FORUM
NORTH CAROLINA MEDICAL BOARD
PRIMUM NON NOCERE
FALL 2011

FROM THE PRESIDENT

Managing disruptive behavior (Pg. 6)

Keeping the emphasis on medicine in telemedicine

NCMB President, Janice E. Huff, MD, says "Establishing absolute rules for telemedicine seems unrealistic to me. . .However, some additional guidelines would seem prudent."

Imagine you are an ER physician in rural North Carolina. A patient presents with stroke-like symptoms, but you are not 100 percent sure and the nearest neurologist is three hours away. Should you start treatment? What if you could have that patient examined by a neurologist via video conference? Together, you and the consultant could make the appropriate treatment decisions and potentially prevent significant morbidity or even save a life.

Now imagine a patient (who may or may not have an established primary care provider) who calls a 1-800 telephone number and pays a fee with a credit card to talk to a random doctor, physician assistant or nurse practitioner. She describes her symptoms and receives a diagnosis and a prescription, which is electronically transmitted to her local pharmacy. Both scenarios are examples of telemedicine as practiced in the modern medical landscape. But are both examples of good medicine?

I think most clinicians would consider the first scenario to be acceptable—if not optimal—quality care. But the second example? While it may have the advantage of being more "accessible" and possibly cheaper than visiting a local practitioner, I'd argue that the quality of care provided in such a scenario is, at least, debatable.

As telemedicine becomes more widely practiced, health care practitioners must remember that they have an obligation to provide care that meets acceptable standards, regardless of how care is delivered. That is the Medical Board's bottom line, expressed in its formal position statement on telemedicine. Use the QR code on the following page to read the position statement on your smart phone, or take a look at it online.

If treatment provided through some iteration of telemedicine falls short, the Medical Board will not look to the insurance company, health system, retail drug chain or other "owner" of the telemedicine venture. The Board will hold the physician or physician assistant who provided the care accountable.

Whatever else telemedicine is, for technology companies, hospitals and health systems, insurance companies, entrepreneurs and other business interests, it is also an opportunity to make money. Increasingly, clinicians are being approached to participate in ventures that deliver care in ever more creative technology-assisted ways.

Possible telemedicine concepts include placing video kiosks in retail drugstores, where patients would go for telemedicine evaluations with a physician, or even having patients consult with medical practitioners from their home computers using instant messaging or video conferencing technology.

IN THIS ISSUE

I mention these projects purely as examples of telemedicine arrangements licensees are likely to see in the marketplace and, perhaps, be recruited to participate in. I'm not suggesting that care delivered in either of these models would necessarily be substandard. That said, it is imperative for licensees to be aware of potential risks.

Physicians and others may assume that the owner of a telemedicine venture would not ask them to do something contrary to accepted standards of medical care. This is a dangerous assumption. The truth is telemedicine hasn't worked through all of its attendant issues of quality and patient safety. In some cases, those driving telemedicine ventures aren't even considering quality as they forge ahead.

It is also essential that licensees involved in telemedicine be adequately trained to use all applicable technology. That may seem obvious, but it's worth stating: technology can only benefit patients when clinicians know how to use it!

Don't misunderstand me. I think telemedicine can be a tremendous benefit to patient care in all fields of medicine under the appropriate circumstances, and I am certain it has already saved numerous lives. But as with any medical issue, telemedicine is rife with slippery slopes.

In recent years, the NCMB has shown a willingness to work with telemedicine providers that have demonstrated concern about meeting accepted standards of care. In one case that received some media attention, the NCMB gave a psychiatric practice seeking to reach patients in rural parts of the state its blessing to have practitioners issue prescriptions to patients after a telemedicine consult. In most circumstances, the Board expects licensees to conduct a face-to-face examination before writing prescriptions. (See the Board's position statement on *Contact with patients before prescribing*.)

Establishing absolute rules for telemedicine seems unrealistic to me, as what is appropriate will be dictated by the specialty or medical problem in question. However, some additional guidelines would seem prudent.

If there is no established relationship between physician and patient, should some type of healthcare provider be physically present with the patient during the encounter? Is a video examination by the remote practitioner good enough? What is the patient's responsibility? Will access to and continuity of care be better or worse, as use of telemedicine becomes more commonplace?

The Board considered these questions and more during a retreat held in September. The NCMB periodically conducts retreats to allow for strategic planning and discussion of topics that are likely to come before it. You might be surprised at the diversity of opinions about telemedicine among Board members! It was clear to me that much more dialogue and time is needed to determine the best way forward for telemedicine in North Carolina.

Licensees should be part of that dialogue, and I am truly interested to hear your views. I hope you will take a few moments to share them, either by commenting on the online version of this article, or by sending an email.

I'm hopeful that I may hear from many of you, judging by the enthusiastic response to the NCMB survey on treating self and family, which was featured in the last issue of the *Forum*. In all, the Board received more than 1,000 responses. The Board greatly values this feedback from licensees and considered the responses carefully as part of its position statement review. See page 4 of this issue for an update on that process, as well as the full results of the survey.

Finally, as my year as president comes to a close, I want to thank my fellow Board members and the staff of the NCMB for a very productive year. I look forward to another fruitful year under the able leadership of your new president, Ralph Loomis, MD, and the rest of my colleagues on the Board.

Thanks, as well, to all of you. It has been my honor to serve our profession. •

Send feedback to *forum@ncmedboard.org*

Access the Board's position statement on telemedicine by scanning the QR code using an application on your smart phone (*www.redlaser.com*) and your phone's camera.

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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.

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Application process change for IMGs

As of October 1, all International Medical Graduates (IMGs) are required to use the Federation of State Medical Board's Credential Verification Service (FCVS) when applying for a full, unrestricted medical license in North Carolina.

It generally takes at least four months to complete the FCVS process, or as much as six months if the physician waits until after January 1 to begin establishing his or her FCVS profile. The NCMB advises any IMG who intends to begin work as a licensed physician by July 2012 to start the FCVS process now. Please note: Graduates of Canadian medical schools are not considered to be IMGs and will not be required to use FCVS.

FCVS was established in 1996 to provide a centralized, uniform process for state medical boards to obtain a verified record of a physician's core medical credentials. FCVS obtains primary source verification of medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows a physician to establish a confidential, lifetime professional portfolio with FCVS that can be forwarded, at the physician's request, to any state medical board, hospital, health care organization or any other entity that has established an agreement with FCVS.

Learn more about FCVS at *www.fsmb.org/fcvs_overview.html*

Board adopts "three attempt" rule for exams

The NCMB has amended the administrative rules regarding proof of medical licensure examination passage within a specified number of attempts, based on feedback that the requirement was unclear. As of October 1, the rules are amended to state:

If the licensee is qualified based on the COMLEX, each of the following must be passed within three attempts:

- COMLEX Level 1
- COMLEX Level 2 Component 1 (cognitive evaluation)
- COMLEX Level 2 Component 2 (performance evaluation)

If the licensee is qualified based on the USMLE, each of the following must be passed within three attempts:

- USMLE Step 1
- USMLE Step 2 Component 1 (clinical knowledge)
- USMLE Step 2 Component 2 (clinical skills)

The "three attempt" rule will apply to resident training licensure applicants as well as applicants for a full and unrestricted physician license. Previously, there was no specified limit on the number of attempts RTL applicants may make in their efforts to pass applicable exams.

