FORUM
NORTH CAROLINA MEDICAL BOARD
FOR THE BENEFIT AND PROTECTION OF THE PEOPLE OF NORTH CAROLINA
SUMMER 2012

Preserving healthy physicians — Pg. 6

Electronic Health Records:
A benefit only when used wisely

This issue's President's Message is a cautionary tale for those of you using electronic health records. Now before you scoff, call me a technophobe and flip to the back of the newsletter to see the disciplinary actions, let me explain.

I've been using EHR in my own practice since 2003 and, overall, it has been a positive experience. I firmly believe that a good system, well used, forces a physician or physician assistant to think in an organized manner. The process of completing the EHR entry can help ensure that the patient record thoroughly and accurately documents what went on during a patient encounter.

As a member of the Board I've seen enough examples of illegible, chicken-scratch, handwritten records to understand how valuable that is. From the Board's perspective, it's relatively easy, upon review of a well done EHR, to reconstruct what happened during a given episode of care and make some determination about the appropriateness of a licensee's actions. Clinicians who use their EHR systems effectively may be confident that, if needed, they will be able to defend their records and their care.

Here's the problem: Everyone who is using an EHR system isn't necessarily using it well. The Board has noticed an increased instance of disciplinary cases in which improper use of EHR is a factor. The problems fall in two main categories:

1. The licensee is overusing template content provided through the EHR, which results in incomplete and/or inaccurate records.
2. The licensee lacks the time to become proficient in the use of his or her EHR, which results in incomplete and/or inaccurate patient records.

EHR template content: NOT a substitute for a good exam

Sometimes the errors or omissions in poorly executed EHRs are glaring and ridiculous. For example, in the course of reviewing a case, the Board may look at a record that purports to accurately document a physical examination of a female patient. Yet, upon review, it is determined that the record indicates that male genitalia were examined, with no abnormalities present (a great relief to the patient, no doubt).

Here's a brief sampling of other EHR-related documentation errors observed by the Board and its staff:

- A morbidly obese woman with a history of four C-sections and two laparoscopic ab-

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dominal procedures described in the record as having a "flat abdomen" with "no scars."

- The records of a patient with chronic cellulitis, chronic epididymitis and chronic low back pain contain exams that do not match the history, with numerous "normal" skin, musculoskeletal and neuro exams.
- A patient is prescribed increasing doses of opioids for low back pain, although records show the history of present illness is identical for many visits, raising questions about the need to continue/increase opioid therapy.

Why are these sorts of errors problematic? First, it diminishes the value of the record to other treating clinicians, who will glean little meaningful information about the patient. And from the Board's perspective, a template-driven record raises doubts about the overall quality of the licensee's care. To be blunt, how careful can the Board assume an examination was if the licensee describes a female patient as having male anatomy? What else might the licensee have gotten wrong? Did the licensee even examine the patient? Obviously, this is not the direction a licensee would want the discussion to move in when his or her case is before the Board.

To be sure, template content in EHRs can be helpful. It can improve billing by ensuring that insurance company requirements are met. It can save time by reducing the need for the practitioner to manually enter each component of care. However, templates cannot take the place of a good, detailed, accurate physical exam and history. All of us are under incredible time pressures and it may be tempting to rely on templates to get through your documentation more quickly. Don't do it. Bottom line, if you didn't do something, don't put it in the record. When you do use templates to document an exam, take the time to customize the record to ensure you document it accurately.

Don't know how to use your EHR? Get help

That brings me to my second assertion, that many problems the Board sees with EHRs has to do with the fact that licensees are too swamped to make the time to learn to properly use their EHR system. I suspect this is the case for most of the licensees we see with evident problems using EHR well.

Learning to properly use your EHR is absolutely critical. Truly, how can anyone afford not to? I know taking days or weeks out of already packed work schedules to learn a new system is difficult. But when one considers the extremely high cost to purchase and run most EHRs (typically at least a few thousand dollars a month, plus a sizeable upfront investment), investing the additional time and expense to train on the system is negligible.

Many established EHR vendors have intensive training available, for an additional fee. However, to address the specific concerns raised in this article NC AHEC, which received a federal grant to help medical practices become meaningful users of EHR, may be an even better choice. A primary goal of the NC AHEC program is to help practices use EHR to help improve care and satisfaction for practitioners, their patients and staff.

NC AHEC had a tremendous response to its grant program, which provided free or subsidized training to primary care practices. It is now in the process of transitioning to a fee-based EHR training service that will be available to clinicians in all practice areas. To learn more about the service or to sign your practice up as a potential client, visit *www.ncahecrec.net* and email the program administrators for more information.

