

**Maine Board of Licensure in Medicine
State Examination Review Materials
Relevant Laws, Rules, Policies, Opinions
For The Practice Of Medicine In The State Of Maine
Second Edition, 2006
Revised March 19, 2007**

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BOARD RULES

1. Boundary Violations and Sexual Misconduct

Chapter 10: SEXUAL MISCONDUCT

SUMMARY: This chapter defines sexual misconduct by physicians and physician assistants and sets forth the range of sanctions applicable to violations of this rule pursuant to Title 32 §3269 (7) and 3270-A, B, C., and 32 M.R.S.A. §2562, 2594-C.

§1 DEFINITIONS

1. "Physician" an individual who is qualified and licensed according to the provisions of 32 M.R.S.A. §3270 et seq. and 32 M.R.S.A. §2571 et seq.
2. "Physician Assistant" an individual who is qualified and licensed or certified according to the provisions of 32 M.R.S.A. § 3270-A and 3270-B and 32 M.R.S.A. § 2594-A and 2594-B.
3. "Physician/physician assistant sexual misconduct" is behavior that exploits the physician/physician assistant-patient relationship in a sexual way. This behavior is nondiagnostic and/or nontherapeutic, may be verbal or physical, and may include expressions or gestures that have a sexual connotation or that a reasonable person would construe as such. Sexual misconduct is considered incompetence and unprofessional conduct as defined by 32 M.R.S.A. 2591-A (2) and 32 M.R.S.A. 3282 -A (2).

There are two levels of sexual misconduct: sexual violation and sexual impropriety. Behavior listed in both levels may be the basis for disciplinary action.

- A. "Sexual violation" is any conduct by a physician/physician assistant with a patient that is sexual or may be reasonably interpreted as sexual, even when initiated by or consented to by a patient, including but not limited to:
 1. sexual intercourse, genital to genital contact;
 2. oral to genital contact;
 3. oral to anal contact or genital to anal contact;
 4. kissing in a sexual manner (e.g. - french kissing);
 5. any touching of a body part for any purpose other than appropriate examination, treatment, or comfort, or where the patient has refused or has withdrawn consent;
 6. encouraging the patient to masturbate in the presence of the physician/physician assistant or masturbation by the physician/physician assistant while the patient is present; and,
 7. offering to provide practice-related services, such as drugs, in exchange for sexual favors.

- B. "Sexual impropriety" is behavior, gestures, or expressions by the physician/physician assistant that are seductive, sexually suggestive, or sexually demeaning to a patient, including but not limited to:
1. kissing;
 2. disrobing, draping practices or touching of the patient's clothing that reflect a lack of respect for the patient's privacy; deliberately watching a patient dress or undress, instead of providing privacy for disrobing;
 3. subjecting a patient to an examination in the presence of another when the physician/physician assistant has not obtained the verbal or written consent of the patient or when consent has been withdrawn;
 4. examination or touching of genitals without the use of gloves;
 5. inappropriate comments about or to the patient, including but not limited to making sexual comments about a patient's body or underclothing; making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation (homosexual, heterosexual, or bisexual); making comments about potential sexual performance during an examination or consultation (except when the examination or consultation is pertinent to the issue of sexual function or dysfunction); requesting details of sexual history or sexual likes or dislikes when not clinically indicated;
 6. using the physician/physician assistant-patient relationship to solicit a date or initiate romantic relationship;
 7. initiation by the physician/physician assistant of conversation regarding the sexual problems, preferences, or fantasies of the physician/physician assistant; and,
 8. examining the patient without verbal or written consent.

§2 SANCTIONS

If the Board finds that a licensee has engaged in sexual misconduct as defined in section 1 of these rules the licensee shall be disciplined in accordance with these rules.

1. All disciplinary sanctions under 32 M.R.S.A. § 2591-A, § 3282-A and 10 M.R.S.A. § 8003 are applicable.
2. Sexual Violations - Findings of sexual violations are egregious enough to warrant revocation of a physician/physician assistant's medical license. Boards may, at times, find that mitigating circumstances do exist and, may impose a lesser sanction.
3. Sexual Impropriety - Findings of sexual impropriety will result in harsh sanction, which may include revocation. Special consideration should be given to at least the following when determining an appropriate sanction:
 - A. patient harm;
 - B. severity of impropriety;
 - C. culpability of licensee;

- D. psychotherapeutic relationship;
- E. inappropriate termination of physician/physician assistant-patient relationship;
- F. age of patient;
- G. physical /mental capacity of patient;
- H. number of times behavior occurred;
- I. number of patients involved;
- J. period of time relationship existed; and,
- K. evaluation/assessment results.

EFFECTIVE DATE: March 12, 1997

2. Opioids and Pain Management

Chapter 11: USE OF CONTROLLED SUBSTANCES FOR TREATMENT OF PAIN

Preamble: The Boards recognize that principles of quality medical practice dictate that the people of the State of Maine have access to appropriate and effective pain relief.

The Boards acknowledge that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery, and chronic pain, whether due to cancer or non-cancer origins. Fears of investigation by federal, state and local regulatory agencies should not preclude appropriate and adequate treatment of chronic pain patients. However, the Boards recognize that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use.

The Boards encourage physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and as especially important for patients who experience pain as a result of a terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.

Accordingly, the Boards adopt these rules to clarify their positions on pain control and prescribing, specifically related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

§1. Definitions: As used by the Boards when evaluating practice and prescribing issues.

- A. "Acute Pain" is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to controlled substances therapy, among other therapies.
- B. "Addiction" is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.
- C. "Analgesic Tolerance" is the need to increase the dose of controlled substances to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.
- D. "Chronic Pain" is a pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.
- E. "Pain" is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.
- F. "Physical Dependence" on a controlled substance is a physiologic state of neuroadaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.
- G. "Pseudoaddiction" is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

- H. "Substance Abuse" is the use of any controlled substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.
- I. "Tolerance" is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose.

§ 2. Principles of Proper Patient Management: Each of these principles is essential in the treatment of patients with pain.

- A. Evaluation of the Patient: Evaluation should initially include a pain history and assessment of the impact of pain on the patient, a directed physical examination, a review of previous diagnostic studies, a review of previous interventions, a drug history, and an assessment of coexisting diseases or conditions.
- B. Treatment Plan: Treatment planning should be tailored to both the individual and the presenting problem. Consideration should be given to different treatment modalities, such as a formal pain rehabilitation program, the use of behavioral strategies, the use of non-invasive techniques, or the use of medications, depending upon the physical and psychosocial impairment related to the pain. If a trial of controlled substances is selected, the physician should ensure that the patient or the patient's legally authorized representative is informed of the risks and benefits of controlled substance use and the conditions under which controlled substances will be prescribed. Some practitioners find a written agreement specifying these conditions to be useful. A controlled substances trial should not be done in the absence of a complete assessment of the pain complaint.

If the evaluation cannot be completed at the initial visit, controlled substances should only be prescribed in limited quantities, until completion of the evaluation, using the best judgment of the prescribing practitioner based on the information available.

In the instance of chronic end of life pain, please see Section 3.

- C. Informed Consent and Agreement for Treatment: The physician should discuss treatment with the patient, persons designated by the patient, or with the patient's legally authorized representative if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy, where possible. If the patient is determined to be at high risk for medication abuse or has a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities. Suggested elements of such an agreement are provided in Appendix 1.
- D. Consultation: The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in-patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients.
- E. Periodic review of treatment efficacy: Review of treatment efficacy should occur periodically to assess the functional status of the patient, continued analgesia, controlled substances side effects, quality of life and indications of medications abuse. Periodic re-examination is warranted to assess the nature of the pain complaint and to ensure that controlled substances therapy is still indicated. Attention should be given to the possibility of a decrease in global function or quality of life as a result of controlled substance abuse.
- F. Documentation: Documentation is essential for supporting the evaluation, the reason for controlled substance prescribing, the overall pain management treatment plan, any

consultations received, and periodic review of the status of the patient. The physician should document drug treatment outcomes and rationale for changes.

Every prescription must be clearly documented in the patient record. All written prescriptions must include name, address, drug name, amount prescribed, as well as instructions.

- G. Reportable Acts: Information gained as part of the doctor/patient relationship, even if it gives knowledge of possible criminal acts, remains part of the confidential doctor/patient relationship. This needs to be contrasted with persons who use the physician to perpetrate illegal acts such as illegal acquisition or selling of drugs, etc. The physician has an obligation to deal with this behavior up to and including reporting to law enforcement. Reports from other providers, such as pharmacists and ER physicians, suggesting inappropriate or drug-seeking behavior, should be dealt with appropriately.

§ 3. The Principles of End of Life Pain Therapy:

In the instance of chronic end of life pain, a treatment plan which addresses the goals of comfort and personal dignity, developed at the time of original diagnosis is sufficient. Certain suggestions and considerations as noted in Section 2.2,3,4&5 may well not apply to this category of patient. Evaluation and documentation to ensure patient comfort and dignity as well as to manage other aspects of the underlying illness are expected to continue.

EFFECTIVE DATE:

March 22, 1999

Appendix 1.

1. Controlled Substances Contract: Suggested elements of a controlled substance contract are as follows:
 - a) specifies that the physician is the single source of controlled substances;
 - b) may specify the pharmacy;
 - c) written, informed consent to release contract to local emergency departments and pharmacies;
 - d) if written consent is given for release to local emergency departments and/or pharmacies, consent is also being given to the other providers to report violations of the contract back to the physician,
 - e) specifies that if the physician becomes concerned that there has been illegal activity, the physician may notify the proper authorities;
 - f) if the physician has obtained a written release, ER personnel and other providers shall report violations of the contract back to the doctor who prescribed the controlled substance(s).
 - g) specifies that a violation of the contract will result in a tapering and discontinuation of the narcotics prescription;
 - h) specifies that a risk of chronic narcotics treatment is physical dependence (as defined);
 - i) specifies that a risk of chronic narcotics treatment is addiction (as defined);

- j) specifies that it is the responsibility of the patient to be discreet about possessing narcotics and keeping medications in an inaccessible place so that they may not be stolen;
- k) if the patient violates the terms of the contract, the violation should be documented. The physician response to the violation should be documented, as well as the rationale of and changes in the treatment plan.
- l) Physician may consider “fill only at _____ pharmacy” on the prescription form.

3. Physician Assistants

02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

373 BOARD OF LICENSURE IN MEDICINE

Chapter 2: PHYSICIAN ASSISTANTS

SUMMARY: Chapter 2 constitutes rules governing physician assistants who are supervised by Physicians licensed by the Board of Licensure in Medicine. Chapter 2 also establishes a Physician Assistant Advisory Committee. Chapter 3 constitutes rules governing physicians who supervise nurse practitioners practicing as physician extenders.

