

New Executive Director

Dennis E. Smith, J.D., Executive Director

On March 1, 2015, I assumed the position of Executive Director for the Board of Licensure in Medicine. Prior to assuming this position, I was privileged to serve for 14 ½ years as an Assistant Attorney General in the State of Maine Office of Attorney General. During that time I worked within the Professional and Financial Regulation Division, and provided legal advice and support to a number of occupational and professional licensing boards.

For the past 8 years, I served as the legal counsel assigned to the Board of Licensure in Medicine. In that capacity, I worked closely with the Board staff regarding myriad issues related to complaints and investigations, licensing, rule-making, and legislation. I also represented the State during Board adjudicatory hearings involving discipline and licensure.

The Board's mission is to protect the public, which it does in a variety of ways: through its licensing process, which verifies the education, training, and competency of applicants for licensure; through the complaint investigative process, which reviews and acts on complaints against physicians and physician assistants; through education such as this newsletter and the guidelines posted on the Board's website; and through the support of other organizations like the Medical Professionals Health Program, which provides valuable



assistance to physicians and physician assistants.

In addition, the Board protects the public by being aware of emerging issues in medicine such as "telemedicine" and "license portability" – both of which can have an impact on access to care in rural states like Maine. The Board is able to perform this mission due to its capable and dedicated staff with whom it will be my privilege to work. At present, the Board staff is working on a number of initiatives,

including the implementation of on-line physician assistant licensing and updating the Board's website.

As I grow in this role, I hope to be able to provide education outreach regarding the Board and its services. I welcome your comments and suggestions about this education outreach goal, and other matters of concern to you. My email address is: dennis.smith@maine.gov. ■

Notes of a Psychiatry Watcher (with apologies to Lewis Thomas)

George McNeil, M.D.

The Editor has kindly invited me to comment, on the eve of my retirement, from a perspective that might represent a professional apex of sorts—or a nadir if one shares William Osler's opinion on "the uselessness of men above sixty years of age."¹ Perhaps the reader will decide.

My license from Maine's Board of Registration hangs, yellowing, before me, dated November, 1973. At the time, I experienced the Board as a welcoming old boys' club. As such, I suppose it reflected the broader culture of American medicine. (This may sound a bit cynical, but discussions with women who were physicians

at the time reveal that the club was not very welcoming to them.) In what has to be one of the most sweeping demographic shifts in the history of medicine, women

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now represent 47% of US medical students, according to a 2013-14 census of the American Association of Medical Colleges. With the leveling of the educational playing field has emerged the dirty secret that women

seem generally to be academically superior to their male counterparts.² They certainly are better endowed with social and communication skills³—important assets as medical paternalism gives way to a new culture of shared decision making.

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Of course the admission of women into the club has been paralleled by purposeful recruitment by our colleges and medical schools of talented minorities. The old boys' culture, which certainly eased my way into college and medical school, is becoming historic artifact; and I think that medicine is far better for the change. As I write, we are mid-way in our residency recruitment season—wherein I get to know a cross section of psychiatry's future. They are from all manner of races, classes, and ethnicities (many the children of recent immigrants). Various sexual orientations are discussed matter-of-factly, remarkable in a medical specialty that counted homosexuality as pathologic when I was in training. As a group they seem committed to social justice and service. Having grown up, perhaps, in a more tolerant and inclusive culture, they are better people than I—giving me hope for medicine's future.

And they are entering a world of neuroscience and molecular medicine that is staggeringly exciting. The genomic revolution is beginning to shed light on the remarkable complexity of serious mental illness, casting doubt on our crude diagnostic categorization, even on the newly minted Diagnostic and Statistical Manual (DSM-5). Big Science, practiced by large research consortia trolling the genomes of thousands of patients and controls in genome wide association studies, has demonstrated multiple genes of interest which cut across traditional psychiatric diagnosis.⁴ Similarly, modern functional neuroimaging belies our widely accepted categorical nosology. As a result, the National Institute of Mental Health has proposed a new schema, focusing on functional dimensions of behavior (like arousal, cognition, or negative affect). These so-called Research Domain Criteria (RDoC) indeed transcend DSM diagnoses and will drive the next generation of psychiatric research.

