FORUM
NORTH CAROLINA MEDICAL BOARD
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SPRING 2011

Pg. 10 - Year in Review:
Data from 2010

Caring for each other:
Helping health care professionals in need

The stresses on the medical professional have never been greater. There is the uncertainty of pending federal health care laws, the shifting landscape of insurance reimbursement and the confusing maze of maintenance of certification and licensure. And these don't even include what, for most of us, is a constant stressor—ensuring that our patients receive the best possible care. How many hours of sleep have each of us lost reliving an encounter with the day's most challenging patient, wondering whether our clinical decision making was sound?

To maintain balance in our lives, it is paramount that we find healthy outlets. Some of us recharge through travel, exercise, reading or hobbies (I think I have finally convinced my husband of the beneficial aspects of "shoe therapy!").

Sadly, though, some choose a path that, like Odysseus' Sirens, entices with immediate gratification while bringing them ever closer to destruction. National data suggest that the incidence of substance abuse and addictive behavior is somewhat higher among health care professionals when compared to the general population. The resulting impairment puts patients at risk for irreparable harm and endangers careers that are often a lifetime in the making.

NCMB President Janice E. Huff, MD, says "One of my goals. . .is to raise awareness of NCPHP and its services, so that any licensee who needs assistance will know that help is available, and how to get it."

We are extremely fortunate in this state to have the North Carolina Physicians Health Program (NCPHP). Originally established as a committee of the North Carolina Medical Society, it began seeing impaired physicians in December 1988. Changes to state law have since enabled physician assistants (PAs), anesthesiologist assistants (AAs) and licensed perfusionists (LPs) to receive services as well.

One of my goals as NCMB president is to raise awareness of NCPHP and its services, so that any licensee who needs assistance will know that help is available, and how to get it. Licensees who are concerned about a colleague should remember that it is the Board's position that licensees have a professional obligation to act when they suspect a colleague may be impaired or incompetent to practice. If we don't care for each other, who will? Often, NCPHP is the best way to help your friend get the help he or she needs. Referrals can even be made anonymously, if you prefer.

I have had a personal interest in NCPHP from the very beginning. In 1988, one of my colleagues developed a substance dependence problem and entered into a contract with NCPHP. This program saved his career. Today, he is a successful physician who finds tremendous satisfaction in helping others in their own recoveries.

For those of you who may be unfamiliar with NCPHP, its mission is this: To improve

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the quality of health care for the people of North Carolina through assurance of healthy medical professionals. NCPHP assesses individuals to determine abuse/addiction, assists with referrals to appropriate treatment, if needed, and monitors individuals in recovery to ensure their compliance. In addition, NCPHP is an advocate for its participants and an intermediary between participants and the NCMB. NCPHP does not provide treatment services.

A guiding principle of NCPHP is that early identification of substance abuse or dependence, coupled with appropriate intervention and treatment, is the best way to prevent harm, both to patients and to health care practitioners' careers and personal lives. Dr. Warren Pendergast, the nationally respected addiction psychiatrist who serves as NCPHP's medical director, says it best, "People have two choices: They can get help early, or they can wait until they get worse and things come crashing down around them."

Yet I suspect many physicians who are struggling with alcohol or substance abuse, or colleagues who suspect a friend or practice partner is veering out of control, fail to seek assistance early because they fear the consequences. I've heard that many licensees believe seeking help from NCPHP will result in their automatic "outing" to the NCMB and, possibly, the loss of their medical license.

This is just not the case. Most licensees who seek assistance early—for example, before they have had an arrest for DUI or a loss of hospital privileges that would make both their identity and their substance problem known to the NCMB—are able to participate in NCPHP on a confidential basis. The Board does not know the names of all participants, and affords licensees with alcohol/substance abuse problems or other health issues the opportunity to remain anonymous at license renewal, provided they are participants in good standing with NCPHP.

There are some important exceptions. Under state law, no one who is determined to be an imminent danger to the public or to him- or herself can participate in NCPHP anonymously. In addition, individuals under contract with NCPHP who refuse to fully cooperate with that organization, who refuse treatment when treatment is needed, who remain impaired after treatment or who demonstrate professional incompetence cannot remain unknown to the medical board. And while this article deals principally with licensees with substance/alcohol issues, no one who is referred to NCPHP for professional sexual misconduct may remain anonymous. It's also important to recognize that NCPHP deals with an array of issues beyond alcohol and substance abuse, including stress, depression and behavioral difficulties such as disruptive behavior. Licensees may seek help for these issues while remaining anonymous to the NCMB, as well.

Virtually all of the individuals whose identities are unknown to the NCMB at the time of initial referral to NCPHP are able to remain anonymous as they proceed with assessment, treatment and recovery. NCPHP requires health care practitioners who are unsafe to practice to sign binding non-practice agreements, which they must comply with in order to remain anonymous to the NCMB.

The NCMB also deals with a significant population of licensees whose alcohol and substance abuse problems are well known to the Board. Often, these practitioners have experienced an adverse event, such as an arrest, termination of employment or privileging action that brought them to Board attention. The vast majority of these licensees are referred to NCPHP as part of remediation ordered by the NCMB and, thus, cannot be anonymous to the Board.

Through my role on the NCMB, I have seen NCPHP in action and I truly believe it is one of the greatest assets North Carolina has to help health care professionals in need.

I have been on the NCPHP Board of Directors for the past three years and currently serve as its Chair. In addition, for the past three years I have been a member of the NCPHP's Compliance Committee, which is composed of three members of the NCMB, including a public member of the Board, as well as other physicians and PAs. The Compliance Committee discusses all new NCPHP participants, including new anonymous NCMB licensees, as well as all current participants who are struggling. The committee then makes recommendations to the NCMB, including whether it is necessary to make an anonymous licensee known to the medical board. The decision to break anonymity is never made lightly and

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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.

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is made infrequently, for noncompliance issues that have the potential to threaten a participant's recovery, and thereby, patient safety. In some cases, breaking anonymity can serve as the clarion call that focuses the licensee's attention on taking the necessary steps to get better, helping their recovery process in the long run.

There is objective evidence to support that North Carolina's approach is working. A chart review of NCPHP participants seen for substance impairment during the years 1995-2000 concluded that 91 percent of physicians and 59 percent of physician assistants had a good outcome. These results meet or exceed national standards for similar monitoring programs, according to a 2005 article in the *Journal of Addictive Diseases*.

It has been my personal experience that the overwhelming majority of NCPHP participants are able to maintain good recoveries and regain productive lives, careers and personal relationships.

The North Carolina Physicians Health Program aids your colleagues and their families when addiction, depression or work-related stress is adversely affecting their lives.

