

FORUM

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FROM THE PRESIDENT

Coming to terms with opioid prescribing: Safe treatment is the goal

Pascal O. Udekwu, MD

In recent months, I've sent emails to all North Carolina Medical Board (NCMB or the Board) licensees to make them aware of the Board's recent effort to increase oversight of opioid prescribing, the Safe Opioid Prescribing Initiative (SOPI). Many physicians and physician assistants (PAs) are concerned about the prospect of being investigated in relation to the initiative. It is my expectation that SOPI will impact a small fraction of NCMB's 45,000 licensees (to date, approximately 70 cases have been opened through the new initiative). Nonetheless, some prescribers have contacted the Board with questions and concerns, indicating they are unsure what NCMB expects of licensees who treat pain.

NCMB approaches matters related to quality of care with the conviction that, given good information about standards and expectations, the vast majority of licensees will act appropriately. Opioid prescribing is no exception. NCMB has no desire to see chronic and acute pain go untreated or undertreated for fear of regulatory intervention. The Board wants pain to be effectively treated, including treatment with opioids, in a responsible manner. That is NCMB's ultimate goal.

Prescribers in this state are granted the discretion, by the Board and through NC law, to exercise appropriate professional judgment in managing patient care, including opioid prescribing. Some states have taken a more heavy-handed approach, enacting laws to limit the number of days of opioid medications patients can receive, or establishing legal limits on opioid dosages. New York is the most recent to pass an opioids law, and several other states in the Northeast have enacted similar ones.

Put simply, the Board expects its licensees to practice in accordance

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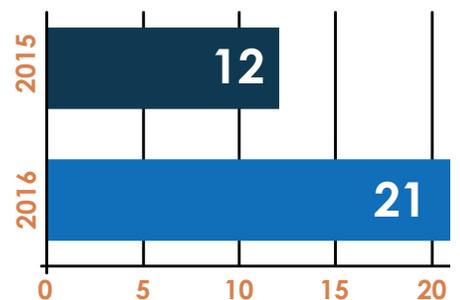
IN THIS ISSUE

- Trending topic: Urine drug screening 3
- Coming soon: Mandatory NCCSRS registration 5
- Seeking help for depression, without fear 6
- New position statement: Corporate ownership 7
- Easing challenges associated with reentry 8

SPOTLIGHT

NCMB's efforts to expand outreach are bearing fruit. As of the first half of 2016, the Board had increased the number of presentations given by 75 percent compared to the same period in 2015.

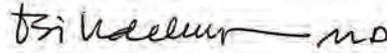
NCMB outreach (Jan - June)



with generally accepted standards of medical practice in NC whenever they prescribe opioids. NCMB does not tell its licensees in advance whether to prescribe opioids, or specify what dosage or amount of opioids should be prescribed. NCMB encourages safe and appropriate practice by directing licensees to resources that can be used to guide opioid prescribing decisions. These resources include policies developed by the Board, as well as information and instructional modules developed by government and/or independent clinical and educational organizations. I am in the process of completing the Safe and Competent Opioid Prescribing Education (SCOPE of Care) modules created by Boston University and have found them to be excellent. This free course and other resources are available at www.ncmedboard.org/safeopioids

There's no doubt opioid prescribing is currently subject to an unprecedented level of scrutiny. I expect that will continue, as will the Board's efforts to proactively address this issue. The best advice I can give licensees is to keep the focus on providing safe and appropriate care. This will serve you, and your patients, well.

Sincerely,



Pascal O. Udekwu, MD
NCMB President

Board confirms officer slate for 2016-2017

The Board approved its leadership team for the 2016-2017 operating year during the July Board Meeting.



2016 North Carolina Medical Board

In accordance with NCMB's Bylaws, the current President-elect of the Board, Eleanor E. Greene, MD, will automatically become Board President effective Nov. 1. The Board voted to approve the following slate of other officers. Along with the Board President and Immediate Past President, these individuals make up the Executive Committee of the Board.

President-elect: Timothy E. Lietz, MD

Secretary-treasurer: Barbara E. Walker, DO

At-large member: Michael J. Arnold, MBA

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The *Forum* of the North Carolina Medical Board is published four times a year. Articles appearing in the *Forum*, including letters and reviews, represent the opinions of the authors and do not necessarily reflect the views of the North Carolina Medical Board, its members or staff, or the institutions or organizations with which the authors are affiliated. Official statements, policies, positions, or reports of the Board are clearly identified.

We welcome letters to the editor addressing topics covered in the *Forum*. They will be published in edited form depending on available space. A letter should include the writer's full name, address, and telephone number.

Urine Drug Screening

Current standards of care related to opioid prescribing encourage physicians and physician assistants to take appropriate steps to monitor their patients. Urine drug screening (UDS) is a popular monitoring method. Other methods include regular use of the state's prescription database to check patient prescription histories, or requiring regular pill counts.

The Board has recently noticed an increase in patient calls in regards to UDS in particular. Concerns raised by patients include overuse of UDS, poor or nonexistent insurance coverage, alleged incorrect interpretation of test results, and poor communication of practice policies related to UDS.

UDS can be a useful tool when administered and interpreted correctly. Licensees are encouraged to fully inform themselves about this monitoring method to ensure its benefit. Presented at right are a few examples of calls related to UDS that have been handled by Board staff in recent months.



Avoiding problems and miscommunications with UDS: Three scenerios

Possible overuse of UDS

Scenario: A patient contacts the Board, stating that the medical practice providing pain management care requires routine monthly UDS of all opioid patients. The patient indicates that medical insurance has deemed monthly UDS medically unnecessary and declines to cover it. The practice has advised that future UDS must be paid for out-of-pocket. The patient is reluctant, stating that all UDS tests have come back within accepted ranges.

Discussion: The Board does not have a policy that provides specific guidance on the administration of UDS. Providers are expected to use their professional judgment to determine the appropriate frequency of UDS, if they choose to use it. NCMB encourages licensees to educate themselves about current accepted practices. UDS and other monitoring methods are covered in detail in many opioid CME courses. Check www.ncmedboard.org/safeopioids for a selection of free or very low cost CME opportunities.

