

## Maine Board of Licensure in Medicine Home Page



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[Downloadable PDF Version](#)

In this issue:

[New Legislation](#)

[Physician Assistant Renewal Changes](#)

[David Jones, MD](#)

[Closing a Practice](#)

[Book Review](#)

[Adverse Actions](#)

[The Problem of Obtaining Meaningful Informed Consent](#)

[New Zealand Alert](#)

[Download Our Newsletter](#)

[License and Registration Reminders](#)

## Recently Enacted Legislation Affecting the Board and/or Its Licensees

The Maine Legislature passed a number of laws in the current session that affect the Board and/or its licensees.

### *Opioid Prescribing*

- L.D. 273 – “An Act To Add an Exception to Prescription Monitoring Program Requirements”  
Public Law Chapter 488 requires that on or after January 1, 2017, upon initial prescription of a benzodiazepine or opioid medication and every 90 days thereafter for as long as the prescription is renewed, a prescriber shall check prescription monitoring information for records related to the person. This law creates a second exception to the requirement for prescribers to check prescription monitoring information (PMP). There are now 2 exceptions:

- When a licensee directly orders or administers a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility (This first exception was further amended by L.D. 1031 to include “or in connection with a surgical procedure.”); and
  - When a licensee directly orders, prescribes or administers a benzodiazepine or opioid medication to a person suffering from pain associated with cancer treatment or end-of-life, palliative or hospice care.
- L.D. 479 – “An Act To Inform Patients of the Dangers of Addicting Opioids”  
This law requires that health care entities and licensees of the Board whose scope of practice includes prescribing opioid medication develop and implement a policy no later than January 1, 2018, regarding procedures and practices related to risk assessment, informed consent and counseling on the risks of opioid use.
  - L.D. 1031 – “An Act To Clarify the Opioid Medication Prescribing Limits Laws” (EMERGENCY)  
In 2015, the Legislature enacted Public Law Chapter 488, which created a number of requirements and exemptions regarding prescribing opioid medication and use of the Controlled Substances Prescription Monitoring Program (PMP). L.D. 1031 makes the following clarifications to these requirements and exemptions:
    - The definition of “palliative care” now includes the language “palliative care does not always include a requirement for hospice care or attention to spiritual needs.”
    - The definition of “serious illness” now includes “chronic, unremitting or intractable pain such as neuropathic pain” as an example of a serious illness.
    - Access to PMP information was expanded to include designated “staff members of a group practice of prescribers.”
    - The requirement to check the PMP does not apply for surgical procedures.
    - Dispensing opioid medication in connection with a surgical procedure is exempt from the 100 morphine milligram equivalents limitation because surgical procedures routinely require higher dosages.
    - The limitation on prescribing no more than a 7-day supply of an opioid medication for acute pain was amended to include the language “unless the opioid product is labeled by the federal Food and Drug Administration to be dispensed only in a stock bottle that exceeds a 7-day supply as prescribed, in which case the amount dispensed may not exceed a 14-day supply.”
  - L.D. 1363 – “Resolve, Regarding Legislative Review of Portions of Chapter 11: Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications, a Late-filed Major Substantive Rule of the Department of Health and Human Services”  
This resolve authorized DHHS to finally adopt Chapter 11 subject to the following

changes:

