those notifications through the mail. Each year hundreds of these notices are returned because licensees have not updated their addresses, as required by 32 MRS ?3300-A. This amounts to a waste of both staff resources and money.

Based on this information, the Board is considering notifying its licensees of renewal by e-mail. When there is no record of an e-mail address the notification would be sent by US mail.

**The Board is seeking comments from its licensees prior to making a decision.** If you have comments, please e-mail them to the Board?s Executive Director, Dennis Smith, at Dennis.E.Smith@maine.gov

We look forward to hearing your opinion.

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