



Maine Medicine

a quarterly publication of the Maine Medical Association

JULY/AUGUST/SEPTEMBER 2020

Maine Medical Association Mission: **SUPPORT** Maine physicians, **ADVANCE** the quality of medicine in Maine, **PROMOTE** the health of all Maine citizens.

MMA'S 17TH ANNUAL GOLF TOURNAMENT TO BENEFIT THE MMET SCHOLARSHIP FUND

Chaired by Brian Jumper, M.D., MMA's 17th Annual Golf tournament took place at the Augusta Country Club on Monday, July 13, 2020. The tournament proceeds will benefit the scholarship fund of the Maine Medical Education Trust which will assist Maine students in their pursuit of a medical education. Thirteen teams participated in the event in compliance with the Club's COVID-19 protocols. "We enjoyed a beautiful Maine summer day on one of the state's premier golf courses and raised \$xxxx to support Maine students going to medical school," said Dr. Jumper. "I thank every player and every sponsoring organization for their support of our event," added Dr. Jumper.



L-R Front Row: Charles Therrien, John Doyle, Jr.
L-R Back Row: Richard Willett, Diane Johansson



L-R: Steve Leverett, Tom Kincaid, Brian Jumper, Robert Timothy



L-R Greg Klatsky, Gordon Smith, Fred Aronson, Ron Beaulé

[More golf photos on page 3](#)

TO SERVE OR NOT TO SERVE - MAINE'S PRELITIGATION SCREENING PANELS

By Marilyn Ashcroft, Esq.

You receive a letter or phone message asking whether you would be willing to serve on a medical malpractice prelitigation screening panel. You cringe and prepare to send the letter to the nearest rubbish bin or erase the phone message...yet another solicitation to volunteer your precious time. But before you send the invitation to that bin, read on:

In the mid-1980s, the medical insurance industry, medical providers, hospital institutions and trial attorneys sought a way to handle medical malpractice claims in a more efficient and cost saving manner than through the general court process. Their work resulted in the Maine Legislature passing a law requiring all medical malpractice claims to be screened before a case can be filed in court. The purpose of the screening panel, then and now, is the same – to identify and encourage the early resolution of meritorious claims and to encourage the early withdrawal or dismissal of claims that lack merit. To achieve those goals, the screening panel process relies on volunteers from the medical and legal communities for each case.

A three-member panel consists of a retired judge, an attorney and a health care practitioner in the same specialty as the person accused of negligence. Panel members have the opportunity to review the medical record, hear testimony from expert witnesses (often world renowned), ask questions and discuss the case among themselves prior to making a decision. The hearing lasts a day. The proceedings before the panel are confidential, but the panel findings may be admissible in a later court action.

The panel addresses three questions, with the answers unanimous or split:

1. Whether the acts or omissions complained constitute a deviation from the applicable standard of care
2. Whether the acts or omissions complained of caused an injury
3. If negligence on the part of the practitioner is found, whether any negligence of the patient was equal to or greater than that of the practitioner

In order to prevail, the Claimant must meet the "preponderance" standard, that is, "is it more likely than not that there was a deviation and that it caused an injury.

In one physician's view, a prelitigation panel is the only "jury of my peers" that will assess the case. As one attorney noted: "My client, the respondent physician, remarked to me that he felt extremely good about the process he had just been through. He said that no matter what the panel ultimately decided, he would feel comfortable with the outcome, as he believed he had a fair opportunity to present his defense to a knowledgeable, prepared, attentive and respectful group of professionals."

Peter Michaud, Esq, retired Associate General Counsel of the Maine Medical Association, opined that although it's a tough task for a practitioner to answer "yes" to questions one and two, there are cases in which "yes" is the right response. There are also cases in which the proper response is "no". Do we want to see a doctor who acted properly found liable because the jury did not understand? Do we want to see a doctor who truly acted negligently be absolved of all blame by a jury that fails to understand the case? Neither the profession nor the public benefits from those kind of results."

[Continued on page 3](#)

BEYOND THE STETHOSCOPE: MAROULLA GLEATON HAS A PASSION FOR CYCLING

Note: "Beyond the Stethoscope" is now a regular article in Maine Medicine highlighting an interesting aspect of a member's life outside of the practice of medicine. Please send any suggestions for future articles to Andrew MacLean, CEO at amaclean@mainemed.com.

Maroulla Gleaton has long relied on physical exercise to deal with the stress of practicing medicine and managing a private medical practice in a challenging environment. For years, she was a runner. As she aged and in consideration of her joints, she concentrated her exercise routine on lower impact activities, such as walking, hiking, and bicycling. Maroulla and her husband, Dick, also an active person, have enjoyed combining their interests in cycling and travel. During the past twenty years, they have participated in cycling tours of Italy, Spain, France, and Costa Rica. "It's a great way to see a country," she says. "The experience is much more intimate than traveling in a motorized vehicle. You can admire the scenery, smell the air, and visit with the local people," Maroulla added. They have traveled with tour companies, Backroads Bicycle Tours and VBT, with groups of 12-18 guests. "We like leaving the planning to the experts at the tour companies, so we can relax and focus on the experience," says Maroulla. Maroulla and Dick have both hybrid and road bikes, but find the hybrids best for touring. Of course, they take their cycling helmets and clothing when they travel, but as experienced riders, they are particular about their gear such that they also travel with their cycling shoes and clip-in pedals. Unfortunately, they canceled a planned tour of Puglia this Spring because of COVID-19, but they are considering a tour in Greece (Maroulla's family heritage is Greek) in the next couple of years when travel is safer. Maroulla and Dick have a home in Bar Harbor and regularly ride the 50+ miles of carriage trails on their hybrids or the Park Loop Road on their road bikes in the Spring when access is limited to bikes and pedestrians. To maintain their fitness level in the winter months, Dick spins, but Maroulla prefers the elliptical. They are making the most of this prime riding season!

