CASE STUDY #1

A 30-year-old male DO working in an adult internal medicine practice sees a female patient in her late 20s for complaints of upper respiratory illness with persistent cough. During the patient encounter DO and patient establish that they attended the same university at around the same time.

Patient examination is completed, a diagnosis of bronchitis is established, and a treatment plan is made.

A few days after the patient visit, DO is browsing Facebook and notes that patient is among a college friend's Facebook friends. DO messages the patient, asking how she is feeling. The patient replies: "Better. Do you follow up like this with all your patients?" DO acknowledges that it is not a typical practice and adds that he "really enjoyed meeting" the patient and wondered if she'd "like to get a drink some time. I felt a connection and thought maybe you did too."

Patient replies that she does not think meeting socially is a good idea. She later submits a complaint to the medical board, reporting the incident. In her complaint statement, patient reveals that she was uncomfortable during the physical examination DO conducted. Patient indicates that during the physical examination DO lifted the back of her shirt, exposing part of her bra, in order to place the stethoscope to listen to her lungs. Before dropping the patient's shirt, DO commented, "You have excellent muscle tone. You must work out!" Patient wrote in her complaint statement that she felt at the time that this behavior was inappropriately flirtatious but indicated that she did not say anything during the office visit because she felt it wasn't "egregious" and that she could "let it go." Patient wrote that DO's conduct during the examination seemed more significant after DO contacted her for a date.

Additional information about the case:

- DO has had one prior Board complaint regarding inappropriate conduct/comments during a physical examination of a female patient. Case was resolved with no formal action (accept as information with comments) but DO was advised to familiarize himself with the NCMB position statement "*Avoiding misunderstandings during physical examinations*". DO did NOT contact patient or ask to see patient socially.
- When asked by a Board investigator to explain conduct in the most recent case, DO acknowledged that he "sometimes forgets" to maintain boundaries when treating a female patient who is close to his own age, especially when there is "rapport and easy conversation".
- DO told Board investigator that he did read the Board position statement on avoiding misunderstandings during examinations and usually "does a better job" of maintaining appropriate boundaries.

Questions:

- What aspects of conduct or care are concerning?
- What are some possible grounds for discipline for the Board to take action, if any? (refer to disciplinary terms glossary)
- Is conduct serious enough to warrant Board Action? Private action (remediation) or public action (discipline)?

Case Study #2

MD is a 28-year-old third-year psychiatry resident with a history of anxiety and depression, which she has managed with medication and healthy lifestyle since her teens. Although MD's mental health has been stable for several years, the increased intensity of her practice since the onset of the COVID-19 pandemic has taken a toll. Due to a significant increase in demand for psychiatric consults, MD has been working long and irregular hours, disrupting her meals, social life, and regular exercise schedule. Work demands even caused MD to cancel her most recent appointment with her psychiatrist, with whom she typically meets at least twice a year. MD's fellow residents and other members of the clinical team have noticed that, while MD is known for her compassion and dedication to patients, lately she has seemed rushed, irritable, and less approachable. MD has started to worry that she may not have what it takes to practice medicine.

MD is called to evaluate a 17-year-old female who presents with a long-standing history of eating disorder, depression, and anxiety. The patient presents to the emergency room accompanied by her mother. The patient expresses recent acceleration of her eating disorder symptoms; she is experiencing weight loss, fatigue, mental fog, and moodiness. She is falling behind in school and her anxiety has become overwhelming. The mother reports that her daughter has told her that, in her darkest moments, she has wondered if death is a way out. This case represents the 5th admission for MD, who is on the tail end of a 24-hour shift. She has slept little and has had snacks between admissions but no meal and very little to drink. MD is sympathetic to the young patient, finding it challenging to maintain a therapeutic distance due to similarities with her personal narrative.

MD withdraws to a nearby workspace to prepare her notes and orders for admission when she hears a code being called for the cubicle where the patient is waiting. The ER response team finds the patient in cardiac arrest and begins resuscitation. The team questions the mother about medications in the home; the mother notes she takes blood pressure medication and uses potassium supplements. The patient requires resuscitation, stabilization, and transfer to the intensive care unit. MD feels responsible for the events and struggles to complete her shift. She does so and returns home where she is alone. She experiences overwhelming sadness.