Possible misinterpretation of UDS results

Scenario: A patient is prescribed and uses Fioricet with Codeine to manage migraines. At the request of the prescribing physician, the patient completes a UDS. The results come back positive for morphine. The patient states that, upon receipt of the UDS results, the practice sent a dismissal letter, citing alleged morphine use. The patient is adamant the only medication used prior to the UDS was Fioricet with Codeine. The patient finds information that indicates morphine is a normal codeine metabolite. The patient wants the practice to reconsider its decision to dismiss.

Discussion: This example highlights the importance of thoroughly educating oneself about appropriate use and interpretation of UDS results, and related pharmacology. False-positive or misinterpreted UDS results may occur with office-based UDS and many commonly prescribed medications. In the instance described above, the patient was advised to write a letter to the prescribing physician explaining the circumstances that resulted in the positive UDS results.

No or poor communication to patients regarding UDS

Scenario: A patient contacts the Board after learning that UDS will be required before monthly refills of opioid prescriptions will be issued. The caller states patients were previously directed to request refills approximately three days before needed. The patient is disabled and opioid dependent and relies on a spouse for transportation to medical appointments. The patient is concerned it will not be possible to complete UDS before a refill is needed and indicates interest in filing a complaint.

Discussion: The Board does not have an established policy on how and when patients should be notified of changes in practice policy. This example is offered as an instance of how a communication issue can spiral into serious patient dissatisfaction. In this instance, the patient was advised that filing a complaint could result in the patient's dismissal. The patient was advised to contact the practice to request a partial refill to allow additional time for the patient to comply with the UDS policy.

2016 Legislative update

Legislation passed in the final days of the recently adjourned session of the NC General Assembly – HB728 – made several changes that affect NCMB, its licensees and the practice of medicine.

Physician fee increases

The bill raises the physician license application and physician annual renewals fees in NC for the first time since 2005. Effective Oct. 1, the physician license application will be \$400 (currently \$350) and the physician annual renewal fee will be \$250 (currently \$175). The Board expects the fee increase to raise annual operating revenues by approximately \$3.7 million.

Expanded protections for NCPHP participants

HB728 also modernizes and updates statutory language regarding the NC Physicians Health Program (NCPHP). New language requires that NCPHP participants have the opportunity to request written copies of any assessment or treatment recommendations, including information about the basis for recommendations. NCPHP currently has a procedure in place to fulfill this requirement.



The North Carolina Legislative Building in downtown Raleigh

Requirement to report medical records suspensions lifted

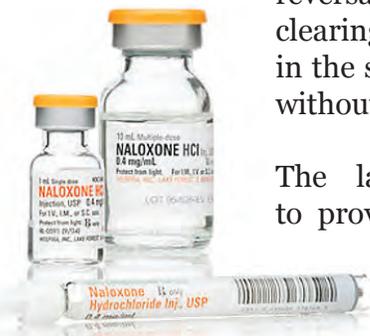
The bill repeals the requirement for hospitals to report suspensions due to delinquent medical records to NCMB. The Board found that these reports did not provide meaningful information. NCMB believes these issues are best handled at the facility/health system level.

Email communication with licensees

HB728 includes language to authorize the Board to use or make email addresses available for the purpose of disseminating or soliciting information “affecting public health or the practice of medicine.” This provision will allow NCMB to communicate more freely with its licensees via email. For example, NCMB may elect to email occasional policy updates and other news to licensees. The Board will not send frivolous or excessive email communications.

Expanded access to overdose “rescue” drug

A new state law signed in June by Gov. Pat McCrory authorizes NC’s State Health Director to issue a statewide standing order for the opioid overdose-reversal medication naloxone, clearing the way for pharmacies in the state to provide the drug without a prescription.



The law allows pharmacies to provide naloxone to opioid users and/or family members of opioid users. Previously,

the medication could be dispensed only with a prescription or with a standing order issued by a physician. Session Law 2016-17 took effect June 20.

North Carolina is the third state in the country to issue a statewide standing prescription order for naloxone.

Naloxone prevents opioid overdose by blocking the brain’s opioid receptors. This averts respiratory depression, which is the typical cause of death in cases of opioid overdose. Naloxone is harmless to people who are not experiencing opioid overdose.

Coming soon: Mandatory registration with state controlled substances database

The state appropriations bill includes a provision to require mandatory registration with the NC Controlled Substances Reporting System (NCCSRS) of all licensed medical professionals who are authorized to prescribe controlled substances. Licensees would be required to register for access to the NCCSRS within 30 days of issuance or annual renewal of their NC professional license. The requirement will not be in effect until NCCSRS completes certain technical upgrades and the system is fully operational within the NC Department of Health and Human Services and

connected to the statewide health information exchange.

However, there's no need to wait to register. NCMB encourages all controlled substances prescribers to register for access to NCCSRS and regularly use the system to monitor patients' prescription histories. The database is a valuable tool that can help prescribers avoid inappropriately prescribing to a patient who is abusing or diverting medications. Yet, according to the system's administrators, well under half of NC prescribers who hold valid DEA registrations are currently regis-

tered for access. To make signing up for access easier, NCMB built an online NCCSRS registration form that allows licensees to register through their licensee information page, or during annual license renewal.

NCCSRS REGISTRATION

- Visit www.ncmedboard.org
- Select Update licensee information page (under Resources, bottom left of home page)
- Log in and select Training & CSRS



Patrick Burnside, MD

One physician's experience using NCCSRS

Dr. Patrick Burnside practices emergency medicine in Charlotte, NC. He shared his thoughts on using the state's prescription drug database in daily practice. Dr. Burnside has been using the system since 2009. Reach Dr. Burnside at burnside.patrick@gmail.com

Q: How do you use the NCCSRS to monitor your patients?