Maroulla Gleaton, M.D. practices ophthalmology with Atlee Gleaton Eyecare in Augusta. A native of Lancaster, PA, she received her undergraduate degree from Franklin & Marshall College and earned her medical degree from Temple University. She completed her residency in ophthalmology at the Mayo Clinic in Rochester, MN and began her practice in Augusta with Ed Atlee, M.D. in 1987. Maroulla and her husband, Richard Phippen, live in Palermo. Maroulla has the distinction of being the MMA's first female President in 2003 and still serves on the Board of Directors as one of two delegates to the AMA House of Delegates.



Consider virtual attendance at MMA's 167th Annual Session – see insert!

TUFTS MAINE TRACK STUDENT ATTENDS AMA MEDICAL STUDENT ADVOCACY AND REGION CONFERENCE

By Patrick D. Conroy, Maine Track Program M23, Tufts University School of Medicine

In March, I attended the AMA Medical Student Advocacy and Region Conference (MARC) annual meeting in our nation's capital. This was not my first time visiting Washington, D.C., but this time I was awed by the city in a new way. This time I came not to just view the sites and learn our history, but this time I came to be a part of the democratic-republic process. I was not just a tourist, but I was there on business. This made me see things in a unique light. The capitol building wasn't just a photogenic building, it was a building I was to go into, and talk with our representatives charged with making change in the country, hopefully for better.

The point of the conference was to first teach advocacy specifically in the setting of being a physician. The first part of the conference was very interesting where we had guest speakers come in, two congressmen who were physicians for decades and then decided to represent their districts/states in Congress. This was an incredible experience to hear them discuss how they took their medical knowledge and experience to make and influence medical legislation on the national level. The second part of the conference was the time for action. I was the only Maine Representative within the larger Region 7 Medical Student Section (CT, ME, MA, NH, NY, RI, and VT). This meant I went personally to Senator King's and Congresswoman Pingree's offices and educated and advocated for multiple bills coming up. One was an addendum allowing Medicare reimbursement for telemedicine, and the other was a bill allowing Marijuana samples to be used in research institutes to establish indications and contraindications. Both bills address important issues and are very applicable to Maine resident needs.

Both parts of the conference were very educational, gave me unique experience in advocacy, and inspired me to use my medical expertise to help on a larger public health level. I learned that physicians can enact high-level change and can make a real impact on making sure good, science-based legislation can be passed. I want to thank both Tufts Medical School and the Maine Medical Association for an experience of a lifetime and allowing me to grow in a unique way to help my community now and in the future.



L-R: Patrick Conroy, Maine Track M23, with medical students from Tufts University School of Medicine mainemed.com.

PRESIDENT'S CORNER

By Amy Madden, M.D., President, Maine Medical Association



It's not unusual for my husband to respond to medical calls in the middle of the night. Not at the hospital, where he works as an ER doc, but in our little town of Belgrade. He volunteers for the local fire and rescue service as a first responder and sometimes

on-scene medical control for serious medical events. For him, the world of pre-hospital medicine is his joy. He loves his work in the ER as well, but he is most alive and filled with purpose when he is at a rescue scene working with rescue personnel. This is where his medical career started, volunteering as a first responder outside of Bath when he was 18.

For some physicians, there is an obvious congruence between their passion and their purpose. From the outside, it can appear beautiful – I often feel drawn by the sheer power of someone's commitment to a goal.

I was fortunate to spend a Sunday morning recently speaking with a physician who clearly demonstrates this passion and purpose. I first met Dr. Phil Caper early in my tenure with the medical association. I have admired his steady, unwavering commitment to universal health care for all people. As well, his depth of understanding of the historical and current factors shaping the delivery of healthcare in the United States is profound.

Originally from Los Angeles, Dr. Caper attended undergrad and medical school at UCLA. He did his internal medicine internship on the Harvard Medical Unit at publicly-funded Boston City Hospital. He recalls when, as a resident in 1966, following the passage of Medicare and Medicaid, he stood on the inpatient ward and thought, "his place is going to change". Even then, he understood that how the US decides to pay for medical care is a primary driving force behind how healthcare is delivered.

In 1969, the first of several events occurred that shaped Dr. Caper's commitment to ensuring universal healthcare for all people. Senator Edward Kennedy toured Boston City Hospital. Kennedy was interested in improving upon the federal Hill-Burton hospital construction act to see more money allocated to urban hospitals and requested that someone "in the trenches" lead the group. That duty fell to Dr. Caper as chief resident of the Harvard Medical Service and President of the House Officers Association.

That interaction led to Dr. Caper joining Senator Kennedy, the newly appointed Chairman of the US Senate Labor and Human Resources Subcommittee on Health, as a full-time professional staff member. It was there that his education in American health care policy

and politics began in earnest. During his time working in the US Senate, Dr. Caper was involved in several large pieces of healthcare legislation, dealing with health care education, financing and the structure of the delivery system, fueled by Senator Kennedy's vision of providing national health insurance to all Americans.

Throughout his career that has included a term as vice-chancellor at UMass medical school, professorships at Dartmouth and U Mass, faculty positions at Harvard's Kennedy Schools of Government and Public Health, and Johns Hopkins School of Public Health, Dr. Caper has always felt that "doctors have an obligation not only to clinical practice, but to help mold the environment in which our practices are embedded".

As such, he believes that doctors should be involved in health policy as it directly affects the care of patients. Treating medicine as a business instead of as a public good is, in his words, one of the "underlying pathologies" of our medical system that generates the symptoms of out of control costs, spotty quality and access inequities, as well as burnout of physicians and other caregivers. He believes that in public policy, as in clinical medicine, the underlying pathology, not just the signs and symptoms of the disease, must be addressed if we hope to cure the patient.