NCMB adds new Web content

The NC Medical Board has added new features to its website to help licensees and others keep better track of Board initiatives and news. To see the new content, visit *www.ncmedboard.org* and click on "About the Board" in the top right corner of the Home Page.

The "What's New" section includes:

- **Meeting Summary** Provides brief descriptions of selected actions taken during the most recent NCMB meeting. Typically posted within two weeks of the close of the meeting.
- **Rule Change Tracker** Displays proposed rules and proposed amendments to existing rules. Visitors may view proposed rule text, check the current status of a proposed rule and find instructions for attending a public hearing or submitting written comments.
- **New Licensees** A list of all physician and physician assistant licenses issued by the Board. Posted every two months.
- **Recent Board Actions** A chronological listing of all public actions executed by the Board, both disciplinary and non-disciplinary. New actions are typically posted within 48 hours.

Seeking smart, engaged readers for the *Forum* Editorial Panel

Does this describe you? Of course it does!

The *Forum* is establishing a group of licensee-readers to regularly critique the newsletter, as well as suggest ideas for articles and other content. It's part of the NCMB's ongoing efforts to make the *Forum* a more relevant and responsive publication. Membership on the editorial panel may involve completing detailed questionnaires about the *Forum*, as well as participating in teleconferences and/or one-on-one telephone interviews.

If you are interested in participating in the *Forum* Editorial Panel, email Jean Fisher Brinkley at *forum@ncmedboard.org* Please provide your name, your current area of practice and your location.

The results are in. . .

Survey results reveal licensee bias against prescribing controlled substances to self/family, provide insight to NCMB Task Force

For some months now, the *Forum* has sought ways to engage readers and solicit direct feedback from licensees of the Board. So when the Board took up the subject of treating self and/or family, we saw it as an opportunity to take those efforts one step further. In the Summer 2011 issue of the *Forum*, Board President Janice E. Huff, MD, asked licensees to participate in an online survey to share their views.

Readers impressed the NCMB with their enthusiastic response to its first-ever licensee survey. More than 1,000 licensees completed the survey on treating self, family and other close associates. That makes the survey the most successful endeavor in Board history to collect feedback directly from licensees. Thank you to everyone who participated!

The online survey augmented the NCMB's efforts to solicit licensees' views on its position statement entitled, *Self-treatment and treatment of family members and others with whom significant emotional relationships exist*, which is under review. The survey was live on the NCMB's website for a period of about three weeks beginning in late July. More than 700 respondents took the time to provide optional written comments with their survey responses. Members of the Board's Task Force on Self Treatment read and considered these comments as part of their review of the existing position statement.

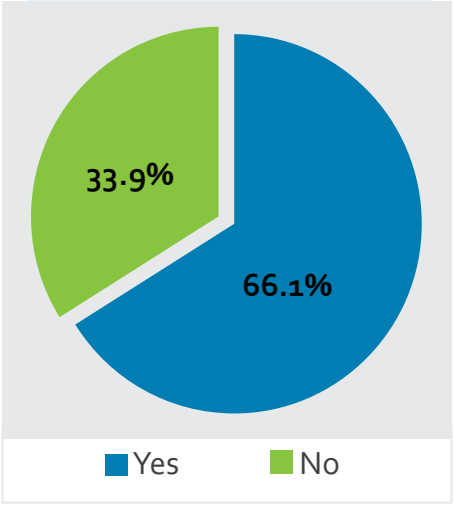
In addition, more than 60 *Forum* readers posted comments to the online version of Dr. Huff's President's Message on treating self/family, setting a new record for comments to articles. These comments were also included in the Task Force's review materials.

Position statement update

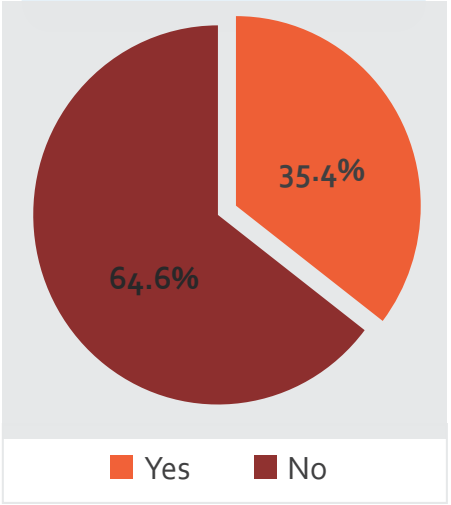
The Board's Policy Committee reviewed a revised draft of the existing position statement on treatment of self/family at its September meeting. The Board voted to table the matter to allow the Policy Committee to consider additional changes to the position statement. The Policy Committee expects to present an updated version of the statement for consideration by the full Board at the November Board meeting.

On a related note, the Board voted in September to pursue an administrative rule that would prohibit licensees from writing prescriptions for controlled substances for themselves, immediate family members and certain others. This decision was based on feedback from licensees and other interested parties, who made clear in comments to the Board that they consider prescribing controlled substances to self and/or family to be inappropriate.

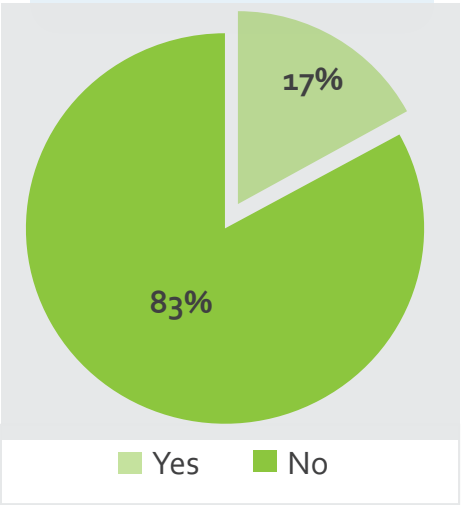
Should the NCMB have a formal position statement on the treatment of self, immediate family and other close associates?



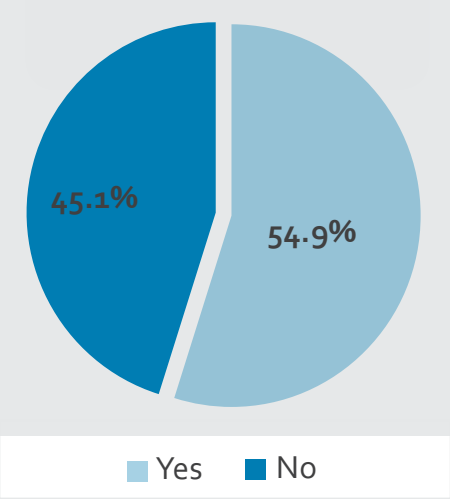
Should licensees treat themselves or others close to them if the medical concern is outside the licensee's area of training and/or current area of practice?



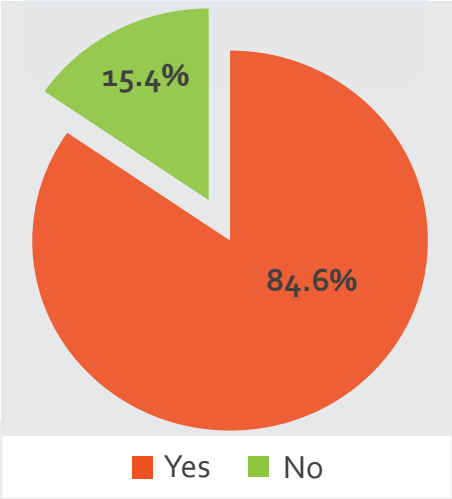
Should licensees be able to prescribe controlled substances to themselves or to immediate family members and others close to them?