A: I query the database when considering any controlled substances for patients with risk factors for misuse of these agents. Evidence-based

medicine shows that age less than 40, psychiatric and substance abuse history and benzodiazepine use are particularly high risk factors. ED recidivism, unusual "allergy" lists and tobacco smoking are other risk factors. Cigarette smoking is commonly overlooked yet increases opioid misuse risk threefold. On average, I query the system 2-4 times per shift.

Q: When you do an NCCSRS query, what information are you looking for in particular and how do you use it?

A: I first make certain that I pull the proper NCCSRS profile for each patient, though NCCSRS is incredibly

accurate. Then I use the system to 1. Help me counsel patients with concerning prescription profiles and 2. Potentially tailor my therapy to the safest analgesic practices for this subgroup. I look for patterns of poly-provider and poly-hospital utilization, as well as specific prescriptions with negligible clinical value/abuse potential ratios (carisoprodol is a great example). A very common yet dangerous prescribing pattern to identify is benzodiazepine-opioid overlap.

Q: Many prescribers complain that NCCSRS is too cumbersome and time-consuming for busy clinicians to use. Do you agree? How have you overcome this in your practice?

A: These are unfounded concerns, given current technology. Clinicians in current practice have heavy data entry and computer interface burdens, but voice recognition software drastically shortens access time. It takes about five minutes to create a voice command and it takes 20-30 seconds to load NCCSRS at the beginning of a shift. Pulling a profile then takes 20-25 seconds.



Licenses who are in stable treatment for depression can remain anonymous to the Board.

Seeking help for depression, without fear

Scott Kirby, MD, Chief Medical Officer

ARTICLE SUMMARY

- Licensees should not forgo treatment for depression for fear of medical board interference
- Licensees who are stable under treatment typically do not need to reveal their diagnosis to the Board at renewal
- Licensees who are stable under treatment for depression may skip the NCMB renewal question on medical conditions

Every year when physicians and physician assistants complete their annual license renewals with the Board, they are confronted with a question, which asks, “Since you last renewed have you become aware of any medical condition that impairs or limits, or could possibly impair or limit, your ability to practice medicine safely? Medical condition includes...psychiatric or psychologic conditions or disorders...”

If you are depressed or contemplating seeking help how should you answer this question? If you are seeing a physician or psychiatrist and stable on medication what should your answer be? And, just as important, what will the Medical Board do with the information you provide?

This article is intended to encourage physicians and other NCMB licensees to seek help free of the unwarranted concern that doing so will automatically lead to Board intervention, discipline, or licensure limitation.

It is recognized that individuals who consider suicide may lose the ability to think clearly or to develop a plan to cope with the situation. These individuals often end up believing self-destruction is the only solution. Most psychiatrists concede that often nobody really knows why someone commits

suicide, and survivors are left with many unanswered questions and inadequate answers. Despite this, something can be done to help.

There are resources available to physicians and other medical professionals who are struggling with depression. The North Carolina Physicians Health Program (NCPHP) can provide non-disciplinary and confidential assistance that ensures the physician’s identity is protected, provided patient care has not been negatively impacted by the physician’s behavior. The NCMB renewal question specifically states, “If you are an anonymous participant in the NC Physicians Health Program and in compliance with your contract, you do not need to list any medical conditions related to that contract.” In other words, a licensee who reaches out to NCPHP for help with depression or other psychological problems is generally not required to disclose his or her mental health issues to the Board. Physicians are allowed to remain anonymous so long as NCPHP can establish they are safe to practice, are not an imminent danger to the public, or have not committed sexual boundary violations. Self-referrals to NCPHP are encouraged, especially when it results in licensees seeking help earlier in their illnesses. If you are burned out, depressed, under severe stress, or considering suicide, the Board’s primary concern is that you get the help you need.

Licenses who seek treatment independent of NCPHP may also remain confidential to the Board. A physician or PA who is currently under the care of a physician for a stable psychiatric condition that does not impair or limit his or her ability to practice medicine is not required to report that condition or treatment during renewal.

Even if depression or other psychological issues have

already negatively impacted your practice or patient care, there are resources available to help you heal and rebuild. NCPHP boasts many, many stories of successful participants who return to productive personal and professional lives after receiving the help they need. Where appropriate and necessary, NCPHP is willing to advocate on behalf of successful participants to help them obtain licensure or reinstatement with the Board.

If a licensee reports a condition at license renewal, the Board will review the answer with the intent to determine if there is a clear connection between the reported condition and the licensee's ability to practice safely and competently. On occasion the Board may request additional information or clarification, such as a fitness to practice letter from a treating physician. The Board expects licensees

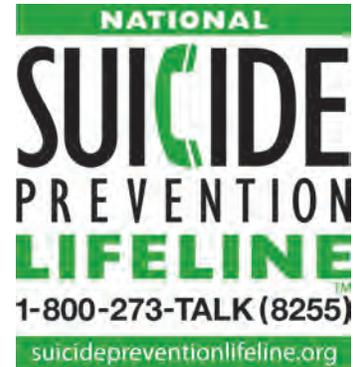
who report conditions to act in a professional and ethical manner and appropriately self-limit practice as needed.

The important point is to avoid the impulse to let a serious problem go untreated due to unwarranted concerns about Medical Board interference. Obtaining timely assistance may, in fact, be essential to preserving both your life and livelihood.

North Carolina Physicians Health Program (NCPHP)

For more information about NCPHP and the services it provides visit:

www.ncphp.org/



New position statement addresses practice ownership

NCMB regularly investigates and takes action in cases that involve aiding the unlicensed practice of medicine in NC due to unlawful practice ownership arrangements. The Board adopted a position statement, *Corporate practice of medicine*, in March 2016 to clarify its expectations.

As a general rule, the North Carolina Professional Corporations Act (N.C. Gen. Stat. §55B, et. seq.) requires corporations that provide certain professional service to be owned entirely by licensees of that profession. Applying this general rule, medical practices must be owned by licensed physicians. Under some circumstances, a medical practice may be jointly owned by a combination of other authorized clinicians as listed in N.C. Gen. Stat. § 55B-14(c).

