Portland Cognitive and
Behavioral Neurology

Dennis E Smith, Executive Director
via email: dennis.e.smith@maine.gov
Maine Board of Licensure in Medicine
137 State House Station
161 Capital Street
Augusta, ME 04333-0143

Susan E Strout, Executive Secretary
via email: susan.e.strout@maine.gov
Maine Board of Osteopathic Licensure
142 State House Station
Augusta, ME 04333-0142

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Dear Allopathic and Osteopathic Medical Board members,

Thank you for reviewing our comments to the Chapter 2 reproposal. As physicians representing various medical specialties, and an organization representing 12,000 physicians, residents, medical students, and assistant physicians interested in patient safety in scope of practice matters, we are grateful to have the opportunity to submit comments.

These comments focus on two areas: (1) requirements for scope of practice agreements and (2) protection from retaliation for physicians who decline to enter into collaborative agreements, practice agreements, or similar agreements presented by their health care system or physician group practice with credentialing and granting of privileges exempt from a Board-approved collaborative or practice agreement.

**Requirements for Scope of Practice Determinations**

In section 7, subsection 9, paragraph A, the rules state, “In reviewing a proposed scope of practice delineated in a collaborative agreement or in a practice agreement, The Board may request any of the following from the physician assistant:”. We suggest “may request” be changed to “shall be required” to create more baseline uniformity in scope of practice agreement determinations.

Similarly, we suggest the documentation of clinical practice in section 6, subsection 8, paragraph D, be standardized. We suggest that the section read “Acceptable documentation of clinical practice includes, but is not limited to, all of the following:” The current language (“Acceptable documentation of clinical practice includes, but is not limited to the following”) does not specify

whether all - or how many - of the five items are required for acceptable documentation of clinical practice.
The reasons that scope of practice determinations in the Chapter 2 rules is so extraordinarily important is that the current scope of practice for physicians is determined prior to licensure by completion of four years of medical education accredited by the Liaison Committee of Medical Education (LCME) or the American Osteopathic Association Commission on Osteopathic College Accreditation (COCA) and a three- to seven-year residency program that is accredited by the Accreditation Council of Graduate Medical Education. As written, Chapter 2 effectively permits PAs to become licensed to provide many of the same medical services as licensed physicians without a similarly intensive and extensive academic and supervised clinical training. Although scope of practice is not determined at the Maine state licensure level, in the case of physicians an exhaustive process exists prior to physicians' applying for a state medical licensure that establishes physicians' competency to practice in a given area. The same process to determine safe scope of practice for PAs prior to state licensure does not exist. Thus the need for standardization at the Maine Medical Board level assumes infinitely more gravity for assuring the safety of the public.

**Protection from Retaliation for Physicians who Decline to Participate**

The practice of medicine by physicians includes ethical and legal considerations. We urge rulemaking to include a provision to protect physicians from retaliation in employment, medical staff status, and credentialing when they do not want to enter into collaboration agreements, practice agreements, or the correlate of these agreements presented by their health care system or physician group practice that has a system of credentialing and granting of privileges. We urge the Boards to protect physicians who disagree with the contractual rules by a health care system or physician group that require physicians to enter into such formal agreements with PAs. Physicians must not be compelled to participate in a process if they deem it undesirable or unsafe to patients. Maine is a conscience clause state and a physician's right to conscientiously refrain or object from various medical practices is an established right.

We propose the following language be added to section 6, subsection 8, as a new subparagraph E:

> E. Relief From Retaliatory Actions.—
> (1) No hospital or physician shall be permitted to retaliate against a physician who declines to participate in a collaborative agreement or practice agreement with a physician assistant.
>
> (2) A physician shall be entitled to all relief necessary to make that physician whole, if that physician is terminated, demoted, limited, restricted, suspended, revoked, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment, medical staff membership, or hospital/practice credentialing because of the physician's declining or refusing to enter into a collaborative agreement or practice agreement with any physician assistant.

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Despite the statement in section 6, subsection 6 that, “A physician assistant is legally liable for any medical service rendered by the physician assistant,” in considering whether to enter into a practice agreement or collaborative agreement with a PA, a physician may determine there is still substantial legal exposure. This exposure includes not only malpractice exposure, but also licensure exposure and potential exposure to claims made by the federal government or other payors for certifying services not permitted by them to be provided solely by PAs despite that Chapter 2 permits the services to be provided by PAs. This added liability is a practical consequence of these agreements and further justifies the need to protect the right of physicians to decline to participate in such arrangements without retaliation by health care systems and employer group practices.

We thank you for taking the time to read our comments and for your hard work on this difficult task of rule-making.

Sincerely,

**Physicians for Patient Protection**
Rebekah Bernard, President

**American Academy of Emergency Medicine**
Lisa A. Moreno, MD, MS, MSCR, FAAEM, FIFEM, President
Evie Marcolini, MD, FFAAEM, FACEP, FCCM, Chair, EM Workforce Committee

**Maine Association of Psychiatric Physicians**
Matthew Davis, MD, President
Edward Pontius, MD, Legislative Affairs Representative

**Portland Cognitive and Behavioral Neurology**
Alyson Maloy, MD, FAPA, FABIHM, President