Have you self-treated or prescribed for yourself?



Have you treated/prescribed for an immediate family member, a significant other, close friend, etc?



IN THEIR OWN WORDS

More than 700 licensees provided written comments to the survey, which asked: *What steps can the NCMB take to improve its position statement on treatment of self/family?*

Most written comments focused on the following:

Controlled Substances: Physicians should not prescribe controlled substances to self and/or family.

Treating Family Members: Physicians should be able to treat themselves and/or family for minor acute illnesses.

Scope of Practice: Treatment of self and/or family should be allowed if it is within the physician's scope of practice.

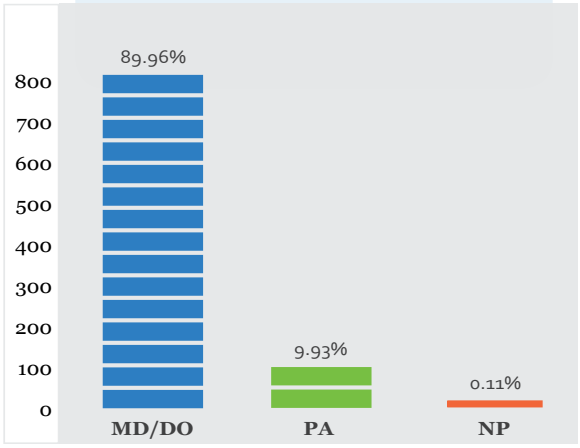
A majority of respondents felt that the Board's current position statement on self treatment was both too strict and too vague. Many agreed that physicians are capable of using good judgment in treating all patients, even self and family.

All written comments received were considered as part of the Board's review and revision of the current position statement.

**The term 'family' encompasses family members and others with whom a significant emotional relationship exists.*

Who took the survey?

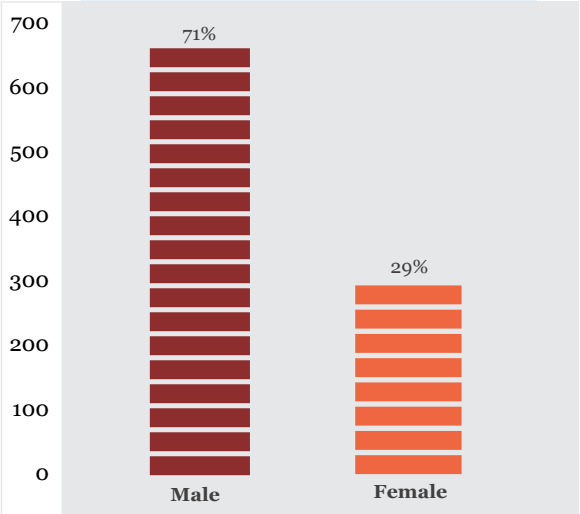
License type: MD/DO, PA and NP



Age Ranges

Age Range	Total
20-29	1.10%
30-39	19.08%
40-49	25.77%
50-59	33.88%
60-69	16.45%
70-79	3.29%
80-89	0.43%

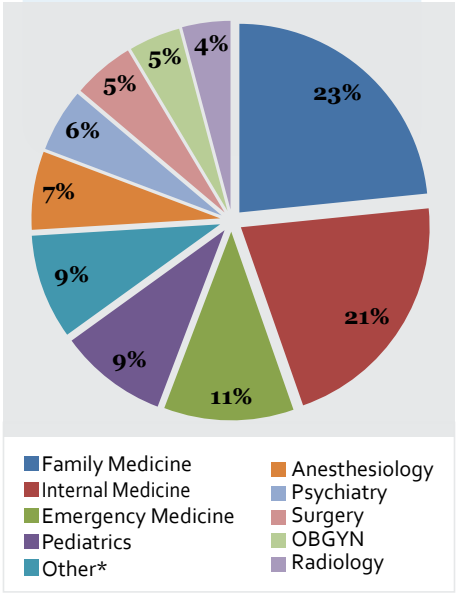
Gender: Male and Female



Practice Setting

Practice Setting	Total
Academic	4%
Both Rural and Urban	2%
Hospital	2%
Private Practice	3%
Retired	1%
Rural	26%
Suburban	7%
Urban	55%

Top 10 Areas of Practice



**Includes misc. areas of practice with less than '5' response rate (i.e. Geriatrics, Pain Medicine, Pulmonology, etc.)*

Managing disruptive behavior

The surgeon who curses and throws instruments. The cardiologist who insists that staff in the cath lab do things "her way"— or else. Attending physicians who seem to delight in publicly dressing down subordinates.

For decades, this kind of conduct was endured and ignored in many, if not most, hospitals and practice groups. That has changed over the last decade or so, with the emergence of professional codes of conduct such as the ACGME's six core competencies and the Joint Commission's adoption in 2009 of new standards that call on hospitals to crack down on "disruptive" behavior.

This package presents two perspectives on addressing disruptive conduct and teaching positive interpersonal skills.

Disruptive behavior: The NCPHP approach

Warren Pendergast, MD, NCPHP Medical Director

The NC Physicians Health Program (NCPHP) has been known for its work with physicians and PAs who suffer from alcohol or drug dependence, but we also assist individuals with a number of other problems that impact the ability to safely practice medicine.

Disruptive behavior is the primary concern in about 21 percent of all cases referred, up from about 15 percent in 2006. Here's how NCPHP approaches interventions with individuals who exhibit disruptive behavior.

Approach to treatment

Physicians and PAs exhibiting problematic behavior are sometimes referred for individual psychotherapy, but increasingly NCPHP finds that a coaching approach is effective. There is often less stigma attached to coaching, which can give this approach an advantage over therapy.

A second advantage is that a coach can focus on teaching positive skills to the physician or PA. This model works well for those who have spent many years in a classroom or other learning environment, and are adept in the didactic setting.

Psychotherapy and/or medication management is nonetheless indicated in some cases, especially for individuals who have suffered earlier trauma, or in cases where depression, bipolar disorder or substance-related issues are present. It is critical for professional coaches to be adept at recognizing these problems and making appropriate referrals when indicated.

Another important intervention in many cases involves helping the physician or PA deal with personal stress. Most individuals try to maintain a "firewall" between their personal and professional lives, but this only works up to a point. If a clinician has ongoing personal stress, it will likely spill over into the professional arena if it is not addressed.

Factors affecting outcomes

NCPHP is best able to help the clinician and the referring agency when all of the following are true. The more factors that exist, the better the anticipated outcome.