At the same time, emerging findings in epigenetics remind us of the vital interplay of genes and life experience. By way of fascinating example, it has been shown that DNA methylation signatures in a promotor region of the

glucocorticoid receptor gene are altered in children of male holocaust survivors—an example of trans-generational interaction of gene and environment that would warm the heart of any Lamarckian.⁵

The point of this is that we can ill afford to ignore the patient's life story. Yet the past few decades have seen an insidious retreat in psychiatry from psychotherapy and from a focus on the patient's life narrative. No doubt this is driven in part by the "wow factor" of neuroscience. This, in turn, resonates with aggressive marketing by the pharmaceutical industry (whose latest unsavory practice involves direct-to-consumer appeals to "ask your doctor" for Abilify or some other agent you almost certainly don't need) and by an insurance industry averse to the labor-intensive process of spending time with patients. The resulting pharmacologic reductionism is

seductive—simply match a DSM diagnosis, or even a symptom, to a drug.... Amazingly, this seems to work sometimes, but frequently it fails, remanding us to the harder but more sub-

stantive work of psychotherapy. Or, to the extent that we and our patients stay stuck in the thrall of the drug model, we may embark on an odyssey of medication trials. Again, these sometimes bear fruit. But too often they seem marked by futility, resulting in bizarre poly-pharmacy (for example, the increasingly common daily cocktail combining stimulants and benzodiazepines—*Valley of the Dolls*, redux).⁶

Today's trainees seem up to the task of confronting these challenges—if they can be kept from drowning in debt (school loans north of \$300,000 for many) or from being utterly demoralized by the deluge of required paperwork, e-learns, and meetings that distract them from patient care. The bloated bureaucracy that supports these mandates needs somehow to be reformulated if we hope to preserve the idealism of tomorrow's physicians and to support the sacred in their work—fodder, perhaps, for a future screed. ■

Dr. McNeil will step down this summer after 35 years as Director of Resident Education in Psychiatry at Maine Medical Center.

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Adverse Actions

DESAI, ROBERT K., M.D.; License# 15475; 2/10/15. On June 11, 2013, the licensee entered into an Interim Consent Agreement to the continued suspension of his license to practice medicine in the state of Maine until such time as the Board takes final action – either by hearing and decision and order or by Consent Agreement – regarding Complaint No. CR 13-86. On February 10, 2015, the licensee entered into a Consent Agreement that finally resolved complaint No. CR 13-86 by surrendering his Maine medical license based upon: 1) habitual substance abuse that has resulted or is foreseeably likely to result in the licensee performing services in a manner that endangers the health or safety of patients, and 2) unprofessional conduct.

DOANE, STEPHEN H., M.D.; License #MD11995; 3/10/15. At the conclusion of an Adjudicatory Hearing held on February 10, 2015, the Board voted to: 1) censure the licensee, and 2) place the licensee on probation. Terms of probation are as follows: 1) the licensee may oversee only one mid-level practitioner at a time for the remainder of his licensure, 2) the licensee may oversee no more than 200 beds in a maximum of 2 facilities for the remainder of his licensure, 3) the licensee may provide no longer than a 7-day prescription for patients leaving a facility he is employed at for the remainder of his licensure, and 4) the licensee will engage a practice monitor, approved by the Board, who will review all cases in which the licensee writes prescriptions for more than one week of controlled substances and report to the Board every four months for a period of one year. The Board voted to assess the licensee \$12,000 in actual costs that have already been incurred by the Board in the execution of its investigation and enforcement duties in the matter, payable within 12 months. These disciplinary actions are based on the Board's findings and conclusions that the licensee had: 1) demonstrated incompetence, 2) engaged in unprofessional conduct, and 3) violated a Board Rule.

ORVALD, THOMAS O., M.D.; License# MD19730; 2/10/15. In lieu of further proceedings regarding complaint CR 14-85 Dr. Orvald concedes that should the matter proceed to an Adjudicatory Hearing, the Board would have sufficient evidence to conclude that he engaged in unprofessional conduct based upon information received from the state of Washington, Department of Health, Medical Quality Assurance Commission, regarding an

1. Osler, W. *The Fixed Period, from Aequanimity With Other Addresses*, 2nd ed. Blakiston: Philadelphia, 1925.
2. Buchmann, C., DiPretz, T. *American Sociological Review*; August, 2006.
3. I admit that this last observation is highly informed by my life as a husband, father, and teacher. For a more nuanced discussion of male deficiencies, see Daniel Goleman, *The Brain and Emotional Intelligence*, *Psychology Today*, April 29, 2011.
4. For example see Psychiatric Genomics Consortium: Identification of risk loci with shared effects on five major psychiatric disorders: a genome wide analysis, *Lancet*, Feb. 27, 2013.
5. Yehuda, et al., *American J. Psychiatry*, August, 2014.
6. For those interested in exploring this controversy, it has been nicely illuminated by former *New England Journal of Medicine* editor Marcia Angell, *The Truth About Drug Companies*, NY: Random House, 2004; and by Stanford anthropologist Tanya Luhrmann, *Of Two Minds*, NY: Vintage, 2001.

action taken against Dr. Orvald's medical license in that state for his conduct in qualifying a patient for the medical use of cannabis because asthma caused bronchospasms that was in violation of RCW 18.130.180(4). As discipline for this conduct, Dr. Orvald agrees to accept, and the Board agrees to issue, the following discipline: 1) prohibition during which time licensee shall not issue medical cannabis authorizations or certifications to any patients for the treatment of asthma, 2) monitoring by the Board until the monitoring requirement is modified or rescinded in writing by agreement of all of parties to this Consent Agreement, and 3) licensee shall be responsible for all costs associated with his compliance with the terms and conditions of this Consent Agreement.