- Cancer Aftercare. Exemption Code A for active and aftercare cancer treatment must be amended to remove the 6-month limit for aftercare cancer treatment post remission;
- Second prescriptions for opioids. Exemption Code H must be amended to provide that if an individual is prescribed a second opioid after proving unable to tolerate the first opioid, the individual is not required to return the initial opioid prescription to the pharmacy prior to dispensation of the second prescription;
- Early refills. Dispensers may provide an early refill if, in the judgment of the dispenser, the early refill does not represent a pattern of early refill requests by the individual;
- Verification by dispensers. A new paragraph is added to allow dispensers to contact prescribers by telephone to verify and document information about prescriptions;
- Out-of-state prescriptions. A new paragraph is added to establish a process for a dispenser who receives a prescription for an opioid medication from an out-of-state prescriber that does not comply with DHHS rules. The new paragraph will allow the dispenser to fill the prescription if the dispenser records an oral confirmation of the validity of the prescription from the out-of-state prescriber and documents any missing information such as diagnosis code, exemption code and acute or chronic pain notation, and the dispenser makes a reasonable effort to determine that the oral confirmation came from the prescriber or prescriber's agent, which may include a telephone call to the prescriber's telephone number listed in a telephone directory or other directory;
- Delayed implementation of ICD-10 codes. The requirement for dispensers to provide information to the PMP on the exemption code and ICD-10 code is delayed until July 1, 2018 and a provision is added to authorize a waiver after that date from the Department for dispensers who are unable with good cause to comply with the requirement.

### *Laws Related to Licensing*

- L.D. 593 – “An Act To Update the Licensure Renewal Provision of the Board of Licensure in Medicine”

First, this law updates the Board's license renewal process to authorize it to notify its licensees by email of the need to renew their licenses. The Board has been using email renewal notification for several months. The Board staff emails the notifications 60 days prior to the expiration of the license. The email notification includes a link to the Board's online license renewal application so that licensees can quickly and efficiently renew their licenses. Following the implementation of this process, the Board staff noticed a large uptick in licensees who renew online and do so well before the date of license expiration. For the present time, the Board will

continue to send licensees notifications by both regular mail and email, but plans to eventually phase out the regular mail notifications.

Second, the previous process of expiring, administratively suspending, and then lapsing a license has also been changed to bring the Board's statute in line with other professional licensing boards' laws and to eliminate the potential adverse consequences to licensees for having their licenses "administratively suspended" during the lapse process. **This new process will go into effect on September 30, 2017.** Under the new law, if an administratively complete application has not been received prior to the license expiration date, the license will immediately and automatically expire. Once the license expires, the individual cannot practice medicine or render medical services. An individual has up to 90 days after expiration to renew his/her license by filing an application, renewal fee, and late fee. If an individual fails to file a renewal application within 90 days of the expiration of her/his license, the license then lapses. Once a license lapses, an individual must apply for reinstatement.

- L.D. 985 – “An Act To Promote Medical Care for Visiting Athletic Teams”  
This law exempts a physician who holds a current and unrestricted medical license in another state from having to obtain a Maine medical license when the physician, pursuant to a written agreement with an athletic team located in another state, accompanies the athletic team to Maine. The law permits the physician to provide medical services to:
  - A member of the athletic team;
  - A member of the athletic team's coaching, communications, equipment or sports medicine staff;
  - A member of the band or cheerleading squad accompanying the team;
  - The team's mascot.

The physician may not provide medical services at any health care facility in Maine, including a hospital, ambulatory surgical facility or any other facility providing outpatient or inpatient medical care.

- L.D. 1200 – “An Act Relating to the Licensure of Physicians”  
This law prohibits the Board from requiring an applicant for licensure or re-licensure to obtain and/or maintain certification from a specialty medical board as a condition of licensure. The Board has never required certification by a specialty medical board as a precondition to licensure or re-licensure. Similar laws have been enacted in other states where such a requirement existed.
- L.D. 1359 – “An Act to Adopt the Interstate Medical Licensure Compact”  
The Interstate Medical Licensure Compact (Compact) is an agreement among sovereign states, and was developed to provide an expedited process for licensure of

physicians in member Compact states who meet certain criteria. Participation in the Compact is voluntary. More information regarding the Compact can be found at the following websites:

<https://www.ama-assn.org/sites/default/files/media-browser/specialty%20group/arc/fsmb-interstate-medical-licensure-compact-issue-brief.pdf>  
<http://www.imlcc.org/>

## Physician Assistant Renewal Changes

As all of you know, the Rule regarding Physician Assistants (Chapter 2) changed last July. The rule provided many changes requested by the profession, including:

- One license;
- Consistent fees and rules between Boards;
- The ability to keep an active license without a supervisory relationship;
- Delegation to medical assistants
- Schedule II Prescribing Authority; and
- The addition of a Secondary Supervisor (specialist).