His commitment to achieving universal, high-quality and affordable health care for all people is the foundational principle of Maine AllCare, which he helped start in 2010 as the Maine Chapter of Physicians for a National Health Program with then Maine House Representative Charles Priest from Brunswick.

Despite the difficulties in bringing about meaningful change in the US healthcare system, Dr. Caper continues to find rewards - and frustrations - in his passion for this work and his mission of addressing the underlying pathology of medicine as a business instead of a public good. He believes that access to healthcare by everybody is fundamentally a moral issue, tied up in inequities across the board, whether wealth disparities, including systemic racism, homelessness, incarceration, and other social determinants of health.

How we feed the passion that drew us to medicine fuels our purpose in what we do. Whether it is helping a neighbor in an emergency or working to shift the forces that shape our healthcare system, we reconnect with the source of our purpose. Finding the opportunities to do this can feel daunting in the face of our busy schedules, but many would argue that our personal and professional wellness benefits from doing so. The Maine Medical Association is ready to assist you in any way we can. I can be reached at president@mainemed.com or 207-495-3323.

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NOTES FROM THE CEO

By Andrew MacLean, J.D., CEO, Maine Medical Association



I hope that each of you has had, or soon will have, an opportunity to take a break from the COVID-19 response and other daily pressures of your practices to enjoy summer in Maine. Like most people, I'm not traveling for business or pleasure under the

circumstances, so my "stay-cation" during the July 4th holiday week gave me the chance to visit Baxter State Park and to hike Mt. Katahdin with family. The experience was as exhilarating and the view from Baxter Peak as magnificent as I remembered. Back at the office after vacation, we faced one of many COVID-19-influenced decisions: whether we attempt to execute a 2020 Annual Session and, if so, whether we present it in person, virtually, or a "hybrid" of each. Lisa Ryan, D.O., Past President and Chair of the Annual Session Planning Committee led the staff and board analysis, including the results of a membership survey. Based upon the survey results and other factors, the Board of Directors elected to proceed with a "hybrid" model for whereby we will limit in-person attendance at the Harborside Hotel & Marina in Bar Harbor to 50 individuals, as required by the Governor's pandemic protocols. But, we also decided to make a significant investment in A/V technology support for to promote virtual participation in the important components of the Annual Session. Because of the COVID-19 restrictions, MMA will present an abbreviated 2020 Annual Session,

beginning on Friday afternoon, September 18th and ending with the Awards Banquet and Inauguration of Karen Saylor, M.D. as the next President on the evening of Saturday, September 19th. The four substantive CME components of the Annual Session will be available remotely from anywhere in the state in real time: the opening presentation on the history of medicine in Maine and the women's suffrage movement in Maine by Richard Kahn, M.D. and three segments on Saturday, September 19th – the General Membership Meeting; the keynote presentation on Maine's response to the COVID-19 pandemic by representatives of Governor Mills' COVID-19 task force; and a forum moderated by Stephen Sears, M.D., M.P.H. during which we hope members will share their own experiences and observations about Maine's response to the pandemic. The MMA was founded by a small group of physicians who gathered at the Tontine Hotel in Brunswick in 1853, no doubt to discuss the critical clinical and health policy issues of the day, and we will endeavor to keep that tradition alive – offering an opportunity once a year for physicians to convene in a collegial atmosphere, or to participate through a high-quality remote connection, to discuss and debate the current issues affecting your lives and daily practice of medicine.

Please contact me any time by email at amaclean@mainemed.com, by phone at 207-480-4187 (Office) or 207-215-7462 (Mobile/talk or text) if you have suggestions about how MMA can better serve the physicians of Maine.

Continued from page 1...To Serve or Not to Serve - Maine's Prelitigation Screening Panels

The feedback from both attorney and physician panelists after their participation is overwhelming positive:

- "I learned much more than I would have in a seminar and liken it to professional jury duty"
- "The CME is well earned"
- "I just wanted to thank you for allowing me to serve on a medical malpractice panel. It was a fascinating insight into the world of medical-legal issues and I really appreciate to have been given the opportunity to study, learn and appreciate. Thanks to you and the lawyer on the panel, my confidence in justice and fairness in the world of medical malpractice has been restored. As a practicing physician, we frequently hear about frivolous cases and bad judgment, but it has been really refreshing to see brilliant minds at work and

doing the right thing in my community. A truly and remarkable experience for me."

- "It is my hope that other members of my group would volunteer to participate in the future, as I believe that The Panel is important in separating meaningful from frivolous litigation."
- "Interesting, thought provoking and quite educational; it was my privilege to be asked to participate."

So, if you are ever asked to serve on a medical malpractice screening panel, please say "Sign me up!" You will find the experience rewarding, informative and professionally stimulating and a true service to the medical profession.

(Marilyn Ashcroft, a former Judge has served as Chair since 1991, handling over 1200 cases. Please contact her at m.c.ashcroft@gmail.com with any questions.)



L-R: Andrew MacLean and Katherine Ayer



L-R: JD Hadiaris, Mark Lavoie, Jon Brogan, Dan Rile



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Information in this newsletter is intended to provide information and guidance, not legal advice. Since exact language and definitions of key terms are critical to understanding the requirements of legislation, rules or laws, we encourage you to read each carefully. Articles submitted to Maine Medicine represent the views of the author only and do not necessarily represent MMA policy.

MMA WELCOMES OUR NEWEST CORPORATE AFFILIATE:

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We appreciate their support!