Until next time,

Ralph

NCMB President, Ralph C. Loomis, MD, says "I firmly believe that a good system, well used, forces a physician or physician assistant to think in an organized manner."

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Forum staff

Publisher
NC Medical Board

Editor
Jean Fisher Brinkley

Associate Editor
Dena M. Konkel

Editor Emeritus
Dale G Breaden

Contact Us

Street Address
1203 Front Street
Raleigh, NC 27609

Mailing Address
PO Box 20007
Raleigh, NC 27619

Telephone / Fax
(800) 253-9653
Fax (919) 326-0036

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

Have something for the editor?
forum@ncmedboard.org

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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.

Highlights from the 100th Meeting of the FSMB

Every year the NC Medical Board sends a delegation of Board Members and staff to the annual meeting of the Federation of State Medical Boards (FSMB). The FSMB is a national membership organization that represents and supports state medical and osteopathic regulatory boards in the United States and territories.

This April, the FSMB held its 100th annual meeting in Ft. Worth, TX. The summary below highlights significant actions taken by the House of Delegates, the governing body of the FSMB. For more information visit *www.fsmb.org*

Impact of medical board regulatory actions

The NC Medical Board has received feedback from licensees, professional groups and others that medical board actions frequently result in unintended and undesirable consequences to the licensee, such as the loss of specialty board certification. The NCMB does not believe these consequent actions are always necessary or appropriate. As a result the Board introduced a resolution (Resolution 12-1) in the Federation's House of Delegates that would address this issue

Resolution 12-1 was **ADOPTED**: *Resolved, the FSMB shall convene a meeting with the ABMS and AOA BOS to collaborate on strategies to achieve the common goal of avoiding unintended limitations of specialty board certification and recertification based on state board disciplinary action, while protecting the public and maintaining high standards of specialty practice, and shall report back to the House of Delegates on its progress at the 2013 Annual Meeting.*

Limited exemption from CME requirements

Medical Boards recognize that participation in American Board of Medical Specialties (ABMS) Maintenance of Certification programs or American Osteopathic Association Bureau of Osteopathic Specialists/Osteopathic Continuous Certification programs represent a significant commitment to continuing education on the part of a licensee. The Minnesota Board of Medical Practice introduced Resolution 12-3 to allow participants in ABMS MOC and AOA BOS/OCC programs to use this participation to meet CME requirements for the purpose of license renewal.

The NCMB has adopted rule changes consistent with this resolution; the rules won final approval in July and are set to take effect August 1, 2012 (see CME Rule article, pg. 16)

Resolution 12-3 was **ADOPTED**: *Resolved, that the FSMB supports the use of, and encourages state boards to recognize, a licensee's participation in an ABMS MOC and/or AOA BOS OCC program as an acceptable means of meeting CME requirements for license renewal.*

Social media, reentry to clinical practice policies

The FSMB establishes workgroups to study relevant issues in medical regulation and form policy recommendations that may be adopted by the Federation and, in some instances, serve as guidelines for state medical boards.

The FSMB House of Delegates took the following actions related to reports offered by two workgroups:

1. *The Model Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice* contained in BRD RPT 12-1; Report of the Special Committee on Ethics and Professionalism were **ADOPTED** as policy and the remainder of the report filed.

Some points covered in the guidelines include:

- Physicians should only have online interaction with patients when discussing the patient's medical treatment within the physician-patient relationship—and these interactions should never occur on personal social networking or social media websites.
- Patient privacy and confidentiality must be protected at all times, especially on social media and social networking websites. Although physicians may discuss their experiences in non-clinical settings, they should never provide any information that could be used to identify patients.
- Physicians should be aware that any information they post on a social networking site may be disseminated to a larger audience, and that what they say may be taken out of context or remain publicly available online in perpetuity.

2. The 12 recommendations contained in BRD RPT 12-2; Report on the Special Committee on Reentry to Practice were **ADOPTED** as policy and the remainder of the report filed.