Often, NCMB will investigate situations where a licensee is

employed to work in a practice owned by medical professionals who are not licensed in NC or that is owned by individuals who are not medical professionals. A physician or PA who practices in an arrangement not in compliance with the Professional Corporation Act may be found to have aided the unlicensed practice of medicine. Also, licensees may be held accountable for following clinical protocols established by corporate owners if such protocols result in substandard patient care.

Another common pitfall NCMB sees frequently is the problem of “straw ownership” of medical practices. A straw ownership arrangement is one in which a licensed physician is made the sole shareholder of a practice controlled and operated by a non-physician. In this arrangement, a physician is made the shareholder of the corporation on paper to

disguise the fact that real control and decision-making authority in the practice resides with a non-physician. In many instances, the physician straw owner signs a management agreement with a non-physician whereby the bulk of the practice's revenue goes to the non-physician. In these situations, the physician straw owner can still face disciplinary action by NCMB for aiding and abetting the unlicensed practice of medicine, as well as unethical fee-splitting.

NCMB recognizes medical practices owned by hospitals, or health maintenance organizations as exceptions. State law authorizes these licensed and regulated entities to provide direct patient care.

The full *Corporate practice of medicine* position statement can be found online at:

www.ncmedboard.org

Easing challenges associated with reentering the practice of medicine

Eleanor E. Greene, MD, MPH, and Karen Burke Haynes, MD

ARTICLE SUMMARY

- Clinicians who seek relicensure after an extended break are often unaware of obstacles to reentry
- Careful planning before inactivating the professional license can help ease reentry
- NC reentry applicants are responsible for demonstrating competence to practice

Physician reentry into the workforce is a topic that has received greater attention in recent years, gaining recognition as an important workforce issue in 2002. Mark et al. defined reentry as “returning, after an extended absence, to the professional activity/clinical practice for which one has been trained, certified or licensed.”

The past decade has seen a significant rise in the number of clinicians, both male and female, who have chosen to leave active practice for periods of time that often exceed two years. Reasons vary from starting a family, caring for elderly parents, burnout or personal health and wellness needs.

Clinicians who choose to cease active clinical practice are often unaware of the potential hurdles they may encounter when reentry into practice is attempted.

In North Carolina, physicians and physician assistants (PAs) who allow their professional licenses to lapse for a length of time greater than two years may face barriers to successful reinstatement. For some, the acquisition of hospital privileges and professional liability insurance coverage may not be assured without additional training or some other reentry activity. A review of the literature regarding the subject reveals a wide variation in the criteria used by state licensing boards regarding the length of time a medical professional is allowed to be inactive before reentry/fit for duty requirements apply.

Clinicians who are unaware of reentry policies are often blindsided by the significant requirements that typically must be met to obtain reinstatement of an inactive NC license or issuance of a new NC license and reestablish practice. Additionally, research in the area of performance after an absence from active patient

care has established a decline in clinical skills that may impact patient outcomes. These facts suggest that maintaining fitness for duty during absence from active practice would be beneficial. This requires preparation and commitment to staying abreast of educational needs, changes in clinical practice and administrative requirements related to the reentry in one’s state of residence intended practice.

For approximately the past decade, NCMB’s practice was to work with individuals on a case-by-case basis to determine specific needs to be addressed upon reentering practice. This process typically resulted in a reentry program that involved the licensee securing a professional mentor and completing a phased reentry process that culminated with the reentry candidate practicing independently. In recent years, however, it became obvious to the Board that reentry candidates needed more attention and expertise than NCMB can provide. Administrative rule 21 NCAC 32B .1370 states the Board’s current reentry requirement and process.

Although NCMB no longer takes



Clinicians may face challenges when returning to practice after an extended break.

an active role in developing or directly supervising reentry programs, the Board has an interest in informing both inactive clinicians who are pondering reentry to active practice and licensees who may be considering a break about current expectations.

The American Academy of Pediatrics (AAP) and associated organizations have led the charge in better understanding the demographics of clinicians who choose to take time off from active practice and the obstacles to reentry they encounter. These organizations have also led the way in developing strategies for making the reentry process more attainable, and less stressful.

The authors recommend the Physician Reentry into the Workforce website sponsored by the AAP as an excellent resource. Practitioners can use this site to research the topic of reentry, educate themselves about developments and access tools for planning. Perhaps the most promising resource is the reentry portal developed for physicians. Topics covered include strategies for exiting practice, activities to pursue while out of practice, and information regarding the safe practice of medicine. While the needs of all subspecialties are not addressed with this tool, it is a valuable starting point.

NCMB recognizes that the current medical practice environment places great demands on clinicians, many of whom may value a season away from clinical care. If this is something you are considering, understand that planning and preparation will ease the pathway to reentry when you are ready to resume practice.

For current reentry rules and reentry resources see the box to the right.



CURRENT REENTRY RULES

NCMB adopted administrative rule 21 NCAC 32B .1370 in March 2016. The rule sets out the Board's expectations for clinicians seeking reentry to active clinical practice. The Board requires applicants who have not held an active license for two or more years to comply with the rule.

Factors that may affect the length and scope of the reentry plan include:

1. The applicant's amount of time out of practice;
2. The applicant's prior intensity of practice;
3. The reason for the interruption in practice;
4. The applicant's activities during the interruption in practice, including the amount of practice-relevant continuing medical education;
5. The applicant's previous and intended area(s) of practice;
6. The skills required of the intended area(s) of practice;
7. The amount of change in the intended area(s) of practice during the time the applicant has been out of continuous practice;
8. The applicant's number of years of graduate medical education;
9. The number of years since the applicant completed graduate medical education; and
10. As applicable, the date of the most recent ABMS, AOA or National Commission on Certification of Physician Assistant certification or recertification.

Source: 21 NCAC 32B .1370

REENTRY RESOURCES ONLINE

Access information about reentry on NCMB's website at:
www.ncmedboard.org/licensure/reentry

Board to explore issues facing employed physicians

NCMB will host a roundtable discussion in November to explore challenges specific to physicians who work in salaried positions, as opposed to independent solo or group practice.