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Thank you to the following practices who have shown support for the MMA's long-term growth by renewing at an additional sustaining membership level.

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SPECIALTY SOCIETY MEETINGS

September 18-19, 2020

28th Annual MAFP Family Medicine Update & Annual Meeting-
Virtual Meeting

Visit <http://www.maineafp.org/cme/mafp-cme-meeting-for-details>

Contact Deborah Halbach at 207-938-5005 or maineafp@tdstelme.net

September 19, 2020

Maine Society of Anesthesiologists
Business Meeting

Virtual Meeting – 2:00pm – 5:00pm

Contact: Lisa Montagna 207-620-4015 or mesahq@gmail.com

September 25, 2020

Maine Chapter of American College
of Physicians Meeting

Virtual Scientific Meeting

Contact: Warene Eldridge 207-215-7118 or mainechapteracp@gmail.com

September 26-27, 2020

American Academy of Pediatrics,
Maine Chapter Annual Meeting

Virtual Meeting

Contact: Dee Kerry 207-480-4185 or dakerry@aap.net

October 2-4, 2020

19th Annual Downeast Ophthalmology
Symposium

(Presented by the Maine Society of
Eye Physicians and Surgeons)

Virtual Meeting –

Visit www.maineeyemds.com for details

Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

October 8-9, 2020

Maine Association of Psychiatric Physicians,
14th Annual Program

Sexual Health in Psychiatric and Medical Practice

Virtual Meeting –

Visit www.mainepsych.org for details

Contact Dianna Poulin at 207-480-4194 or dpoulin@mainemed.com

The Pandemic Is Affecting Chronic Disease Management

By Martha Morrison, MedHelp Maine

Limited access to non-emergency care and patient fear of contracting COVID-19 were the initial reasons many Americans neglected the ongoing management of their chronic diseases. With the rise of pandemic-related unemployment and the loss of employer-sponsored health insurance, they now cite cost as the chief reason they forgo care. Indeed, reports of patients ignoring life-threatening symptoms, cancelling diagnostic tests, or even discontinuing chemotherapy or stretching out their supplies of costly insulin are not uncommon. You may already be seeing sicker patients who had delayed treatment and now require more urgent and expensive care.

MedHelp Maine reminds Maine's clinicians that new insurance options exist, and that programs that provide free or low-cost prescription medicines are now available for many previously ineligible individuals. Routinely asking your patients if they are having trouble affording their care is the first step to lessening nonadherence and maintaining health. Maine's 15 hospital-based prescription assistance programs relieve the burden from area medical practices of identifying and then applying to the most appropriate sources of help. Please remember them if your own practice does not have the resources to fully help your patients adhere to the treatment you prescribe. Feel free to contact me at medhelpmaine@gmail.com and (207) 793-4462.

PUBLIC HEALTH SPOTLIGHT

By Sidney R. Sewall, M.D., M.P.H.



Vaccine Exemptions – Real, Borderline, and Bogus

With the passage of L.D. 798 in 2019 and our successful effort in the March referendum, primary care providers will likely see an increase

in requests for MEDICAL exemptions from “vaccine hesitant” parents. It would be VERY unusual, however, for a child to have a condition making ALL of the required vaccines medically contraindicated.

The standard list of accepted medical contraindications and precautions is available at the CDC web site: <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html>. It is fairly restrictive regarding absolute contraindications:

- Live viral vaccines (MMR, VZV, Rotavirus) should not be given to kids who are immunosuppressed – whether from a congenital defect, medications, or a disease process (there is a useful chart in the annual CDC vaccine schedule update);
- Live viral vaccines should be deferred during pregnancy, and also around the time of infusions of products containing gamma globulin (there are charts with intervals);
- A vaccine should not be given to a child who has had an anaphylactic reaction to prior doses, or to a known vaccine component;
- DTaP or Tdap should not be given to a child who developed encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP or DTaP;
- No Rotavirus vaccine if prior intussusception;

There are other situations where the vaccine dose is not contraindicated, but there are “precautions” listed on the CDC guidelines -- most practitioners would be conservative.

These include:

- Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy -- defer DTaP until neurologic status clarified;
- History of ITP and MMR;

- Prior Guillain-Barre within six weeks of a vaccine dose (live viral, tetanus toxoid);
- Severe local reaction (Arthus type) after prior tetanus or diphtheria dose (wait 10 years...);

High fever, irritability, or even a febrile seizure after a prior dose – none are considered either a precaution or contraindication but spending time reassuring families will be necessary to minimize resistance. While studies have shown that spreading out vaccines doesn't decrease febrile reactions, it does work as a strategy to help anxious parents gain some sense of control.

The most common “precaution” seen in practice is “Moderate or severe acute illness with or without fever” but there is no definition of “mild” vs. “moderate.” While mild illness or being on antibiotic treatment are not valid reasons for deferral, if parents are still hesitant after a discussion and will reliably bring back their child, it is reasonable to avoid conflict. Deferring for only a week and doing a call-back if there is a no-show helps minimize the consequence of these missed opportunities.

In addition to the above considerations, the alternative medicine community has generated a list of their own, sometimes based on misinterpretation of genetic information. While it is certainly legitimate to research whether there are genetic markers that predict adverse responses to vaccines, nothing has been proven up to this point – in particular is the lack of any association of MTHFR variants with problems related to the required vaccines. If parents show up with commercial genetic reports to justify exemptions, primary care clinicians can do the research themselves or refer to genetics if necessary.

Clinicians can use a similar process for immunology – based issues. If there is a glimmer of validity to any raised concern that you are unable to successfully address, it is reasonable to enlist the help of the appropriate specialist. It shows parents you are taking them seriously.