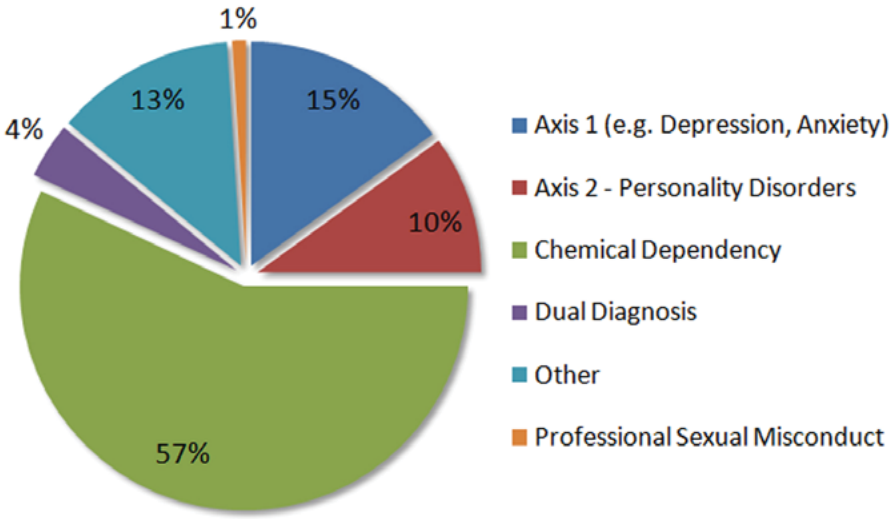
If you, or someone you know, is in need, I hope you won't hesitate to get help.

For more information, visit *www.ncphp.org*.

Send comments on this article to: *Forum@ncmedboard.org*

NCPHP REFERRAL SOURCES AND TYPES 2010

Another State PHP	2
Attorney	5
Family/Friend	0
Group/Employer	15
Hospital Administrator/Chief of Staff	21
Medical Colleague/Local PHEP	1
NC Medical Board	88
NCVMB	2
Other	0
Residency Director	12
Self-Referral	26
Treatment Center	4
Unspecified	0
Total	**176**



DID YOU KNOW?

Each time a physician renews his or her license, $21 of the $175 fee goes to NCPHP. For PAs, AAs and LPs, $15.75 of the renewal fee goes to NCPHP. The NCMB contributed $720,000 to NCPHP's annual operating budget in 2010.

Why?

The NCMB is committed to helping licensees function at their highest level. The Board's direct financial support of NCPHP ensures that this important resource remains available to physicians, physician assistants and other health care practitioners.

Supporting treatment scholarships

Many licensees choose to provide voluntary contributions to NCPHP's scholarship fund, which makes awards to help participants and their families defray the cost of treatment or other expenses.

Licensees are given the option to make a donation to this fund at the end of the NCMB's online license renewal process. In 2010, licensees donated more than $114,000 to this program. Due to their generosity, many NCPHP participants have been able to attend treatment.

Gifts to the PHP Scholarship Fund may be sent directly to the address below. Make checks to NCPHP and be sure to identify your contribution as a gift to the fund.

NCPHP
220 Horizon Drive, Ste. 201
Raleigh, NC 27615

Site visits find most PAs in compliance, but many are unaware of requirements

Since 2005, the NC Medical Board has conducted annual site visits to ensure compliance with administrative rules regarding the supervision of midlevel practitioners. The Board reviews a certain number of physician assistants, who are selected at random, each year. The NCMB is publishing a summary of the results of site visits conducted in 2010 in an effort to raise awareness of common areas of noncompliance and to encourage greater compliance.

2010 results

Sixty percent of physician assistants/sites reviewed in 2010 were found to be in full compliance with Board rules. In 30 percent of sites reviewed, the Board noted one or more instances of noncompliance. However, in all cases the PAs corrected the noted discrepancies and the Board took no formal action against their licenses. In the remaining 10 percent of sites reviewed, the Board issued confidential Private Letters of Concern (PLOC) to the PAs. In each of these cases, the PA began treating patients before filing an 'Intent to Practice' (ITP) with the Board. PAs must confirm that the Board has received their ITP before they perform any clinical duties.

Discrepancies noted during the 2010 compliance reviews included the following:

- No written instructions for prescribing and/or policy for periodic review of these instructions as required according to rules 21 NCAC 32S .0212 and 21 NCAC 32S .0213;
- Prescription blank did not contain the PA's approval/prescribing number as required according to rule 21 NCAC 32S .0212 (5) (b);
- Statement of Supervisory Arrangement was not signed as required according to rule 21 NCAC 32S .0213 (c);
- Back up supervising physician list was not signed/dated as required according to rule 21 NCAC 32S .0215 (b);
- Statement of Supervisory Arrangement lacked a clear explanation of the physician's supervision of the PA as required according to rule 21 NCAC 32S .0213 (b); and
- Quality Improvement Meeting documentation was not available for inspection as required according to rule 21 NCAC 32S .0213 (d)

What you can do

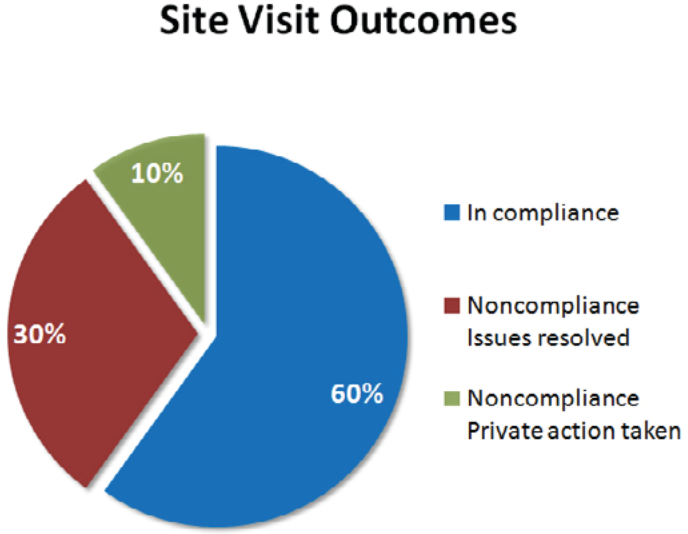
The NC Medical Board is already conducting PA compliance reviews for the current year. Don't wait to be selected to make sure you are in compliance. Visit *www.ncmedboard.org* and go to the Professional Resources section to review the PA rules and regulations. A complete description of the information PAs should expect to provide during a compliance review is available on the Physician Assistant Site Visit/Interview Form, which is posted on the NCMB's public website. Investigators use this prepared checklist when completing a site visit. Go to *www.ncmedboard.org/professional_resources/pa_forms/* to download or print a copy of the site visit checklist.

PA site visits: How they work

PAs selected for review are notified in advance by a Board investigator, who schedules a face-to-face meeting. During this meeting, the PA is asked to produce certain documents that must be kept on file at the PA's practice location. These documents include, but are not limited to: the Statement of Supervisory Arrangements (signed); written instructions for prescribing and/or policy for periodic review of these instructions; prescription blanks used by the PA; and an up-to-date list of backup supervising physicians. The Board investigator also asks the PA a series of questions regarding his or her practice arrangement, such as how frequently he or she has one-on-one direct contact with the supervising physician.

PA SITE VISIT: Items to have on hand

- Proof of licensure and registration
- Statement of supervisory arrangement with primary supervising physician (This document provides a detailed description of the PA's scope of practice)
- Signed and dated record of Quality Improvement meetings between primary supervising MD and PA relevant to clinical problems and QI measures
- List of all back-up supervising physicians, signed and dated by MDs (primary and backups) and PA
- Written prescribing instructions to include written policy for periodic review of these instructions by primary supervising MD
- DEA registration and pharmacy permit, if applicable



New position statement closes out Board task force's work on "drift"

The NC Medical Board voted in March to adopt a new position statement on physician scope of practice.