As more physicians have moved to employment arrangements, NCMB has noticed that policies

and protocols put in place by employers sometimes make it challenging for the employed licensee to comply with individual professional obligations to patients. For example, when a physician retires or departs a practice, the Board's expectation is that the physician will be permitted to provide appropriate notice to pa-

tients, ensure continuity of care, and allow patient selection.

The roundtable is tentatively scheduled for the afternoon of Tuesday Nov. 15. Do you have suggestions for issues related to employed physicians that should be discussed at this event? Send them to forum@ncmedboard.org

GETTING TO KNOW THE PEOPLE OF THE NC MEDICAL BOARD

Five Questions: Barbara Walker, DO

FAMILY PRACTICE & OMT | SOUTHEAST AREA HEALTH EDUCATION CENTER(SEAHEC) | APPOINTED 2013 | BOARD MEMBER

Q: Why did you want to serve on the Medical Board?

A: My years of family medicine experience in both military and civilian practice environments, as well as in academic medicine, prepared me well for serving on the Board. I also believe it is important to have osteopathic representation on the Board. This is especially important with the presence of an osteopathic medical school at Campbell University and the growing osteopathic physician base in North Carolina.

Q: What do you find most rewarding about practicing medicine?

A: As an osteopathic family physician, I have been honored to have patients share their pain and concerns as well as to be included in their joys and celebrations. From singing "Happy Birthday" at the delivery of an infant, to watching that child grow, to caring for their parents and grandparents, it is an amazing privilege to share so many moments with patients.

Q: What is the best lesson you have learned from your personal or professional life experiences?

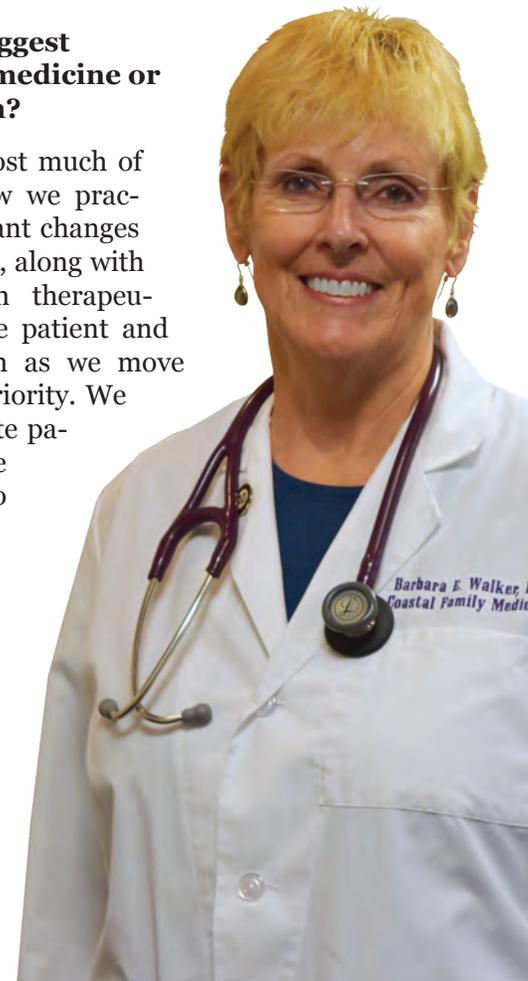
A: It is important to focus on the positive aspects of life. I love the Cherokee story of the old grandfather Indian Chief who tells his grandson, "A fight is going on inside of me. It is between two wolves. One is anger, envy, sorrow, regret, greed, arrogance, self-pity, guilt, resentment, inferiority, lies, self-pride, superiority, and ego. The other is good - he is joy, peace, love, hope, serenity, humility, kindness, benevolence, empathy, generosity, truth, compassion, and faith. The same fight is going on inside you, and inside every other person, too." The grandson thinks about it for a minute and then asks his grandfather, "Which one will win?" The old Cherokee replies, "The one you feed!" It reminds me to continue to feed the good in my life.

Q: What advice would you give to someone entering the medical profession?

A: I like the comment by Dr. Andrew Taylor Still, the founder of osteopathy, who said, "To find health should be the object of the doctor. Anyone can find disease." Focus on the healthy patient with the illness and guide them back to their health. It's an amazing journey.

Q: What are the biggest challenges facing medicine or medical regulation?

A: Physicians have lost much of the control over how we practice. There are constant changes in medical regulation, along with constant changes in therapeutics. Focusing on the patient and on preventive health as we move forward must be a priority. We also need to reeducate patients that it is not the goal of medicine to make life pain-free. Daily life and activities will cause some pain, especially as we become more "age-gifted". The goal is not to eliminate the pains of life, but to guide patients to adaptations for functional living.



North Carolina Medical Board

Quarterly Board Actions Report | February 2016 - April 2016

This report lists public adverse actions of the Board. A complete listing of all public actions, adverse and non-adverse, can be found on the Board's website. Visit www.ncmedboard.org and select "Access recent Board actions" under Topics of Interest (bottom right corner of the home page.)