L.D. 798 doesn't become effective until Fall 2021. This year, the logistical challenge will be catching up all those kids entering either primary school or middle school for the first time, who had missed their scheduled vaccines over recent months. Most practices and some public health agencies are already working to remove impediments to the catch-up process, like allowing vaccine delivery at nurse visits without an exam, or organizing shot clinics. Hopefully we will be back on track by the end of the school year.

I have more hope now than ever before.

WE'RE NOT OUT OF THE WOODS YET...

By Edward Pontius M.D., DLFAPA, Founding Director, Maine FrontLine WarmLine



We're very fortunate to be in Maine at this moment in the pandemic. As I write this (07/16/20) Maine has had 3,598 confirmed cases of COVID-19, and 114 deaths attributed to the virus. These deaths are tragic losses, but at (8.6/100,000), here in Maine we have had less than 5% the rate of pandemic death New Jersey has experienced. So far. Our state, oldest in the nation, is one of the most at risk for COVID-19 complications. Data suggests that at least 90% of Mainers are as vulnerable to the virus as they were when the pandemic started. The virus is NOT finished with us yet. We need to be prepared for a surge that may come, particularly as we attempt to re-open schools and the economy and enter the virus-friendly fall season. The rational view of the situation is that we are now balanced on a knife-edge.

And the front line people who are working day and night to care for us and keep us safe – they need support. Many of the jobs they do for us in hospitals, clinics, long-term care facilities and in home and hospice, in ambulances, dispatch offices and police cars – these are not easy jobs in the best of times. Doing these same jobs wearing a mask and PPE, in summer heat, dealing with people

who are frustrated, stressed, and worried is much more challenging. Maine's front line stands up for us against the virus, and in addition to the personal risks they face they and their families face all of the same difficulties we all face. Concerns about children and child care and education. Concerns about family members getting sick. Economic impacts and uncertainty.

For all these reasons, Maine's front line deserves support. This is why we have the **Maine FrontLine WarmLine**. More than 100 Maine health professionals have trained to provide support for Maine front line providers and their families. From 8 a.m. to 8 p.m. three shifts of volunteers are there to talk to any front line person or family member.

But not everyone gets help when they need it most. Unfortunately, front line people are often so oriented to helping others that they fail to take care of themselves, or to ask for help when they most need it. It's very much like the perilous issue that American air crew encountered in WWII – becoming so focused on the mission that they neglected to start the O2 needed to keep them alive at high altitudes.

COVID-19 is a hazardous mission. As physicians we are the role models for our teams, our crews. It is crucial that we model responsible behavior. That includes self-care. That includes making sure that we are calling for support when we could benefit. We're not just doing this for us, we're doing this for our teams.

By Dan Morin, Director of Communications and Government Affairs



Plan The Work; Work The Plan

It's important for professional associations to have a clear process on developing a strategic plan for advocacy.

Professional organizations are a crucial component of the legislative process but more importantly, they must have a clear idea of their legislative interests and concerns as they seek to influence sound public policy. In addition, it is often more effective when groups collaborate with others possessing the same agendas and priorities.

During the next couple of months, we will be taking feedback from members to develop a plan and a legislative platform in preparation for the next meeting of the Maine Legislature in 2021. The process should take several months in order for MMA's Legislative Committee and the Board of Directors to review and approve the plan and provide adequate time to communicate the platform to MMA members, build coalitions, and most importantly, work with legislators and the Governor's Office to earn support.

While defining and prioritizing issues early is the most important step, "political capital" is a close second. Political capital can be defined as how much influence can be exerted on decision makers to produce desired legislative, or regulatory outcomes. And like traditional capital, it is limited and can be exhausted. It also involves people and time. Therefore, in my experience, issues need to be first defined and prioritized into three categories: primary, secondary, and tertiary issues. Clearly defining

two or three primary issues can greatly increase the likelihood of success and will keep MMA from getting side-tracked on issues that may be of interest but are not critical.

The MMA Board of Directors, Legislative Committee, and statewide specialty societies are currently being asked to identify two or three priority issues, what change is needed, how to change it, and what potential proposals from others that they are likely to oppose. Opposition to bad legislation can indeed be considered a priority issue.

From there, we will decide what it will take to familiarize decision makers and identify and match members with legislators. If elected officials are not given a clear sense of what benefits your patients, there is always a risk of getting 'solutions' that may make a problem worse or create new problems. Legislators and candidates are already developing ideas and hearing from Mainers who want their issues addressed. Unfortunately, isolated anecdotes too often drive policy discussions because stories are more memorable than data or science. Stories are important because they contain both facts and emotion. This plan will also apply to influencing various activities within the executive branch.

Many positive solutions can be complicated, expensive, and tough to sum up in a soundbite. Legislators in Maine are part-time and not policy experts. Therefore, when poring through thousands of bills they often rely on colleagues or knowledgeable constituents for feedback. However, too often, they rely on the mental shortcut affect heuristic and make decisions based on mood or feelings—i.e., go with their gut.

Individual members can also reach out to me directly any legislative suggestions, ideas, or concerns at dmorin@mainemed.com or (207) 838-8613.

NAMI MAINE: SUPPORTING MENTAL WELLNESS AND MANAGING SUICIDE RISK DURING A PANDEMIC

By Greg A Marley, LCSW, Clinical Director, NAMI Maine



As the deep impacts of COVID-19 continue nationwide, there remains concern over contagion and deep uncertainty of what the future will bring. The stresses triggered by this crisis affect healthcare provider and patient alike as we all simultaneously practice social distancing and

a constrained work and social life, and seek to carry out the daily tasks and opportunities of our lives. The financial impact and the social uncertainties triggered by closing down schools, businesses, and a significant portions of our economy, along with enforced social isolation has placed many people at increased risk. There has been a significant increase in diagnosable depression and anxiety disorders at a time when many are delaying needed care because of concerns of exposure to the virus. And access to care for many has been hampered by the strictures of the crisis.

