



# Notes from Your Licensing Board

Maine Board of Licensure in Medicine Summer 2010

## Nursing Board Statute Allowing Advanced Practice Registered Nurses (APRN) to Work Under Delegation has been Repealed effective July 12, 2010

Historically, under the Nursing Board statute (32 MRSA §2205-B, sub-§B), certified nurse midwives or certified nurse practitioners who were approved by the Board of Nursing as an advanced practice registered nurse could perform **medical diagnosis or prescribe therapeutic or corrective measures beyond their scope of practice when** these services were **delegated by a licensed physician**. The 124th Maine Legislature repealed the statute which allowed APRNs to practice under the delegation of a physician effective July 12, 2010.

As of the effective date, the nurse practitioner (NP) and certified nurse midwife (CNM) may no longer practice outside of their scope of practice under “delegation” of the physician.

After July 12, 2010, nurse practitioners and nurse midwives:

- Will continue to provide services within his/her scope of practice as certified by the national certifying body and as licensed by the Board of Nursing.
- Will no longer be allowed to accept delegation beyond their scope of practice.
- Will no longer need to complete the APRN Form C Registration with the Board of Licensure in Medicine.

All physicians, NPs and CNMs currently under delegation will receive a letter in June from the Board of Licensure in Medicine and the Maine State Board of Nursing explaining future ineligibility of NPs and CNMs to accept delegated practice. No grandfathering of current delegative relationships was allowed in the law change.

The Board of Licensure in Medicine’s rule on APRN delegation (Chapter 3) will also be repealed this summer since the authorizing statute was repealed.

If you have any questions or concerns about how this new law will affect you or your practice, please contact The Board of Nursing at 207-287-1133 or the Board of Licensure in Medicine at 207-287-6930.



## Case Reviewers Needed

The Board of Licensure in Medicine often receives complaints relating to the quality of care. In its evaluation of a complaint relating to the medical care that the patient received, the Board sometimes seeks expert opinion to assist in reaching a decision. For instance, the Board may elect to have an orthopedic case reviewed by an orthopedist.

The Board often has difficulty in finding physicians willing to provide reviews. I don’t think any of us enjoy criticizing our colleagues and all of us are busy. The Board recognizes that medicine is not an exact science; that complications and less than perfect outcomes do occur despite appropriate care. The same problem may be approached differently by different practitioners yet each approach is acceptable.

However, we also have an obligation to our patients and our profession to ensure that medical care delivered in the State of Maine meets the standard of care. Both complainants and licensees deserve the best possible analysis of the case. The Board sometimes needs help in determining whether a particular treatment is acceptable, an outcome expected, and if the care meets the standard of care.

The Board will pay a nominal fee for your time. As a service to your fellow licensees and the citizens of our state, please consider providing an expert review if approached by the Board. You may also call or email me at 287-4713, [mark.cooper@maine.gov](mailto:mark.cooper@maine.gov) to offer your services.

Thank you.

Mark S. Cooper, MD  
Medical Director  
Board of Licensure in Medicine

# Important Pharmacological Updates

## Schedule II Prescriptions

A practitioner may provide individual patients with multiple prescriptions for the same schedule II controlled substance to be filled sequentially. The combined effect of these multiple prescriptions is to allow the patient to receive, over time, up to a 90-day supply of that controlled substance. There is no federal limit as to the amount of controlled substances a provider can legitimately prescribe. The rule also does not stipulate how many separate prescriptions per schedule II controlled substance may be issued for the 90-day supply. All prescriptions for controlled substances must be dated as of, and signed on, the day when issued. The prescriber may indicate a “do not fill until” date on multiple prescriptions.

DEA’s current policy on changes to a schedule II prescription is that all the essential elements of the prescription written by a practitioner (such as the name of the controlled substance, strength, dosage form, and quantity prescribed) may not be modified orally. DEA realizes that this is in opposition to previous policy and plans to resolve this matter through future rulemaking. Until that time, pharmacists are instructed to adhere to state regulations and policy regarding those changes that a pharmacist may make to a schedule II prescription after oral consultation with the prescriber.

## Electronic Prescribing

The interim rule allowing electronic prescribing of all controlled substances goes into effect June 1, 2010. A practitioner will be able to issue electronic controlled substance prescriptions only when the electronic prescription application the practitioner is using complies with the requirements of the interim final rule.

Please visit the DEA website for details: [www.deadiversion.usdoj.gov](http://www.deadiversion.usdoj.gov).

## FDA Approves New Formulation for OxyContin

In April, the U.S. Food and Drug Administration approved a new formulation of the controlled-release drug OxyContin that has been designed to help discourage misuse and abuse of the medication.

OxyContin is made to slowly release the potent opioid oxycodone to treat patients who require a continuous opioid analgesic for management of their moderate to severe pain for an extended period of time. Because of its controlled-release properties, each OxyContin tablet contains a large quantity of oxycodone, which allows patients to take their drug less often. However, people intent on abusing the previous formulation have been able to release high levels of oxycodone all at once, which contributes to high rates of OxyContin abuse.

The reformulated OxyContin is intended to prevent the opioid medication from being cut, broken, chewed, crushed or dissolved to release more medication. The new formulation may result in less risk of overdose due to tampering, and will likely result in less abuse by snorting or injection; but it still can be abused or misused by simply ingesting larger doses than are recommended.