The position statement is the product of the NCMB's Special Task Force on Practice Drift, which brought specialists, primary care doctors, insurance industry representatives and others together with members of the Board for a public meeting in October 2010.

That group affirmed the idea that all licensees have a professional obligation to provide care that meets accepted and prevailing standards, even if the licensee did not complete formal training in the area of practice in which treatment has been rendered. The task force also discussed the NCMB's obligation to act whenever it determines that any licensee has provided substandard care, regardless of specialty area or the licensee's level of training.

The Board has no interest in stalling the natural evolution of medical practice; nor does it seek to prevent licensees from pursuing areas of practice that are of interest to them for a variety of reasons. The Board hopes simply to make clear its expectation that any licensee who moves into a new area of practice is able to meet accepted standards of care.

The full text of the position statement appears below. It is also published online at *www.ncmedboard.org* along with all the Board's position statements.

PHYSICIAN SCOPE OF PRACTICE

This Position Statement is intended to guide physicians who undertake to perform new procedures, use new technologies, or migrate into areas of practice for which they have not received formal graduate medical education. The Board recognizes that medicine is a dynamic field that, along with individual practices, continues to evolve. Economic pressures, business opportunities, lifestyle considerations, and access to care are all reasons that physicians move into new areas of practice. However, patient harm can occur when physicians practicing outside areas in which they were trained are unable to meet accepted and prevailing standards of care in the new practice area.

The informed, prudent care of patients begins with adequate training and the selection of appropriate patients. Follow up care and the ability to address complications is paramount. Physicians intending to expand their practice to an area outside of their graduate medical education should ensure that they have acquired the appropriate level of education and training.

It is the Board's position that all physicians, irrespective of their training, will be held to the standard of acceptable and prevailing medical practice as set forth in N.C. Gen. Stat. § 90-14(a)(6).* It also may be prudent for physicians to confirm that their liability insurance provides coverage for the procedures they intend to perform.

* In some instances, the Board may have provided relevant guidance to particular practice areas. See for example the Board's position statements on *Laser Surgery, Office-Based Procedures, Care of the Patient Undergoing Surgery or Other Invasive Procedure, and Advertising and Publicity*

NCMB adopts rules for reentry

The NC Medical Board has adopted administrative rules that set out its expectations for licensees who wish to resume practice. The rules took effect March 1.

It is the NCMB's position that any physician or physician assistant applying for a license to practice in North Carolina, who has not actively practiced or who has not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application, must complete a program of reentry. The purpose of such a program is to demonstrate that the applicant is competent in his or her intended area of practice. The Board adopted a position statement on reentry in 2006 entitled, *Competence and reentry to the active practice of medicine*, which states the Board's expectation for reentry candidates to develop a satisfactory reentry program.

The reentry rules (21 NCAC 32B.1370) standardize the Board's reentry program by listing specific factors that affect the terms of an individual's reentry program. These factors include the length of time out of practice, the prior intensity of practice, the skills needed for the intended area of practice, the reason for the interruption in practice, and the licensee's activities during the interruption in practice, including the amount of practice-relevant CME completed.

The rules also define a reentry program as consisting of a multiphase period of mentoring under a physician approved by the Board. Phases of the program include an observation phase, during which the reentry candidate observes his or her mentor in practice; a phase during which the reentry candidate practices under their mentor's direct supervision; and a final phase during which the reentry candidate practices under the mentor's indirect supervision.

To read the rule in its entirety, visit *www.ncmedboard.org/professional_resources/rules/* and click on the PDF document at the right of the page. The reentry rule is in Subchapter 32B, License to Practice Medicine.

Prescribing controlled substances responsibly

Long term drug therapy has its place in care when handled appropriately

Patients and physicians benefit from safe and effective treatment of chronic pain. However, the risks of prescribing opioids and other controlled substances for use over the long term are undeniable.

In NC, unintentional overdose from prescription medications accounts for nearly three deaths a day, according to the latest data from the NC State Center for Health Statistics. Fatalities are not limited to young people who acquire drugs from dealers, friends or by taking them from family medicine cabinets (though this type of activity does, of course, lead to some deaths). In fact, the highest mortality occurs among adults between the ages of 45 and 54 who are prescribed high daily doses of opioids by their own family medicine or internal medicine doctors. The single largest source of prescription medications associated with unintentional overdoses is established physician-patient relationships.

From the Office of the Medical Director

SCOTT G. KIRBY, MD

Improper prescribing was a factor in 68 NCMB cases that resulted in public discipline last year, or about 30 percent of the total. Most, though not all, of these cases involved one or more opioids or other controlled substances. Board actions, which are determined based on the unique facts of each situation, ranged from non-disciplinary Public Letters of Concern to indefinite suspension of the practitioner's license. In one case last year, the Board voted on an emergency basis to suspend a prescriber whose practice essentially consisted of writing high doses of controlled substances for no legitimate medical purpose, in exchange for a $100 office visit fee.

The NCMB has heard that some physicians are reluctant to prescribe opiates for chronic pain because they are afraid they will be disciplined by the Board. These concerns may have led some licensees to limit or even discontinue care of patients with chronic pain, making it difficult for some patients with a legitimate need for treatment to receive care. The Board recognizes that quality medical care includes the appropriate, effective treatment of chronic pain and supports patients' rights to access such care. The Board further recognizes that prescribing controlled substances over the long term may be an essential part of an appropriate treatment program.

This article will clarify the Board's perspective on prescribing controlled substances for the treatment of chronic pain, both by identifying poor practices that frequently lead the Board to take action against licensees and by suggesting some steps prescribers can take to improve their care. Although this article is primarily directed to prescribing opioids for treatment of chronic pain, many of the same concepts and practice management principles apply to long term prescribing of all controlled substances for other conditions.

Prescribing for chronic pain: Elements of appropriate care

Evaluation of the patient

- Medical history and physical examination is obtained, evaluated and documented in the medical record
- Medical record should document the nature and intensity of pain, current and past treatments for pain, underlying or coexisting diseases or conditions, effect of pain on physical and psychological function, and history of substance abuse.
- Medical record should also document one or more recognized medical indications for use of a controlled substance

Treatment plan

- Should state objectives that will be used to determine treatment success, including pain relief and/or improved physical and psychosocial function
- Should indicate if further diagnostic evaluations or other treatments are planned
- After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient.
- Alternative treatment modalities or a rehab program may be needed

Informed consent

- Physician should discuss risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity
- Patient should receive medications from one physician and one pharmacy
- If patient is at high risk for medication abuse or has a history of substance abuse, physician should consider use of a written agreement that states the number and frequency of all prescription refills, the reasons for which drug therapy

Improper prescribing: examples

Licensees should also understand that, while the Board views improper prescribing of controlled substances as a serious problem, the NCMB takes a reasoned approach when evaluating care. Cases that result in public discipline typically involve significant departures from recognized standards of care, failures to act in the face of evidence of abuse or diversion or other aggravating factors.