- **A pattern of behavior has been established and documented** Examples of behavior and consequences to the hospital or clinic should be clearly documented. Examples are useful to explore the problem with the physician or PA and may help identify underlying triggers and issues that can be addressed. Often, the clinician has little or no insight into the effect he or she has on others, or how often the behavior has been a problem. If NCPHP has no documentation of specific instances of disruptive behavior, it is difficult to help. NCPHP usually does not (and generally should not) receive referrals for an isolated incident or minor instances of disruptive behavior.
- **There is a treatable condition, and/or no severe personality disorder** "Disruptive behavior" is not a psychiatric diagnosis in and of itself. The prognosis for improvement is usually best for those with a well-defined Axis I diagnosis such as depression, bipolar disorder or chemical dependence. Axis II personality disorders, such as narcissistic or obsessive-compulsive, often require long-term treatment or intervention and the prognosis varies greatly. The prognosis for improvement in those simply prone to angry outbursts ("impulse-control disorders") also varies and often depends largely on potential consequences.
- **The physician/PA is willing to take some responsibility for his or her behavior** The clinician must be willing to acknowledge that he or she is at least part of the problem. If, on the other hand, he or she is unwilling or unable to do this, no intervention is likely to be effective.
- **The referral is presented and intended as assistance, not punishment** Some physicians/PAs view a

Continues on facing page:

Traits of a "disruptor"

- Consistently curses, without clarifying that the language is not directed at co-workers
- Openly reprimands, demeans, or ignores a coworker in the presence of a patient
- Disparages care rendered by another in the presence of patient, family or colleagues
- Disparages organization to others, (or in notes on chart,) without attempt to ameliorate, correct or investigate the alleged problems
- Imposes requirements on staff that do nothing to improve care and serve only to burden staff with "special" techniques
- Shames others for negative outcomes
- Uses abusive, sarcastic or cynical language; provokes arguments
- Threatens, implying danger, retribution or litigation
- Consistently displays anger or outbursts, even after being warned
- Engages in threatening or intimidating physical contact
- Consistently reacts defensively to suggestions or interruptions

Q&A

Towards positive behavior change: A chat with John-Henry Pfifferling, PhD

John-Henry Pfifferling is an anthropologist who specializes in working with physicians and other health care professionals to address burnout, stress, communication issues and other problematic behaviors, such as disruptive conduct, that create problems in the professional medical workplace. He spoke to *Forum* editor Jean Fisher Brinkley about changing attitudes towards disruptive behavior and how his nonprofit, the Center for Professional Well-Being, works with professionals to address it.

How have attitudes towards disruptive behavior changed in the medical workplace in recent years? Hospitals and medical practices seem more willing to address this issue.

It has changed because there are more professionalism guidelines or what is called codes of conduct. There are now policies and processes to report allegedly disruptive conduct and a Joint Commission standard related to disruptive behavior, and none of that existed 10 years ago. I think the major cultural change though, anthropologically speaking, is that the "specialness" of the physician is no longer a barrier to confronting the uncivil behavior. Physicians and others at that level of power are down a notch and it's now possible to address it. At the same time, the culture that says, "Don't snitch," is still very much alive and well.

Do you routinely come in contact with staff and others who do not feel comfortable reporting disruptive behavior?

Absolutely. It's a huge barrier. When we work with allegedly disruptive physicians we try to get invited to the site and sometimes I have to beg to get people to talk to me. I just called someone in the OR and spent 20 minutes on the phone convincing her that it was confidential, that what she was sharing with me was not identifiable. She was so petrified there would be retaliation and that she was violating the group norm, which was, "Don't snitch."

How responsive is the person identified as disruptive when you speak to them for the first time?

They're often angry. Then they progress from anger to saying, "I'm not the worst. I curse once in a while, but Dr. X or Dr. Y curses all the time." We call that obsessive blame casting. I try to get through to that person and say, "We're on your team." I have to convert them to understanding that we're going to help them and that they are no longer alone.

What are some of the most important predictors of successful rehabilitation?

John-Henry Pfifferling, PhD

That the individual takes responsibility and asks for help. The second part is that the inevitable blaming ... it's the system, it's a colleague, it's the nurse, it's the EMR, it's whatever...At some point they have to transcend that and say, "What can I do?" They've got to learn the skills that are going to help them and they've got to practice them. What we do, and I think we're good at it, is saying to the person, "Yes, you've been labelled a disruptive physician, but all of it is perceptual. How do we change that perception? What can you do that makes a difference so that you're not a target anymore?"

What is the Center for Professional Well-Being's track record at helping people get better?

We're an interventional organization, not a research organization, so we don't have data. We think we're close to 90 percent. But we can't work with everyone and we sometimes "fire" people. That usually happens when someone refuses to stop the blame casting. It's always somebody else and they refuse to take responsibility. I can't afford my time or your practice's money [practices often pay for all or part of at least the initial session], if they're not willing to do that. •

EXPANDED ONLINE CONTENT

Read an extended version of the Q & A and get additional information on disruptive behavior online at *www.ncmedboard.org/newsletter*

From page 6:

referral as punitive no matter how it is presented. Nonetheless, a referral that is made in a positive, cooperative way increases the chance of a good outcome.

- **The referring entity is willing and able to impose consequences if the behavior does not change** The needs of the referral source and the physician/PA are best served if there are clear limits and consequences established and enforced regarding disruptive behavior. It's also important that expections are consistently communicated, and positive feedback is given when appropriate. •

- Routinely blames mistakes on others
- Consistently impedes effective interprofessional care and cooperation
- Appears unable to respond in socially appropriate way, after being confronted with accusations of unprofessional behavior

Source: John-Henry Pfifferling, PhD, Center for Professional Well-Being; NC Physicians Health Program

KNOW SOMEONE WHO NEEDS HELP?

Contact NCPHP, based in Raleigh, at 800-783-6792 or visit *www.ncphp.org*

Reach John-Henry Pfifferling at the Center for Professional Well-Being in Durham at 919-489-9167 or visit *www.cpwb.org*

Taking the mystery out of reporting malpractice payments

What you need to know to submit information appropriately

From the Office of the Medical Director

SCOTT G. KIRBY, MD

It's been nearly two years since the NC Medical Board implemented statutory changes that require it to collect and post certain malpractice information on its website. These changes affect a small fraction of the Board's licensees. In fact, in 2010 the NCMB received malpractice payment reports from less than one percent of the Board's total active licensee population. Just over half met criteria for posting on the NCMB's website.

It is clear, though, that the small number of licensees who have had payments remain uncertain about the obligation to report this information to the Board.

The NCMB receives telephone calls on an almost daily basis from licensees seeking guidance. Many are confused about which malpractice payments require reporting, how and when to report payments, what specific details should be reported and, finally, what information will appear on the licensee's online information page on the website. This article attempts to answer those questions.

Which payments to report

Simply stated, all malpractice payments affecting or involving a licensee must be reported to the Board. This includes payments related to care provided to patients in other states, regardless of where the patient or physician is presently located. Payments made for care provided prior to a physician's licensure in North Carolina also must be reported.

A payment must be reported to the Board regardless of whether it was reported to the National Practitioner's Data Bank (NPDB). In addition, a payment report must be made to the Board even if the licensee was dismissed from the lawsuit and the payment was made on behalf of another defendant such as a group practice, hospital or other healthcare institution. To be blunt, it is not appropriate for a licensee who is employed by a hospital, health system or other entity to fail to report a payment made in the name of his or her employer if the payment stemmed from care provided by the licensee.

Rule of thumb: If in doubt, report. Every malpractice payment report received by the Board from a North Carolina-based licensee is reviewed by NCMB staff, verified against primary sources (such as NPDB reports, or reports submitted by professional liability insurance companies) and screened to determine whether it meets criteria for posting on the NCMB's website.

Finally, although insurance companies that are licensed to do business in North Carolina are required under state law to report malpractice payments to the Board within 30 days of the payment, this duty does not relieve the licensee from his or her personal obligation to report that payment.

How/when to report a payment

It's important to understand that the NCMB collects malpractice information for two distinct and unrelated purposes. First, the Board has a duty to evaluate the care associated with each payment and make a determination if care met accepted and prevailing standards. Second, the Board is obligated to comply with state law, which makes certain information regarding malpractice payments public and sets criteria for posting that information on the NCMB's website.