The link to the full text of Chapter 2 is: <http://www.maine.gov/sos/cec/rules/02/373/373c002.doc>
Full information concerning supervision of Physician Assistants and Schedule II prescribing privileges can be found there.

OTHER BOARD DOCUMENTS

4. Mission Statement of the Board

MISSION STATEMENT BOARD OF LICENSURE IN MEDICINE

The mission of the Board of Licensure in Medicine is to safeguard the health, welfare, safety and lives, of the people of Maine by ensuring that the public is served by competent, ethical and honest practitioners. To accomplish this, the Board will:

- license only qualified medical doctors and physician assistants;
- monitor the practice of medicine to insure the integrity of the profession and to maintain high professional standards and conduct;
- provide the public a forum to have complaints heard and impartially investigated;
- discipline and sanction licensees who violate the standards of conduct or whose performance is below minimum acceptable standards of proficiency;
- undertake special projects, often in collaboration with other interested groups, that both enhance the profession and meet public needs.

5. BoardNotes Article (Fall, 1998): Self/Family Prescribing

PHYSICIAN HEAL THYSELF? THY FAMILY? Editorial comment by Judy Burk, M.D., board member

Medical boards, on occasion, review instances of self-prescribing and instances of prescribing for family members. These come to the attention of regulatory boards through reports from pharmacists, friends, relatives, colleagues, and as incidental information while reviewing material pertinent to unrelated complaints. As a member of such a board, I have observed that considerable confusion reigns about whether or not these practices are acceptable.

Prescribing for self or immediate family is legal in Maine. This includes Schedule II, III, and IV substances. *It does not necessarily follow that doing so is good medicine.*

By way of contrast, in Massachusetts, prescribing schedule II-IV medications for immediate family members is illegal, except "in an emergency." The statute defines "immediate family members" as spouse or equivalent, parent, child, sibling, parent-in-law, brother/sister-in-law, son/daughter-in-law, stepparent, stepchild, step-sibling, or any other person permanently residing in the same residence as the physician.

When reviewing instances of self-prescribing or prescribing for family members, as a board member, I will be seeking to decide whether the physician's conduct was unethical, unprofessional or incompetent.

Controlled Substances - Self or Family Members

Section 8.19 of the **Codes of Ethics** of the American Medical Association states that "*It is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.*" It follows that medical boards may find such practices unacceptable (unprofessional, incompetent or both) and might sanction the licensee, except if "emergency conditions" exist.

Non-controlled Substances - Family Members

Here medical boards seek to determine competency. Was an appropriate history taken, examination done, differential diagnosis considered? Were there appropriate records containing adequate documentation? Was appropriate follow-up arranged? Was consultation sought if indicated? In short, a board would hold the physician to the same standard of care expected if the patient were not a family member. As a board member I would have concerns about a physician providing care to a family member for a problem outside the physician's area of expertise.

In addition to issues of competency, I would be concerned about boundary violations, especially sexual boundary violations. In general, physicians should not provide care for family members around sexually charged concerns or problems requiring examination of breasts, genitalia or rectum.

As a member of a medical board I would also be concerned about a physician providing mental health care to a family member. Arguably, the necessary objectivity would be impossible if the treating physician was a family member. In general, physicians should not treat family members for mental illness.

Noncontrolled Substances - Self

A medical board should be concerned about a physician providing care for him or herself. Meeting competency standards would be very hard such as those outlined above, although theoretically possible. Objectivity would obviously be difficult. The potential for "bad medicine" would be high. Except in very routine, or conversely, emergent situations, I, as a board member, would wish to discourage self-prescribing.

6. BoardNotes article (Spring 2000): Communications

POOR COMMUNICATIONS OFTEN RESULT IN PATIENT COMPLAINTS TO THE BOARD

**By Kimberly K. Gooch, M.D.
Member of Board**

As a relatively new member of the Board of Licensure in Medicine, I have been struck by the number of complaints that arise from simple failures in communication. Although these complaints may not rise to a level requiring Board discipline, the time, energy, and emotional distress involved in dealing with this type of complaint could be prevented. Risk management people have been telling us this all along. Therefore, I'd like to present some tips from my perspective as a Board member.

1. Watch the front. Your office staff is well trained at keeping you on time and saving you from dealing with nonclinical issues. Sometimes after multiple encounters with staff, a patient lodges a complaint just to get your attention. Most of the time, you could solve the problem in less than five minutes if you knew about it. Be sure that your employees know when to refer an issue to you, and take responsibility for it. Its like asking to speak to the manager.
2. Count to ten. If you find yourself angry with something that a patient or co-worker has said, think before you talk. We have all made unintentionally naive comments. In all likelihood, no one meant to question your ability or intentions, but are just requesting your opinion about a consultation, or something on the Internet, or a medical advice column. Do not abruptly dismiss the person, or make a sarcastic or condescending remark. Be diplomatic.
3. Remember the old honey/vinegar adage. It takes no more effort to be nice than to be rude, dismissive, or rushed. Remember to deliver information in a confidential setting, and be careful with the type of information that staff or family members relay to patients. Many persons who lodge a complaint with the Board expect to cause you the humiliation that you have caused them. Treat others as you expect to be treated.
4. Get a life. If your life is a mess, eventually it will affect your relationships with patients. Chronic personal problems, substance abuse, or unresolved issues in your past should be addressed by you before they result in a complaint to the Board. There are many resources available to assist you. Call if you'd like to get help.
5. Respect respect. Physicians year after year maintain their high ranking in public opinion polls. This translates into a high tolerance for your behavior. People realize that you work long hours, may have had little sleep, and deal with a lot of stress. This always puts you in an advantageous position, so, don't push it. Definitely avoid arrogance.

The Board's purpose is to ensure that the public receives competent and professional care from its physician licensees. I believe that the quality of Maine's physicians is high and that we all would rank our relationships with patients as one of the best things about our work. We strive for perfection in our communications. With awareness and effort, we should at least decrease the number of these communication complaints, if not see them disappear entirely.

7. BoardNotes article (Winter 2000): Opioid Prescription Techniques Caution

DIVERSION OF OPIOID ANALGESICS OXYCONTIN - STREET VALUE \$1 MG

The Board of Licensure in Medicine has become increasingly aware of a major problem in the state of Maine. Many licensees received a letter from Jay P. McCloskey, the U.S. Attorney, concerning the diversion of opioid analgesics from legitimate to illegitimate use. Currently Oxycontin tablets are bringing in a dollar per milligram on the street. Other opioids are similarly priced.

The Board recognizes that physicians owe their obligation to the patient. The Board has promulgated rules designed to ensure that no patient will have to suffer because of an inability to obtain adequate pain relief. Relevant features of the rules are:

- The patient must be fully **evaluated** with a complete history, physical, and diagnostic assessment.
- A **treatment plan** should be developed for their specific problem.
- Consideration should be given to **treatment modalities** other than or in addition to controlled substance.
- **Documentation** is essential for supporting the reason for controlled substance prescribing. Every prescription should be clearly documented in the patient record.

To address the conflict between adequate prescribing for pain and diversion of drugs for illicit use, the Board makes the following recommendations to our licensees:

- 1 Physicians could obtain special prescription pads for the writing of opioids and other scheduled substances (schedule 2, 3, 4) prescriptions. These pads, which can be obtained for a nominal amount, are blue in color and when subjected to copying turn white and have the word "VOID" appear across the copy. Use of these special prescription pads will make the copying and reusing of prescriptions much more difficult.
- 2 Physicians might write out the quantity and strength of medication rather than using numerals. Pharmacists have found prescriptions for 25 or 40 tablets changed to 250 or 400 tablets, or strength being similarly altered.
- 3 Physicians should consider writing on their prescriptions which pharmacy the patient has selected. "Fill only at..." will alert another pharmacy should the prescription appear there.
- 4 It may be feasible, depending on your practice location, to fax your prescription to the selected pharmacy. The pharmacist will then be able to compare the fax with the prescription handed in, so that any changes can be noted.
- 5 If you work with PA's or NP's do not pre-sign prescription pads and give them to these practitioners.

It is the Boards hope that these voluntary actions undertaken by Maine's physicians will help stem this disturbing tide of drug diversion. If you have any questions regarding these suggestions please feel free to contact The Board of Licensure in Medicine at (207) 287-3601.

8. Statement of Principle: Telemedicine

NORTHEAST REGION STATE MEDICAL BOARDS
STATEMENT OF PRINCIPLE
September 24, 1999

MEDICAL PRACTICE ACROSS STATE LINES

- Whereas: Technology allows almost instantaneous high quality transmission of images, data, text, audio, and real-time activities without regard to state boundaries; and
- Whereas: Technology has expanded the capability of physicians to provide services using electronic means; and
- Whereas: Medical boards, as the state regulatory authorities charged to protect the health and welfare of their citizens, must have mechanisms to appropriately monitor and discipline professionals providing services within their state boundaries;

NOW THEREFORE: The states named in this document agree in principle that:

EXCEPT FOR CONSULTATION AS DEFINED BY OUR SEVERAL STATES, PROVISION OF ALL MEDICAL SERVICES SHALL REQUIRE A FULL LICENSE IN THE STATE IN WHICH THE PATIENT ENCOUNTER WILL OCCUR.

The following states agree to and support this statement of principle:

Maine Board of Licensure in Medicine – adopted by vote of the board Oct. 12, 1999
Maine Board of Osteopathic Licensure
New Hampshire Board of Medicine
New York Board of Professional Medical Conduct
Vermont Board of Medical Practice

9. Board Brochure: The Consumer's Guide to Licensing Regulation and Discipline of Physicians in Maine

Consumer's Guide

*to the Licensing, Regulating &
Disciplining of Physicians in Maine*

Maine Boards of Medical & Osteopathic Licensure

“For the protection of the health, safety and welfare of the public”

Contact Us:

Board of Licensure in Medicine

137 State House Station, Augusta ME 04333 Phone (207) 287-3601 Fax (207) 287-6590
TTY/TB: 1-800-437-1220
http://www.docboard.org/me/me_home.htm

Board of Osteopathic Licensure

142 State House Station, Augusta ME 04333 Phone (207) 287-2480 Fax (207) 287-3015
TTY/TB: 1-800-437-1220
<http://www.maine.gov/osteo/>

Consumer Assistant

Phone (207) 287-3608 or
Toll Free in Maine (888) 365-9964
TTY/TB: 1-800-437-1220

Other Professional Licensing Boards

Dept. of Professional & Financial Regulation
Licensing & Enforcement Division
Phone (207) 624-8603 Fax (207) 624-8637

Board vs. Malpractice:

- Differences between disciplinary and malpractice actions are significant.
- Boards may discipline a licensee for incompetence, but cannot provide money to the complainant to pay for any harm that was done.
- In a malpractice action in a court, a judge or a jury may award money damages to the complainant if the physician is found to be negligent

Locate Physicians, Administrative, Licensing, & Disciplinary Information:

Online at:

MD http://www.docboard.org/me/me_home.htm

DO <http://www.maine.gov/osteo/>

By Contacting the Consumer Assistant Toll Free in Maine at (888) 365-9964

Some Grounds for Discipline:

- Alcohol/Substance Abuse
- Conviction of a Crime
- Fraud & deceit in obtaining a license
- Inappropriate Prescribing
- Incompetence or Unprofessional Conduct
- Violation of Law, Rule, or Board Order

Possible Results of a Complaint:

1. Closure with no action
2. Closure with a Letter of Guidance (non-disciplinary)
3. Disciplinary Action which may include:
 - warning; censure; reprimand;
 - fine; education; specific conditions of
 - probation; Consent Agreement;
 - suspension; or loss of license.

