CASE STUDY #2

32-year-old PA practicing Emergency Medicine in a large hospital attends a dinner party at a friend's house, during which she consumes wine. On the way home, PA is pulled over by police and asked to submit to Breathalyzer testing, which registers her blood alcohol content at .115 and .130. (in NC it is unlawful to operative a vehicle when blood alcohol content is above .08). PA is arrested for DWI.

The following day, the medical board is notified of PA's arrest via a service it contracts with to monitor arrest records in the state. PA is notified by the Board that she will be investigated to determine her ability to practice safely due to her alcohol consumption and DWI. The medical board orders PA to report to the NC Professionals Health Program (NCPHP) for a substance use assessment. PA's primary supervising physician is contacted and states PA has been a strong clinician for more than eight years, hopes issues can be resolved successfully, and supports PA's need for assessment.

Assessment results are provided to the medical board. The assessment results reveal that PA tested positive for cannabinoids when drug-tested by NCPHP. This led PA to admit that the stress of practicing in the ED "gets to her" and she thought it would help her to decompress with a little (legal) recreational marijuana during a recent ski trip to Colorado during a rare week off. During the NCPHP assessment, PA described herself as a "social drinker" and acknowledged that she regularly indulges in wine to "take the edge off" after work. PA further confided that she has significant educational debt and sometimes picks up shifts at a local urgent care to supplement her income.

The NCPHP assessment diagnoses PA with alcohol use disorder. In addition, the assessment notes that PA exhibits some signs of work-related stress/burnout. PA has successfully completed inpatient treatment for alcohol use disorder. NCPHP recommends PA sign a monitoring contract and work with a wellness coach to address workload and life stressors.

Additional details about the case:

- PA has no prior regulatory history with the Board, or any other jurisdiction
- PA has no prior diagnoses of alcohol or substance use disorder

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 #3

PA works in a Family Medicine practice office with her primary supervising physician, Dr. H, with whom she has worked for more than a year with no issues. Several months ago, Dr. H asked PA to prescribe medication for her husband's attention deficit disorder because his treating psychiatrist was on vacation. PA had never examined Dr. H's husband and in fact had only met him briefly at the office Christmas party, but Dr. H indicated that she would greatly appreciate the favor. In response, PA wrote Dr. H's husband a one-month prescription for Adderall. The next month, Dr. H asked PA to refill the Adderall prescription, this time because she said the psychiatrist was out of town. PA privately wondered why the psychiatrist had not arranged coverage for emergencies and refills, but did not press Dr. H, and ended up writing the refill prescription as requested.

Shortly thereafter, Dr. H confided to PA that she had been having trouble sleeping and asked PA to write a prescription for Ambien. PA had never examined or treated Dr. H and did not ask her if she had a physician of her own. Not knowing how to object, PA reluctantly wrote a prescription for Ambien.

The following month, Dr. H again asked PA to refill her husband's prescription for Adderall because the psychiatrist was out again. PA expressed that she felt uncomfortable continuing to issue refills and told Dr. H she couldn't write her husband any more prescriptions. The supervising physician wasn't happy, but she backed off. Concerned about losing her job, and her ability to continue working productively with Dr. H, PA submitted her resignation.

The case comes to the Medical Board's attention after staff at the pharmacy Dr. H and her husband use notices that the name on the prescription PA wrote for Dr. H matched the name of PA's supervising physician, which is printed on PA's prescription pad. Pharmacy staff reported PA to the Board for inappropriate prescribing. Prescribing to a supervisor is considered a form of self-prescribing since a PA's authority to practice and prescribe is subject to the supervising physician's willingness to serve as supervisor. Prescribing controlled substances to oneself or to close family members is specifically prohibited by administrative rules. The Board also opens an investigation into Dr. H.

Additional details about the case:

- PA has no prior regulatory history with the Board, or any other jurisdiction
- PA has fully cooperated with the Board's investigation and, in her written response to the Board, expressed remorse for her actions.

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

PA is a recent graduate with 14 months of experience working for Dr. S, a family medicine physician who owns two clinics in the region. Dr. S splits his time between the two practices and uses PA and several other APPs to staff each clinic. Dr. S is the primary supervising physician for PA and all other APPs.

Although Dr. S's clinics are advertised as general family medicine practices, more than half of patients are seen for chronic pain. PA and other APPs strictly follow treatment protocols developed by Dr. S, with most patients receiving nearly identical treatment. PA comes to the Board's attention when her name appears on a data report of high-dose, high-volume opioid prescribers provided quarterly by the NC Department of Health and Human Services (NC DHHS) to identify potentially unsafe opioid prescribing. The Board obtained the records of five of PA's chronic pain patients as part of its investigation of PA.

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

- All five 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. Clinical notes are identical for multiple visits, suggesting that PA may be in the habit of cloning notes.
- PA does not display appropriate pharmacovigilance. Specifically, PA does not regularly check the NC Controlled Substances Reporting System to monitor patients' prescription histories and does not follow up on failed drug screens or impose consequences even in the face of evidence of possible diversion or abuse.
- Regular quality improvement meetings with Dr. S are documented but are conducted as group sessions with all APPs attending, rather than one-on-one meetings between each supervisee and his/her supervisor.

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.
- The Board has opened an investigation on Dr. S to evaluate his treatment of chronic pain and supervision of APPs.

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)?