In addition the rule contains some items that have proved to be less popular. These include:

- Enhanced supervisory requirements especially for Schedule II prescriptions;
- New registration forms accompanying the rule; and
- Introduction of notification requirements with monetary and/or disciplinary penalties for failure to report.

All of these items have been, and will continue to be, discussed in our newsletter, on our website, at in-person meetings, and during individual phone calls seeking clarification.

One item that has not had any discussion is the change in the renewal process. Previously, the process granted a 30 day grace period following the expiration date and a 30 day administrative suspension prior to the license lapsing. The PA could render medical services for the first 30 days after expiration and renew their license within 60 days of the expiration with a \$100 late fee.

That process has now changed. The grace and suspension periods have been removed. Once the expiration date has passed, the license is expired. The PA will have up to 90 days past expiration to renew the license without a late fee, but the renewal will take effect the day the application is processed. For example:

The license expires on 8/31/2017 and a renewal application is submitted on 9/9/17. Board staff processes the application on 9/10/17. The license will be renewed as of 9/10/2017 with a 10 day gap. The PA

does not have a license to practice between 9/1/2017 and 9/9/2017. The renewal does not retroactively cover the gap.

Once the 90 day expiration period has passed, the license will lapse. Once the license lapses, a reinstatement application will need to be submitted. The fee to reinstate a lapsed license is currently twice the renewal fee.

In order to give its licensees time to adjust, the Board has not yet implemented this part of the rule, but plans to enforce the rule beginning with the September renewal cycle (licenses that expire 9/30/2017). The Board encourages all its licensees to renew their licenses in a timely manner.

## Retiring Board member David D. Jones, M.D.



### **Some reflections on his service by Dennis E. Smith, Esq., Executive Director**

After 8 years of dedicated service, Dr. David D. Jones, M.D., Secretary of the Board of Licensure in Medicine, will be retiring from his membership on the Board following the July 11, 2017 meeting. He will be greatly missed.

Dr. Jones was first appointed to the Board in July 2009, at which time he took an oath to “faithfully discharge to the best of [his] abilities, the duties incumbent on [him] as a member of the Board of Licensure in Medicine.” He incorporated that oath and made an immediate and positive impact.

Dr. Jones swiftly and ably learned the Board’s processes, including all aspects of complaint investigations and licensing. He understood the Board’s mission to protect the public, and approached the review of all matters keeping that mission paramount. His experience and medical knowledge (a family physician and part-time emergency department physician) contributed greatly to Board reviews and discussions of complaints, license applications, and the development of Board policies and rules.

The Board and its staff quickly recognized Dr. Jones’s incredible work ethic. His conscientious and thorough review of hundreds of complaints (sometimes including thousands of pages of medical records) was evident at every Board meeting. Dr. Jones’s workload expanded exponentially when he was elected Secretary of the Board. This position brought with it the additional responsibilities of reviewing hundreds of applications for licensure and on occasion serving as acting chair for Board meetings.

However, what I will remember most about Dr. Jones’s service on the Board is the depth of his compassion – for complainants and licensees alike - and his abilities as a mentor and educator. Thank you, Dr. Jones for your service. Fare thee well.

**Some thoughts by Dr. David D. Jones, M.D. after serving 8 years on the Board**

It is clear to me that most Maine physicians have no idea what we do. Many see us as a punitive, threatening regulatory Board, and have no idea what a positive experience serving on the Board can be. We serve to protect the public by working very hard to help physicians and PAs remain in Maine, practicing in safer, more effective, and satisfying ways. Maine physicians do not realize how hard the Board works to teach, rehabilitate, and counsel physicians and PAs to keep them actively practicing in Maine.