The Boards Cannot Help With:

- Other Health Care Professionals (e.g. RN, LCSW, DDS, DMD, PT)
- Hospitals, Clinics, or Nursing Homes
- Medical Malpractice
- Billing or Fee Disputes

How to File a Complaint:

Anyone may file a complaint. It must be in writing or by e-mail. Either a letter or a complaint form may be used. Forms are available online or by calling.

The Consumer Assistant, (888) 365-9964, is available to answer questions and guide you through the process

Complaint Process:

Upon receipt, the Board sends a copy of the complaint to the licensee. The licensee has 30 days to respond in writing. A copy of this response is provided to the complainant, unless doing so would jeopardize their health.

The complaint, response, and investigative materials are reviewed approximately 3 months after receipt of the complaint.

Based on its review the Board determines if grounds for disciplinary action exist. If no, the complaint is closed. *See Possible Results of a Complaint*
If yes, the complaint remains open pending further Board action. *See Possible Results of a Complaint*

The complainant is notified of the outcome in writing.

Board History:

For over 100 years, it has been Maine law that a physician must be licensed to practice medicine in our State. Through licensure, the State ensures that all practicing physicians have an appropriate level of education and training and that they abide by recognized standards of professional conduct.

Board Functions:

Protect the public by:

- Licensing Physicians & Physician Assistants
- Investigating Complaints, Providing Guidance, or Imposing Discipline
- Providing information to the Public

Licensure Qualifications:

- Education and Training requirements
- Comprehensive written examination
- Good professional ethics and practices
- Renewal of license every two years including participation in Continuing Medical Education (CME)
- Verification of all information provided to ensure credentials

OTHER IMPORTANT INFORMATION

10. The Maine Medical Association Impaired Physician Program used by this Board

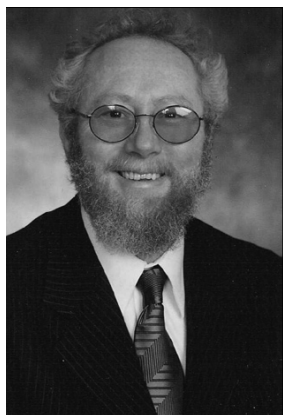
PROTOCOL

- A. NAME: THE COMMITTEE ON PHYSICIAN HEALTH (hereafter The Committee) previously referred to as the IMPAIRED PHYSICIANS COMMITTEE.
- B. PURPOSE:
1. The purpose of The Committee is to develop and implement a comprehensive therapeutic program (hereafter "Program") to address the needs of physicians and physician assistants who have or who could potentially develop alcohol and/or psychoactive drug abuse or dependency that could interfere with the practice of medicine. The physician or physician assistant need not be a member of any professional organization, nor currently licensed in Maine as long as the physician or physician assistant is actively seeking licensure in Maine.
 2. The purpose of this protocol is to define:
 - a. Scope of The Committee
 - b. Administrative structure of The Committee
 - c. Policy and procedures of The Committee
 - d. Relationship of The Committee to its' sponsoring agencies and organizations:
 - The Maine Board of Licensure in Medicine
 - The Maine Board of Osteopathic Licensure
 - The Maine Medical Association
 - The Maine Osteopathic Association
 - Downeast Association of Physician Assistants
- C. NEED:
Numerous studies and surveys have demonstrated that a significant number of physicians and physician assistants have or will develop alcohol and/or psychoactive substance abuse or dependency problems of sufficient magnitude to interfere or potentially interfere with their practice of medicine. It has also been demonstrated that most of these physicians and physician assistants, with proper treatment and monitoring, can be restored to the safe efficient practice of medicine.
- D. ADMINISTRATIVE STRUCTURE:
The Committee on Physician Health is a subcommittee of the Committee on Ethics and Discipline of the Maine Medical Association.

11. Brochure: Maine Medical Association Physician Health Program, 2003.



623-9266



Dr. David J. Simmons became director of the Physician Health Program in early 2003, succeeding Dr. John Dalco. In 1986, after five years of practice as Medical Director of Sunrise Community Health Center in Greeley, Drs. David and Ann Simmons came to Calais, Maine, a small town located on Maine's northeast border with Canada. The Doctors Simmons now are the senior physicians at Calais Regional Hospital where each has served as Chief of Staff. Dr. Simmons has served on the ACP-ASIM Governor's Advisory Council. He has also served all of medicine - serving as President of the Washington County Medical Society and as President of the Maine Medical Association. He has served on the Executive Committee of the Maine Medical Association for a dozen years and in 1999, he was elected as one of Maine's two delegates to the American Medical Association. Dr. Simmons has been particularly involved in the issues of physician health and End-of-Life Care. He leads an EPEC faculty in Maine consisting of a dozen physicians. Diane McMahon is the Administrative Assistant to the program.

Committee Members

Thomas McDermott, MD, *Chair*
Bruce Hansen, MS, PAC
William Head, PAC
Mark Publicker, MD
Guy Raymond, MD

Jerr Roberts, DDS
Norman Rosenbaum, MD
William Sullivan, MD
Carol Williams, RDH

Ask Yourself:

1. *Because of my drinking or drug use, have I felt any of the following: regrets the morning after, guilt, remorse, depression, real loneliness, severe anxiety, terror, or a feeling of impending doom?*
2. *Does my drinking or drug use lead me to questionable environments?*
3. *Do I ever feel I need a drink or drug to face a certain situation?*
4. *Do I need a drink or drug to steady my nerves?*
5. *Do I plan my office routine around my drinking or drug use?*
6. *Have I missed or adjourned patient or other appointments because of my drinking or drug use?*
7. *Do I want or take a drink or drug the next morning?*
8. *Is someone concerned about my drinking or drug use?*

Depression is caused by a chemical imbalance in the brain. It should always be taken seriously. Recognizing its symptoms is important. If the following conditions persist for two weeks or more, you, or a person you know, may suffer from clinical depression.

1. Loss of pleasure or interest
2. Change in eating or sleeping habits
3. Difficulty concentrating
4. Persistent sadness and/or depressed mood
5. Feelings of guilt or worthlessness
6. Slowed movements or restlessness
7. Fatigue or decreased energy
8. Thoughts of death or suicide

If I have answered “Yes” to one or more of the above questions, then I owe it to myself, my family, my patients, and other people who depend on me, to contact the Committee on Physician Health for help.

How the Program Operates

The goal of our program is to identify professionals who are impaired, as early as possible, and to refer them to appropriate treatment facilities so that they may be assisted in returning to their careers.

- *1. All information is confidential. Information concerning a health professional receiving assistance under any of the programs is considered confidential and is available only to those persons within the organization who have responsibility for the effective operation of the program. Likewise, confidentiality will be respected for anyone who contacts the program to obtain assistance for an impaired professional. Confidentiality is limited only by the overreaching responsibility for public safety. Impairments that have or may result in patient harm must be reported under protocols negotiated with the licensing boards.
2. Impaired professionals are treated with compassion and understanding. All programs are operated by concerned professionals.
3. All programs are operated in an ethical manner. Impaired professionals who are referred to outside sources for treatment are asked to cease practice voluntarily until they are rehabilitated.
4. The program abides by applicable state laws.

The American Medical Association defines the impaired physician as “one who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration, through the aging process or lack of motor skills or excessive use or abuse of drugs, including alcohol.”

The Maine Medical Association Physician Health Program helps professionals who suffer from alcohol, chemical dependency, senility, or other illnesses that often are treated inadequately, if at all, when they occur in medical professionals. Members of the Committee on Physician Health act as advocates for their impaired colleagues, providing compassionate, comprehensive, and confidential assistance to medical professionals whose health problems may compromise their professional and personal lives and the lives of their patients. Reports of impairment are accepted by the Committee from colleagues, family members, patients, friends, or the physicians themselves. The clinical director or a member of the Committee then may visit the physician to assess the situation and, if appropriate, arrange for professional diagnosis and treatment. Committee members themselves do not make diagnoses or provide treatment. If no illness or impairment is substantiated, the case is dropped. When treatable illness is diagnosed, the prognosis is excellent.



623-9266
Confidential*

What you can do to assist an impaired professional

If you know a medical professional who is physically or mentally impaired due to the influence of drugs, including alcohol, or other causes - and who needs help - either contact the Clinical Director of the Committee on Physician Health or talk with that professional and have him contact the organization. The sooner treatment begins, the better.

If you, or a colleague, have a potential impairment problem, please:

- 1. Contact the Physician Health Program (623-9266), or*
- 2. Call the office of the Clinical Director (454-8195)*

Remember, the impaired professional need not be a member of any professional society. The objective of the program is that of advocacy - to help return the impaired professional to healthy personal, familial, professional, and social functioning.

Following successful treatment of the participant, the Committee serves as an advocate for the professional returning to practice. Reassurance provided to state agencies, hospitals and colleagues is critical to successful rehabilitation.

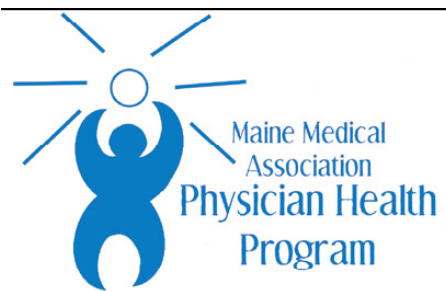
In the case of untreatable illness such as senility, retirement will be encouraged and help in retirement planning will be offered. In conjunction with licensing boards for physicians and dentists, this Committee will not deal with illegal or unethical behavior. Such matters will be referred to the appropriate bodies. If serious, untreatable impairing illness is discovered, the program will aid in finding alternative career choices.

Medical professionals and their families need not suffer alone with chemical dependency, psychological problems, or senility. Help is available.