HANDANOS, NICHOLAS M.D.;

License # MD 16169; 12/9/14. In lieu of proceeding to an Adjudicatory Hearing, the licensee admits that with regard to complaint CR 13-131 the Board has sufficient evidence from which it could conclude that he engaged in: 1) unprofessional conduct, and 2) incompetence. As discipline pertaining to CR 13-131, the licensee agrees to accept, and the Board agrees to issue the following discipline for the mammography issue: 1) a reprimand, and 2) a fine of Five Hundred Dollars and Zero Cents (\$500.00); and for the CHF diagnosis and testing issue a reprimand, and a fine of Five Hundred Dollars and Zero Cents (\$500.00). In addition, the licensee agreed to reimburse the Board Two Hundred Dollars and Fourteen Cents (\$200.14) for the actual costs of the investigation in this matter.

LEONG, KENG CHEONG M.D.;

License # MD 7235; 12/9/14. In lieu of proceeding to an Adjudicatory Hearing, the licensee admits that with regard to complaint CR 14-44 the Board has sufficient evidence from which it could conclude that he engaged in: 1) unprofessional conduct, 2) incompetent medical care, 3) activity that was beyond the scope of the restrictions on his Maine medical license, and 4) activity that violated his Consent Agreement with the Board. The licensee agrees to: 1) immediate and permanent surrender of his Maine medical license, and 2) reimburse the Board Nine Hundred and Twenty-eight Dollars and Eighty Cents (\$928.80) as actual costs of investigation in this matter.

Did You Know?

If a physician or physician assistant submits a renewal application while they have a complaint before the Board, it is the policy of the Board to pend the license renewal application until final action is taken on the complaint. The original license does not expire and Board staff will furnish a letter stating that. Occasionally, a pended license renewal does create difficulties for the licensee with credentialing agencies, third-party payers or Board-certification organizations. The Board policy allows for licensees who experience difficulty due to the pended status of their license to request a waiver and renewal of their license. Physicians and physician assistants who find themselves in this circumstance may write the Board explaining their difficulties and requesting a renewal of their license while the complaint process is on-going. ■



Amended Rule Regarding Citations

Recently amended Board Rule Chapter 4 went into effect on March 10, 2015. The amended rule allows the Board staff to issue citations – resulting in an administrative fine of \$200.00 – for the following:

- Failure to report the existence of an outstanding complaint before the Maine Board of Licensure in Medicine against the applicant on a license application, license renewal application, or other document provided to the Board.
- Failure to provide a response to the notice of a complaint within the statutorily specified 30 days from notice or within the timeframe specified by issuance of an extension of response as granted by Board staff.
- Failure to answer accurately any question on any Board of Licensure in Medicine application.
- Failure to submit a complete application for licensure within 14 days from issuance of an emergency license, unless a waiver has been granted.
- Failure to meet Continuing Medical Education (CME) requirements at license renewal as confirmed by random audit.

Citations will be mailed to individuals, who will have the option of paying the \$200 administrative fine within 30 days, or filing a written response to the citation and requesting a hearing within that same timeframe. An individual who fails to take either of these actions within the prescribed 30-day period risks disciplinary action. In addition, applications for licensure and/or re-licensure will not be further processed until the final resolution of the citation. The \$200 administrative fine does not constitute discipline and is not reportable to the National Practitioner Data Bank or other similar entities.

Maine State Board of Licensure in Medicine

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Get started today by going to:
www.fsmb.org/policy/education-meetings/

BOLIM Guidelines for Telemedicine

Telemedicine is a rapidly developing area of medicine, especially with regard to technology. Physicians who are licensed in Maine and practicing telemedicine should be aware of the Board's telemedicine guidelines. In September 2014, the Board adopted guidelines for the practice of telemedicine, which include:

- Where the practice of medicine occurs (where the patient is located)
- Acceptable technology, which must include both audio and video or store and forward technology (audio only, telephone conversation, e-mail/instant messaging or fax are not acceptable)
- Medical record keeping, including maintenance, accessibility, and confidentiality
- Informed consent to treatment
- Physician-patient interaction needed to establish a diagnosis and treatment
- Primary care v. episodic care
- Prescribing

The full text of the Board's guidelines for each of these elements can be found on its website:
http://docfinder.docboard.org/me/administrative/dw_policy.htm