For example, last year the Board indefinitely suspended the license of a physician who was found to have prescribed controlled substances to multiple pain patients in a manner that was clearly substandard. Concerns identified included: lack of appropriate physical examination or pain evaluation; failure to recognize or monitor ongoing medical conditions that might complicate use of long term opioids; failure to attempt any alternative methods of treatment; failure to recognize or respond appropriately to several clear warning signs of medication diversion or abuse; failure to appropriately document treatment or prescribing; failure to monitor for potential adverse reactions to medications prescribed; inadequate discussions or counseling regarding the risks of long term or high dose opioid treatment; failure to employ any means of ongoing assessment or documentation of the patient's response to treatment; and failure to arrange for referral for specialist care when treatment was ineffective.

By contrast, a physician assistant who prescribed controlled substances to a family member on an occasional basis, without an examination or appropriate documentation, received a Public Letter of Concern.

Appropriate care for pain patients

Licensees who are concerned about the possibility of discipline can best protect themselves (and their patients) by following the accepted standards of care for pain patients. It sounds simple, but in case after case, the Board finds that many prescribers don't do this. The instances when the Board becomes involved in educating or disciplining licensees universally involve failures of the prescribers to use widely recognized principles of acceptable medical care, such as performing a thorough examination and patient history and documenting a legitimate medical purpose for the controlled substance prescriptions. Often, prescribers who come under Board scrutiny also overlooked red flags (lost or stolen prescriptions, running out of medication before refills available) that should have indicated the possibility of diversion, abuse or misuse.

At minimum, practitioners who regularly treat patients for chronic pain should educate themselves about the current standards of care for these patients. Good resources include guidelines developed by the American Society of Interventional Pain Physicians and the University of Wisconsin's Pain and Policies Study Group, as well as the NCMB's own position statement on prescribing controlled substances for the treatment of chronic pain. Generally accepted guidelines for treatment of patients with complaints of chronic pain include: documentation of an appropriately thorough new patient evaluation to include prior medical records; establishing a specific or reasonable differential diagnosis; development of a meaningful treatment plan; evidence of informed consent regarding the risks and benefits of long term controlled substance use; periodic review of the patient's current status with accurate documentation of progress relative to the established treatment plan and goals; indicated adjustments to the course of treatment; review of alternative treatment options; and consultation with specialists as appropriate. Medical records should accurately reflect the care and clearly indicate medications prescribed. While published literature is equivocal on the value of behavioral screening, urine drug screens, pill counts, medication or prescribing agreements, and other tools used

may be discontinued (e.g. for violation of agreement) and requiring the patient to submit to urine/serum screening when requested

Periodic review

- Physician should periodically review the course of pain treatment and any new information about the etiology of pain or the patient's state of health
- Continuation or modification of controlled substances for pain management depends on physician's evaluation of progress toward treatment goals
- Satisfactory response to treatment may be indicated by: decreased pain, increased level of function or improved quality of life
- Objective evidence of improved or diminished function should be monitored and information from family members or caregivers considered in determining patient's response to treatment
- If progress is unsatisfactory, physician should evaluate the appropriateness of continuing current treatment and consider use of alternative modalities

Consultation

- Physician should be willing to transfer the patient as needed for additional evaluation and treatment in order to achieve treatment objectives
- Special attention should be given to patients at risk for medication misuse, abuse or diversion.
- Management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with/referral to an expert in the management of such patients

Source: Federation of State Medical Boards Model Policy for the Use of Controlled Substances for the Treatment of Pain

to identify the potential of medication misuse, these are all approaches that should be considered when prescribing controlled substances to patients over the long term.

NC Controlled Substances Reporting System

In addition, anyone who prescribes controlled substances for chronic pain in North Carolina should use the NC Controlled Substance Reporting System (CSRS). The CSRS is a state-administered database of all controlled substance prescriptions dispensed in North Carolina outpatient pharmacies. Any authorized prescriber of controlled substances may register for access to the system. A prescriber can look up a patient to discover what controlled substances that patient has received recently, the amount dispensed, whether prescriptions are new or refills, the number of refills, the pharmacies where medications were dispensed and the names of practitioners who wrote the prescriptions.

There is no fail-safe means to prevent patients from acquiring controlled substances by deception, but the CSRS is an invaluable resource that can help a practitioner avoid prescribing to a patient who may be "doctor shopping." For example, a licensee who recently contacted the Board related that he used the CSRS to evaluate a new patient who came to him seeking a prescription for Adderall, stating that the prescription from her previous physician had run out two days ago. In addition to running the patient's CSRS profile, the licensee also had the patient take a urine drug screen. The drug screen was negative for Adderall, even though the drug should have been present based on the patient's story, and the CSRS data indicated that the patient had received Adderall from six other prescribers in the area. The licensee said he declined to prescribe and expressed concern about the patient's history. Now this licensee is considering contacting the six other prescribers to suggest that they check the patient's CSRS profile. This type of communication among prescribers treating a common patient is specifically authorized under state law.

Information obtained from the CSRS should ideally be used as an intervention tool to improve patient care, not to exclude patients from care. Although not currently considered the standard of care, I believe routine use of the CSRS should be a part of the practice of any physician who prescribes controlled substances for chronic pain. As with all assessment tools, data from the CSR system is not infallible and should not be the only factor considered when making patient care decisions.

Other assessment tools

Additional tools that should be considered are urine drug screens and enforced controlled substance prescribing agreements. Many versions of these prescribing agreement documents are available. Some question their utility and argue that they interfere with the physician-patient relationship. Nonetheless, the principles embodied in those agreements are basic good medical practice applicable to all safe prescribing, such as obtaining controlled substances from a single source, no sharing of medications, no early refills and instructions to take medications as directed. If agreements and urine drug screens are used, practitioners must monitor patients and take action when there is evidence of noncompliance. The Board regularly sees cases where patients repeatedly violate pro forma prescribing agreements or fail urine drug screens. Yet, time and again, prescribing continues without even an acknowledgement in the medical record that there may be a problem or that any discussion with the patient occurred.

Assessing the patient's progress

Finally, a word about assessing patients who have been prescribed controlled substances over the long term. Current standards of care dictate that prescribing for chronic pain should be accompanied by documentation of unrelieved pain associated with some assessment of impact on the functional status of the patient. Review of relevant controlled substance cases shows that, although physicians may begin with good intentions, they often do not undertake periodic assessment of the patient's progress (or lack of progress) toward specific treatment objectives. Nor do they periodically reassess the risks and benefits of continued treatment. To provide quality care, practitioners must employ some means of periodically assessing the effectiveness and appropriateness of the current treatment plan, the continued prescribing of controlled substances and consideration of alternatives.

Conclusion

In summation, when prescribers learn and follow basic principles of good medical care outlined in numerous and widely available consensus guidelines and management protocols, concerns that come to Board attention are typically resolved without incident. It is always easier to suggest patient care guidelines and procedures than it is to implement them. But I do so with the knowledge and experience that adherence to accepted standards for good practice will result in improved patient care, lessened attention from the Board and fewer unintentional overdose deaths.