The practice of medicine and dentistry are complex responsibilities that require the essential well-being of medical professionals. The potential for impairment of practice may result from addictive, psychiatric or medical disorders including the consequences of advancing age. Other factors, such as professional or financial stressors, may contribute. No one is immune from the dangers of alcohol or other drug use, which can impair one's ability to perform. Medical professionals are subject to high degrees of stress every day. The Committee on Physician Health is here to help the following medical professionals: MD's, DO's, Dentists, Physician Assistants, Dental Hygenists, and Denturists.

The Physician Health Program is conducted by the Maine Medical Association under protocols developed with the Maine Board of Licensure in Medicine, the Maine Board of Osteopathic Licensure, and the Maine Board of Dental Examiners.



623-9266

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12. FSMB Boards Ethics Committee's report

sections from the following report

Federation of State Medical Boards Report of the Special Committee on Professional Conduct and Ethics

Table of Contents
Section I Introduction and Charge
Section II Enhancing Medical Board Authority
Section III Disruptive Behavior
Section IV Internet Prescribing
Section V Sale of Goods from Physician Offices
Section VI Recommendations
Section VII Bibliography

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Section III. Managing Complaints of Disruptive Behavior in Physicians

Complaints alleging disruptive behavior in physicians present a distinct challenge to medical boards. The Committee therefore developed recommendations to assist boards in recognizing physician behavior that may negatively affect patient safety and/or create a hostile practice environment, thereby adversely affecting the quality of patient care.

While disruptive behavior may not, in and of itself, constitute a clear violation of the medical practice act, the effects of this behavior have serious implications on the quality of patient care and patient safety. Patterns of disruptive behavior can have a deleterious impact on patient care and can result in errors in clinical judgment and performance. Additionally, the increased anxiety and intimidation associated with a disruptive physician's behavior may severely compromise the effectiveness of the health care team providing patient care by increasing the level of workplace stress and creating an environment in which errors are more likely to occur.

A. Definitions

For the purposes of this report, the following terms are defined:

Disruptive behavior in physicians – aberrant behavior manifested through personal interaction with physicians, hospital personnel, health care professionals, patients, family members, or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care.

Behavioral sentinel events – episodes of inappropriate or problematic behavior which indicate concerns about the physician's level of functioning and suggest potential for adversely affecting patient safety and welfare. [\[1\]](#)

Characteristics of physicians exhibiting disruptive behavior (behavioral sentinel events) may include, but are not limited to:

1. Profane or disrespectful language
2. Demeaning or intimidating behavior
3. Sexual comments or innuendo
4. Inappropriate touching, sexual or otherwise
5. Racial or ethnic jokes
6. Outbursts of rage or violent behavior
7. Throwing instruments or charts or other objects
8. Inappropriately criticizing health care professionals in front of patients or other staff
9. Boundary violations with staff, patients, surrogates or key third parties
10. Comments that undermine a patient's trust in a physician or hospital
11. Inappropriate chart notes
12. Unethical or dishonest behavior
13. Difficulty working collaboratively with others

14. Repeated failure to respond to calls
15. Inappropriate arguments with patients, family, staff, and other physicians
16. Resistance to recommended corrective action
17. Poor hygiene, slovenliness

Hostile environment – an environment which is intimidating, adverse or offensive to the patient and/or any individual working in that environment and which may interfere with patient care.

Impaired physician program (IPP)– may be synonymous with “physician health program” and refers to a program approved by the state medical board and charged with the management of physicians who are in need of evaluation and/or treatment.

B. Statement of the Problem

Disruptive behavior in physicians creates a hostile environment that interferes with the physician/patient relationship in the following manner(s):

1. The physician’s inappropriate behaviors or emotional outbursts shift the physician’s focus from the patient, which can result in errors in clinical judgment and performance.
2. Physician’s emotional outbursts or other inappropriate behavior can increase apprehension and anxiety of the physician’s patients as well as other patients who may witness such outbursts and inappropriate behavior.
3. Decreased effectiveness of the entire health team. Peers, nurses, allied health professionals, and other members of the health care team may be intimidated and anxious causing a loss of their clinical focus and productivity thereby increasing the propensity for medical errors.
4. Decrease in effective communications among the health care team. [2]

Disruptive behavior in physicians is often a symptom of underlying pathology. The differential diagnosis should include (1) addiction (2) stress (3) psychiatric disorders (e.g. bipolar disorder) or (4) personality disorders (e.g. narcissism). Personality disorders appear to contribute to the majority of referrals for disruptive behavior.[3] Physicians impaired due to disruptive behavior may be effectively treated, without or concurrent with punitive action. Physician health programs may be an appropriate vehicle for evaluation and treatment if such programs incorporate the elements set forth in the Report of the Ad Hoc Committee on Physician Impairment (HOD 1995).

13. Guidelines regarding disciplines reportable to the National Practitioner Data Bank (NPDB) and the Federation of State Medical Boards Disciplinary Database

a. (extracted from the National Practitioner Data Bank Reporting Guidelines)

NPBD HELPLINE: 1-800-767-6732

E. REPORTS

Reporting Adverse Licensure Actions

State Medical and Dental Licensing Boards must report adverse actions to the Data Bank within 30 days from the date an adverse licensure action was taken.

State Medical and Dental Boards must report to the Data Bank certain disciplinary actions related to professional competence or conduct taken against the licenses of physicians or dentists. Such licensure actions include revocation, suspension, censure, reprimand, probation, and surrender. State Medical and Dental Boards must also report **revisions** to adverse licensure actions, such as reinstatement of a license.

b. Federation of State Medical Boards Disciplinary Database

This is a database of all prejudicial actions taken by every medical licensing board in the United States. A private database, it is available to participating medical boards and to other health care providers by subscription. Report to this database is made no later than 60 days after a board prejudicial action is taken. Rapid reporting is encouraged. Actions are reported to other boards within 48 hours.

14. Excerpts from the AMA Code of Ethics

For a complete list of Opinions see the American Medical Association Council of Ethical and Judicial Affairs, Code of Medical Ethics. Or visit the AMA website at www.ama-assn.org

American Medical Association Principles of Medical Ethics, June 2001

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principles of Medical Ethics

- I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
- VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
- IX. A physician shall support access to medical care for all people.

Adopted by the AMA's House of Delegates June 17, 2001

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AMA CODE OF MEDICAL ETHICS CURRENT OPINIONS WITH ANNOTATIONS EXCERPTS

E-7.01 Records of Physicians: Availability of Information to Other Physicians.

The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. A physician who formerly treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient. Proper

authorization for the use of records must be granted by the patient. Medical reports should not be withheld because of an unpaid bill for medical services. (IV) Issued prior to April 1977.

E-7.02 Records of Physicians: Information and Patients.

Notes made in treating a patient are primarily for the physician's own use and constitute his or her personal property. However, on request of the patient a physician should provide a copy or a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient.

Most states have enacted statutes that authorize patient access to medical records. These statutes vary in scope and mechanism for permitting patients to review or copy medical records. Access to mental health records, particularly, may be limited by statute or regulation. A physician should become familiar with the applicable laws, rules, or regulations on patient access to medical records.

The record is a confidential document involving the patient-physician relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community. Medical reports should not be withheld because of an unpaid bill for medical services. Physicians may charge a reasonable fee for copying medical records. (IV) Issued prior to April 1977; Updated June 1994.

E-7.025 Records of Physicians: Access by Non-Treating Medical Staff

Physicians who use or receive information from medical records share in the responsibility for preserving patient confidentiality and should play an integral role in the designing of confidentiality safeguards in health care institutions. Physicians have a responsibility to be aware of the appropriate guidelines in their health care institution, as well as the applicable federal and state laws.

Informal case consultations that involve the disclosure of detailed medical information are appropriate in the absence of consent only if the patient cannot be identified from the information.

Only physicians or other health care professionals who are involved in managing the patient, including providing consultative, therapeutic, or diagnostic services, may access the patient's confidential medical information. All others must obtain explicit consent to access the information.

Monitoring user access to electronic or written medical information is an appropriate and desirable means for detecting breaches of confidentiality. Physicians should encourage the development and use of such monitoring systems.

This Opinion focuses on the issue of access to medical records by medical staff not involved in the treatment or diagnosis of patients. It does not address the need to access medical records for clinical research, epidemiological research, quality assurance, or administrative purposes. (IV) Issued December 1999 based on the report "Records of Physicians: Access by Non-Treating Medical Staff," adopted June 1999.

E-7.03 Records of Physicians upon Retirement or Departure from a Group.

A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation, or other reasons. When a physician retires or dies, patients should be notified and urged to find a new physician and should be informed that upon authorization, records will be sent to the new physician. Records which may be of value to a patient and which are not forwarded to a new physician should be retained, either by the treating physician, another physician, or such other person lawfully permitted to act as a custodian of the records.

The patients of a physician who leaves a group practice should be notified that the physician is leaving the group. Patients of the physician should also be notified of the physician's new address and offered the opportunity to have their medical records forwarded to the departing physician at his or her new practice. It is unethical to withhold such information upon request of a patient. If the responsibility for notifying patients falls to the departing physician rather than to the group, the group should not interfere with the discharge of these duties by withholding patient lists or other necessary information. (IV) Issued prior to April 1977; Updated June 1994 and June 1996.

E-7.04 Sale of a Medical Practice.

A physician or the estate of a deceased physician may sell the elements that comprise his or her practice, such as furniture, fixtures, equipment, office leasehold, and goodwill. In the sale of a medical practice, the purchaser is buying not only furniture and fixtures, but also goodwill, i.e., the opportunity to take over the patients of the seller. A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation, matriculation, or other reasons. Therefore, the transfer of records of patients is subject to the following:

- (1) The physician (or the estate) must ensure that all medical records are transferred to another physician or entity who is held to the same standards of confidentiality and is lawfully permitted to act as custodian of the records.
 - (2) All active patients should be notified that the physician (or the estate) is transferring the practice to another physician or entity who will retain custody of their records and that at their written request, within a reasonable time as specified in the notice, the records (or copies) will be sent to another physician or entity of their choice.
 - (3) A reasonable charge may be made for the cost of locating, duplicating, and mailing records.
- (IV) Issued July 1983; Updated June 2000.

E-7.05 Retention of Medical Records.

Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations:

- (1) Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.
 - (2) If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.
 - (3) In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.
 - (4) Whatever the statute of limitations, a physician should measure time from the last professional contact with the patient.
 - (5) If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority.
 - (6) Immunization records always must be kept.
 - (7) The records of any patient covered by Medicare or Medicaid must be kept at least five years.
 - (8) In order to preserve confidentiality when discarding old records, all documents should be destroyed.
 - (9) Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.
- (IV, V) Issued June 1994.

E-8.062 Sale of Non-Health-Related Goods from Physicians' Offices.