There is an enormous sense of shared pride and success seeing real change in physician or PA behavior and a refinement in their knowledge of medicine and it's practice. This cannot be stated strongly enough.

I have had the chance as secretary to closely evaluate license applicants and identify significant changes in the practice of medicine in Maine; particularly shifts towards telemedicine and locums tenens medicine, which established the need to review these licenses with greater scrutiny and thought.

I am grateful for the chance to participate in reviewing and rewriting chapters 1, 2 and 21 in the BOLIM's rules, to have my thoughts help shape the future of medicine in Maine.

At the same time, I have been amazed at some of the unusual boundary issues, behavioral and prescribing issues that have come before the Board.

***What I will miss most.***

Comradery. Sharing the ability to listen and learn, make and challenge arguments, agreements achieved, enduring mutual respect.

Learning, so much learning, about medicine and professionalism.

The pride and feeling of success in seeing the aha! moment of understanding in a practitioner's face that will allow him or her to change a behavior, or learn/relearn a new skill, or knowledge set and therefore continue to practice in Maine.

Knowing that I and my fellow Board members have worked incredibly hard to help many physicians and PAs continue to practice in Maine, with an improved knowledge base, better professionalism, or successful substance abuse/use treatment through the MPHP. These successes certainly outweigh those instances where we have failed to help practitioners to maintain their licensure.

I will miss the excitement and profound satisfaction of sitting on the Board and making a difference for the better in so many lives – physicians, PAs, and patients.

I will miss my friends.

# Closing a Medical Practice

Peg Duhamel, M.D.  
Medical Director

In the last year alone, the Board has received several complaints regarding both the lack of notice of a medical practice closure as well as patients' inability to obtain a copy of their medical record after their physician retires, moves or changes employment. These are only a couple of the **many** issues involved in closing a medical practice. In 2015 the Maine Medical Association published the "Physician's Guide to Closing A Medical Practice" (1). It is a thorough account of the issues that should be considered well before a practice closes. There are several resources available on the internet as well, such as the American College of Physicians "Closing a Practice Checklist" (2). Some physicians will also consult an attorney, especially when dealing with the dissolution of the business end of the practice.

For some people, losing their doctor or other medical care provider can be very stressful. Complaints of patient abandonment or neglect can be avoided by giving patients sufficient notice of the practice closure. Approximately ninety days is suggested whenever possible. Each patient should receive a letter and notices should appear in local newspapers at least three times over a few months or more. Approximately sixty days prior to closure, patients who require frequent follow up should be referred to other physicians and patients with acute medical problems should have appropriate follow up arranged.

Physicians are ethically obligated to provide a copy of patients' medical records to them or forward the records to their new providers (3). Patients should be informed in the practice closure letter and newspaper notice how to obtain a copy of their records, both before and after the office closes. Historically physicians don't charge for this service, but they may do so as long as they do not exceed reasonable cost as defined by Maine law (4). Physicians should not withhold records for a patient's inability to pay (3).

Medical records retention, storage, retrieval and disposal are extremely important to prepare for. Risk of future liability, physical damage and breach of privacy must be considered. Strong penalties are in place for data breaches.

Retirement should be a time of rejuvenation. Thorough preparation for a practice closure should help prevent possible headaches and or formal complaints from interrupting your new adventures.

(1) Maine Medical Association: "Physician's Guide to Closing A Medical Practice"

<https://www.mainemed.com/sites/default/files/content/Closing%20Practice%20Guide%20FINAL%206.2014.pdf>

(2) ACP "Closing a Practice Checklist"

<https://www.acponline.org/practice-resources/business-resources/office-management/practice-ownership-tools>

(3) AMA "Code of Medical Ethics"

<https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics->



[chapter-3.pdf](#)

(4) Maine Statue Title 22, Subtitle 2: Section 1711-A

<http://legislature.maine.gov/statutes/22/title22sec1711-A.html>

## Book Review

Anna Lembke, M.D. [Drug Dealer, MD: How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop.](#)

Baltimore: Johns Hopkins University Press, 2016. Pp. 172. \$19.95. Dr. Lembke is the chief of addictive medicine and an assistant professor at Stanford University School of Medicine.