The Reentry report encourages state medical boards to develop a standardized process for physicians and physician assistants to demonstrate their competence prior to reentering practice after an extended absence from clinical practice. The NCMB has a well-defined Reentry Program and has been a leader among medical boards in establishing reentry as a regulatory priority. For more information on reentry in North Carolina, visit *www.ncmedboard.org*

The FSMB Special Committee report includes 12 Reentry Guidelines designed to provide medical boards with a framework of common standards and conceptual processes for physician and physician assistant reentry. The guidelines include:

- Education and Communications Issues
- Determining Fitness to Reenter Practice
- Mentoring Practitioners Who Want to Reenter the Workforce
- Improving Regulation of Licensed Practitioners Who Are Clinically Inactive
- The Relationship between Licensure and Specialty Certification

Easy money – Work from Home

From the Office of the Medical Director

SCOTT G. KIRBY, MD

Medical Director

The Medical Board occasionally receives inquiries for information and advice from physicians who have been contacted by recruiters or who have seen advertisements for various telemedicine positions and providers. The Board recognizes that telemedicine is a useful tool with evolving technology that, if employed appropriately, may provide important benefits to patients. However, physicians should protect themselves by thoroughly evaluating a telemedicine provider and proposed means of delivering care before agreeing to treat patients via telemedicine.

Here are several important considerations:

1 **How are you being contacted?** Your point of contact may not be the actual owner of the telemedicine service. A recruiting company, email contact or advertisement may provide vague or incorrect answers to your questions. Affirmatively determine who actually owns the telemedicine service. The owner of the telemedicine practice may be an out-of-state non-physician, which could raise concerns about illegal or unethical business arrangements.

2 **Have an attorney experienced in North Carolina health care law review all contracts and documents.** Confirm that the means you will be using to provide patient care remotely is acceptable and in accord with North Carolina law and Medical Board policies.

3 **If you will be providing telemedicine patient care in more than one state be aware of the multiple state license domino effect.** Many practitioners who primarily practice telemedicine hold medical licenses in multiple states. If an individual is disciplined by a medical board in one state, it often rapidly triggers a series of medical board investigations in all states where a physician is licensed. It's possible to be disciplined by other state medical boards for conduct in a different state, even if you have not provided any patient care—via telemedicine or face-to-face—in those other states.

4 **Physicians practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care.** You will be held to the standard of care applicable to the type of care you are providing. There is no watered down or special standard of care for telemedicine practice. If you are providing primary or family medicine type care you will be held to the standard of care expected of a family medicine physician seeing the patient in person. A failure to conform to the appropriate standard of care may subject the physician to discipline by the Board.

5 **Physicians using telemedicine to provide care to patients located in North Carolina must provide an appropriate examination prior to diagnosing or treating the patient.** Obviously, the examination will not be exactly the same as an exam conducted in person. However, the examination must be substantially equivalent to one that would be conducted in person and allow the practitioner to gather all needed information to make a diagnosis.

6 **Physicians using telemedicine should have some means of verifying that the person seeking treatment is in fact who they claim to be.** For example, it is not appropriate to prescribe antibiotics to a wife who does a telemedicine consultation on behalf of her husband. In some cases the Board is familiar with telemedicine practitioners have prescribed in the name of the patient they are speaking to knowing that the medication is intended for another party. This is clearly substandard practice.

7 **Licensees using telemedicine must ensure the availability of appropriate follow-up care and maintain a complete medical record.** Records must be available to the patient and to other treating health care providers.

8 **Prescribing controlled substances by means of telemedicine is an invitation to disaster.** Don't do it.

View the North Carolina Medical Board's official position statement on *Telemedicine* on the opposite page.
Visit *www.ncmedboard.org* and click 'Professional Resources' to view the entire collection of position statements.

NCMB POSITION STATEMENT ON TELEMEDICINE

"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a licensee in one location and a patient in another location with or without an intervening health care provider.

The Board recognizes that technological advances have made it possible for licensees to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care.

The Board cautions, however, that licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by this Board.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

- **Training of Staff—** Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.
- **Examinations—** Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate examination prior to diagnosing and/or treating the patient. However, this examination need not be in-person if the technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face.

  Other examinations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate examination may be a violation of law and/or subject the licensee to discipline by the Board. (1)
- **Licensee-Patient Relationship –** The licensee using telemedicine should have some means of verifying that the person seeking treatment is in fact who he or she claims to be. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status examination, physical examination and appropriate diagnostic and laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.
- **Medical Records—**The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate evaluation of the patient's presenting symptoms, and relevant components of the electronic professional interaction must be documented as with any other encounter.

  The licensee must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's record constitute one complete patient record.
- **Licensure—**The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina. Licensees need not reside in North Carolina, as long as they have a valid, current North Carolina license. (2)

  North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards website.

(1) See also the Board's Position Statement entitled "Contact with Patients before Prescribing."

(2) N.C. Gen. Stat. § 90-18(c)(11) exempts from the requirement for licensure: "The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State."

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, "The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone." N.C. Gen. Stat. § 90-1.1(5)f.