NAMI Maine has responded to the COVID crisis with innovation and flexibility. We have pivoted to make our Family Respite Program more accessible to families and even offering limited virtual services. Our Teen Support Text Line was initiated during the crisis as a service for adolescents and young adults to connect with support via text. Text to 207-515-TEXT (8398) noon to 10 pm daily. In addition, many of our family and peer support groups have shifted to become virtual and we are offering our Family to Family education program virtually. Visit NAMI Maine at <https://www.namimaine.org/default.aspx>.

Under contract with the Maine Suicide Prevention Program, NAMI Maine continues our close working partnership with the Maine Medical Association supporting evidence-based suicide prevention in medical practices and hospital systems. We are offering a range of training and technical assistance opportunities including:

- Practice-based "Lunch and Learn" opportunities for clinical and non-clinical staff supporting competence and skill-building in the elements of suicide prevention, assessment of risk, and use of Collaborative Safety Planning.
- Clinical training in suicide risk assessment and Safety Planning.
- In-person or virtual presentations to Grand-rounds or professional groups addressing evidence-based suicide prevention and management.
- Workshops on the ethical considerations related to suicide prevention and the implementation of the *Death with Dignity* Act in Maine.

For more information about how we can support suicide prevention and mental health needs in your practice, contact Susan Kring at MMA skring@mainemed.com or NAMI Maine's Suicide Prevention Training Coordinator at MSSP@NAMIMaine.org or 622-5767, ext. 2318.

A PANDEMIC MEETS AN EXISTING AND ONGOING EPIDEMIC

By Gordon Smith, Esq., Director of Opioid Response, State of Maine



I continue to appreciate the opportunity MMA provides me to communicate with MMA members regularly through *Maine Medicine*. The last few months my attention has been focused largely on the intersection of the COVID-19 pandemic with the ongoing opioid

epidemic. It has been quite a challenge and I am sure you have faced your own challenges in your medical practices, as well. Given that addiction is a disease of isolation, the necessity of having persons in recovery stay at home posed real dangers as it removed many of them from their normal support structures, such as 12-step meetings. The treatment and recovery communities in Maine pivoted very quickly to offer dozens of virtual meetings and state and federal laws were relaxed in order to enhance telemedicine. These changes undoubtedly saved lives. And many of the responses to the pandemic have actually improved access to support and treatment by removing the barriers of transportation, childcare, and others. One of the keys going forward will be to retain the pre-COVID-19 practices that were efficient and made sense but to also keep some of the innovations that the pandemic has forced us to adopt. Nowhere is this clearer than the value of telemedicine.

Despite the many positive steps taken to respond to the needs of individuals with substance use disorders during the pandemic, not all persons were assisted to the point of successful recovery. Like most other states, Maine has seen a significant increase in fatal overdoses which has been heartbreaking. Not all of the increases are COVID related. We actually saw the increases beginning last Fall. The reasons are as complex as the causes of addiction, but the responses to the increased mortality are clear.

1. Enactment of L.D. 2153 establishing for the first time in Maine an expert panel to review selected fatal overdoses. I suspect that there is something to be learned from each tragedy.
2. Continuing distribution of Narcan (naloxone) throughout the state. Since 2015, the distribution

by the AG's office and the Mills Administration has resulted in more than 1300 reversals.

3. Distribution of fentanyl test strips through the state supported syringe programs.
4. Creation of a rapid response team in connection with the existing OD Map program in which more than 65 law enforcement agencies are participating.
5. Robust sharing of the many sources of opioid data on a real-time basis to inform policy initiatives allowing for any necessary adaptations.

We also will be working with our colleagues in other states to borrow any successful approaches across state borders that might be appropriate in Maine.

We continue to add MAT providers and have offered State assistance to every county jail providing MAT to inmates with a diagnosis of a substance use disorder. More than 50% of inmates in our jails and prisons have such a diagnosis. Robust treatment of their chronic illness is long overdue. We hope to also grow the emergency department initiatives that have been slowed by the pandemic.

On July 23, Governor Mills hosted the second Annual Opioid Response Summit with nearly 1000 persons participating in the virtual event which featured a fireside chat by former Surgeon General Vivek Murthy, M.D. Dr. Murthy spoke to the Summit's theme of *Compassion, Community and Connection*, which fit it nicely with his recent book entitled *Together*, which deals with the public health aspects of isolation and loneliness. Thank you to those of you who joined us for the conference. We certainly hope to have a physical Third Annual Opioid Response Summit next year in Bangor on July 15, 2021.

I hope to see many of you at the MMA Annual Meeting where the Mills Administration will be presenting a review of the state response to the pandemic. In the meantime, I hope you and your families get out and enjoy the many opportunities to enjoy Maine during this strange summer. I miss you all but continue to believe we are doing important and meaningful work.

Time for a checkup? Physicians Need Protection Too.



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Bringing Order to Chaos

I suspect that the trials of these past few months in the medical, financial and social arenas have caused everyone to pause for just a moment – or two or three, or maybe even longer – to contemplate our relationship with:

- Ourselves;
- Our futures;
- Our families;
- Our professions; and
- Our communities.

The challenge before each one of us is, from what perspective or in what context we will approach these new realities of our lives. In our work with physicians, much of our focus is on the here and now, assisting them in making informed financial decisions as to how to best meet today's financial challenges.

There is, however, a nagging question which needs to be addressed. How does all this play out in the end? Death is inevitable for all of us. Only its timing is an uncertainty. One of our focuses with clients is how to ensure that they and their families are prepared to meet the challenges which accompany death.