Send comments on this article to *Forum@ncmedboard.org*

RESOURCES

- **NC Controlled Substances Reporting System**
  www.ncdhhs.gov/mhddsas/controlledsubstance/
- **NC Medical Board Position Statement**
  www.ncmedboard.org/position_statements/detail/policy_for_the_use_of_controlled_substances_for_the_treatment_of_pain/
- **Federation of State Medical Boards' Pain Policy Resource Center**
  www.fsmb.org/grpol_links.html

Five steps to effective communication

By Anne Micheaux Akwari, MD

Communication—and its antithesis—miscommunication, are the determinants of professional effectiveness; of patient and professional satisfaction; therapeutic adherence; errors and more. Effective communication is not a gift; it is a teachable, learnable skill. Is there a simple, easy secret to good communication? Of course not. However, there are proven strategies that will enhance the probability of achieving more harmonious and effective therapeutic relationships. Here are five basics:

1 Devote CME Hours To Communication One author said failing to communicate effectively is like a surgeon ignoring a bleeder in the operative field. Don't be that surgeon! Learn, develop and refresh communication skills just as you do your clinical skills. Begin by viewing the I*CARE videos at *www.mdanderson.org* or the doccom videos at *www.AACHonline.org*. Make a point of attending communication-related sessions when you attend specialty conferences.

2 Listening Is Kindness The noted surgeon Charles Mayo reportedly observed that none of us is truly a physician until we, ourselves, experience pain. The loss that accompanies illness and injury is treated with listening, empathy, friendliness, warmth, and concern, qualities that accrete more gradually than our diagnostic and therapeutic skills. Practice listening by allowing your patient to state his chief complaint uninterrupted, while maintaining eye contact. Listening creates a virtuous circle: It communicates caring to our patients while we learn understanding that enables us to help our patients in meaningful ways.

3 The Environment Speaks Patients gravitate to settings that respect their dignity and time. The atmosphere you establish within your practice communicates itself to your patients. When you respect the dignity of your colleagues and staff, the result surrounds your patients and is self-reinforcing. When we project our frustrations onto staff and colleagues, like spreading waves on a pond, our patients feel it, too. Whatever comes at us each day, we must meet it with resilience, balance and fortitude.

4 Be A 'Kind Landlord' The writer and literary critic Anatole Broyard wrote that his ideal doctor could enter his condition and look around at it from the inside "like a kind landlord, with a tenant, trying to see how he could make the premises more livable…" Recognize that the world of medicine is largely opaque to patients. Orient your patient to it by giving her clear explanations of what you are doing and why during all phases of evaluation and treatment. Especially, before you put your hand on the doorknob to leave, if you pause and say, "Is there anything else before I go?" your patient may grasp the chance to say what's been hardest for her to bring up. Be a kind landlord and patients will find it easier to speak.

5 Care For You Constant changes to practice models increase the pressures of our demanding profession. Burnout can be the result. An exhausted and depleted physician is more likely to make errors, both communication and medical in nature and to experience diminished fulfillment and satisfaction, both professionally and personally. Pursue, learn, and practice vital, satisfying self-care strategies—discover activities that restore and refresh you. Replenishing yourself is one key to having the resilience and compassion to discern what to say and when or how to say it.

Dr. Akwari's health care consulting firm, A.M. Akwari LLC, is co-sponsor of Strategies for Effective Medical Communication, a 7-hour CME course offered through WakeAHEC several times each year. The next course offering is September 10, 2011.

Contact Dr. Akwari at *anne@amakwari.com*.

Board staff to be nationally recognized

The NC Medical Board is pleased to announce that three of its staff members will be recognized by Administrators in Medicine (AIM) at the organization's annual meeting in Seattle on April 27.

R. David Henderson, the NCMB's executive director, will receive the Doug Cerf Executive Director's Award. The award recognizes Mr. Henderson's participation at the national level in AIM panels, committees and with other organizations.

Hari Gupta, NCMB operations director, will receive the John Ulwelling Special Recognition Award. The award recognizes Mr. Gupta's leadership in the area of medical board technology.

C. Michael Sheppa, MD, NCMB associate medical director, will receive honorable mention for his work on physician and physician assistant reentry programs in NC, continuing the work of his predecessors in establishing a competency program for physicians who have been out of clinical practice for two or more years.

Year in Review:

A look back at data from 2010

This year's annual Year in Review feature highlights a selection of data about the Board's expanded online Licensee Information pages, along with general demographic information and a review of Board work during 2010. Licensee demographic information reflect totals as of December 31, 2010. To date, about 17 percent of physicians and about 15 percent of physician assistants have not responded to Board requests to update and expand their Licensee Information pages, which present detailed information about individual licensees. If you have not logged in to *www.ncmedboard.org* to complete your page, please do. Click on "Update Licensee Info" in the green Quick Links box at the right of the home page.

Many licensees who have updated their pages have not taken the opportunity to provide optional information, such stating a practice philosophy or reporting whether they accept new Medicare and Medicaid patients. And, while most physicians have updated their postgraduate training information to comply with the Board's new format, many still have not. Licensees with no reported postgraduate training are out of compliance with NC law.

Visit the NCMB's Data Center online at *www.ncmedboard.org/data_articles* for additional graphics and information.

SUMMARY OF THE 2010 BOARD ACTION REPORT

PREJUDICIAL ACTIONS*

Annulment:
1 Action (1 Physician)

License Denied:
6 Actions (5 Physicians, 1 PA)

Probation:
23 Actions (20 Physicians, 2 PA, 1 NP)

Revocations:
4 Actions (4 Physicians)

Reprimand:
48 Actions (45 Physicians, 2 PAs, 1 CPP)

Suspensions:
59 Actions [23 Stayed] (48 Physicians, 10 PAs, 1 NP)

Summary Suspensions:
1 Action (1 Physician)

Miscellaneous Actions:
1 Action (1 Physician)

Surrenders:
11 Actions (8 Physicians, 3 PAs)

Public Letters of Concern:
77 Actions (71 Physicians, 4 PAs, 1 NP, 1 LP)

Temporary/Date Licenses Issued to Expire:
10 Actions (6 physicians, 4 PAs)

Temporary/Dated Licenses Allowed to Expire:
1 Action (1 physician)

Conditions on License
56 Actions (46 Physicians, 9 PAs, 1 NP)

2010 POPULATION OF PHYSICIANS AND PHYSICIAN ASSISTANTS

The figures below are illustrations not intended to directly reflect the numeric value of the MD/DO and PA populations.