A few weeks later, MD receives an email from the state medical board notifying her that the mother of the 17-year-old has filed a complaint against her, alleging that MD was negligent in failing to ask about possible ingestion of medications. MD prepares a forthright written response to the complaint, in which she acknowledges to the Board her history of anxiety and depression and her recent struggles with overwork, lack of sleep and declining mental health. MD explains in her response that it was clear the patient needed to be admitted and notes that, in her determination to complete the necessary paperwork before the end of her shift, she may have abbreviated the rest of her examination. MD indicates that, since the near tragedy with the young patient occurred, she has experienced panic attacks after replaying the incident in her mind.

Additional details about the case:

- MD has no prior history of complaints or regulatory actions with the state medical board or any other jurisdiction
- MD self-reported the incident with the young patient to her Residency Program Director. The program has expressed its unequivocal support for MD, who they consider an excellent clinician and an asset to the department. MD has indicated a desire to take a medical leave to address mental health issues, but is concerned about losing her place with the training program, as well as possible adverse effects on her medical licensure.

Questions:

- What aspects of conduct or care are concerning?
- Are issues with conduct or care serious enough to warrant Board Action? Private action (remediation) or public action (discipline)?
- What aspect of this case should take precedence – addressing the MD's depression or executing remediation/discipline for any issues with care?
- What are some potential challenges or barriers to MD getting appropriate treatment?

CASE STUDY #3

DO has 30 years of experience as a family medicine physician. Over the years DO's practice has become centered on the treatment of chronic pain. DO comes to the Medical Board's attention through multiple complaints from former patients, family members of patients and from local pharmacists expressing concern that DO excessively prescribes opioids for pain. The Board obtained the records of five chronic pain patients as part of its investigation.

Initial review of the cases by the Board's medical officers notes the following:

- Chronic pain patients are treated almost exclusively with high-dose opioid therapy and there is no documentation that non-opioid treatments were attempted or even discussed.
- Overall, medical record documentation is poor. Clinic notes are identical for multiple visits, suggesting that DO may be in the habit of cloning notes rather than developing notes for each visit.
- Opioid treatment for chronic pain is extended for conditions that are not routinely treated with opiates and diagnoses are poorly documented or not supported by objective evidence (e.g. based largely on self-reported patient history).
- DO does not display appropriate pharmacovigilance. Specifically, DO does not regularly check the NC Controlled Substances Reporting System (NC CSRS) to monitor prescription history. In addition, although DO does require patients to submit to regular urine drug screening, DO does not follow up on failed drug screens or impose consequences outlined in pain contracts.

Additional details about the case:

- An independent expert reviewer who reviewed all five of the cases included in the Board's investigation determined that overall care was below accepted standards in all cases.
- DO has one previous case from three years prior related to inappropriate opioid prescribing, which was initiated by a complaint from a concerned spouse who believed his wife was being prescribed excessive amounts of pain medication. The case resulted in a private letter of concern requesting that DO complete continuing medical education in medical recordkeeping as well as controlled substances prescribing, which was completed.

Questions:

- What aspects of conduct or care are concerning?
- What are some possible grounds for discipline for the Board to take action, if any? (refer to disciplinary terms glossary)
- Is conduct serious enough to warrant Board Action? Private action (remediation) or public action (discipline)?

CASE STUDY #4

The Board receives a complaint from a pharmacist about a 43-year-old MD who, the pharmacist reports, prescribed tramadol, a Schedule IV controlled substance to himself, a violation of NC administrative rules that specifically prohibit the prescribing of controlled substances to oneself. A check of MD's NC Controlled Substances Reporting System (NC CSRS) prescribing history reveals that MD wrote a prescription for hydrocodone cough syrup, a Schedule II controlled substance, to his spouse approximately six months ago. Prescribing controlled substances to a spouse or other immediate family member is also specifically prohibited by administrative rule.

In his written response to the medical board, MD explained that his orthopedic surgeon wrote him a prescription for Tramadol to treat ongoing pain from a recent shoulder surgery. When MD went to pick up the prescription, which was e-prescribed to his regular pharmacy, he was told that it had not been filled because the medication was not in stock. Rather than contact the surgeon to ask him to cancel the script and write a new one to a different pharmacy – a process MD indicated he feared could take 48 hours or more – MD instead chose issue a new prescription for himself to a different pharmacy. Although the medication was dispensed, a pharmacist later noted that the prescriber and patient were the same person, which led the pharmacist to file a complaint with the medical board.