If a payment meets criteria for posting on the Board's website, it must be reported within 60 days. Payments that are $75,000 or more and were made on or after May 1, 2008, meet posting criteria.

If the payment does not meet posting criteria, the licensee may wait to report the payment until his or her next license renewal (although certainly it may be reported at any time prior to this by going to the Board's website and clicking on "Update Licensee Info Page" from the Home Page.)

There is an important exception to these reporting criteria for any licensed physician who does not have professional liability insurance. Such a licensee must report an award or settlement to the Board within 30 days regardless of whether the award or settlement meets criteria for posting on the website.

Licensees should also be aware that a pending appeal does not alter the 60 day reporting requirement, nor does the timing, sequence or structure of the payment.

Each malpractice payment should be reported to the Board by a licensee only once. For instance, if a malpractice payment is already listed on a licensee's online renewal form it does not need to be reported again. On the other hand, if a licensee is aware of a malpractice payment (of any amount) made on his or her behalf that is not displayed on the malpractice section of the annual renewal, it should be reported.

What information should be reported

It is important to report all relevant information associated with care that resulted in a malpractice payment, regardless of whether the payment meets criteria for posting on the Board's website. This is because, as stated in the previous section, the Board collects malpractice information both for

investigative purposes and for public information purposes. A licensee should not omit details that may help inform the confidential investigation out of concern that those details will be posted on the public website.

The Board reviews the quality of care associated with every malpractice payment affecting or involving licensees with a North Carolina address. After reviewing the quality of care associated with a payment, the Board may take public action if it determines patient care was below accepted and prevailing standards. If the malpractice payment results in public Board action, that action will be posted, regardless of whether the payment itself meets criteria for posting on the website.

In 2010, 161 payments, or 54 percent of the total number of payments reported, met criteria for posting on the NCMB's website. Malpractice information appears on the licensee's individual information page (referred to as the "Licensee Information or LI page") under the tabbed section labelled "Malpractice." The specific information that appears is set by statute.

What will appear on the LI Page

Malpractice judgments and awards, regardless of amount,

Malpractice Reporting Decision Guide

All malpractice payments made on behalf of a licensee must be reported to the Medical Board. This guide breaks down the key questions licensees must answer to determine how to correctly report a payment.

STEP 1:
Is the payment "affecting or involving" me?

The person(s) or entity in whose name the payment is made does not determine a licensee's obligation to report. Nor does the source of the payment (personal funds vs. insurance company, for example.) Ask yourself if the allegation of malpractice that led to the judgment, settlement or other payment stems from care that you provided or were directly involved in. If the answer is yes, the payment must be reported.

STEP 2:
When must the payment be reported?

The NCMB collects malpractice information for two purposes. All payments are reviewed to determine if care was substandard. In addition, payments that meet criteria set by state law must be posted on the Board's website. Payments that meet posting criteria must be reported within 60 days.

When a payment affecting or involving you is made, determine if it meets posting criteria:

A: Is the payment $75,000 or more?

YES - continue to B.

NO - the payment does not meet posting criteria. You may report the payment during your annual license renewal, or at any time before that.

B: Was the payment made on/or after May 1, 2008?

YES - report the payment to the NCMB within 60 days of the date of payment using the Licensee Information portal. Go to *www.ncmedboard.org*, click on "Update Licensee Info Page" and log in.

NO - the payment does not meet posting criteria. You may report the payment during your annual license renewal, or at any time before that.

Malpractice Reporting Examples

EXAMPLE 1

A settlement of $85,000 is made in the name of ABC Academic Medical Center related to carpal tunnel surgery performed on the wrong hand by licensee Jane Jones, MD, who is on the medical center's faculty. The date of payment is March 1, 2011.

How should this payment be reported?

Is the payment "affecting or involving" the licensee? Yes. Although the payment was made in the name of the licensee's employer, the care that formed the basis of the allegation of malpractice was delivered by the licensee.

Is the payment $75,000 or more? Yes.

Was the payment made on or after May 1, 2008? Yes.

The payment meets statutory criteria for publication on the NCMB's website.

It must be reported to the Board within 60 days of the date of the payment, using the NCMB's online Licensee Information portal at *www.ncmedboard.org* or some other means.

EXAMPLE 2

A settlement of $45,000 is made in the name of licensee Sam Smith, MD, related to an allegation of delay in diagnosis of skin cancer. The date of the payment is January 11, 2011.

How should this payment be reported?

Is the payment $75,000 or more? No.

Was the payment made on or after May 1, 2008? Yes.

The payment does not meet statutory criteria for publication on the NCMB's website.

However, since all malpractice payments must be reported to the Board, the licensee must report the payment. He may report the payment when completing his annual license renewal or, alternatively, he may report the payment via the Licensee Information portal.

and settlements of $75,000 or more are displayed for seven years from the date of payment. A settlement is defined as an out of court agreement that resolves a claim of malpractice. A judgment or award follows a judicial decision or jury trial. A settlement of $75,000 or more is posted regardless of whether payment is made in a lump sum or in a series of payments (related to a single incident of alleged malpractice). In the context of this article, "payment" includes any payment that is made as a formal resolution to a claim of medical negligence or substandard care and includes judgments, awards, settlements or any other malpractice payment regardless of whether the payment is made from personal funds, by a third party on behalf of the licensee or from any other source.

A malpractice entry on the LI page includes the date of payment, the licensee's specialty or area of practice, the city, state, and country in which the incident occurred and the date of the incident. The amount of the payment is not posted, nor is any information that might identify the patient, other practitioners or institutions involved in care. The licensee is permitted to submit a brief statement explaining the circumstances that led to the payment and whether the case is under appeal. Explanatory statements are displayed with the payment information as long as they conform to the ethics of the medical profession and do not contain information that discloses the amount of the payment or that would reveal the identity of the patient or any other health care professional. Appropriate explanations of the licensee's involvement in the case are permitted; attempts to shift blame onto other practitioners or institutions are not.

In addition, the Board posts a statement that encourages the public to consider malpractice payment information in context and in combination with other information about the licensee's education, training and professional experience. The website also states that a payment does not necessarily indicate that negligence has occurred, serve as evidence that care was substandard or constitute proof of incompetence, misconduct or an admission of wrongdoing on the part of the licensee. The public is advised that some licensees may have a higher than average incidence of payments due to their areas of practice, and is also informed that insurance carriers often settle cases without a finding of fault or admission of negligence by the licensee.

Conclusion

The Board recognizes the inherent complexity in properly reporting malpractice payments. Physicians and physician assistants are encouraged to communicate with their attorneys, their malpractice insurance companies or with NCMB staff when reporting a payment. Or, feel free to contact me directly. I am available by telephone at (919) 326-1109 x 247 or via email at *scott.kirby@ncmedboard.org* •

PAs and NPs may now sign death certificates

Effective October 1, physician assistants and nurse practitioners may legally complete death certificates.

Amendments to state law (NCGS 90-18.1) require that PAs and NPs be specifically authorized to complete death certificates by the supervising physician under the terms of the supervisory arrangement or collaborative practice agreement. As with any other delegated tasks, the supervising physician is ultimately responsible for ensuring that death certificates are properly filled out and filed.