The sale of non-health-related goods by physicians presents a conflict of interest and threatens to erode the primary obligation of physicians to serve the interests of their patients before their own. Furthermore this activity risks placing undue pressure on the patient and risks demeaning the practice of medicine.

Physicians should not sell non-health-related goods from their offices or other treatment settings, with the exception noted below.

Physicians may sell low-cost non-health-related goods from their offices for the benefit of community organizations, provided that

- (1) the goods in question are low-cost;
- (2) the physician takes no share in profit from their sale;
- (3) such sales are not a regular part of the physician's business;
- (4) sales are conducted in a dignified manner; and
- (5) sales are conducted in such a way as to assure that patients are not pressured into making purchases. (I, II) Issued June 1998 based on the report, "Sale of Non-health-related Goods from Physicians' Offices," adopted December 1997.

E-8.063 Sale of Health-Related Products from Physicians' Offices

"Health-related products" are any products that, according to the manufacturer or distributor, benefit health. "Selling" refers to the activity of dispensing items that are provided from the physician's office in exchange for money and also includes the activity of endorsing a product that the patient may order or purchase elsewhere that results in direct remuneration for the physician. This Opinion does not apply to the sale of prescription items which is already addressed in Opinion 8.03, Conflicts of Interest: Guidelines.

Physicians who engage in in-office sales practices should be aware of the related guidelines presented in Opinion 8.062, Sale of Non-Health-Related Goods from Physicians' Offices; Opinion 8.03, Conflicts of Interest: Guidelines; Opinion 8.032, Conflicts of Interest: Health Facility Ownership by a Physician; Opinion 3.01, Nonscientific Practitioners; Opinion 8.20, Invalid Medical Treatment; as well as the Reports from which these Opinions are extracted.

In-office sale of health-related products by physicians presents a financial conflict of interest, risks placing undue pressure on the patient, and threatens to erode patient trust and undermine the primary obligation of physicians to serve the interests of their patients before their own.

- (1) Physicians who choose to sell health-related products from their offices should not sell any health-related products whose claims of benefit lack scientific validity. When judging the efficacy of a product, physicians should rely on peer-reviewed literature and other unbiased scientific sources that review evidence in a sound, systematic, and reliable fashion.
- (2) Because of the risk of patient exploitation and the potential to demean the profession of medicine, physicians who choose to sell health-related products from their offices must take steps to minimize their financial conflicts of interest. The following guidelines apply:
 - (a) In general, physicians should limit sales to products that serve the immediate and pressing needs of their patients. For example, if traveling to the closest pharmacy would in some way jeopardize the welfare of the patient (e.g., forcing a patient with a broken leg to travel to a local pharmacy for crutches), then it may be appropriate to provide the product from the physician's office. These conditions are explained in more detail in the Council's Opinion 8.03, Conflicts of Interest: Guidelines, and are analogous to situations that constitute exceptions to the permissibility of self-referral.
 - (b) Physicians may distribute other health-related products to their patients free of charge or at cost, in order to make useful products readily available to their patients. When health-related products are offered free or at cost, it helps to ensure removal of the elements of personal gain and financial conflicts of interest that may interfere, or appear to interfere, with the physician's independent medical judgment.

(3) Physicians must disclose fully the nature of their financial arrangement with a manufacturer or supplier to sell health-related products. Disclosure includes informing patients of financial interests as well as about the availability of the product or other equivalent products elsewhere. Disclosure can be accomplished through face-to-face communication or by posting an easily understandable written notification in a prominent location that is accessible by all patients in the office. In addition, physicians should, upon request, provide patients with understandable literature that relies on scientific standards in addressing the risks, benefits and limits of knowledge regarding the health-related product.

(4) Physicians should not participate in exclusive distributorships of health-related products which are available only through physicians' offices. Physicians should encourage manufacturers to make products of established benefit more fairly and more widely accessible to patients than exclusive distribution mechanisms allow. (II) Issued December 1999 based on the report, "Sale of Health-Related Products from Physicians' Offices," adopted June 1999.

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RELEVANT MAINE STATUTES

All copyrights and other rights to statutory text are reserved by the State of Maine. The text included in this publication is current to the end of the Second Regular Session of the 119th Legislature, which ended May 12, 2000, but is subject to change without notice. It is a version that has not been officially certified by the Secretary of State. Refer to the Maine Revised Statutes Annotated and supplements for certified text.

15. Mandatory Reporting

TITLE 24 MAINE HEALTH SECURITY ACT

24 MRSA § 2505. Committee reports

Any professional competence committee within this State and any physician licensed to practice or otherwise lawfully practicing within this State shall, and any other person may, report the relevant facts to the appropriate board relating to the acts of any physician in this State if, in the opinion of the committee, physician or other person, the committee or individual has reasonable knowledge of acts of the physician amounting to gross or repeated medical malpractice, habitual drunkenness, addiction to the use of drugs or professional incompetence. The failure of any such professional competence committee or any such physician to report as required is a civil violation for which a fine of not more than \$1,000 may be adjudged. [1977, c. 492, § 3 (new).]

Except for specific protocols developed by a board pursuant to Title 32, section 1073, 2596-A or 3298, a physician, dentist or committee is not responsible for reporting misuse of alcohol or drugs or professional incompetence or malpractice as a result of physical or mental infirmity or by the misuse of alcohol or drugs discovered by the physician, dentist or committee as a result of participation or membership in a professional review committee or with respect to any information acquired concerning misuse of alcohol or drugs or professional incompetence or malpractice as a result of physical or mental infirmity or by the misuse of alcohol or drugs, as long as that information is reported to the professional review committee. Nothing in this section may prohibit an impaired physician or dentist from seeking alternative forms of treatment. [1997, c. 107, §3 (amd).]

24 MRSA § 2506. Provider, entity and carrier reports

A health care provider or health care entity shall, within 60 days, report in writing to the disciplined practitioner's board or authority the name of any licensed, certified or registered employee or person privileged by the provider or entity whose employment or privileges have been revoked, suspended, limited or terminated or who resigned while under investigation or to avoid investigation for reasons related to clinical competence or unprofessional conduct, together with pertinent information relating to that action. Pertinent information includes a description of the adverse action, the date, the location and a description of the event or events giving rise to the adverse action. Upon request, the following information must be released to the board or authority: medical records relating to the event or events; written statements signed or prepared by any witness or complainant to the event; and related correspondence between the practitioner and the provider or entity. The report must include situations in which employment or privileges have been revoked, suspended, limited or otherwise adversely affected by action of the health care practitioner while the health care practitioner was the subject of disciplinary proceedings, and it also must include situations where employment or privileges have been revoked, suspended, limited or otherwise adversely affected by act of the health care practitioner in return for the health care provider or health care entity terminating such proceeding. Any reversal, modification or change of action reported pursuant to this section must be reported immediately to the practitioner's board or authority, together with a brief statement of the reasons for that reversal, modification or change. The failure of any health care provider or health care entity to report as required is a civil violation for which a fine of not more than \$1,000 may be adjudged. [1997, c. 697, §5 (amd).]

Carriers providing managed care plans are subject to the reporting requirements of this section when they take adverse actions against a practitioner's credentials or employment for reasons related to clinical competence or unprofessional conduct that may adversely affect the health or welfare of the patient. [1997, c. 271, §3 (new).]

16. Patients' Rights to Personal Medical Records

22 MRSA §1711-A. Fees charged for records

Whenever a health care practitioner defined in section 1711-B furnishes requested copies of a patient's treatment record or a medical report or an addition to a treatment record or medical report to the patient or the patient's authorized representative, the charge for the copies or the report may not exceed the reasonable costs incurred by the health care practitioner in making and providing the copies or the report. The charge for copies of records may not exceed \$10 for the first page and 35¢ for each additional page. [2003, c. 418, §2 (amd) .]

22 MRSA §1711-B. Patient access to treatment records; health care practitioners

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings. [1997, c. 793, Pt. A, §3 (amd); §10 (aff); 1999, c. 512, Pt. A, §6 (aff).]

A. "Health care practitioner" has the same meaning as in section 1711-C, subsection 1, paragraph F.

[1997, c. 793, Pt. A, §3 (amd); §10 (aff).]

B. "Treatment records" means all records relating to a patient's diagnosis, treatment and care, including x rays, performed by a health care practitioner.

[1997, c. 793, Pt. A, §3 (amd); §10 (aff).]

2. Access. Upon written authorization executed in accordance with section 1711-C, subsection 3, a health care practitioner shall release copies of all treatment records of a patient or a narrative containing all relevant information in the treatment records to the patient. The health care practitioner may exclude from the copies of treatment records released any personal notes that are not directly related to the patient's past or future treatment and any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. The copies or narrative must be released to the designated person within a reasonable time. [1997, c. 793, Pt. A, §4 (amd); §10 (aff).]

If the practitioner believes that release of the records to the patient is detrimental to the health of the patient, the practitioner shall advise the patient that copies of the treatment records or a narrative containing all relevant information in the treatment records will be made available to the patient's authorized representative upon presentation of a written authorization signed by the patient. The copies or narrative must be released to the authorized representative within a reasonable time. [1997, c. 793, Pt. A, §4 (amd); §10 (aff).]

Except as provided in subsection 3, release of a patient's treatment records to a person other than the patient is governed by section 1711-C. [1997, c. 793, Pt. A, §4 (amd); §10 (aff).]

3. Person receiving the records. Except as otherwise provided in this section, the copies or narrative specified in subsection 2 must be released to: [1997, c. 793, Pt. A, §§5, 6 (amd); §10 (aff).]

A. The person who is the subject of the treatment record, if that person is 18 years of age or older and mentally competent;

[1991, c. 142, §2 (new).]

B. The parent, guardian ad litem or legal guardian of the person who is the subject of the record if the person is a minor, or the legal guardian if the person who is the subject of the record is mentally incompetent;

[1997, c. 793, Pt. A, §5 (amd); §10 (aff)]

C. The designee of a durable health care power of attorney executed by the person who is the subject of the record, at such time as the power of attorney is in effect; or

[1997, c. 793, Pt. A, §5 (amd); §10 (aff).]

D. The agent, guardian or surrogate pursuant to the Uniform Health-care Decisions Act.

[1997, c. 793, Pt. A, §6 (new); §10 (aff).]

3-A. Corrections and clarifications of treatment records. A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem may submit to a health care practitioner health care information that corrects or clarifies the patient's treatment record, which must be retained with the treatment record by the health care practitioner. If the health care practitioner adds to the treatment record a statement in response to the submitted correction or clarification, the health care practitioner shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem. [1999, c. 512, Pt. A, §3 (amd); §7 (aff).]

4. Minors. This section does not affect the right of minors to have their treatment records treated confidentially pursuant to the provisions of, chapter 260. [1995, c. 694, Pt. D, §28 (amd); Pt. E, §2 (aff).]