Name/license #/location	Date of action	Cause of action	Board action
ANNULMENTS			
NONE			
SUMMARY SUSPENSIONS			
LIETZKE, Christiana Marie, MD (201400017) Rutledge, TN	03/18/2016	MD suffers from a medical condition that, left untreated, makes her unfit to practice medicine. Medical professionals have opined that MD is not currently fit to practice.	Summary Suspension of License
REVOICATIONS			
NONE			
SUSPENSIONS			
CHAPMAN, (III), William H. Harrison, MD (009401392) Greenville, NC	03/18/2016	MD inappropriately prescribed controlled substances to a family member and to his girlfriend. MD asked multiple individuals he worked with and supervised to prescribe controlled substances and non-controlled substances to his girlfriend, a family member and to himself, knowing that the prescribing would occur outside of an established and appropriately documented physician-patient relationship.	MD's license is suspended from October 12, 2015, to April 17, 2016. MD has entered into a contract with NCPHP to help him better understand appropriate boundaries to avoid inappropriate prescribing in future.
LIETZKE, Christiana Marie, MD (201400017) Rutledge, TN	04/28/2016	MD is unfit to practice medicine due to symptoms consistent with bipolar disorder, manic phase, which MD declines to control with medication.	Indefinite suspension
MARCHETTI, Louis Joseph, MD (000017224) Vass, NC	04/14/2016	MD wrote prescriptions in the names of three patients who were unaware that these prescriptions were issued, with the understanding that the medication would, in fact, be provided to a member of MD's family.	Indefinite suspension
OUDEH, Ibrahim Naim, MD (000034428) Dunn, NC	03/17/2016	Concerns about quality of care; MD treated a family member and prescribed controlled substances to a family member.	Indefinite suspension, stayed. MD must enter into an agreement to be monitored and mentored by an organization approved by the Board for a period of no less than two years. If the monitoring company opines that MD is practicing below accepted standards, the Board has the right to summarily suspend MD's license. MD is restricted from prescribing controlled substances in Schedules I, II/IIIN and III/IIIN.
SASS, Maria, LP (100000203) Durham, NC	04/15/2016	In March 2016, LP consumed tramadol, a controlled substance that was not lawfully prescribed for her, in violation of her NCPHP monitoring contract. This followed two prior instances of violating the NCPHP contract, after which no public action was taken.	LP is indefinitely suspended, immediately stayed, except for a period of 30 days.
SHANNON, (Jr.), Walter Daniel, MD (200301170) Kinston, NC	04/29/2016	MD prescribed for and treated psychiatric patients in NC during an extended stay in Hawaii. In some instances, MD prescribed controlled substances in the face of signs that patients were abusing and/or diverting the medications. MD failed to respond in the face of aberrant urine drug screens. MD billed for complex medical visits when the care he provided via telemedicine did not justify it. Documentation of medical visits did not consistently correspond with billing.	MD's license is suspended for 12 months, immediately stayed except for a period of 30 days. MD's active suspension is deemed already served, as he ceased practice for a period of at least 30 days while under investigation by the Board. MD shall pay a \$3,000 fine and complete the ProBe course on ethics within six months of the date of the order. MD must complete CME in medical recordkeeping and comply with other conditions.

BOARD ACTIONS

Name/license #/location	Date of action	Cause of action	Board action
SMITH, Bryan Dorsey, MD (200201531) Durham, NC	03/03/2016	Relapse of alcohol use disorder; MD consumed alcohol, amphetamines and benzodiazepines.	Indefinite suspension
WAHBA, Wasseem John, PA (000102441) Cary, NC	04/01/2016	PA video recorded a female patient during a physical examination using his cell phone camera.	Indefinite suspension
WOLICKI-SHANNON, Joanna, MD (200001033) Kinston, NC	04/29/2016	MD prescribed for and treated psychiatric patients in NC during an extended stay in Hawaii. In some instances, MD prescribed controlled substances in the face of signs that patients were abusing and/or diverting the medications. MD billed for complex medical visits when the care she provided via telemedicine did not justify it. Documentation of medical visits did not consistently correspond with billing.	MD's license is suspended for 12 months, immediately stayed except for a period of 30 days to run from May 1, 2016, until May 15, 2016. MD is given credit for a 15 day period during the investigation, during which she did not practice. MD shall pay a \$3,000 fine and complete the ProBe course on ethics within six months of the date of the order. MD shall complete CME in medical recordkeeping and comply with other conditions.
PROBATION/LIMITATIONS/CONDITIONS			
MELINE, Lewis John, MD (201500165) Spokane, WA	02/26/2016	Boundary violation/professional sexual misconduct. While practicing in Washington, MD entered into a sexual relationship with a patient who is a prostitute. MD inappropriately prescribed controlled substances to this patient and also provided between \$50,000 and \$60,000 of financial support to the patient. This conduct led MD to enter into an order with the medical board in Washington, which placed MD's license on probation.	MD is placed on probation; MD must comply with Washington medical board order.
REPRIMANDS			
GARG, Shyam Lal, MD (000026531) Hampstead, NC	04/21/2016	Quality of care; inappropriate prescribing of controlled substances, inadequate documentation.	Reprimand; \$2,000 fine; MD must complete 10 hours of CME in controlled substances prescribing and medical record keeping.
JACOBS, James William, MD (009401420) Cary, NC	03/02/2016	MD did not employ appropriate pharmacovigilance in monitoring a patient whose ADD was being managed with narcotics. Prescribing of narcotics increased in the face of possible drug diversion behavior by the patient, who eventually died of heroin overdose.	Reprimand; MD shall continue changes made in practice to ensure proper pharmacovigilance with patients who are prescribed controlled substances.
KELLY, Timothy Gerald, MD (000033074) Wilmington, NC	04/12/2016	Quality of care; MD failed to treat a patient's intraocular pressure in a timely manner.	Reprimand
LALLINGER, Gunther Josef, MD (000025928) Chapel Hill, NC	03/17/2016	MD failed to timely and appropriately diagnose testicular torsion in a 14 year old male, contributing to the eventual development of necrosis and loss of the testicle.	Reprimand; \$1,000 fine
LITTLE, (Jr.), James Conrad, MD (000015968) Climax, NC	02/12/2016	MD hired a woman he was dating to work as his office manager and as a clinical assistant in his practice. MD occasionally directed this person, who had no prior clinical training or experience, to write prescriptions, which MD signed. An investigation determined that the woman wrote seven prescriptions, all for controlled substances, for herself and two family members without MD's knowledge or consent. MD failed to appropriately supervise and ensure that the employee was assigned duties commensurate with her education, training and experience.	Reprimand
SEITZ, Kent, MD (200900067) Charlotte, NC	03/18/2016	Quality of care, inappropriate prescribing of controlled substances; MD allowed an unlicensed staff member to use undated, unsigned prescription blanks to issue prescriptions, including for Suboxone, when he was unavailable. MD failed to appropriately respond to patients' positive urine drug screens.	Reprimand; \$2,000 fine; MD shall complete a course in appropriate prescribing of Suboxone.
SKEEN, James Thomas, MD (009801061) Greensboro, NC	03/17/2016	MD self-prescribed on two occasions; Medical records were inaccurate and/or insufficient; History of prescribing controlled substances	Reprimand; MD shall attend a proctored medical records course approved by the Board within six months of the date of the order.