Authorizing PAs and NPs to complete death certificates —the law previously named physicians as the lone type of clinician who could complete these important documents— could help reduce delays in getting completed certificates to the decedent's family. Lack of a completed death certificate can hold up funeral arrangements, estate proceedings and other legal matters.

Death certificates: Some basics

Death certificates must be completed and filed no more than three days after the patient's death. The certificate must state the cause of death in definite and precise terms. It is vital to distinguish between the underlying cause of death (which is required to be listed) and the mode of death (which should not be listed.) For example, "Cardiac or Respiratory Arrest" is not a legitimate cause of death, but "Acute Exacerbation of Chronic Obstructive Airway Disease" or "Chronic Bronchitis" is appropriate. Multiple causes should be listed in order of priority, with as much specificity as possible.

Clinicians may not decline to sign a certificate because they are uncertain of all causes of death. Clinicians are merely expected to exercise their best clinical judgment under the circumstances when assigning cause of death.

Deaths should be referred to the medical examiner's office only in extremely limited circumstances. For example, cases where it is more likely than not that a fatal injury, drugs or foul play was involved are appropriate referrals. Likewise, deaths involving patients less than fifty years of age without negative medical history should also be referred. Deaths should never be referred to the medical examiner's office because a clinician involved in a patient's care is not comfortable attributing a cause of death or believes it is another clinician's responsibility to complete the death certificate.

Detailed guidance on properly filling out a death certificate can be found in the Centers for Disease Control's, "The Physician's Handbook of Medical Certification of Death," available at *www.cdc.gov/nchs/data/misc/hb_cod.pdf*

Officers chosen to lead Medical Board in 2012

The NC Medical Board has seated its Board officers for the coming year. Ralph C. Loomis, MD, of Asheville, NC, will serve as president; William A. Walker, MD, of Charlotte will serve as president elect and Karen Gerancher, MD, of Winston-Salem will act as secretary/treasurer. Terms run from November 1, 2011-October 31, 2012.

Ralph C. Loomis, MD, President

Dr. Loomis took his undergraduate degree, cum laude, at Vanderbilt University, and his MD degree from Indiana University. He did his internship at Indiana and his residency in neurosurgery at the same institution. He also took the Theodore Gildred Microsurgical Course and was coauthor of an article in the Annals of Surgery.

Dr. Loomis

Dr. Loomis is certified by the American Board of Neurological Surgery and is a fellow of the American College of Surgeons. He represents the neurosurgery section of Mission Hospitals in the level II trauma section of the western region of North Carolina and is past chief of surgery for Mission Hospitals.

Dr. Loomis has served on the Reentry, Executive, Best Practices and Complaint/Malpractice committees and on the CPP Joint Subcommittee. He was chair of the Licensing, Disciplinary and Joint Pharmacy/Medical Board committees. He also served as the Board's treasurer and secretary. Dr. Loomis was appointed to serve on the Bylaws Committee of the Federation of State Medical Boards from 2007-2010 and became chair of the committee for 2010-2011.

He practices at the Carolina Spine and Neurosurgery Center in Asheville, NC.

William A. Walker, MD, President Elect

William A. Walker, MD, earned his BA in chemistry and psychology and his MD from the University of North Carolina, Chapel Hill. He completed his internship and residency training in general surgery at the University of Michigan in Ann Arbor. He also completed a fellowship in colon and rectal surgery at the University of Minnesota in Minneapolis.

Dr. Walker

Throughout his career, he served in a number of administrative and professional positions. He currently serves on the North Carolina Medical Society's Quality of Care and Performance Improvement Committee. He is immediate past chief of staff at Presbyterian Hospital, in Charlotte, and president of Charlotte Colon and Rectal Surgery Associates. In 2009-2011, Dr. Walker served on the Editorial Committee of the Federation of State Medical Boards, and now serves on the FSMB's Audit Committee.

Dr. Walker is a fellow of the American College of Surgeons and the American Society of Colon and Rectal Surgeons. He has coauthored numerous publications and given presentations across the United States.

Dr. Walker was appointed to the Board in 2007. He chairs the Disciplinary Committee and serves on the Executive and Allied Health Committees.

Karen Gerancher, MD, Secretary/Treasurer

Karen Gerancher, MD, graduated from Florida State University summa cum laude, earning a BS in biology. After studying Art and Italian language in Florence, Italy, she earned a graduate certificate, masters in biology/genetics from the University of Birmingham, United Kingdom, and her MD from the University of Florida College of Medicine. She completed her residency training in obstetrics and gynecology at Bowman Gray School of Medicine in Winston-Salem, NC.

Dr. Gerancher

Dr. Gerancher currently serves as medical director for the Forsyth County Health Department's Family Planning Clinic. She is assistant professor, section head of gynecology and residency program director for the Department of Obstetrics and Gynecology at Wake Forest University School of Medicine.

Dr. Gerancher is a fellow of the American College of Obstetricians and Gynecologists. She also participates in the Committee for Improvement of OB/GYN Patient Care in the Emergency Department at Forsyth Medical Center.

Dr. Gerancher is board certified by the American Board of Obstetrics and Gynecology and is active in the maintenance of certification process. She was appointed to the NCMB in 2010 and serves on the Disciplinary and Licensing Committees.

North Carolina Medical Board

Adverse Actions Report | May - July 2011

The Board actions listed below are published in an abbreviated format. The report does not include non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. Recent Board actions are also available at *www.ncmedboard.org*. Go to "Professional Resources" to view current disciplinary data or to sign up to receive notification when new actions are posted via the RSS Feed subscription service.

Name/license#/location	Date of action	Cause of action	Board action
ANNULMENTS			
[NONE]			
SUMMARY SUSPENSIONS			
[NONE]			
REVOCATIONS			
STOWELL, Steven Douglas, MD (009701607) Cranberry Township, PA	06/16/2011	MD was convicted of a felony: Commonwealth of Pennsylvania v. Steven Douglas Stowell, M.D., case number, CR-181-08	Entry of revocation
SUSPENSIONS			
ALEXANDER, Joe McKnitt, MD (000033605) Fayetteville, NC	05/26/2011	MD inappropriately authorized more than 100 prescriptions for patients who, in most circumstances, he had not met or examined. MD wrote the prescriptions as part of an agreement to help another MD, whose license had been indefinitely suspended due to inappropriate prescribing, continue to see patients	MD's medical license is indefinitely suspended, effective 06/30/2011
GILLIAM, Linda Harris, MD (200300982) Jonesboro, AR	05/03/2011	History of narcotic abuse; MD improperly prescribed controlled substances to patients. AK medical board summarily suspended MD's license and later stayed a revocation on conditions	Indefinite suspension of NC medical license
GREIMEL, Deborah White, MD (009701378) Greenville, NC	07/28/2011	History of substance abuse/dependence; MD acknowledged in 02/2011 that she relapsed and used a substance prohibited by her NCPHP contract	Indefinite suspension of NC medical license
HEATH, Jerry Anderson, PA (000100336) Hays, NC	06/16/2011	Care provided to five patients whose records were reviewed by the Board was substandard; PA committed a boundary violation with a patient he was treating for behavioral health issues	Indefinite suspension of NC physician assistant license
LONG, Scott David, PA (00103319) Madison, NC	05/06/2011	PA obtained controlled substances for personal use by writing prescriptions in the names of others and diverting the medications for himself	Indefinite suspension of NC physician assistant license
WISE, Daniel Edwin, MD (000017813) Charlotte, NC	07/28/2011	MD inappropriately prescribed controlled substances to his NP whom he supervised and engaged in an intimate personal relationship with. When questioned by the Board about his relationship with the NP, MD provided false information. MD entered into a consent order in 4/2010, wherein he was reprimanded for prescribing inappropriately. MD's deception prevented the Board from fully evaluating his conduct	Via consent order, MD's license is suspended for 30 days beginning August 1, 2011. He is fined $10,000
PROBATIONS			
[NONE]			
REPRIMANDS			
ANDERSON, Alton Ray, MD (000024334) Wilson, NC	06/27/2011	Deficiencies in record keeping, prescribing and quality of care, based on a review of six patient medical charts	Via consent order, MD is reprimanded. Must complete CME and obtain a practice monitor approved by the Board to complete chart review on 75% of patient charts
BARBER, James Bernard, MD (000036626) Durham, NC	05/04/2011	MD prescribed controlled substances to at least four patients for a variety of reasons; in some instances, care was below accepted and prevailing standards	Via consent order, MD is reprimanded. License is limited/restricted to preforming disability determinations for the NC Disability Determination Services