Preserving a scarce human resource: Healthy physicians

Recognizing and addressing the signs of burnout is key

John-Henry Pfifferling, PhD, founder and director of the Center for Professional Wellbeing

The exhausted and tense man in my office at the Center for Professional Wellbeing hardly fit the role of compassionate caregiver. I listened as he described his attitudes about his work in a busy internal medicine practice. "I was angry, discouraged and unmotivated," he said. "I saw patients as enemies and all paperwork demands as intrusive." He looked across the desk at me, eyes flashing. "I worked hard, I passed my Boards and now I have to settle for substandard fees. I have to justify every test. I'm forced to swear that I didn't lie about procedures I ordered. And on top of it all, I have to deal with hostility from staff, patients and health plan representatives."

Worse still, this physician went on, peers and practice partners seemed oblivious or indifferent to his suffering. Colleagues always wanted him to see just one more case. If he objected, some even made derogatory remarks suggesting that he didn't have the "right stuff" to make it as a physician— "Can't you take the heat?" they'd chide. "That's what practicing is all about."

The client described above displays the hallmark characteristics of physician "burnout."

The physician couldn't easily describe what aspects of his work were triggers for his anger and exhaustion. He couldn't begin to imagine how to make his work environment better. He just wanted to leave medicine.

Our job at the Center was to help him rekindle his desire to practice. We showed him this was possible only through the judicious practice of self-care. We helped him learn strategies for "burnout-proofing" his practice. As part of this process, he was asked to become more assertive and stop enabling a system that left him personally depleted. After completing a guided analysis of his current work situation and stressors, this physician even asked for— and got— a medical scribe to help with documentation and paperwork. Today he is practicing with a much-renewed spirit and with far more enjoyment than he would have dreamed possible.

This article will provide an overview of burnout and describe its devastating effect on medical practitioners' professional and personal lives. It will define the qualities of a healthy, well-functioning (not burned-out) clinician. It will provide the reader with tools for assessing risk for burnout and describe the often severe consequences of allowing oneself to become burned out. Finally, it will share some strategies for "burnout-proofing" one's practice environment.

Burnout: An unrelenting problem

Burnout among physicians has reached epidemic proportions since it was first described among human services workers in the 1970s. When physicians experience overload, loss of control (autonomy) and a lack of reward (perceived or real) for their contributions, their risk for emotional exhaustion, otherwise known as the burnout syndrome, is astronomical. When physicians begin the downward spiral into burnout, they no longer contribute with their leadership and motivational energy. Instead, they become needy and unintentionally sap energy away from the group. Worse, this syndrome is highly contagious and can systematically infect a whole practice or clinic by reducing meaningful contact among its individual members.

The burnout process is similar to the process of grieving. Grieving occurs when there is loss or change. Some

losses are significant (death of a child, spouse or parent) and result in more profound episodes of grief. Some are negligible (favorite sports team loses a game) and might be experienced as little more than disappointment. Burnout closely mimics the type of grief experienced after a serious loss.

Physicians who suffer burnout typically grieve for the loss of a life dream—no question a significant loss. Most physicians enter practice with the hope of fulfilling a caring, supportive, challenging and rewarding role. They expect reasonable work requests, relative autonomy and a commensurate reward for their efforts. What they get is unrelenting pressure to see more patients in less time, limited control over how medical care is delivered, constant scrutiny and quality "assessments" and increasing demands from patients. The path to burnout begins when these professionals suffer a clash of expectations and recognize the serious mismatch between their actual day-to-day job and their deep-seated internal expectations (Cf., Maslach and Leiter, 1997. *The Truth About Burnout*.)

Some evidence suggests that the incidence of burnout is rising among physicians and is striking earlier in their careers. Most recent data see an increase in burnout scores, derived from the MBI (Maslach Burnout Inventory) among residents and new practitioners. These are professionals who, in theory, should be at their most motivated and idealistic stage of practice. Instead, they report that they are increasingly cynical, with burnout percentages of up to 80 percent upon entry to practice.