Total physician population: 31,997

Total PA population: 4,410

Physicians in-state: 22,879

PAs in-state: 3,784

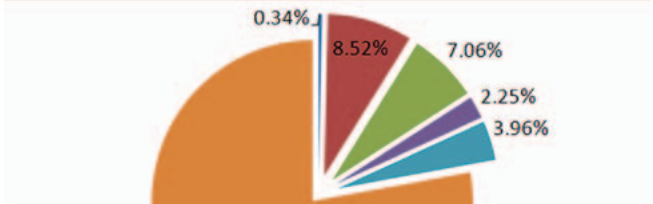
Physicians out-state: 9,118

PAs out-state: 356

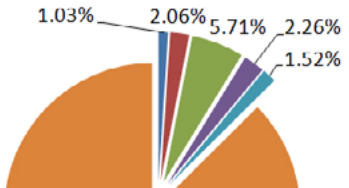
Male: 23,037 | Female: 8,959

Male: 1,719 | Female:2,690

PHYSICIAN LICENSEES BY RACE/ETHNICITY



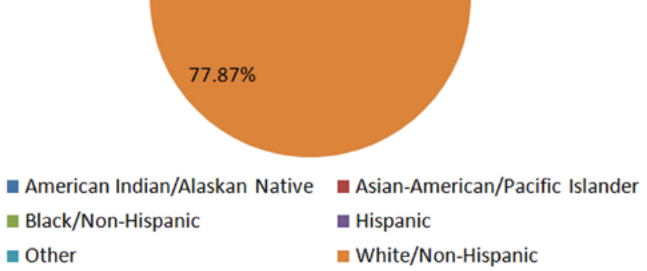
PA LICENSEES BY RACE/ETHNICITY

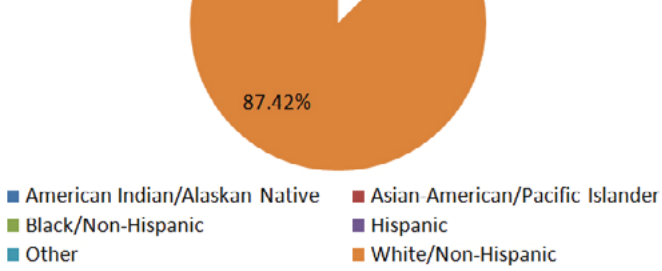


Limitations/Restrictions on License
19 Actions (18 Physicians, 1 PA)

TOTALS: Prejudicial actions in 2010 related to 226 persons (197 physicians; 25 PAs; 2 NPs; 1 CPP, 1 LP)
Prejudicial actions in 2009 related to 218 persons (192 Physicians; 24 PAs; 1 NPs; 1 CCP)

*Prejudicial Action: A "prejudicial action" is adverse in nature and reflects a violation of the Medical Practice Act by the practitioner.





LICENSEE INFORMATION

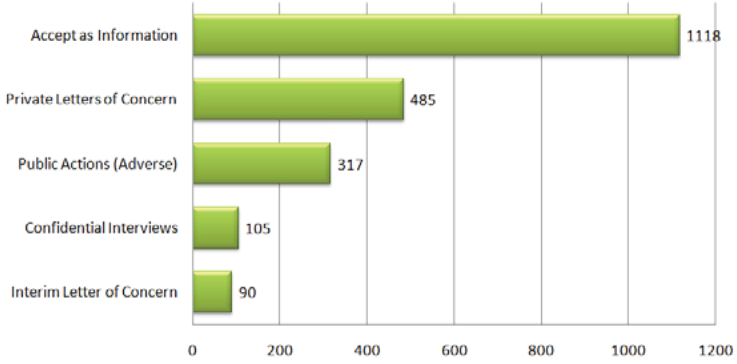
Many licensees still have not responded to Board requests to update their Licensee Information pages. Data show licensee response since October 2009.

Licensee	Responded	Not Responded
MD/DO	26,579	5,523
PAs	3,594	617
Total	30,173	7,429

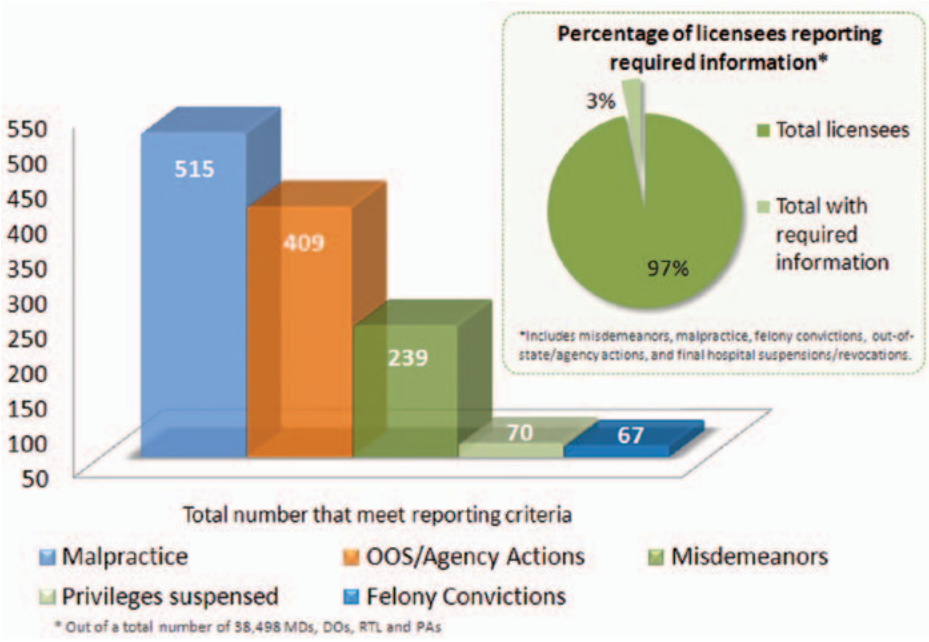
MATTERS REVIEWED 2009-2010

Matters Reviewed	2010	2009
Complaints Received	1,371	1,113
Malpractice Reports	298	351
Investigations	910	969
Total Items Reviewed	**2,579**	**2,433**