Name/license #/location	Date of action	Cause of action	Board action
THOMBS, Everett Bernard, MD (000025194) Kings Mountain, NC	04/21/2016	Quality of care; deficiencies in MD's medical record documentation, management of co-morbid conditions and controlled substances prescribing practices.	Reprimand; MD must obtain a practice monitor as specified in the order and complete CME in medical record keeping and controlled substances prescribing. In future, if the Board finds that MD's controlled substances prescribing does not meet accepted standards, the Board reserves the right to summarily suspend MD's controlled substances prescribing privileges.
TOLMAN, Phillip William, PA (000103958) Wilmington, NC	02/12/2016	PA was disciplined by the South Carolina medical board related to allegations that he sexually harassed a female coworker.	PA's NC physician assistant license is reinstated, with a reprimand
DENIALS OF LICENSE/APPROVAL			
ROBERTSON, Valerie Jean, MD (NONE) Tucson, AZ	02/08/2016	MD made false statements and misrepresentations on her NC license application, related to a malpractice payment made on her behalf in January 2014.	Denial of application for NC medical license.
SURRENDERS			
ACOSTA, Daniel, MD (200100499) Washington, NC	04/25/2016		Voluntary Surrender of NC medical license
FITZGERALD, Dwight Melvin, MD (000020792) Taylorsville, NC	03/08/2016	History of disruptive conduct.	License surrendered, via non-Disciplinary Consent Order
HERNANDEZ, Mario Augusto, MD (201000567) Charlotte, NC	02/04/2016		Voluntary surrender of NC medical license
JENNINGS, Christopher Ray, MD (201502283) Anderson, SC	03/31/2016		Voluntary surrender of NC medical license
WATFORD, Douglas Elry, MD (000035546) Kinston, NC	04/19/2016		Voluntary surrender of NC medical license
PUBLIC LETTERS OF CONCERN			
AHMED, Syed Fakruddin Ali, MD (200801321) Rocky Mount, NC	04/15/2016	The Board is concerned MD failed to adequately monitor the potassium level of a patient admitted with sepsis. The patient was admitted with elevated potassium and received treatment that returned potassium levels to a normal range. MD assumed care of the patient and oversaw the patient's treatment for six days, during which the patient's potassium levels dropped. The patient eventually died from cardiac arrhythmia, which may have been caused by potassium deficiency.	Public letter of concern
ALBRIGHT, Elizabeth Rae Bakisac, PA (001004908) Fayetteville, NC	03/07/2016	PA consumed alcohol in violation of NCPHP contract; PA has successfully completed inpatient treatment.	Public letter of concern; PA shall maintain NCPHP contract and abide by all terms.
BERCHUCK, Andrew, MD (000031435) Durham, NC	04/05/2016	MD failed to timely diagnose and treat a patient's uterine cancer. The Board notes that this was a difficult case with a poor prognosis regardless of when the diagnosis was made.	Public letter of concern
BEURSKENS, Maureen Leonie, MD (000035584) Charlotte, NC	02/02/2016	The Board is concerned that MD's treatment of a patient who presented with a fibroid and 1.1 mm endometrial stripe may not have conformed to accepted standards of care. An expert reviewer opined that MD should have ordered a biopsy when the fibroid and endometrial stripe were detected, which might have resulted in a more timely diagnosis of the patient's endometrial cancer.	Public letter of concern
BYRNE, Thomas John, MD (000025001) New York, NY	02/26/2016	Concerns about quality of care and history of Board actions in other states; MD presented evidence that he is currently licensed without restriction in these states.	Public letter of concern
DIXON, Donovan Dave, MD 201001347) Pembroke, NC	02/16/2016	Unprofessional conduct; MD broke the terms of a lease for his medical office space, resulting in a judgment against him for \$64,000.	Public letter of concern
ELLIOTT, John Daniel, DO (201201920) Elizabeth City, NC	02/12/2016	The Board is concerned that DO failed to appropriately diagnose and manage a patient's lower leg arterial insufficiency. The patient ultimately underwent below the knee amputation.	Public letter of concern