By Louisa Barnhart, M.D. Dr. Barnhart is a psychiatrist and a member of the Board of Licensure in Medicine.

Did you ever wonder why doctors' attitudes towards opioids shifted so dramatically and so rapidly in just one generation? Read this book and don't feel so personally responsible as a prescriber for the opioid epidemic. Dr. Lembke describes the whole wide picture of this epidemic, from the connection between Big Pharma's production, promotion, and distribution of opioids to the crises and successes of recovery in individual patients. She documents a sad tale of how organized medicine -- our supposedly watchdog institutions -- were co-opted into spreading misconceptions about opioids, including their effectiveness in treating chronic pain.

This slim volume is reader-friendly but still usefully documented with 160 references. The pages are woven with insightful tales of classical addictions in patients, grounded with a liberal use of statistics to bolster the author's arguments about causes and correlations.

The basic mechanisms of addiction and recovery are discussed and analyzed. Dr. Lembke outlines a strong argument for raising critical concern about our "thought leaders" particularly when Big Pharma heavily subsidizes them. She documents a pivotal and controversial study published in the NEJM that retrospectively followed only 38 patients and concluded opiates are not addictive. Did you know the early pain quantification charts were provided to JCAHO (the Joint Commission on Accreditation of Healthcare Organizations) by Purdue Pharma (maker of OxyContin) for free? JCAHO went on to insist on pain as the fifth vital sign. Acceptance of these analog scales predictably increased the use of prescription opioids. JACHO promoting opiates for Purdue? Who knew?

Dr. Lembke reviews the parts played by all our major medical organizations. It's clear that solving the opioid epidemic is going to require transformation not only of prescribing physicians' habits but of our major institutions' thinking as well.

This is a cautionary tale that may well be applied to many other medications and biological formulations that are presented by our journals while being backed by Big Pharma, and

which have very expensive price tags. Dr. Lembke has written a thought-provoking blueprint of the factors we would do well to consider in playing our part to guide medicine's way forward, and not only with regard to the opioid crisis.

## Adverse Actions

### **Sally L. Van Snepson-Barnett, P.A. License #PA817**

Date: May 9, 2017

Action: Consent Agreement - Censure, a civil penalty of \$500, and a license probation for two years, with conditions including: Compliance with all terms imposed by the Arizona Regulatory Board of Physician Assistants (ARBPA); may not render medical services in the State of Maine.

Basis: Misuse of 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, for failing to disclose substance misuse issues on an application, and for disciplinary action taken by the National Commission on Certification of Physicians Assistants and the Arizona Regulatory Board of Physician Assistants related to substance misuse.

### **Francesco Lupis, MD License #MD19839**

Date: May 9, 2017

Action: Consent Agreement - Voluntary surrender of license.

Basis: Failure to disclose open allegations against him on his license renewal application that were pending with the Connecticut Department of Public Health, Healthcare Quality and Safety Branch and the Connecticut Medical Examining Board.

### **Andre Benoit, Jr., MD License #MD9835**

Date: April 11, 2017

Action: Acceptance of Dr. Benoit's request to withdraw his application for renewal of license while under investigation.

### **Harry M. Peddie, MD License #MD5232**

Date: April 11, 2017

Action: Acceptance of Dr. Peddie's request to surrender his license while under investigation.

### **Peter P. Huang, MD License #MD14673**

Date: April 11, 2017

Action: Consent Agreement - Reprimand and a civil penalty of \$1,000.

Basis: Failure to make a required disclosure on his license renewal application.

### **Vijil K. Rahulan, MD License #MD19716**

Date: April 11, 2017

Action: Consent Agreement - Warning and a civil penalty of \$500.