5. HIV test. Release of information regarding the HIV infection status of a patient is governed by Title 5, section 19203-D. [1999, c. 512, Pt. A, §4 (amd); §7 (aff).]

6. Hospital records. Release of treatment records in a hospital is governed by the provisions of section 1711. [RR 1993, c. 2, §11 (cor).]

7. Retention of records. This section does not alter the existing law or ethical obligations of a health care practitioner with respect to retaining treatment records. [1991, c. 142, §2 (new).]

8. Violation. A person who willfully violates this section commits a civil violation for which a forfeiture of not more than \$25 may be adjudged. Each day that the treatment records or narrative is not released after the reasonable time specified in subsection 2 constitutes a separate violation, up to a maximum forfeiture of \$100. [1991, c. 142, §2 (new).]

22 MRSA §1711-C. Confidentiality of health care information

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

A. "Authorized representative of an individual" or "authorized representative" means an individual's legal guardian; agent pursuant to Title 18-A, section 5-802; attorney-in-fact pursuant to Title 18-A, section 5-506; or other authorized representative or, after death, that person's personal representative or a person identified in subsection 3-B. For a minor who has not consented to health care treatment in accordance with the provisions of state law, "authorized representative" means the minor's parent, legal guardian or guardian ad litem.

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

A-1. "Authorization to disclose" means authorization to disclose health care information in accordance with subsection 3, 3-A or 3-B.

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

B. "Disclosure" means the release, transfer of or provision of access to health care information in any manner obtained as a result of a professional health care relationship between the individual and the health care practitioner or facility to a person or entity other than the individual.

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

C. "Health care" means preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, treatment, procedures or counseling, including appropriate assistance with disease or symptom management and maintenance, that affects an individual's physical, mental or behavioral condition, including individual cells or their components or genetic information, or the structure or function of the human body or any part of the human body. Health care includes prescribing, dispensing or furnishing to an individual drugs, biologicals, medical devices or health care equipment and supplies; providing hospice services to an individual; and the banking of blood, sperm, organs or any other tissue.

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

D. "Health care facility" or "facility" means a facility, institution or entity licensed pursuant to this Title that offers health care to persons in this State, including a home health care provider, hospice program and a pharmacy licensed pursuant to Title 32. For the purposes of this section, "health care facility" does not include a state mental health institute, the Elizabeth Levinson Center, the Aroostook Residential Center or Freeport Towne Square.

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

E. "Health care information" means information that directly identifies the individual and that relates to an individual's physical, mental or behavioral condition, personal or family medical history or medical treatment or the health care provided to that individual. "Health care information" does not include information that protects the anonymity of the individual by means of encryption or encoding of individual identifiers or information pertaining to or derived from federally sponsored, authorized or regulated research governed by 21 Code of Federal Regulations, Parts 50 and 56 and 45 Code of Federal Regulations, Part 46, to the extent that such information is used in a manner that protects the identification of individuals. The Board of Directors of the Maine Health Data Organization shall adopt rules to define health care information that directly identifies an individual. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

"Health care information" does not include information that is created or received by a member of the clergy or other person using spiritual means alone for healing as provided in Title 32, sections 2103 and 3270.

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

F. "Health care practitioner" means a person licensed by this State to provide or otherwise lawfully providing health care or a partnership or corporation made up of those persons or an officer, employee, agent or contractor of that person acting in the course and scope of employment, agency or contract related to or supportive of the provision of health care to individuals.

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

G. "Individual" means a natural person who is the subject of the health care information under consideration and, in the context of disclosure of health care information, includes the individual's authorized representative.

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

H. "Third party" or "3rd party" means a person other than the individual to whom the health care information relates.

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

2. Confidentiality of health information; disclosure. An individual's health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility except as provided in subsection 3, 3-A, 3-B, 6 or 11. Nothing in this section prohibits a health care practitioner or health care facility from adhering to applicable ethical or professional standards provided that these standards do not decrease the protection of confidentiality granted by this section. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

3. Written authorization to disclose. A health care practitioner or facility may disclose health care information pursuant to a written authorization signed by an individual for the specific purpose stated in the authorization. A written authorization to disclose health care information must be retained with the individual's health care information. A written authorization to disclose is valid whether it is in an original, facsimile or electronic form. A written authorization to disclose must contain the following elements: [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

A. The name and signature of the individual and the date of signature. If the authorization is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature;

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

B. The types of persons authorized to disclose health care information and the nature of the health

care information to be disclosed;

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

C. The identity or description of the 3rd party to whom the information is to be disclosed;

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

D. The specific purpose or purposes of the disclosure and whether any subsequent disclosures may be made pursuant to the same authorization. An authorization to disclose health care information related to substance abuse treatment or care subject to the requirements of 42 United States Code, Section 290dd-2 (Supplement 1998) is governed by the provisions of that law;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

E. The duration of the authorization;

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

F. A statement that the individual may refuse authorization to disclose all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences;

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

G. A statement that the authorization may be revoked at any time by the individual by executing a written revocation, subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation, instructions on how to revoke an authorization and a statement that revocation may be the basis for denial of health benefits or other insurance coverage or benefits; and

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

H. A statement that the individual is entitled to a copy of the authorization form.

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

3-A. Oral authorization to disclose. When it is not practical to obtain written authorization under subsection 3 from an individual or person acting pursuant to subsection 3-B or when a person chooses to give oral authorization to disclose, a health care practitioner or facility may disclose health care information pursuant to oral authorization. A health care practitioner or facility shall record with the individual's health care information receipt of oral authorization to disclose, including the name of the authorizing person, the date, the information and purposes for which disclosure is authorized and the identity or description of the 3rd party to whom the information is to be disclosed. [1999, c. 512, Pt. A, §5 (new); §7 (aff).]

3-B. Authorization to disclose provided by a 3rd party. When an individual or an authorized representative is unable to provide authorization to disclose under subsection 3 or 3-A, a health care practitioner or facility may disclose health care information pursuant to authorization to disclose that meets the requirements of subsection 3 or 3-A given by a 3rd party listed in this subsection. A health care practitioner or facility may determine not to obtain authorization from a person listed in this subsection when the practitioner or facility determines it would not be in the best interest of the individual to do so. In making this decision, the health care practitioner or facility shall respect the safety of the individual and shall consider any indicators, suspicion or substantiation of abuse. Persons who may authorize disclosure under this subsection include: [1999, c. 512, Pt. A, §5 (new); §7 (aff).]

A. The spouse of the individual;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

B. A parent of the individual;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

C. An adult who is a child, grandchild or sibling of the individual;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

D. An adult who is an aunt, uncle, niece or nephew of the individual, related by blood or adoption;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

E. An adult related to the individual, by blood or adoption, who is familiar with the individual's

personal values; and

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

F. An adult who has exhibited special concern for the individual and who is familiar with the individual's personal values.

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

4. Duration of authorization to disclose. An authorization to disclose may not extend longer than 30 months, except that the duration of an authorization for the purposes of insurance coverage under Title 24, 24-A or 39-A is governed by the provisions of Title 24, 24-A or 39-A, respectively. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

5. Revocation of authorization to disclose. A person who may authorize disclosure may revoke authorization to disclose at any time, subject to the rights of any person who acted in reliance on the authorization prior to receiving notice of revocation. A written revocation of authorization must be signed and dated. If the revocation is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature. A health care practitioner or facility shall record receipt of oral revocation of authorization, including the name of the person revoking authorization and the date. A revocation of authorization must be retained with the authorization and the individual's health care information. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

6. Disclosure without authorization to disclose. A health care practitioner or facility may disclose, or when required by law must disclose, health care information without authorization to disclose under the circumstances stated in this subsection or as provided in subsection 11. Disclosure may be made without authorization as follows: [RR 2001, c. 1, §26 (cor).]

A. To another health care practitioner or facility for diagnosis, treatment or care of individuals or to complete the responsibilities of a health care practitioner or facility that provided diagnosis, treatment or care of individuals, as provided in this paragraph.

(1) For a disclosure within the office, practice or organizational affiliate of the health care practitioner or facility, no authorization is required.

(2) For a disclosure outside of the office, practice or organizational affiliate of the health care practitioner or facility, authorization is not required, except that in nonemergency circumstances authorization is required for health care information derived from mental health services provided by:

(a) A clinical nurse specialist licensed under the provisions of Title 32, chapter 31;

(b) A psychologist licensed under the provisions of Title 32, chapter 56;

(c) A social worker licensed under the provisions of Title 32, chapter 83;

(d) A counseling professional licensed under the provisions of Title 32, chapter 119; or

(e) A physician specializing in psychiatry licensed under the provisions of Title 32, chapter 36 or 48.

This subparagraph does not prohibit the disclosure of health care information between a licensed pharmacist and a health care practitioner or facility providing mental health services for the purpose of dispensing medication to an individual;

[RR 2001, c. 1, §26 (cor).]

B. To an agent, employee, independent contractor or successor in interest of the health care practitioner or facility or to a member of a quality assurance, utilization review or peer review team to the extent necessary to carry out the usual and customary activities relating to the delivery of health care and for the practitioner's or facility's lawful purposes in diagnosing, treating or caring for individuals, including billing and collection, risk management, quality assurance, utilization review and peer review. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

C. To a family or household member unless expressly prohibited by the individual or a person acting

pursuant to subsection 3-B;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

D. To appropriate persons when a health care practitioner or facility that is providing or has provided diagnosis, treatment or care to the individual has determined, based on reasonable professional judgment, that the individual poses a direct threat of imminent harm to the health or safety of any individual. A disclosure pursuant to this paragraph must protect the confidentiality of the health care information consistent with sound professional judgment;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

E. To federal, state or local governmental entities in order to protect the public health and welfare when reporting is required or authorized by law or to report a suspected crime against the health care practitioner or facility;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

F.

[1999, c. 512, Pt. A, §5 (rp); §7 (aff).]