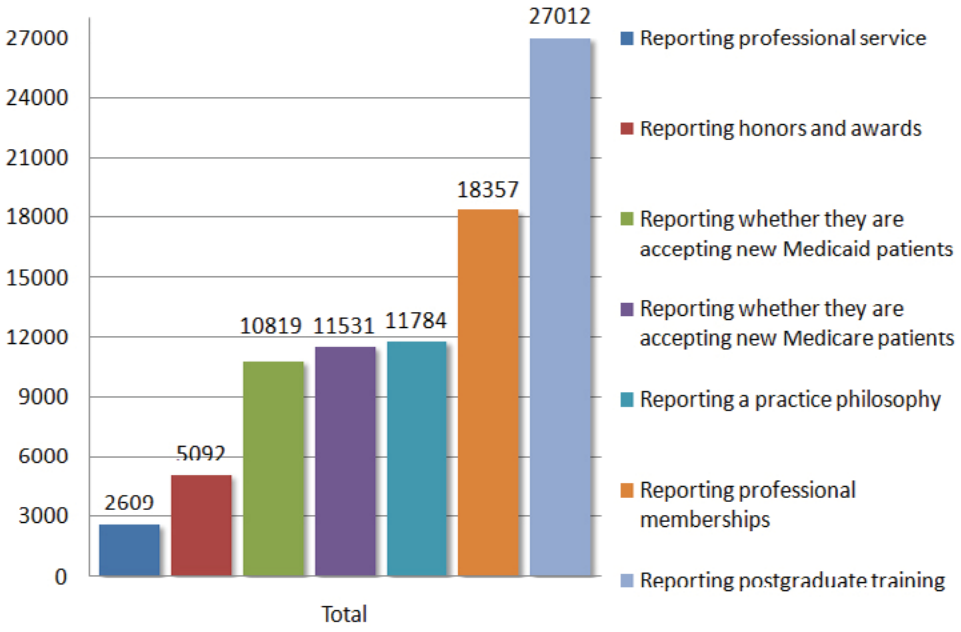
PUBLIC AND PRIVATE ACTIONS 2010



TOTAL NUMBER OF LICENSEES REPORTING ADVERSE INFORMATION AS OF 03/1/2011*



TOTAL NUMBER OF LICENSEES REPORTING IN OPTIONAL INFORMATION CATEGORIES AS OF 3/1/2011



North Carolina Medical Board

Quarterly Disciplinary Report | November 2010 - January 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			
[NONE]			
SUSPENSIONS			
REZAI, Reza, MD (200701238) Jamestown, NC	11/10/2010	MD wrote Ritalin prescriptions for himself in the name of a family member, leading to MD having a problem with the abuse of Ritalin.	MD's license is indefinitely suspended
SMITH, Barbara Hollandsworth, MD (000029200) Greensboro, NC	12/08/2010	MD entered into a consent order with the Board on February 18, 2008, and agreed not to supervise midlevel practitioners due to concerns about deficiencies in MD's care and management of a particular patient. In May 2010, the Board reviewed five patient charts and found several deficiencies.	MD's license is indefinitely suspended
TOMPKINS, Kenneth James, MD (009701625) Kitty Hawk, NC	01/06/2011	History of alcohol abuse. MD self-reported to the Board that he had been charged with DWI on Sept. 4, 2010. MD has resumed his prior contract with NCPHP and is in full compliance.	MD's license is indefinitely suspended, immediately stayed. MD is reprimanded.
WASHINGTON, Clarence J., III, MD (000032295) Fayetteville, NC	12/21/2010	MD's performance of second trimester dilation and evacuation procedures on two patients was below accepted and prevailing standards of care. In both cases, the patients suffered uterine perforations and other complications.	Suspension of NC medical license, immediately stayed. If MD intends to perform second trimester dilation and evacuations, he must observe 10 procedures/other requirements.
PROBATION			
[NONE]			
REPRIMAND			
BLASKO, Edward Conrad, MD (000031247) Wadesboro, NC	01/31/2011	Prescribed multiple controlled substances to a patient/personal friend without maintaining a patient chart documenting the prescriptions, patient history, examinations, or treatment plans for the patient. Wrote prescriptions for a close family member without maintaining a patient chart.	Reprimand
GERSHENBAUM, Bart Keith, DO (201002113) Weston, FL	12/16/2010	Florida Board of Osteopathic Medicine took action on allegations that DO prescribed over the Internet without performing physical examinations.	Reprimand; $5,000 fine
KALE, Milton Paul, MD (009400285) Jacksonville, FL	12/21/2010	MD regularly prescribed for close family members, including several prescriptions for Schedule II and Schedule IV controlled substances.	Reprimand

Name/license#/location	Date of action	Cause of action	Board action
LOVETTE, Kenneth Maurice, MD (000024606) Greenville, NC	12/07/2010	Board obtained medical records of Patients A-E, who were all treated by MD for pain. An independent expert reviewer determined that the care rendered to Patients A-E failed to conform to prevailing and accepted standards of care.	Reprimand. MD shall not prescribe controlled substances for chronic pain and for a period lasting longer than six weeks.
MCGRATH, Timothy, MD (200200571) Mebane, NC	12/08/2010	On more than one occasion, MD prescribed to family members, including prescriptions for controlled substances.	Reprimand
MONTGOMERY, Sean Paul, MD (201002055) Chapel Hill, NC	12/02/2010	MD failed to timely renew his medical license in the state of Georgia, which led him to practice with a lapsed license. He entered into consent order with the GA Medical Board in May 2008.	Consent order executed; MD is issued an NC medical license, with a reprimand
PATEL, Jirpesh Raojibhai, MD (200101261) New York, NY	01/07/2011	MD failed to disclose on his 2009 application for reinstatement an April 2008 incident that arose from a medical condition. When asked about medical conditions, MD failed to disclose that he suffered from Dissociative Fugue.	Reprimand. The Board shall issue MD a license to practice medicine and surgery. MD must maintain a contract with NCPHP.
SLOAN, Randy Mark, MD (009501103) Hampstead, NC	01/03/2011	MD abruptly closed his practice without proper notice to patients, including some patients for whom MD was the primary care physician.	Reprimand. MD must pay $1,000 fine within 30 days of the date of order.
SMART, Carl Andre, MD (009400640) Charlotte, NC	12/22/2010	While on call, MD based diagnosis and treatment of a patient on phone calls and failed to examine the patient at the bedside once he was called in. MD continued to manage the patient over the phone amid increasing complications.	Reprimand
WILCOX, Robert Nelson, MD (000013662) Wesley Chapel, FL	01/18/2011	MD aided and abetted the unlicensed corporate practice of medicine through his employment by a medical services corporation that is not owned and operated by physicians. NC law requires such businesses to be physician-owned.	Reprimand
DENIALS OF LICENSE/APPROVAL			
PASTORINI, Paul Richard, MD (000030447) New London, NC	12/09/2010	History of alcohol and substance abuse; incomplete and/or inaccurate responses on multiple questions on reinstatement application.	Denial of application for reinstatement of NC medical license
WEBSTER, Laurence Seaton, MD (009500269) High Point, NC	01/26/2011	Prior history of discipline. Indefinite suspension of license on 07/24/2009 due to boundary violations with patients and staff, self-administration of testosterone and practicing medicine below acceptable and prevailing standards.	Denial of application for reinstatement of NC medical license
SURRENDERS			
DILL, Gregory Oran, MD (200300462) Asheville, NC	01/18/2011		Voluntary surrender of NC medical license
DUGLISS, Malcolm Andrew John, PA (000103305) Asheville, NC	01/19/2011		Voluntary surrender of NC physician assistant license
KILBY, Michael Warren, MD (009801335) Danbury, NC	01/13/2011		Voluntary surrender of NC medical license
LONG, Scott David, PA (000103319) Madison, NC	01/05/2011		Voluntary surrender of NC physician assistant license
PEARCE, Larry Allen, MD (000013200) Mocksville, NC	01/06/2011		Voluntary surrender of NC medical license
PEGRAM, Paul Samuel, Jr., MD (000016925) Winston-Salem, NC	11/21/2010		Voluntary surrender of NC medical license
PUBLIC LETTER OF CONCERN			
CHOWDHURY, Shabbir Ahmed, MD (200401185) Fayetteville, NC	11/16/2010	MD was out of the country and unavailable to a patient he treated for multiple psychiatric conditions. He did not refer the patient to another physician and other efforts to ensure access to care were inadequate and/or undocumented. Patient committed suicide during MD's absence.	Public letter of concern issued