Burnout: What it looks like

Burnout is characterized by:

- An erosion of engagement with the job presenting as exhaustion, cynicism and ineffectiveness; and an erosion of positive emotions, particularly loss of enthusiasm and idealism (Maslach & Leiter)
- The discrepant fit between the person and the job, experiences as personal imbalance and not recognized as unrealistic job demands
- The betrayal of expectations or the clash between the "spirit" (core passion, values and purpose) and the demands of the work environment

Common "Emotional" symptoms

- Recurrent sense of sadness
- Decreased interest in work and personal life
- Increased incidence of anxiety dreams
- Recurrent sense of helplessness and hopelessness
- Decreased control of anger
- Difficulty in self-motivation
- Decreased creativity, can't give anymore
- Increased fear and terror
- Increased anticipatory anxiety
- Increased agitation and sluggishness
- Severe self-criticism

Common physical symptoms

- Sleep changes; No resilience from rest
- Increased physical distress (generalized)
- Digestive difficulties
- Decreased immunity to prevalent illnesses
- Increased "heart-pains" that, upon medical workup are not physiological

Common "transpersonal" or spiritual symptoms

- Increased hopelessness
- Withdrawal from community involvement
- Withdrawal from faith and social relations
- Difficulty concentrating (including prayer/meditation)
- Obsession with transgressions and failures
- Enhanced sense of isolation and loneliness
- Increased anger at suffering, God, other people
- Inability to empathize
- Lessened access to experiencing "making a difference"
- Anticipating work as exhausting and going home exhausted
- Nagging feelings (guilt; self-criticism) when treating patients as objects/diseases

Consequences of Burnout

Burnout takes a toll not just on the person experiencing it, but on each person, group and "system" that person interacts with on a daily basis. Spouses of burned-out physicians describe feeling as though they live with a stranger or a robot. Nurses and other subordinates admit to avoiding contact with the burned-out physician to avoid unpleasant outbursts, even when failure to speak up or ask questions may result in errors or less than optimal care. Alternatively, burning-out individuals may withdraw, viewing contact with others as yet another demand on their time. At best, the burned-out physician is a "weak link" who hurts productivity because he or she is unable to contribute fully. At worst, the burned-out individual is a destructive force who threatens practice morale and may even imperil patient care.

Some specific consequences of burnout include:

- Less ability to perceive the patient is a whole person
- Less energy to "go the extra mile"
- Diagnosing quickly out of a belief that such speed will "get me off of the treadmill"
- Less likely to follow preventive cardiology or healthy habits
- Anger at how medicine only gives lip service to healthy habits
- Increased mal-occurrences, errors or mistakes

- Likelihood to blame the system
- Greater depression
- Poorer work and personal relationships
- Increased tendency to practice defensive medicine due to pessimism-induced litigation fears
- Less team-oriented; Views each interaction with team members as a drain on time
- Taking short cuts in care delivery (while hating the pressure that makes short-cuts seem necessary)
- Lessened ability to dispense hope to patients
- Earlier retirement, or changing careers
- Leaving or selling practice

Physicians: Hardwired for burnout?

The U.S. system for educating and training physicians in many ways sets young doctors up for burnout. Modeling by peers and teachers rewards always going "the extra mile" and labeling as weak those who cannot keep pace. Individuals who ask for help are perceived as incompetent or insecure. Peers fear intimacy or constructive feedback, so social tension is high and feedback is low. Perhaps most important, physicians are routinely rewarded for not setting boundaries and failing to say "no."

The risk appraisal tool below is designed to help clinicians identify their level of risk for burnout. Note how many risk factors are also behaviors traditionally rewarded or praised among physicians.

How to score: Mark a Y or N beside each of the following statements. The greater the number of "Ys," the higher your risk for burnout. Four or more positives indicate you are at high risk.

Burnout Risk Appraisal

- You tend to avoid setting and maintaining boundaries
- You only grudgingly ask for/accept help
- You often make excuses, such as, "It's faster to do it myself than to show or tell someone"
- Given a choice, you always prefer to work alone
- You do not have a close confident with whom you feel safe discussing problems
- You tend to blame external factors for problems in your work environment (It's not me…it's my nurse, it's the OR staff, it's the hospital pharmacy, it's the insurance company, etc.)
- Your work relationships are asymmetrical. E.g., you are always giving, but never receive needed assistance/support
- Your personal identity is tightly bound to your work role or professional identity (Your worth/value is strongly tied to your role as a clinician)
- You do not value commitments to yourself such as exercise or down time as much as you value the com-

Practicing self-care:
Resources for physician wellbeing

Christopher Snyder, III, MD

Dr. Snyder

As medical professionals, we spend our lives and careers focused on the health and welfare of others. For the health of the profession, and the good of society, we must not forget to look after ourselves, as well.

As physicians, we have been taught to do it all by ourselves, to do it perfectly, to never say "no" and to deny, sometimes, our most basic needs. Imagine that a patient has acknowledged driving him- or herself in this fashion on a regular basis. What would you say to that patient? Relax. Slow down. Start taking better care of yourself.