F-1. As directed by order of a court or as authorized or required by statute;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

F-2. To a governmental entity pursuant to a lawful subpoena requesting health care information to which the governmental entity is entitled according to statute or rules of court;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

G. To a person when necessary to conduct scientific research approved by an institutional review board or by the board of a nonprofit health research organization or when necessary for a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. A person conducting research or a clinical trial may not identify any individual patient in any report arising from the research or clinical trial. For the purposes of this paragraph, "institutional review board" means any board, committee or other group formally designated by a health care facility and authorized under federal law to review, approve or conduct periodic review of research programs. Health care information disclosed pursuant to this paragraph that identifies an individual must be returned to the health care practitioner or facility from which it was obtained or must be destroyed when it is no longer required for the research or clinical trial. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

H. To a person engaged in the assessment, evaluation or investigation of the provision of or payment for health care or the practices of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to statutory or professional standards or requirements. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales;

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

I. To a person engaged in the regulation, accreditation, licensure or certification of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to standards or requirements for regulation, accreditation, licensure or certification;

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

J. To a person engaged in the review of the provision of health care by a health care practitioner or facility or payment for such health care under Title 24, 24-A or 39-A or under a public program for the payment of health care or professional liability insurance for a health care practitioner or facility or to an agent, employee or contractor of such a person;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

K. To attorneys for the health care practitioner or facility that is disclosing the health care information or to a person as required in the context of legal proceedings or in disclosure to a court or governmental entity, as determined by the practitioner or facility to be required for the practitioner's or facility's own legal representation;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

L. To a person outside the office of the health care practitioner or facility engaged in payment activities, including but not limited to submission to payors for the purposes of billing, payment, claims management, medical data processing, determination of coverage or adjudication of health benefit or subrogation claims, review of health care services with respect to coverage or justification of charges or other administrative services. Payment activities also include but are not limited to:

- (1) Activities necessary to determine responsibility for coverage;
- (2) Activities undertaken to obtain payment for health care provided to an individual; and
- (3) Quality assessment and utilization review activities, including precertification and preauthorization of services and operations or services audits relating to diagnosis, treatment or care rendered to individuals by the health care practitioner or facility and covered by a health plan or other payor;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

M. To schools, educational institutions, camps, correctional facilities, health care practitioners and facilities, providers of emergency services or a branch of federal or state military forces, information regarding immunization of an individual;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

N. To a person when disclosure is needed to set or confirm the date and time of an appointment or test or to make arrangements for the individual to receive those services;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

O. To a person when disclosure is needed to obtain or convey information about prescription medication or supplies or to provide medication or supplies under a prescription;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

P. To a person representing emergency services, health care and relief agencies, corrections facilities or a branch of federal or state military forces, of brief confirmation of general health status;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

Q. To a member of the clergy, of information about the presence of an individual in a health care facility, including the person's room number, place of residence and religious affiliation unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B;

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

R. To a member of the media who asks a health care facility about an individual by name, of brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; and

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

S. To a member of the public who asks a health care facility about an individual by name, of the room number of the individual and brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B.

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

7. Confidentiality policies. A health care practitioner or facility shall develop and implement policies, standards and procedures to protect the confidentiality, security and integrity of health care information to ensure that information is not negligently, inappropriately or unlawfully disclosed. The policies of health care facilities must provide that an individual being admitted for inpatient care be given notice of the right of the individual to control the disclosure of health care information. The policies must provide that routine admission forms include clear written notice of the individual's ability to direct that that individual's name be removed from the directory listing of persons cared for at the facility and notice that removal may result in the inability of the facility to direct visitors and telephone calls to the individual. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

8. Prohibited disclosure. A health care practitioner or facility may not disclose health care information for the purpose of marketing or sales without written or oral authorization for the disclosure.

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

9. Disclosures of corrections or clarifications to health care information. A health care practitioner or facility shall provide to a 3rd party a copy of an addition submitted by an individual to the individual's health care information if: [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

A. The health care practitioner or facility provided a copy of the original health care record to the 3rd party on or after February 1, 2000;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

B. The correction or clarification was submitted by the individual pursuant to section 1711 or 1711-B and relates to diagnosis, treatment or care;

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

C. The individual requests that a copy be sent to the 3rd party and provides an authorization that meets the requirements of subsection 3, 3-A or 3-B; and

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

D. If requested by the health care practitioner or facility, the individual pays to the health care practitioner or facility all reasonable costs requested by that practitioner or facility.

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

10. Requirements for disclosures. Except as otherwise provided by law, disclosures of health care information pursuant to this section are subject to the professional judgment of the health care practitioner and to the following requirements. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

A. A health care practitioner or facility that discloses health care information pursuant to subsection 3, 3-A or 3-B may not disclose information in excess of the information requested in the authorization.

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

B. A health care practitioner or facility that discloses health care information pursuant to subsections 3, 3-A, 3-B or 6 may not disclose information in excess of the information reasonably required for the purpose for which it is disclosed.

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

C. If a health care practitioner or facility believes that release of health care information to the individual would be detrimental to the health of the individual, the health care practitioner or facility shall advise the individual and make copies of the records available to the individual's authorized representative upon receipt of a written authorization.

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

D. If a health care practitioner or facility discloses partial or incomplete health care information, as compared to the request or directive to disclose under subsection 3, 3-A, 3-B or 6, the disclosure must expressly indicate that the information disclosed is partial or incomplete.

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

11. Health care information subject to other laws, rules and regulations. Health care information that is subject to the provisions of 42 United States Code, Section 290dd-2 (Supplement 1998); chapters 710 and 711; Title 5, section 200-E; Title 5, chapter 501; Title 24 or 24-A; Title 34-B, section 1207; Title 39-A; or other provisions of state or federal law, rule or regulation is governed solely by those provisions. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

12. Minors. If a minor has consented to health care in accordance with the laws of this State, authorization to disclose health care information pursuant to this section must be given by the minor unless otherwise provided by law. [1997, c. 793, Pt. A, §8 (new); §10 (aff).]

13. Enforcement. This section may be enforced within 2 years of the date a disclosure in violation of this section was or should reasonably have been discovered. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

A. When the Attorney General has reason to believe that a person has intentionally violated a provision of this section, the Attorney General may bring an action to enjoin unlawful disclosure of health care information.

[1997, c. 793, Pt. A, §8 (new); §10 (aff).]

B. An individual who is aggrieved by conduct in violation of this section may bring a civil action against a person who has intentionally unlawfully disclosed health care information in the Superior Court in the county in which the individual resides or the disclosure occurred. The action may seek to enjoin unlawful disclosure and may seek costs and a forfeiture or penalty under paragraph C. An applicant for injunctive relief under this paragraph may not be required to give security as a condition of the issuance of the injunction.

[1999, c. 512, Pt. A, §7 (amd); §6 (aff).]

C. A person who intentionally violates this section is subject to a civil penalty not to exceed \$5,000, payable to the State, plus costs. If a court finds that intentional violations of this section have occurred after due notice of the violating conduct with sufficient frequency to constitute a general business practice, the person is subject to a civil penalty not to exceed \$10,000 for health care practitioners and \$50,000 for health care facilities, payable to the State. A civil penalty under this subsection is recoverable in a civil action.

[1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

D. Nothing in this section may be construed to prohibit a person aggrieved by conduct in violation of this section from pursuing all available common law remedies, including but not limited to an action based on negligence.

[1999, c. 512, Pt. A, §5 (new); §7 (aff).]

14. Waiver prohibited. Any agreement to waive the provisions of this section is against public policy and void. [1997, c. 793, Pt. A, §8 (new); §10 (aff).]

15. Immunity. A cause of action in the nature of defamation, invasion of privacy or negligence does not arise against any person for disclosing health care information in accordance with this section. This section provides no immunity for disclosing information with malice or willful intent to injure any person. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

16. Application. This section applies to all requests, directives and authorizations to disclose health care information executed on or after February 1, 2000. An authorization to disclose health care information executed prior to February 1, 2000 that does not meet the standards of this section is deemed to comply with the requirements of this section until the next health care encounter between the individual and the health care practitioner or facility. [1999, c. 512, Pt. A, §5 (amd); §7 (aff).]

17. Repeal. [2001, c. 346, §1 (rp).]

17. Disciplinary Proceedings and Possible Sanctions

TITLE 32 REGULATION OF PROFESSIONS

32 MRSA § 3282-A. Disciplinary sanctions

1. Disciplinary proceedings and sanctions. The board shall investigate a complaint, on its own motion or upon receipt of a written complaint filed with the board, regarding noncompliance with or violation of this chapter or any rules adopted by the board.

The board shall notify the licensee of the content of a complaint filed against the licensee as soon as possible, but not later than 60 days after receipt of this information. The licensee shall respond within 30 days. The board shall share the licensee's response with the complainant; unless the board determines that it would be detrimental to the health of the complainant to obtain the response. If the licensee's response to the complaint satisfies the board that the complaint does not merit further investigation or action, the matter may be dismissed, with notice of the dismissal to the complainant, if any.

If, in the opinion of the board, the factual basis of the complaint is or may be true and the complaint is of sufficient gravity to warrant further action, the board may request an informal conference with the licensee. The board shall provide the licensee with adequate notice of the conference and the issues to be discussed. The complainant may attend and may be accompanied by up to 2 individuals, including legal counsel. The conference must be conducted in executive session of the board, pursuant to Title 1, section 405, unless otherwise requested by the licensee. Before the board decides what action to take at the conference or as a result of the conference, the board shall give the complainant a reasonable opportunity to speak. Statements made at the conference may not be introduced at a subsequent formal hearing unless all parties consent. The complainant, the licensee or either of their representatives shall maintain the confidentiality of the conference.

When a complaint has been filed against a licensee and the licensee moves or has moved to another state, the board may report to the appropriate licensing board in that state the complaint that has been filed, other complaints in the physician's record on which action was taken and disciplinary actions of the board with respect to that physician.

When an individual applies for a license under this chapter, the board may investigate the professional record of that individual, including professional records that the individual may have as a licensee in other states. The board may deny a license or authorize a restricted license based on the record of the applicant in other states.

If the board finds that the factual basis of the complaint is true and is of sufficient gravity to warrant further action, it may take any of the following actions it determines appropriate.

A. With the consent of the licensee, the board may enter into a consent agreement that fixes the period and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the licensee. A consent agreement may be used to terminate a complaint investigation, if entered into by the board, the licensee and the Attorney General's office. 1991, c. 824, Pt. A, §68 (rpr).]]

B. In consideration for acceptance of a voluntary surrender of the license, the board may negotiate stipulations, including terms and conditions for reinstatement that ensure protection of the public health and safety and serve to rehabilitate or educate the licensee. These stipulations may be set forth only in a consent agreement signed by the board, the licensee and the Attorney General's office. [1991, c. 824, Pt. A, §68 (rpr).]

C. If the board concludes that modification or nonrenewal of the license is in order, the board shall hold an adjudicatory hearing in accordance with Title 5, chapter 375, subchapter IV. [1993, c. 600, Pt. A, §218 (amd).]

D. If the board concludes that suspension or revocation of the license is in order, the board shall file a complaint in the District Court in accordance with Title 4, chapter 5. [1999, c. 547, Pt. B, §67 (amd); §80 (aff).]

The board shall require a licensee to notify all patients of the licensee of a probation or stipulation under which the licensee is practicing as a result of board disciplinary action. This requirement does not apply to a physician participating in an alcohol or drug treatment program pursuant to Title 24, section 2505, a physician who retires following charges made or complaints investigated by the board or a physician under the care of a professional and whose medical practices and services are not reduced, restricted or prohibited by the disciplinary action.