“Although this new formulation of OxyContin may provide only an incremental advantage over the current version of the drug, it is still a step in the right direction,” said Bob Rappaport, M.D., director of the Division of Anesthesia and Analgesia Products in the FDA’s Center for Drug Evaluation and Research.

“As with all opioids, safety is an important consideration,” he said. “Prescribers and patients need to know that its tamper-resistant properties are limited and need to carefully weigh the benefits and risks of using this medication to treat pain.”

The manufacturer of OxyContin, Purdue Pharma L.P., will be required to conduct a postmarket study to collect data on the extent to which the new formulation reduces abuse and misuse of this opioid.



# Termination of the Physician-Patient Relationship

Termination of the physician-patient relationship may be initiated by the patient, the physician, or both. Some situations which may result in termination of care include disruptive behavior, noncompliance with medical care, and failure of the patient to meet financial obligations. There may also be instances when the personalities of the clinician and the patient just don't mesh.

Maine does not have a specific statute regarding this issue. When termination of the relationship becomes necessary, physicians must insure it is done within the ethical guidelines of medical practice. A violation of ethical standards could be considered unprofessional conduct and grounds for discipline. If termination is initiated by the physician, sufficient notice must be given to allow the patient to obtain alternative care. Regardless of who initiates the dissolution of the relationship, the physician must provide the patient with 30 days of emergency care and access to medications. The physician must not impede the transfer of care to the new provider. A copy of all medical records in the physician's possession should be provided in a timely manner to either the patient or new provider. For instance, records may not be withheld from the new physician until an outstanding bill is paid.

In determining whether the termination of a patient would rise to the level of unprofessional conduct, the Board is guided by the AMA Code of Medical Ethics with Current Opinions and Annotations 2008-2009. Two sections are relevant in this discussion.

## Section 8.11 Neglect of Patient

Physicians are free to choose whom they will serve. The physician should, however respond to the best of his or her ability in cases of emergency where first aid treatment is essential. Once having undertaken a case, the physician should not neglect the patient.

And

## Section 8.115

Physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured.

A discussion of this topic raises additional questions and concerns. How long should a physician work with a "difficult" patient prior to terminating care? Before terminating the patient, to what extent should the physician attempt to educate the patient regarding their behavior? Even "difficult" patients deserve access to medical care. In many areas of the state access to care is limited by geography and a lack of providers. What becomes of the patient terminated from a practice who has very limited alternatives? There are no simple answers to these questions. They should, however cause you to pause and at least consider them prior to terminating a patient simply as a "knee-jerk" response when providing that care becomes frustrating.

## Effectively Communicated Office Policies Enhance Patient Satisfaction

*David Jones, M.D.*

*Member, Maine Board of Licensure in Medicine*

The following are some thoughts from the Board of Licensure in Medicine (BOLIM) concerning the development of office policies, and effectively communicating them to the public.

There have recently been an increasing number of complaints addressed to BOLIM concerning office and physician policies. These complaints against physicians, P.A.s and office staff center around miscommunication, or more often lack of communication, concerning office policies. Most of the complaints focus on patients not being seen when they arrive late for an appointment, even if they have traveled long distances or have significant medical needs.

While BOLIM would encourage all practices to be as flexible and understanding of patients' need for services even if they arrive late, it also recognizes the need for an office and physician to stay on time.

Other complaints involve communication with the physician's office, made in person or by phone call; questions about medical issues, paper work, prescriptions, appointment scheduling, referrals, and transfer

out of or dismissal from the practice. The complaints are generated by patients' anger over their own, or the office staff's, lack of knowledge of office policies; or the ambiguity or lack of these policies.

BOLIM urges all physicians and their offices to develop clear policies, simply stated, concerning the above issues. BOLIM encourages the posting of these policies in obvious places in exam rooms or in the common areas of an office, or distribution in writing in the initial contact with the patient, either by mail or in person.

These policies need to be reviewed yearly by the physicians, mid levels and the staff of a practice. They need to be understood by the staff and able to be verbally communicated in a simple and clear manner to the public.

If these general recommendations are followed, patient care will be enhanced, as will patient satisfaction. The likelihood for misunderstandings and complaints due to practice policies will be significantly decreased.

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## Upcoming Webinars

### Prescription Monitoring Program (PMP)

To combat prescription drug abuse in Maine, all prescribing MD's and Physician Assistants are urged to register with the Maine Office of Substance Abuse, Prescription Monitoring Program. Upcoming training sessions are scheduled for **June 24th at 12noon**. For information on future training sessions visit: [www.maine.gov/dhhs/osa](http://www.maine.gov/dhhs/osa).

## Notify the Board of Business and Home Address Changes Immediately

Many people experience problems at renewal time because they have neglected to notify the Board of an address change. To prevent delays or even loss of license due to lapse, notify the Board immediately of any change in your addresses.

To verify that the Board has your correct addresses on file, visit either of the following sites:

[www.maine.gov/md](http://www.maine.gov/md) or

[www.docboard.org/me/me\\_home.htm](http://www.docboard.org/me/me_home.htm)

and click on "Find a Licensee" in the lower left.

If the address is incorrect, simply send a signed note with changes to the Board or submit the new information online at [www.maine.gov/online/doclicensing/](http://www.maine.gov/online/doclicensing/).

## Confidential Help Available

**Committee on Physician Health:** Confidential professional help for substance abuse is available by calling these confidential numbers: **622-3374** or **623-9266**.