Unfortunately physicians are far better at giving medical and lifestyle advice than we are at following it ourselves. The end result is a healthcare system in which doctors feel isolated, fatigued, overburdened and unable to render the care they wish they could provide. This pattern of self-neglect is not sustainable. Society needs physicians well able to care for patients in a professional and capable manner. It doesn't need any more bitter and cynical physicians.

I have been interested in physician wellness for some time. Through my involvement in the NC Academy of Family Physicians, I have led efforts to offer CME related to physician wellbeing, and the NCAFP's Council on Health of the Public has taken up the charge to continue these efforts.

In this article, I have gathered a repository of resources that may help physicians and other clinicians become more attuned to their personal and professional needs. Some physicians may need guidance in some aspect of their careers. Some of us just need a reminder of the good and noble aspects of the practice of medicine. Some may sense that they are fraying at the seams and need ideas for how to recharge and repair. Many doctors won't need any of these resources. If you are one of those few, I bet you know someone who could benefit. The NC Medical Board has agreed to add the resources listed in this article to the "Links" section in the Professional Resources portion of the NCMB's website.

I'll close with a favorite quote, from Brian Dyson, who was CEO of Coca Cola Enterprises from 1959-1994: "Imagine life as a game in which you are juggling five balls in the air. You name them—work, family, health, friends, spirit—and you are keeping all of these in the air. You soon discover that work is a rubber ball. If you drop it, it will bounce back. But the other four balls—family, health, friends, spirit—are made of glass. If you drop one of these, they will be irrevocably scuffed, marked, nicked, damaged, or even shattered. They will never be the same. You must understand that and strive for balance in your life."

Be well.

Dr. Snyder, a family physician, is Medical Director of Patient Centered Medical Home Development for Novant Medical Group and is a past president of the NC Academy of Family Physicians.

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mitments you make to others
- You often overload yourself and have a difficult time saying "no"
- You have few opportunities for positive and timely feedback outside of your work role
- You easily become frustrated, sad or angry when performing your regular work tasks
- It is harder now for you to easily establish warmth with your peers and/or clients/patients
- You feel guilty when you "play" or rest
- You get almost all of your needs met through helping others
- You continually put others' needs before or above your own needs

Avoiding burnout: Keep the candle burning

Virtually all medical practitioners working in today's high-pressure environment are at risk of burnout at some phase of their careers. To prevent burnout, physicians and organizations that employ physicians must work proactively to spread awareness of the problem and encourage attitudes and behaviors that promote health and balance. This is no small task. Nonetheless, it is a wise and necessary investment in one of society's most precious and scarce human resources: physicians.

Organizations that employ or otherwise rely on physicians (hospitals, surgery centers, medical practices) have a vested interest in spending the time, energy and resources needed to keep doctors well.

As the process of burnout progresses, the affected individual can no longer give to patients or the practice; They are so depleted that they can only guard against their own fatigue. In fact, people who are burning out can negatively impact productivity and morale by sapping energy from the organization. Organizations can guard against this by "burnout proofing" through positive changes to work practices and professional environments. Doing so has an important side benefit of demonstrating to physicians and other clinicians that the organization is committed to preserving medical professionals as whole people. As such, "burnout proofing" is useful as a retention strategy.

What organizations can to do "burnout proof"

Cultivate a work culture that emphasizes and/or makes readily available the following:
- Unconditional respect for the professional from peers: honest PRAISE
- Regular timely feedback so corrections/adjustments can be made
- Collective thinking/problem solving and a collaborative approach to devise and implement solutions
- Acceptance of transition/change as reality, with vis-

Resources continued

The list below is by no means complete, and you are invited to add to it. Please send your favorite resources, books, pearls and comments to *forum@ncmedboard.org*
Disclaimer: *Neither the NCMB nor Dr. Snyder endorses the organizations or individuals listed below or represents them in any way.*

PHYSICIAN WELLBEING
NC Physicians Health Program
www.ncphp.org/

Center for Professional Wellbeing
www.cpwb.org/default.html

Finding Balance in a Medical Life:
www.findingbalanceproductions.com/
Book: *Finding Balance in a Medical Life*, Lee Lipsenthal, 2007

Center for Professional and Personal Renewal:
www.cppr.com/index.htm

Kitchen Table Wisdom
Rachel Naomi Remen, M.D. Riverhead Books, New York; 1996

WORK ADDICTION
Work addiction inventory:
www.darvsmith.com/dox/workaddiction.html

Co-Dependency-Care Addiction:
Referenced in *Chained to the Desk: A Guidebook for Workaholics, Their Partners, and Children, and the Clinicians Who Treat Them*; by Bryan E. Robinson (New York University Press, 1998)