Name/license#/location	Date of action	Cause of action	Board action
BONNER, Steven Paul, MD (00028004) Charlotte, NC	06/03/2011	The Board reviewed medical records of four patients treated by MD for a variety of complaints,. An independent expert reviewer found that MD's prescribing and other aspects of care fell below accepted and prevailing standards.	Via consent order, MD is reprimanded. License is limited/ restricted. May not prescribe controlled substances in Schedules II/III. Must complete CME
CALDWELL, Chad Dewey, MD (200100652) Oxford, NC	07/07/2011	MD was unavailable to perform a corrective surgery in a patient who suffered complications following laparotomy with resection of a portion of the small bowel and lysis of adhesions. A lawsuit filed against MD alleged his unavailability led to a delay in performing the second surgery, resulting in prolonged recovery	Via consent order, MD is reprimanded.
DENIALS OF LICENSE/APPROVAL			
FREEMAN, William James, MD (NA) Tullahoma, TN	07/07/2011		Application for NC medical license denied
GUALTEROS, Oscar Mauricio, MD (009900236) Southern Pines, NC	05/19/2011	Prior history of inappropriate contact with patients; Prior NCMB disciplinary history	Application for reinstatement of NC medical license denied
PARIKH, Himanshu Pravinchandra, MD (009600671) Cary, NC	06/03/2011	Board reviewed allegations that MD asked patients to bring pill bottles to his office after filling prescriptions for opioid medications, then diverted the drugs. Ordered to NCPHP for an assessment, and asked to provide a urine sample. It was later determined that the sample provided was likely water. MD denied substituting water. A valid urine and hair sample tested positive for oxycodone. MD was not being prescribed oxycodone and denied taking the drug. Later admitted to inappropriately taking oxycodone	Application for reinstatement of NC medical license denied
SINTHUSEK, Hatai Jan, MD (NA) Tucson, AZ	06/03/2011	Between 08/06 and 09/09, MD worked and practiced medicine without a NC medical license at a medical practice in Winston-Salem owned by a relative. MD also failed to disclose that he was placed on academic probation during medical school in 1996	Denial of application for NC medical license
SURRENDERS			
HART, Darlington Ibifubara, MD (009800560) Charlotte, NC	06/01/2011		Voluntary surrender of NC medical license
JAMES, James Franklin, MD (000015359) Greenville, NC	07/19/2011		Voluntary surrender of NC medical license
JOHNSON, Janet, MD (000034366) Raleigh, NC	05/12/2011		Voluntary surrender of NC medical license
MCDONALD, Janice Adelaide, MD (200101474) Elizabeth City, NC	06/21/2011		Voluntary surrender of NC medical license
RUSSELL, Anthony Otis, MD (000035491) Elkin, NC	06/22/2011		Voluntary surrender of NC medical license
PUBLIC LETTER OF CONCERN			
ALTER, Lauren Jill, MD (200901875) Hamlet, NC	05/25/2011	The Board is concerned that MD issued numerous prescriptions to herself, and without appropriate documentation, from 2006 to 2010. On two occasions, MD wrote prescriptions for personal use in someone else's name	Public letter of concern
COOMBE, Courtney Fickle, NP (5004130) Mooresville, NC	06/28/2011	While involved in an improper relationship with her supervising physician, NP received prescriptions from him that were called into the pharmacy under the names of other physicians with whom NP did not have a physician-patient relationship	Public letter of concern; must complete NC Board of Nursing CME in ethical and legal decision making.
DUBIK, Michael Carlyle, MD (000029984) Norfolk, VA	07/07/2011	The Board is concerned that, according to a consent order dated 08/19/10 with the Virginia Board of Medicine, MD wrote four prescriptions for a total of 360 dosage units of Mirapex in the name of a family member, which he then diverted for personal use	Public letter of concern
FINK, Gary Lee, MD (000028409) Faith, NC	07/19/2011	MD prescribed controlled substances to friends and family. In one instance, MD called in prescriptions and personally picked up the medication and delivered it to the patient	Public letter of concern. MD is required to attend a Category 1 CME course on maintaining proper boundaries with patients

Name/license#/location	Date of action	Cause of action	Board action
GYARTENG-DAKWA, Kwadwo, MD (200500050) Durham, NC	06/01/2011	MD's care of a patient with a history of chronic pain due to fibromyalgia/reflex sympathetic dystrophy was below accepted standards. The patient died of methadone toxicity two days after MD prescribed 30 mg of methadone three times a day. The patient's most recent prescription was 20 mg of methadone once a day	Public letter of concern
HALL, Gregory Bruno, MD (009600335) Mooresville, NC	07/22/2011	MD performed an elective laparoscopic Nissen fundoplication on a patient, during which the patient suffered a bile duct injury that led to complications and rehospitalization. MD performed an elective incisional herniorrhaphy in a patient who developed post-operative infection. MD failed to properly identify the etiology of the post-operative infection and this caused the patient to experience recurrent infection and rehospitalization	Non-disciplinary consent order to serve as a public letter of concern
HAYNES, Gregory Delano, MD (200800455) Lenoir, NC	05/02/2011	On two separate occasions, MD's attempts to perform screening colonoscopies resulted in patients suffering bowel perforations	Public letter of concern; MD required to obtain appropriate CME
HENDRICKS, Jonathan Cleon, PA-C (001002871) Fort Myers, FL	07/18/2011	While practicing in Florida, PA made an incision for the insertion of a chest tube on the incorrect side. The Florida Department of Health issued a Letter of Concern, $8,000 fine, required PA to pay $2,664 in administrative costs, ordered him to complete 70 hours of community service, five hours of continuing education and present a one hour lecture/seminar on wrong site surgeries	Public letter of concern
KERNER, Paul Jason, MD (200800627) Durham, NC	07/14/2011	MD performed an ankle stabilization procedure on the left ankle of a patient when he was, in fact, to perform the operation on the patient's right ankle. The right ankle was identified and marked; however, the wrong leg was subsequently draped, resulting in the wrong-side surgery	Public letter of concern
LOCKLEAR, Kenneth Edward, MD (000024605) Red Springs, NC	05/26/2011	MD's care of a patient with recurrent bilateral lower extremity cellulitis and secondary lethargy, bilateral basilar infiltrates, acute or chronic renal failure, anemia, narcolepsy and obstructive sleep apnea and thrombocytopenia was below accepted standards of care	Public letter of concern
MALLETTE, Julius Quintin, MD (000028261) Kinston, NC	05/06/2011	MD's recognition of a deteriorating fetal heart rate pattern was delayed during the course of his management of a patient's labor	Public letter of concern; MD must complete 10 hours of CME in interpretation of fetal monitoring
PONTZER, John Tucker Hayward, MD (200000936) North Wilkesboro	07/06/2011	Regarding MD's management of a patient who was ultimately diagnosed with Rocky Mountain Spotted Fever. The Board is concerned that a different interpretation of laboratory results and patient symptoms by MD may have led to a more timely diagnosis and treatment of progressive illness. The patient died 11 days after initially presenting in 06/08	Public letter of concern
SLAWEK, David Francis, MD (000017902) Hendersonville, NC	05/06/2011	The Board is concerned that MD accessed private and protected health information without a legitimate medical purpose; it is further concerned that MD prescribed a controlled substance to a patient's mother without an examination or medical records	Public letter of concern
TAMBAKIS-ODOM, C. Roseann, MD (200201414) Wilmington, NC	06/01/2011	MD aided and abetted the unlicensed practice of medicine through her involvement with two tattoo parlors that perform laser tattoo removal and are not owned by licensees of the Board. The Board considers laser tattoo removal to be the practice of medicine and medical practices in NC must be owned by licensees of the Board	Public letter of concern
WATTS, Lawrence James, MD (009701194) Clinton, NC	07/06/2011	Over an 18-month period, MD prescribed, treated and ordered tests for family for a variety of health conditions that were neither minor nor emergencies	Public letter of concern