Basis: Failure to disclose discipline taken against his license in Michigan on his license renewal application.

**Mark E. Cieniawski, MD License #MD13544**

Date: April 11, 2017

Action: Consent Agreement - Reprimand, a civil penalty of \$1,000, and a two year period of probation during which a Board approved consultant will make reports to the Board.

Basis: Engaging in unprofessional conduct and violating Board rules related to use of controlled substances for the treatment of pain.

**Robin E. Locke, MD License #MD18128**

April 11, 2017

Action: Interim Consent Agreement - Immediate suspension of her license to practice medicine until the Board holds an adjudicatory hearing.

Basis: Allegations that Dr. Locke obtained controlled substances from March 2012 through February 2017 under the names of a physician and advance practice registered nurse, who reported that they worked with Dr. Locke but did not treat her as a patient nor provide her with any prescriptions.

## The Problem of Obtaining Meaningful Informed Consent

A recent article in the *AAMCNews* poses the question: “Whose Decision Is It? Teaching Students and Physicians About Informed Consent.” The author points out reasons supporting the conclusion that learning how to engage patients in treatment decisions is a skill, one that can be learned but is too seldom taught carefully and deliberately. The article can be found at <https://news.aamc.org/patient-care/article/whose-decision-teaching-informed-consent/>

However, the article does not provide guidelines for meeting this obligation to teach and learn the skills involved for such engagement with patients. As one remedy for this deficiency, the Board has devised a set of guidelines, which follow in abbreviated form. The complete document is available on the Board’s website. [www.maine.gov/md/](http://www.maine.gov/md/)

### INFORMED CONSENT

#### Guidelines from the Maine Board of Licensure in Medicine\*

Obtaining and recording informed consent before major diagnostic, therapeutic, and invasive procedures is a physician’s legal obligation, and giving that consent is the patient’s exclusive right. Routine decisions about minor medical problems may be treated differently.

## **The Goal**

The goal of offering these guidelines is to help physicians move beyond a limited consent model that emphasizes primarily the physician's legal obligation to disclose information and the patient's legal right to make independent decisions. The Board advocates a different model that emphasizes a certain kind of transaction between patient and physician. The norms that govern such transactions are clarity, relevance, accuracy, and sincerity. There is no standard form, nor any uniform procedure that will fit all cases calling for informed consent in this model, but there is an underlying ethical obligation to ensure the patient and the physician participate together in a transaction that takes into account these norms.

## **Shared Decision Making**

Shared decision making for the patient is not the same as mere acquiescence, or compliance based on partial or slanted information, or indifference due to habit or apathy, nor is it the same as conformity to custom – such as the custom of “following doctor’s orders.”

Shared decision making is a process for reaching a mutual commitment through informed judgment. The heart of the matter is the control of information; to the extent information about a problem can be shared, decisions about potential solutions can be shared. Physicians have privileged access to medical information through their education, experience, and expertise. This privilege carries with it the duty to disclose *clearly* such information as is *relevant* and is supported by *accurate* scientific information in a *sincere* manner for consideration by the patient.

Generally, physicians control the medically relevant information patients need in order to ask the questions they may want to ask but might not be able to formulate on their own. Successfully sharing that information is a matter of 1) the physician’s willingness to do so, and 2) the physician’s ability to apply the skills of communication required to do so. It is also a matter of 3) the patient’s willingness to participate in the process, and 4) the patient’s ability to understand the information, apply it to his or her situation, and then express a reasoned judgment based on the relevant medical information as well as on personal values, wishes, and goals.

The physician personally initiates the process of informing the patient by presenting the medically reasonable options relevant to the patient’s condition. The medical reasonableness of these options is tied to the available and reliable evidence base of expected benefit and risk for each alternative. The physician’s judgment about these options should not be biased in any way by personal self-interest, religious beliefs, or unfair racial or gender preferences. Some such beliefs may rightfully restrict the physician’s practice in other ways, but they should play no role in attempting to influence a patient’s decision making.