BURNOUT
Burnout inventory:
www.mindtools.com/stress/Brn/BurnoutSelfTest.htm

Compassion Fatigue
www.compassionfatigue.org/index.html

Professional Quality of Life
www.proqol.org/Home_Page.php

Maslow Self Actualization
www.abraham-maslow.com/m_motivation/Self-Actualization.asp

SELF CARE-IMPROVEMENT
AMA Physician Resources
www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/healthier-life-steps-program/physicians-personal-health.page

Life stress inventory
www.harvestenterprises-sra.com/The%20Holmes-Rahe%20Scale.htm

Heart Math
www.heartmath.com/

Exercise is Medicine
www.exerciseismedicine.org/

Weight Management
www.amihungry.com/

Adult Apgar
http://adultapgar.wordpress.com/dr-shay-bintliff-2/

Zung Depression scale
http://healthnet.umassmed.edu/mhealth/ZungSelfRated-DepressionScale.pdf

Canada—physicians in training
http://ephysicianhealth.com/

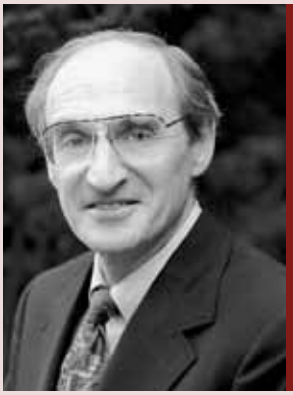
British Medical Association:
www.bma.org.uk/doctors_health/index.jsp

ible reinforcement by management
- Workshops on chaos and transition to help clinicians develop a comfort level with being "out of control"
- Workshops that acknowledge burnout as a risk of clinical practice, with de-stigmatization of burnout as a primary goal
- Avenues and/or training for constructive conflict management/dispute settlement
- Leadership training, including effective mentoring as a skill
- Parent effectiveness training (problems at home increase stress at work and vice versa)
- Availability and access to trained independent mediators (from outside the organization)
- A willingness at the organizational/management level to acknowledge that the system may create or exacerbate stress not primarily individuals
- "Juggling" workshops, especially peer-led, that let thriving practitioners share how they balance personal and professional life; Sharing by senior professionals of how they coped with disappointment, dilemmas and stress
- Availability of curricular (CLE/CME or otherwise) training in stress management
- General availability of peer support groups and peer coaching
- Availability of counseling on career fits that do not conform to the workaholic model
- Periodic creativity exercises and retreats

Conclusion

A physician who is burning out is not weak — he or she is simply human. Acknowledging and de-stigmatizing burnout is an important first step towards addressing risks and building professional environments that support well being and, over the long term, physician satisfaction.

What is patently clear is that the work environment and expectations for the practice of medicine are unrealistic. Demands are often unmanageable and overwhelming. Outside and inside pressures to do more with less deny a sense of control in the role. Reward systems often emphasize productivity and efficacy and clash with humane values. System pressure against physician community-building denies a sense of community, reinforcing the individual "lone wolf" culture modeled during training. Responses to reduce burnout must come from assertive physician wellbeing programs and systems that recognize interdependence to promote lifelong vitality.



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, that create problems in the professional medical workplace. He is founder and director of the Center for Professional Wellbeing in Durham, NC.

NCMB honors Watauga County physician

The NC Medical Board spends much of its resources licensing physicians and disciplining or correcting those who practice poorly. Too rarely does the Board have an opportunity to applaud a physician for showcasing the true definition of professionalism.

Dr. Derrick

The Board did just that recently, when it honored William A. Derrick, MD, of Boone, for his invaluable assistance to the patients of a physician who abruptly closed his practice in July 2011 and left the country. Dr. Derrick, a retired family physician who was a longtime director of Student Health Services at Appalachian State University, stepped forward and offered to take temporary custody of the abandoned patient records. Working with a Board investigator and attorney, Dr. Derrick arranged for the records to be moved to Blowing Rock Hospital. With the help of his wife, Liz, he worked for several months, often under less than ideal conditions, to locate patient records and get them to their owners. Their efforts helped hundreds of patients who would otherwise have lost their records obtain their files.

NCMB President Ralph C. Loomis, MD, and R. David Henderson, the NCMB's executive director, attended a meeting of the Watauga County Medical Society in May to surprise Dr. Derrick with a plaque recognizing his service to the Board, the profession and the patients of the high country.

The NC Medical Board is grateful to Dr. Derrick for his efforts and his commitment to North Carolina patients.