In responding to the medical board about the hydrocodone syrup prescribed to his spouse, MD explained that he and his wife were visiting family in another city, about a two-hour drive from the couple's regular doctor, when the wife developed an upper respiratory illness and a severe, persistent cough that disrupted her sleep. MD indicates that, before issuing the prescription for hydrocodone syrup, he checked the medical board's position on prescribing to oneself and to family members. Although the position generally advises against such prescribing, it notes "urgent, acute medical problems" as an exception. MD said he felt his wife's illness fit this description. However, MD failed to note that the policy specifically references administrative rules that prohibit the prescribing of ANY controlled substance to oneself or to an immediate family member. When informed of this rule, MD acknowledged that he should not have written the prescription while emphasizing that, at the time, he believed he was prescribing consistent with the Board's position statement and "must have missed" the specific prohibition on controlled substances prescribing.

Additional information about the case:

- A review of MD's medical records reveals that MD did receive a medically appropriate prescription for Tramadol. Interviews with pharmacy staff confirm MD's story that he was not able to fill the prescription at his regular pharmacy due to low stock.
- MD did not create a medical record documenting an examination of his spouse or establishing a diagnosis for her.
- Additional review of MD's NC CSRS prescribing history reveals that MD prescribed controlled substances for two members of his practice's medical staff. Review of medical records reveals that, while the prescriptions appear to be medically appropriate, MD does not consistently document an appropriate patient examination prior to prescribing to the staff members. When asked to explain MD acknowledged that, out of a desire to help staff and save them the cost of a medical visit, he has prescribed more informally than he would with a scheduled patient.

Questions:

- What aspects of conduct or care are concerning?
- What are some possible grounds for discipline for the Board to take action, if any? (refer to disciplinary terms glossary)
- Is conduct serious enough to warrant Board Action? Private action (remediation) or public action (discipline)?

CASE STUDY #5

The medical board receives notification from a major academic medical center in the state that it has terminated hospital privileges for a DO obstetrical resident training at their facility. An investigation is initiated, and the board learns that the resident was suspended due to unprofessional conduct and possible HIPAA violations related to resident's sharing of information about her experiences training in OB/GYN on social media.

DO has an active TikTok account, on which she shares content related to her work in OB/GYN, often inserting her personal opinions about the behavior or appearances of patients and family members.

In one video that discusses the use of episiotomy, the resident jokes, "We explained that episiotomy can help prevent an even more painful tear, but the mom's husband still looked pretty green when the surgical scissors came out. I don't think he's going to want to go down there any time soon." In another posted video, DO talks about an obese woman's scheduled Cesarean section to deliver a 10-pound baby, commenting, "Dad is pretty big himself. What are the odds this little guy is going to develop Type II diabetes by the time he's in middle school? It's practically child abuse." In another post, DO holds up a pair of clean compression underwear provided to new mothers post-delivery, and comments, "Medicine's contribution to non-hormonal birth control. NO ONE looks good in these things!" Posts are generally made within a day or two of the clinical events that took place and resident references time frames – "last night", "two days ago", etc. This information, in combination with details on DO's TikTok profile page that identify DO as an OB/GYN resident at a specific hospital system, may make it possible for patients, their family members or others to identify the specific patients or family members referenced in DO's content.

Additional details about the case:

- No complaints from patients or family members have been received by the hospital system, the medical board or any other authority. A member of the nursing staff reported DO to the hospital after she saw the resident taking videos at work and DO acknowledged it was content for TikTok.
- DO writes in her response to the Board that she "never intended to hurt anyone" and, while acknowledging that her comments about patients and family members could be offensive or even humiliating to the individuals involved, states that she "got caught up in trying to be clever and funny".
- DO never posted identificable images or videos of patients or family members and indicates she is aware of HIPAA privacy laws.
- DO has permanently deleted her TikTok account.

Questions:

- What aspects of conduct or care are concerning?
- What are some possible grounds for discipline for the Board to take action, if any? (refer to disciplinary terms glossary)
- Is conduct serious enough to warrant Board Action? Private action (remediation) or public action (discipline)?