## **Skills for Eliciting Informed Consent**

By far the most important skill is **empathetic listening**, which is the capacity for acquiring objective knowledge about the perspective taken by another person. It is a way of

listening that requires temporary suspension of one's personal point of view while trying to assume another's point of view. It is a means for gathering data. It is not synonymous with being compassionate or sympathetic, even though its mere presence can have a beneficial effect. The primary purpose of empathy in this sense is to become well informed about the patient's point of view.

Next is skill in **disclosing and explaining**. 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 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* from a scientific point of view, while at the same time fail to be *satisfying* from the patient's point of view. Informed consent depends on the physician's success in providing both kinds of explanation.

Third is **framing**. Anything that can be said, can be said another way. Decisions are often influenced by the way alternatives are presented. For example, typically for a patient choosing between surgery and radiation, surgery appears much less attractive when described using mortality rather than survival statistics. The difference between 10% mortality (for surgery) and 0% mortality (for radiation) is more impressive than the difference between 90% survival (for surgery) and 100% survival (for radiation). A physician may knowingly or unwittingly nudge a patient toward one option simply by the way the range of options is described, or framed.

### **Definition of Informed Consent**

In conclusion, the Board recommends the following definition of informed consent be adopted and applied by Maine physicians.

Informed consent for treatment has been obtained when: 1) the physician has disclosed and explained *to the patient's satisfaction* the process used to arrive at the medically reasonable and recommended intervention(s), which is based on reliable evidence of expected benefit and risk of each alternative, and which is free of any impermissible bias; 2) the patient, who has demonstrated capacity, has been given ample opportunity to ask questions about the process and the recommended intervention(s), *to the extent the patient wishes*, all questions then having been answered *to the patient's satisfaction*; and 3) the patient gives consent in writing to the intervention(s) agreed to jointly with the physician.

Achieving informed consent is the physician's personal responsibility. This responsibility cannot be wholly delegated. Other medical staff (PA's, NP's and others) may usefully participate in the process, but no amount of shared videos, questionnaires, and pamphlets can substitute *entirely* for personal communicative transaction with the physician. Finally, proof of informed consent cannot be reduced merely to a signature on a form. A note from the physician about the process of gaining that signature should be attached to the form.

\*This is an abbreviation of the full text which may be found on the Board's website.

## Medical Council of New Zealand Alert

Each year Board staff sends a number of license verifications to the Medical Council of New Zealand on behalf of our licensees who are looking to spend some time in that country. This seems to be a successful way for many of our licensees to spend some time away.

The Board recently received an alert from the Medical Council that there is a scam in progress attempting to recruit physicians to St. Theresa's Hospital, St. Vincent Ranui Hospital and Wakefield Hospital, all in Wellington. The first two hospitals do not exist. The third hospital, Wakefield Hospital, does exist, but its name is being used by the scammers. You should contact that hospital directly if you have questions about employment.

Additional information can be found on the Medical Council's web site at <https://www.mcnz.org.nz/news-and-publications/media-releases/internet-scam-st-theresa-s-hospital-st-vincent-ranui-hospital-and-wakefield-hospital-wellington-new-zealand/>

The Board reminds all of its licensees that, as a general rule, you should always check to make sure an opportunity is legitimate before providing any information or fees.

## Downloadable Version of the Newsletter

The Board introduced its electronic newsletter last year and it has been well received. However, there are some licensees who prefer paper when reading the newsletter. We listened and want to make the newsletter as accessible as possible. Therefore, we are introducing a link at the top of the newsletter that will take you to a .pdf version that can be easily printed and read offline.

If you are interested in any information that is linked, you can either reopen the electronic newsletter when you have time, or type the appropriate address into your browser the next time you open it.

We hope you find this modification useful and, as always, we appreciate your feedback.

# License and Registration Reminders

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

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

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

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

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