If we can be frank for a moment, our deaths create an intersection of three extremely complex and powerful systems: medical, financial and legal. Left unattended, this intersection will bring a chaotic clash of opposing, nonaligned forces, placing a tremendous amount of stress upon the family we have left behind. However, with a bit of planning, with a little allocation of your time, your emotional and intellectual energy, as well as your financial resources, you can bring order to this chaos!

The healthcare system has responded to this chaos by introducing Palliative and Hospice care protocols to help patients address the medical issues surrounding end of life. Estate Planning expertise I needed to help clients address the financial and legal issues surrounding end of life.

The following is a snapshot of how physicians themselves are doing in addressing these financial and legal issues.



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Lawrence Perry is a registered representative of and offers securities and investment advisory services through MML Investors Services, LLC. Member SIPC. Branch Address: 200 Clarendon Street, 19th & 25th Floors. Boston, MA 02116. 617-585-4500. CRN202207-268153

MAINE DHHS UPDATE

By Lisa M. Letourneau, M.D., M.P.H., Senior Advisor for Delivery System Change



An Unequal Burden: The Disproportionate Impact of COVID-19 on Racially & Ethnically Diverse Populations - A Call to Action for Maine Physicians

I didn't want to write this article. As a white person who grew up and worked in Maine my entire career – the better part of which,

ironically, focused on advancing health care quality – I will acknowledge a deep sense of discomfort when it comes to talking about racial disparities – both in health care, and more broadly in this country and in our state. I cringe when I see the hugely disproportionate impact that the COVID-19 pandemic has had on racially and ethnically diverse populations in this state, but also admit I've been slow to act – and have been known to hide behind the familiar smoke screen: "but Maine doesn't have many minorities – it's not a problem here."

But the numbers don't lie and, Maine, we have a problem: Black and other people from diverse background have experienced nearly 29% of the COVID-19 cases in Maine, while representing less than 6% of our population, giving Maine the dishonorable distinction of one of the worst rates of disproportionate impacts of COVID-19 in the nation. And while we clearly must work to better understand the factors that contribute to these disparities, there is a growing acknowledgment that COVID-19 has not created these issues, but rather, has starkly unmasked a 400-year history of racial inequity, deeply-rooted structural racism, and resulting economic disadvantage for diverse communities; for centuries, we have created and maintained a nation where white people benefit, and minority communities live and work in situations that chronically disadvantage them, putting them at significantly higher risk for contracting the disease and experiencing worse outcomes when infected. The problem is not new, and we need to own it, now.

So, where to start? In recent conversations with Carl Toney P.A., retired professor and health care consultant, he offered the following advice: get out into the community, talk with people from diverse communities, and listen. Listen to the hardships that they've experienced, listen to the large and small aggressions they experience in health care and in other parts of their life every day, and most importantly, listen with humility and openness and without defensiveness. He urged me to understand that "white privilege" is not just a benefit that I occasionally acknowledge with an awkward downward glance, but also that it fundamentally means my life is not made harder every day by the color of my skin.

I clearly have a long way to go in my own journey to better understand and address racism in health care and more broadly, but I'm committing to start, and look forward to working with other clinicians interested in advancing their journey. To begin, we must recognize

that doing the same things will not be enough; if we want an inclusive system that eliminates the current disparities experienced by people from racially and ethnically diverse communities, our behavior must change.

In the next several editions of this newsletter, I look forward to exploring opportunities for clinicians to take action. As an immediate focus, we must work now to better protect diverse communities from COVID-19 infection, and urge clinicians to consider the following:

- Make minority populations more visible in our communities, and in our practices. If we are not seeing people of racially and ethnically diverse populations in our practices, we need to ask why. Consider working with local community organizations and community health workers to remove barriers and build trust to help minority populations get access to the health care they need.
- Take action to promote testing for racially and ethnically diverse individuals. People from ethnic and racially diverse groups are at higher risk for contracting COVID-19; take symptoms seriously, and actively encourage individuals to get tested, even if asymptomatic. If your institution does not support asymptomatic testing for these populations, consider setting up a system to send tests to the state lab where they can be tested.
- When testing, recognize that people need culturally and language-appropriate information that clearly outlines the specifics of quarantine, isolation, and contact tracing. Consider using a cultural broker or community health worker to help deliver information and ask patients about potential barriers to quarantine and isolation such as inadequate access to food or housing.
- When patients with limited English proficiency test positive, notify the Maine CDC of their language needs when reporting test results. CDC staff can bring in interpreters or cultural brokers to improve their ability to connect with these individuals and help ensure that their close contacts are reached.
- Let patients know that social services are available to support them during isolation. Maine DHHS has contracted with local Community Action Program (CAP) agencies, Catholic Charities of Maine, and Wabanaki Public Health to coordinate services for isolation support.

I appreciate the opportunity to share my own painful discomfort with this issue and look forward to continuing the conversation to work with Maine physicians and other clinicians to take action. It's time for a change.

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Hand-off Communication: How patient hand-off communication can be improved

Make high-quality patient hand-offs a priority for helping to sustain a culture of patient safety.

High-quality patient hand-offs require the use of excellent communication skills by the person/team sending the patient (sender) and the person or team receiving the patient (receiver), to ensure the receiver understands the patient care information provided by the sender.

Excellent communication skills require both the sender and receiver to:

- Seek information (ask pertinent questions: "is there anything else I should know?");
- Give information (clear, concise, and complete);
- Verify information (clarify, repeat back, double-check calculations/equipment settings);
- Validate each other (communicate with warmth and respect, thank the other);
- Use clear language. Avoid unclear or potentially confusing terms ("she's a little unstable," "he's doing fine," or "she's lethargic"). Avoid abbreviations or jargon that could be misinterpreted;
- Review this Practice Tip on communication:
 - Strategies for Effective Communication at <https://www.medicalmutual.com/risk/practice-tips/tip/strategies-for-effective-communication/135>.