Name/license#/location	Date of action	Cause of action	Board action
COLE, John Peter, MD (009300065) Alpharetta, GA	11/29/2010	MD entered into a consent order with the Georgia Composite Medical Board on April 1, 2010, related to his participation in the unlicensed practice of medicine. MD permitted unlicensed individuals to dispense medications/administer local anesthetic to patients.	Public letter of concern issued
HUNTLEY, Danny Edward, MD (000022743) Atlanta, GA	12/16/2010	The Board is concerned that MD's documentation of his diagnosis and treatment of a patient who received treatment of the medium and small veins in the left leg does not reflect whether the patient had a history of deep vein thrombosis.	Public letter of concern issued
KANDEL, Laurence Bruce, MD (000027379) Muskogee, OK	12/07/2010	MD entered a non-disciplinary assurance of compliance on May 30, 2008, with the Nebraska Department of Health and Human Services in relation to allegations that he failed to timely report a DUI conviction and a resignation of privileges.	Public letter of concern issued
KASA, Kurian David Solomon Raj, MD (200501561) Burlington, NC	01/24/2011	Failure to appropriately diagnose and treat patient for suspected subarachnoid hemorrhage	Public letter of concern issued
KOWALCZYK, Teresa Danuta, MD (009600598) Greenville, TX	01/18/2011	MD entered into a corrective order dated April 9, 2010, with the Texas Medical Board based on allegations that MD slapped an uncooperative and hostile patient who presented in active labor.	Public letter of concern issued
LAMBERT, Christopher Thomas, MD (201100012) Columbus, GA	01/05/2011	MD answered two questions on his application for an NC medical license inaccurately.	Public letter of concern issued
KAPLAN, Katherine Margaret, MD (000038525) Marshfield, WI	11/30/2010	MD's care of a pregnant patient who suffered fetal demise was below accepted and prevailing standards. MD failed to detect non-reassuring fetal heart tracing and other signs of fetal compromise after placing the mother on an electronic fetal monitor.	Public letter of concern issued
ROLAND, Romie Earl, MD (200601107) Atlanta, GA	11/18/2010	The Georgia Medical Board suspended MD's license on September 22, 2009, for failure to comply with his child support obligations. On October 20, 2009, the Georgia Board terminated the suspension after MD complied with these obligations.	Public letter of concern issued
SHERIDAN, David Paul, MD (000036597) Katy, TX	11/22/2010	MD's Texas license was acted against related to a patient complaint that materials provided to her contained potentially misleading statements about MD's recommended treatments. MD also told patient that prescriptions would be filled at a pharmacy financially connected to the owner of the MD's practice.	Public letter of concern issued
SKEEN, James Thomas, MD (009801061) Pinehurst, NC	11/29/2010	MD issued prescriptions for controlled substances to a family member without conducting an appropriate exam or maintaining proper medical records. Prescribing to family members, except in cases of minor illness or emergencies, is in conflict with Board policy.	Public letter of concern issued
SLADICKA, Stephen Joseph, MD (009801062) Taylorsville, NC	01/10/2011	While serving as on-call surgeon, MD failed to timely evaluate a patient presenting to the ER with a warm, swollen and painful right knee three days after knee surgery performed by another surgeon. The patient's condition worsened and she subsequently died.	Public letter of concern issued
YOUNG, Noel William, Jr., MD (000013955) Durham, NC	11/23/2010	Failure to diagnose ocular melanoma in a patient.	Public letter of concern issued
WHITESIDE, Carl Thomas, MD (00016480) Asheville, NC	1/13/2011	MD's treatment of patients with chronic pain is below standard.	Public letter of concern issued

Name/license#/location	Date of action	Cause of action	Board action
WILLIAMS, Edward Joseph, DO (009800164) Albemarle, NC	11/2/2010	DO's treatment of a patient who underwent a total abdominal hysterectomy complicated by extensive endometriosis with dense adhesions was below accepted/prevailing standards.	Public letter of concern issued
MISCELLANEOUS ACTIONS			
HAMEL, Theresa Lyn, MD (000039947) Asheville, NC	01/14/2011	MD was charged with DWI on or about August 1, 2010, and convicted of Level 5 DWI on October 4, 2010. MD has entered into a monitoring contract with NCPHP.	MD must maintain NCPHP contract and refrain from all mind- and mood-altering substances, including alcohol
ROSNER, Michael John, MD (000026865) Hendersonville, NC	11/5/2010	Concerns that MD over diagnosed certain conditions and, in some cases, performed unnecessary surgeries.	Full license issued. Must comply with terms and conditions. Prohibited from treating patients under 18 years of age and must have patients considering any cervical spine surgery obtain an independent neurologic exam performed by a Board certified neurologist.
SHIELDS, Wright Davis, MD, (000033892) New Bern, NC	11/10/10	MD was involved in a motor vehicle accident on April 28, 2010, after which he blew a .09 on a breathalyzer test. MD was arrested and charged with Driving While Under the Influence (DWI) and making an Unsafe Movement.	Non-disciplinary consent order; Board shall issue a Public Letter of Concern.
CONSENT ORDERS AMENDED			
LARSON, Michael Joseph, MD (000028661) Raleigh, NC	11/30/2010	MD entered into a consent order with the Board on October 19, 2005, wherein the Board indefinitely suspended his medical license due to his violation of physician-patient boundaries and falsifying a medical record to conceal this behavior.	Consent order amended: NC medical license reinstated. MD may treat all patients, male and female. MD must maintain NCPHP contract.
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
BOYD, William Scott, PA (000102927) Siler City, NC	11/18/2010		Temporary physician assistant license replaced with full license
ADKINS, Paula Clark, MD (009900745) Pinehurst, NC	01/20/2011		Temporary medical license extended; expires 05/31/2011
JAMES, James Franklin, MD (000015359) Greenville, NC	01/20/2011		Temporary medical license extended; expires 05/31/2011
NOWLAN, Ashley Elizabeth, PA (001001770) High Point, NC	12/14/2010		Dated PA license issued; expires 6/14/2011
PAUL, Robert Allen, PA (000102781) Clayton, NC	11/18/2010		Dated PA license extended; expires 11/30/2011
PIXTON, Jan Maree, PA (000102080) Greensboro, NC	11/18/2010		Dated PA license extended; expires 11/30/2011
SESSOMS, Rodney Kevin, MD (000033927) Clinton, NC	11/18/2010		Temporary medical license extended; expires 01/31/2011
SESSOMS, Rodney Kevin, MD (000033927) Clinton, NC	01/25/2011		Temporary medical license extended; expires 07/31/2011
SLOAND, Timothy Peter, MD (200301292) Gastonia, NC	11/18/2010		Temporary license made full and unrestricted
COURT APPEALS/STAYS			
[NONE]			
DISMISSALS			
[NONE]			

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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

May 18-20, 2011 (Full Board)
June 16-17, 2011 (Hearings)
July 20-22, 2011 (Full Board)
August 18-19, 2011 (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.

"Like" us or not, we're on Facebook

Like Queen Elizabeth II and the White House, the NC Medical Board has joined Facebook. The NCMB's page on the social media network can be accessed at *www.facebook.com*; search for *North Carolina Medical Board*.

The NCMB hopes to use Facebook to raise awareness of the Board, provide news and updates and let visitors give their feedback on new initiatives, position statements and other matters.

Be sure to click the "Like" button on the Board's Facebook page to have the following content delivered direct to your smartphone or email account:

- Board notices and announcements
- Notice of public actions, including disciplinary actions
- Board meeting agendas and minutes
- Notice of *Forum* e-newsletter availability
- Video clips, and more...

Facebook is the Board's first foray into social media. Next up: Twitter and YouTube. We'll keep you posted as the NCMB's social media efforts progress.

QR codes make content mobile

The NCMB will begin using QR codes, or quick response codes, to allow readers a faster and easier way to access featured content.

- QR codes are special bar codes that lead to links and images on a mobile browser.
- Scan a QR code using an application on your smartphone (*www.redlaser.com*) and your phone's camera.
- Scan the code at right to access the Board's Facebook page.