Name/license#/location	Date of action	Cause of action	Board action
MISCELLANEOUS ACTIONS			
VANPALA, Henry Joseph, MD (000028586) Greenville, NC	05/25/2011	MD pleaded guilty to illegally prescribing controlled substances in 1986; Also in 1986, MD pleaded guilty to larceny and conspiracy for his involvement in a stolen car ring. MD surrendered his NC medical license in January 1986. He has been evaluated by CPEP and has addressed and completed all issues identified. MD has passed certification exam of the American Board of Internal Medicine	Via consent order, MD is issued a resident training license for the purpose of completing a 12-month mini-residency at East Carolina University, Department of Internal Medicine; the Board is under no obligation to approve a full license
REZAI, Reza, MD (200701238) Jamestown, NC	03/25/2011	History of substance abuse.	MD is issued an NC medical license via consent order; must maintain contract with NCPHP and comply with conditions.
CONSENT ORDERS AMENDED			
[NONE]			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
ADKINS, Paula Clark, MD (009900745) Pinehurst, NC	05/19/2011	History of addiction to hydrocodone; MD has successfully completed treatment and is in compliance with NCPHP contract	Temporary physician license extended; expires 09/30/2011
BOOK, Roy Dewayne, MD (009701700) Greensboro, NC	05/19/2011	History of alcohol abuse; MD has completed inpatient treatment and is in compliance with NCPHP contract	Via consent order, MD is issued a temporary medical license to expire 11/21/2011; he must complete a program of reentry under the mentorship of a preceptor approved by the NCMB
BOOK, Roy Dewayne, MD (009701700) Greensboro, NC	07/21/2011	History of alcohol abuse; MD has completed inpatient treatment and is in compliance with NCPHP contract	Temporary license extended; Expires January 31, 2012
CALDWELL, Chad Cameron, PA-C (200103163) Winston-Salem, NC	06/07/2011	History of alcohol dependence; PA is compliant with NCPHP contract	Via consent order, PA is issued a temporary license to expire October 7, 2011; Must maintain a contract with NCPHP
GUARINO, Clinton Toms Andrew, MD (009900062) Hickory, NC	05/20/2011	History of alcohol/substance abuse	Temporary physician license extended; expires 11/30/2011
JAMES, James Franklin, MD (000015359) Greenville, NC	05/19/2011	History of diverting benzodiazepines and sleep medications prescribed for family members and patients; MD has completed appropriate treatment and is in compliance with NCPHP contract	Temporary physician license extended; expires 11/30/2011
LAND, Phillip Barton, PA (000102750) Winston-Salem, NC	05/19/2011	History of opiate dependence; prior arrest for 'going armed in the terror of the public'; PA must maintain NCPHP contract	Temporary physician assistant license replaced with full license
NOWLAN, Ashley Elizabeth, PA (001001770) High Point, NC	05/19/2011	History of chemical dependence; PA has completed treatment and is compliant with NCPHP contract	Temporary physician assistant license extended; expires 11/30/2011
SESSOMS, Rodney Kevin, MD (000033927) Clinton, NC	07/21/2011	MD has addressed multiple areas of concern	Temporary physician license replaced with full license
STROTHER, Eric Furman, MD (009901620) Durham, NC	05/19/2011	History of chemical dependence; MD is in recovery and is in compliance with NCPHP contract	Temporary physician license replaced with full license
SHUMWAY, David Lucius, MD (000021310) Knoxville, TN	07/21/2011	History of alcohol abuse	Temporary license extended; Expires July 31, 2012
WILKINSON, Heather Lee, DO (200400777) Charlotte, NC	05/02/2011	History of narcotic dependence	Dated physician license issued; expires 11/02/2011
COURT APPEALS/STAYS			
[NONE]			
DISMISSALS			
[NONE]			

North Carolina Medical Board
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EXAMINATIONS

Residents Please Note USMLE Information

United States Medical Licensing Examination
Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at *www.fsmb.org*.

Special Purpose Examination (SPEX)
The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

BOARD MEETING DATES

November 16-19, 2011 (Full Board)
December 8-9, 2011 (Hearings)
January 18-20, 2012 (Full Board)
February 16-17, 2012 (Hearings)

Meeting agendas, minutes and a full list of meeting dates can be found on the Board's website
ncmedboard.org

Visit the Board's website at *www.ncmedboard.org* to change your address online. The Board requests all licensees maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 30 days of a move.

Fines, discipline possible for some CME cases

The Board has noticed an increase in the number of licensees who fail to respond in a timely manner when notified that they are not in compliance with North Carolina Continuing Medical Education (CME) requirements. The NCMB has a statutory obligation to enforce the law and rules related to CME, which require physicians to earn a total of 150 hours over a three year period.

The Board is considering new procedures for addressing cases in which the licensee who is out of compliance with CME requirements fails to resolve the issue within 120 days. The Board has discussed referring most of such cases to the Board's Investigations Department, which would open a case and work with the Board's Legal Department to prosecute CME deficiencies. The proposed system contemplates executing fines, as well as both private and public actions, in CME deficiency cases, depending on aggravating and/or mitigating factors that may be present.

It should be noted that the vast majority of licensees comply with CME requirements, and the Board appreciates the professionalism of these licensees. When licensees are found to have completed less than the minimum required number of hours, the Board's preference is to allow them to come into compliance. This is not always possible, however.

Do we know how to reach you?

Licensees are required to keep a current mailing address on file with the NCMB. Is your information up to date? Please ensure that the Board has your current contact information and mailing address. This is the best way to ensure that you receive important communications from the NCMB, including notifications of CME deficiency.

Thank You!

The NCMB received a tremendous response to its call for independent expert medical reviewers, which appeared in this space in the last issue of the *Forum*. The Board received inquiries from licensees in many different specialties and subspecialties. Thanks to those who expressed interest in providing this invaluable service.