Define success:

- What does a successful inter-facility hand-off look like for the sender, receiver, and patient?

- What does a successful shift change hand-off look like?
- What is the right amount of information to share for a short-term hand-off to diagnostic imaging?
- Monitor success and use this data to identify opportunities for process improvements?

Educate the key players:

- Importance of quality patient hand-off information;
- When a patient hand-off is required?
- What is the most effective and efficient method to provide essential patient hand-off information?

Plan the hand-off:

- Coordinate resources such as patient information, transport equipment, and personnel;
- Allow for adequate time;
- Choose a quiet location and minimize interruptions;

Use a standardized form or tool:

Standardize critical content to be communicated. Tailor the hand-off protocol to its users, the environment in which the hand-off is occurring, such as the emergency department, and to the type of patient.

Examples include:

- Checklists such as a pre-operative, pre-MRI, "ticket to ride" and discharge;
- Mnemonics:

ISBARR

- Introduction - introduce yourself including your department and role;

- Situation - specify the situation. What has triggered this conversation and what is the patient's current condition;
- Background diagnosis, pertinent medical history, and care to date;
- Assessment - assess current needs, any outstanding studies or information;
- Recommendation - explain what is being requested ("I would like you to see the patient now," or "I would like to schedule the ambulance, when will you be ready to receive the patient?");
- Repeat - ask the receiver to summarize the important details and ask if there are any questions;

I-PASS

- Illness Severity;
- Patient Summary;
- Action List;
- Situation Awareness and Contingency Planning;
- Synthesis by Receiver;

Medical Mutual Insurance Company of Maine's "Practice Tips" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.



Medical Professionals Health Program — Burnout and Compassion Fatigue

By Guy R. Cousins, LCSW, LADC, CCS, Director MPHP

I recently did an in-service with an integrated behavioral health organization on the subjects of burnout and compassion fatigue. The hour long in-service ended up lasting two hours long due to the extended question and answer period.

We discussed the ideas of burnout and compassion fatigue and how we defined them. Burnout and compassion fatigue do have similarities, but they are very different.

Burnout often is the result of stress that accumulates over time and it often happens with highly demanding jobs and work environments. On the other hand, compassion fatigue often develops from caring for others who are going through a great deal of trauma and pain. Being exposed to such situations for a prolonged period of time can reduce a health care professional's ability to express compassion and care. Health care professionals are exposed to a great deal of primary and secondary trauma in their day to day interactions with patients/clients. The cumulative effect of both burnout and compassion fatigue can result in the professional not being able to perform at their optimal level. Burnout and compassion fatigue can often lead to:

- the inability for professionals to express compassion and care for patients
- due to fatigue, they may not be able to make the best decisions for their patients, and medical errors become more likely to occur
- providing a sub-level of care may reduce patients' satisfaction and interfere with their recovery
- disconnect with patients can leave professionals feeling dissatisfied and dejected
- professionals often report struggling with intense feelings of guilt, shame, and anger

While it can be scary for professionals to realize that they might be experiencing burnout and/or compassion fatigue (or both), there are things that they can do to manage their responses differently.

- Make time for self-care (investing time to put needs first—fun, healthy, activities)
- Set boundaries (establish emotional & physical boundaries)
- Find support (connect with colleagues, family, friends)
- Get mindful (learn to be in the moment, on purpose, without judgment)
- Take regular breaks (refresh & re-energize moments)
- Remember that you are human (it's not about perfection, more about excellence)
- Rediscover what work means to you (re-discover your passion for the work)

These ideas are not to be considered a quick fix. Where I come from there is saying, "it's a mile into the woods, it's a mile out." Don't expect things to miraculously be different immediately. **Do expect** that things will become different and change if you do things differently. We are in the field of helping others and should recognize

that we all could use an extra hand at times. Be the type of professional that doesn't ask their patients to do anything that they wouldn't do. Reaching out for help is transformative; it changes how you see and experience the world. Legendary coach John Wooden once said, "failure is not fatal, but failure to change can be."



The Medical Professionals Health Program has moved their office from 20 Pelton Hill Road in Manchester around the corner to 16 Association Drive, Manchester, ME 04351. The phone number remains the same: 207-623-9266.

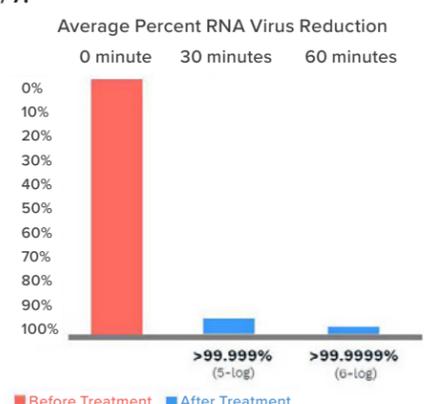


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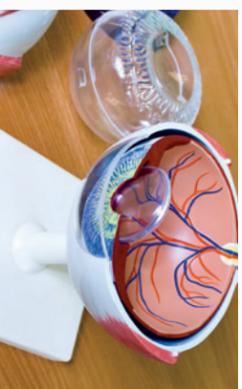
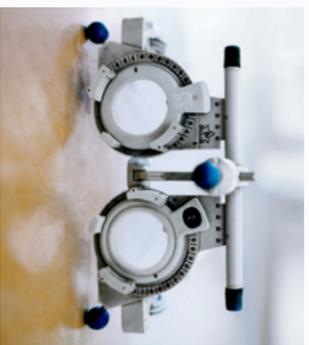


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