[1999, c. 547, Pt. B, §67 (amd); §80 (aff).]

2. Grounds for discipline. The board may suspend or revoke a license pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, restrict, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

- A. The practice of fraud or deceit in obtaining a license under this chapter or in connection with service rendered within the scope of the license issued; [1983, c. 378, §53 (new).]
- B. 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; [1993, c. 600, Pt. A, §218 (amd).]
- C. A professional diagnosis of a mental or physical condition that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients; [1993, c. 600, Pt. A, §218 (amd).]
- D. Aiding or abetting the practice of medicine by an individual who is not licensed under this chapter and who claims to be legally licensed; [1993, c. 600, Pt. A, §218 (amd).]
- E. Incompetence in the practice for which the licensee is licensed. A licensee is considered incompetent in the practice if the licensee has:
 - (1) Engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public; or
 - (2) Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed; [1993, c. 600, Pt. A, §218 (amd).]
- F. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed; [1993, c. 600, Pt. A, §218 (amd).]
- G. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or relates directly to the practice for which the licensee is licensed, or conviction of a crime for which incarceration for one year or more may be imposed; [1993, c. 600, Pt. A, §218 (amd).]
- H. A violation of this chapter or a rule adopted by the board; [1993, c. 600, Pt. A, §218 (amd).]
- I. Engaging in false, misleading or deceptive advertising; [1983, c. 378, §53 (new).]
- J. Prescribing narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes; [1989, c. 291, §4 (amd).]
- K. Failure to report to the secretary of the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee; [1997, c. 680, Pt. C, §6 (amd).]
- L. Failure to comply with the requirements of Title 24, section 2905-A; or [1997, c. 680, Pt. C, §7 (amd).]
- M. Revocation, suspension or restriction of a license to practice medicine or other disciplinary action; denial of an application for a license; or surrender of a license to practice

medicine following the institution of disciplinary action by another state or a territory of the United States or a foreign country if the conduct resulting in the disciplinary or other action involving the license would, if committed in this State, constitute grounds for discipline under the laws or rules of this State. [1997, c. 680, Pt. C, §8 (new).]

18. Authority of the Board to Take Emergency Actions

TITLE 32 REGULATION OF PROFESSIONS

32 MRSA § 3286. Emergency action

Upon its own motion or upon complaint, the board, in the interests of public health, safety and welfare, shall treat as an emergency a complaint or allegation that an individual licensed under this chapter is or may be unable to practice medicine with reasonable skill and safety to patients by reason of mental illness, alcohol intemperance, excessive use of drugs, narcotics or as a result of a mental or physical condition interfering with the competent practice of medicine. In enforcing this paragraph, the board may compel a physician to submit to a mental or physical examination by physicians designated by it. Failure of a physician to submit to this examination when directed constitutes an admission of the allegations against the physician, unless the failure was due to circumstances beyond the physician's control, upon which a final order of disciplinary action may be entered without the taking of testimony or presentation of evidence. A physician affected under this paragraph must, at reasonable intervals, be afforded an opportunity to demonstrate that the physician can resume the competent practice of medicine with reasonable skill and safety to patients. [1993, c. 600, Pt. A, §219 (amd).]

For the purpose of this chapter, by practicing or by making and filing a biennial license to practice medicine in this State, every physician licensed under this chapter who accepts the privilege to practice medicine in this State is deemed to have given consent to a mental or physical examination when directed in writing by the board and to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the grounds that the testimony or reports constitute a privileged communication. [1997, c. 271, §11 (amd).]

Injunctions must issue immediately to enjoin the practice of medicine by an individual licensed to practice under this chapter when that individual's continued practice will or may cause irreparable damage to the public health or safety prior to the time proceedings under this chapter could be instituted and completed. In a petition for injunction pursuant to this section, there must be set forth with particularity the facts that make it appear that irreparable damage to the public health or safety will or may occur prior to the time proceedings under this chapter could be instituted and completed. The petition must be filed in the name of the board on behalf of the State. [1993, c. 600, Pt. A, §219 (amd).]

19. Disciplines, Letters of Guidance, Data Banks

TITLE 10 **REGULATORY BOARDS**

10 MRSA § 8003. Departmental organization; duties

5. Authority of bureaus, offices, boards or commissions.

A-1. For each violation of applicable laws, rules or conditions of licensure or registration, the bureau, office, board or commission may take one or more of the following actions:

(1) Issue warnings, censures or reprimands to a licensee or registrant. Each warning, censure and reprimand issued must be based upon violations of different applicable laws, rules or conditions of licensure or must be based upon separate instances of actionable conduct or activity;

(2) Suspend a license or registration for up to 90 days for each violation of applicable laws, rules and conditions of licensure or registration or for instance of actionable conduct or activity. Suspensions may be set to run concurrently or consecutively and, in total, may not exceed one year. Execution of all or any portion of a term of suspension may be stayed pending successful completion of conditions of probation, although the suspension remains part of the licensee's or registrant's record;

(3) Impose civil penalties of up to \$1,500 for each violation of applicable laws, rules and conditions of licensure or registration or for instances of actionable conduct or activity; and

(4) Impose conditions of probation upon an applicant, licensee or registrant. Probation may run for such time period as the bureau, office, board or commission determines appropriate. Probation may include conditions such as: additional continuing education; medical, psychiatric or mental health consultations or evaluations; mandatory professional or occupational supervision of the applicant, licensee or registrant; and other conditions as the bureau, office, board or commission determines appropriate. Costs incurred in the performance of terms of probation are borne by the applicant, licensee or registrant. Failure to comply with the conditions of probation is a ground for disciplinary action against a licensee or registrant. [1995, c. 502, Pt. H, §10 (amd).]

B. The bureau, office, board or commission may execute a consent agreement that resolves a complaint or investigation without further proceedings. Consent agreements may be entered into only with the consent of: the applicant, licensee or registrant; the bureau, office, board or commission; and the Department of the Attorney General. Any remedy, penalty or fine that is otherwise available by law, even if only in the jurisdiction of the District Court, may be achieved by consent agreement, including long-term suspension and permanent revocation of a professional or occupational license or registration. A consent agreement is not subject to review or appeal, and may be modified only by a writing executed by all parties to the original consent agreement. A consent agreement is enforceable by an action in Superior Court. [1995, c. 502, Pt. H, §10 (amd); 1999, c. 547, Pt. B, §78 (amd); §80 (aff).]

C. The bureau, office, board or commission may:

(1) Require all applicants for license or registration renewal to have responded under oath to all inquiries set forth on renewal forms;

(2) Require applicants for license or registration renewal to present proof of satisfactory completion of continuing professional or occupational education in accordance with each bureau's, office's, board's or commission's rules. Failure to comply with the continuing education rules may, in the bureau's, office's, board's or commission's discretion, result in a decision to deny license or registration renewal

or may result in a decision to enter into a consent agreement and probation setting forth terms and conditions to correct the licensee's or registrant's failure to complete continuing education. Terms and conditions of a consent agreement may include requiring completion of increased hours of continuing education, civil penalties, suspension and other terms as the bureau, office, board, commission, the licensee or registrant and the Department of the Attorney General determine appropriate. Notwithstanding any contrary provision set forth in a bureau's, office's, board's or commission's governing law, continuing education requirements may coincide with the license or registration renewal period;

(3) Refuse to renew a license or registration when the bureau, office, board or commission finds a licensee or registrant to be in noncompliance with a bureau, office, board or commission order or consent agreement;

(4) Allow licensees or registrants to hold inactive status licenses or registrations in accordance with each bureau's, office's, board's or commission's rules. The fee for an inactive license or registration may not exceed the statutory fee cap established for the bureau's, office's, board's or commission's license or registration renewal set forth in its governing law; or

(5) Delegate to staff the authority to review and approve applications for licensure pursuant to procedures and criteria established by rule. Rules developed pursuant to this subparagraph are routine technical rules as described in Title 5, chapter 375, subchapter II-A. [1999, c. 386, Pt. B, §4 (amd).]

D. The bureau, office, board or commission may require surrender of licenses and registrations. In order for a licensee's or registrant's surrender of a license or registration to be effective, a surrender must first be accepted by vote of the bureau, office, board or commission. Bureaus, offices, boards and commissions may refuse to accept surrender of licenses and registrations if the licensee or registrant is under investigation or is the subject of a pending complaint or proceeding, unless a consent agreement is first entered into pursuant to this chapter. [1995, c. 502, Pt. H, §10 (amd).]

E. The bureau, office, board or commission may issue letters of guidance or concern to a licensee or registrant. Letters of guidance or concern may be used to educate, reinforce knowledge regarding legal or professional obligations and express concern over action or inaction by the licensee or registrant that does not rise to the level of misconduct sufficient to merit disciplinary action. The issuance of a letter of guidance or concern is not a formal proceeding and does not constitute an adverse disciplinary action of any form. Notwithstanding any other provision of law, letters of guidance or concern are not confidential. The bureau, office, board or commission may place letters of guidance or concern, together with any underlying complaint, report and investigation materials, in a licensee's or registrant's file for a specified amount of time, not to exceed 10 years. Any letters, complaints and materials placed on file may be accessed and considered by the bureau, office, board or commission in any subsequent action commenced against the licensee or registrant within the specified time frame. Complaints, reports and investigation materials placed on file are only confidential to the extent that confidentiality is required pursuant to Title 24, chapter 21, the Maine Health Security Act. [1999, c. 386, Pt. B, §5 (amd).]

F. A bureau, office, board or commission may establish, by rule, procedures for licensees in another state to be licensed in this State by written agreement with another state, by entering into written licensing compacts with other states or by any other method of license recognition considered appropriate that ensures the health, safety and welfare of the public. Rules adopted pursuant to this paragraph are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A. [1999, c. 687, Pt. C, §7 (new).]

The jurisdiction to suspend occupational and professional licenses conferred by this subsection is concurrent with that of the District Court. Civil penalties must be paid to the Treasurer of State.

Any nonconsensual disciplinary action taken under authority of this subsection may be imposed only after a hearing conforming to the requirements of Title 5, chapter 375, subchapter IV, and is

subject to judicial review exclusively in the District Court in accordance with Title 5, chapter 375, subchapter VII, substituting the term "District Court" for "Superior Court," notwithstanding any other provision of law.

- 10. National disciplinary record system.** Within the limits of available revenues, all bureaus, offices, boards or commissions internal or affiliated with the department shall join or subscribe to a national disciplinary record system used to track interstate movement of regulated professionals who have been the subject of discipline by state boards, commissions or agencies and report disciplinary actions taken within this State to that system.