BOARD ACTIONS

Name/license #/location	Date of action	Cause of action	Board action
FISHER-BECK, Jason Andrew, PA (001003399) Sacramento, CA	02/16/2016	PA failed to ensure that a patient's surgical wrap was removed in an appropriate and timely manner. PA assisted in the patient's hip surgery; it is typically the responsibility of the OR nurse or the surgical assistant to remove the surgical wrap. The wrap remained in place for six days and the patient developed extremity vascular compromise resulting in foot ulcers. Ultimately, the patient required lower leg amputation.	Public letter of concern
GILLMAN, John Frederick, MD (009300475) Tacoma, WA	02/29/2016	Action taken by Washington medical board; MD engaged in a sexual relationship with a patient.	Public letter of concern
KREITZ, (Jr.), Michael, PA (000100004) High Point, NC	03/31/2016	Professional boundary violation; A patient alleged that PA viewed photos of an intimate and personal nature on her cell phone without her permission.	Via consent order, PA is issued a public letter of concern
LUGO-SANTIAGO, Irving Amilcar, MD (000030835) Greensboro, NC	02/16/2016	MD and his family developed a close social relationship with a patient under MD's care. MD eventually hired the patient to work in his practice and the individual remained in MD's care, receiving prescriptions for controlled substances among other care. Administrative rules prohibit a licensee from prescribing to someone with whom he has a close personal relationship.	Public letter of concern
MCGINN, (Jr.), Joseph Thomas, MD (201600697) Monroe, NC	04/14/2016	The Board is concerned that an independent expert medical reviewer raised concerns about certain aspects of two CABG procedures performed by MD that the Board requested be reviewed. The Board notes that MD provided expert reviews that support his approach to the cases.	MD is issued a NC license, with a public letter of concern
MEEHAN-DE LA CRUZ, Kathleen, MD (009900813) Norwalk, OH	04/19/2016	MD wrote prescriptions to a person she is involved in a romantic relationship with. MD has since completed remediation courses. She is cautioned not to repeat similar conduct in future.	License reinstated, with a public letter of concern
SPOHN, Peter John, MD (201000005) Deridder, LA	03/14/2016	MD placed a left sided trochanteric nail in a patient undergoing surgery to repair a hip fracture, instead of a right sided nail as intended.	Public letter of concern
VAN ZANDT, Stephanie, MD (201401271) Clearwater, FL	04/26/2016	The Board is concerned that MD was insufficiently aware of preeclampsia in a patient who presented in early preterm labor; The Board is concerned that MD's management of the patient failed to meet current accepted standards.	Public letter of concern; Within six months of the date of this letter, MD must complete the ACOG course on Fetal Heart Rate Monitoring and complete the ACOG Task Force Publication on Hypertensive Disorders in Pregnancy Status.
WILLIAMSON, (Jr.), Charles Edward, MD (000039500) Roanoke Rapids, NC	04/05/2016	MD failed to consider a recurrence of methicillin-resistant staphylococcus aureus as a possible cause of a patient's fever, back pain, leg numbness and other symptoms. The patient has been treated three weeks prior by another physician, who drained the patient's axillary abscess, diagnosed methicillin-resistant staphylococcus aureus and prescribed antibiotics. MD diagnosed the patient with an acute lumbosacral strain and prescribed pain medication. The patient returned to the ER 12 hours later and was ultimately diagnosed with an epidural abscess. The patient underwent decompressive surgery and is now a parapalegic.	Public letter of concern
MISCELLANEOUS ACTIONS			
CARTER, Richard Ford, MD (200800397) Highlands, NC	03/18/2016	History of alcohol use disorder; MD failed to comply with NCPHP monitoring agreement.	MD's license is made inactive
ELSTER, (II), Allen William, MD (201600181) Johnson City, TN	02/08/2016	History of alcohol abuse; history of arrest for indecent exposure (while under the influence of alcohol).	MD is issued a resident training license, must comply with NCPHP contract. MD has successfully completed inpatient treatment and is continuing with outpatient therapy.

Name/license #/location	Date of action	Cause of action	Board action
LATTERNER, Kim Marie, PA (001003471) Matthews, NC	03/30/2016	PA has been charged with multiple counts of statutory rape.	Interim Non-Practice Agreement
THOMASSON, Lori Anne, PA (001003333) Norfolk, VA	03/17/2016	Action by another state medical board; PA's Virginia license was summarily suspended in January 2016.	PA enters into a public Non-Practice Agreement
CONSENT ORDERS AMENDED			
SPIVEY, David Lee, MD (000030582) Winston-Salem, NC	02/18/2016	MD is compliant with all aspects of his September 2015 order	Amended Consent Order: the stayed suspension portion of MD's September 11, 2015, order is lifted effective March 1, 2016.
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
THOMPSON, Joel Wesley, PA (000101018) Charlotte, NC	03/29/2016		PA is issued a dated license to expire on 03/29/2017.
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			

Glossary of Terms

Annulment: Retrospective and prospective cancellation of the practitioner's authorization to practice.

Conditions: A term used to indicate actions or requirements a licensee must complete and/or comply with as a condition of continued licensure.

Consent Order: An order of the Board that states the terms of a negotiated settlement to an enforcement case; A method for resolving a dispute without a formal hearing.

Denial: Decision denying an application for initial licensure or reinstatement, or reconsideration of a Board action.

Dismissal: Board action dismissing a contested case.

Inactive Medical License: Licensees must renew the professional license annually to practice lawfully in the state of NC. The Board may negotiate a provider's agreement to go inactive as part of the resolution of a disciplinary case.

Public Letter of Concern (PubLOC): A letter in the public record expressing the Board's concern about a practitioner's behavior or performance. A public letter of concern is not considered disciplinary in nature; similar to a warning.

Revocation: Cancellation of authorization to practice. Authorization may not be reissued for at least two years.

Stay: Full or partial stopping or halting of a legal action, such as suspension, on certain stipulated grounds.

Summary Suspension: Immediate cancellation of authorization to practice; Ordered when the Board finds the public health, safety, or welfare requires emergency action.

Suspension: Withdrawal of authorization to practice, either indefinitely or for a stipulated period of time.

Temporary/Dated License: License to practice for a specific period of time. Often accompanied by conditions contained in a Consent Order.

Voluntary Surrender: The practitioner's relinquishing of authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.





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BOARD MEETING DATES

September 21-23, 2016 (Full Board) | October 20-21, 2016 (Hearing) | November 16 -18, 2016 (Full Board)
Meeting agendas, minutes and a full list of meeting dates can be found on the Board's website:

www.ncmedboard.org

Rule change update: Opioid prescribing CME requirement

NCMB's plans to require continuing medical education (CME) in pain management and related topics of all licensees who prescribe controlled substances took another step forward at the Board's July meeting.

The final version of the proposed rule includes an important change to the effective date of the CME requirement. The Board voted to make the requirement effective **July 1, 2017**, instead of Jan. 1, 2017, as originally planned. The Board made this change to allow NCMB staff ample time to communicate with affected licensees about the new CME requirement and provide additional time for licensees to comply.

As proposed, the rule changes would require physicians who prescribe controlled substances to complete three hours of CME during each three-year CME cycle. Physician assistants would be required to complete two hours of CME during each two-year cycle. To meet the requirement, courses would have to cover "controlled substances prescribing practices, recognizing signs of the abuse or misuse of controlled substances, and controlled substance prescribing for chronic pain management."

The NC Rules Review Commission is expected to decide whether to grant final approval to the CME rule changes at its meeting on August 18.



Learn more about the new CME requirement
at www.ncmedboard.org/prescribingCME