Position statement update; latest revisions

The NC Medical Board voted to adopt revisions to two positions statements during its meeting in May. The Board approved changes to the position statements: *Availability of licensees to their patients* and *Sexual exploitation of patients*. A summary of the revisions appears below. The revised statements, as well as a complete collection of Board position statements can be found at *www.ncmedboard.org* Click on "Professional Resources," and then "Position Statements."

Availability of licensees to their patients

The Board voted to change the word 'physicians' to licensees throughout the position statement. Significant changes include the addition of a new paragraph that more explicitly informs licensees of their responsibility to provide clear instructions and information to patients on how to seek after-hours care when necessary. Another new paragraph makes clear that the position statement applies to licensees practicing telemedicine as well as traditional medicine.

Sexual exploitation of patients

The Board voted to accept significant changes to the position statement on sexual exploitation of patients. The position statement is now based, in part, upon the Federation of State Medical Board's guidelines regarding sexual boundaries. The statement now distinguishes between two types of professional sexual misconduct: sexual impropriety and sexual violation. More detailed descriptions of each behavior type are also now provided.

FSMB Foundation publishes second edition of prescribing book

The Federation of State Medical Boards (FSMB) Foundation recently released a revised and expanded second edition of the popular prescribing manual, *Responsible Opioid Prescribing: A Clinician's Guide*. The book presents clinicians with effective strategies for reducing the risk of addiction, abuse and diversion of opioids that they prescribe for their patients in pain. Written by pain medicine specialist Scott M. Fishman, MD, the revised and expanded edition features important new material, including research on opioid prescribing that was not available when the first edition was published in 2007, and updated recommendations for prescribers.

The NC Medical Board has distributed hundreds of the first edition book to licensees with identified deficiencies or other problems with prescribing of controlled substances. It is proud to recognize NCMB Medical Director Scott G. Kirby, MD, as a member of the advisory board that reviewed the second edition of the book.

The expanded Clinician's Guide translates best-practice guidelines from leading pain medicine societies and the FSMB into pragmatic steps for risk reduction and improved patient care, including:

- Patient evaluation, including risk assessment
- Treatment plans that incorporate functional goals
- Informed consent and prescribing agreements
- Periodic review and monitoring of patients
- Referral and patient management
- Documentation
- Compliance with state and federal law
- Patient education on safe use, storage and disposal of opioid medication
- Termination strategies for chronic opioid therapy

Since publication of the first edition in 2007, *Responsible Opioid Prescribing* has been widely used and supported in the medical and regulatory communities as the leading continuing medical education (CME) activity for prescribers of opioid medications. For the first time, the FSMB Foundation has released CME activities designed to accompany the book.

BUY THE BOOK, CLAIM THE CME

In order to receive credit, participants will need to obtain a copy of the book, which can be ordered at www.fsmb.org/cme/*index.html* ($16.95 plus shipping; volume discounts available). The content of the CME activity is divided into three modules that together comprise 7.25 AMA PRA Category 1 Credits. In order to receive credit, participants should:

- Read the chapters included in each module
- Go online to *www.fsmb.org/CME*
- Click the link to "Claim Credit for Responsible Opioid Prescribing: A Physician's Guide"
- Enter the access code included in the book
- Select the module you would like to claim credit for and complete the online registration process (participants only need to register once to complete all three modules)

North Carolina Medical Board

Quarterly Adverse Actions Report | February - April 2012

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			
FENN, James David, MD (201000133) Moyock, NC	03/07/2012	History of alcohol abuse, DUI. MD was arrested/ charged with assault on a female; failed to report for a recommended evaluation at an alcohol assessment center. Results of an ordered assessment indicate that MD is alcohol dependent/history of cocaine abuse.	Summary suspension of NC medical license
REVOCATIONS			
HADDON, Werner Scott, MD (000035356) Raleigh, NC	04/23/201	MD was convicted of a felony for kidnapping.	Entry of revocation
SUSPENSIONS			
CHEN, Louis Chai-His, MD (RTL) Seattle, WA	02/24/2012	MD was charged with murder in August 31, 2011.	MD's resident training license is indefinitely suspended.
EVANS, Eric Eugene, PA (001000806) Safat 13007 Kuwait, AE	02/16/2012	While examining a female patient, PA used language that he acknowledged could have been interpreted by the patient as inappropriate. Patient reported that she believed he was going to inappropriately touch her.	PA's license is suspended for six months, stayed; must have a chaperone present for exams of female patients; other conditions
GERANCHER, John Charles, III, MD (009500077) Winston-Salem, NC	02/16/2012	MD pled guilty to one count of indecent exposure.	MD's license is indefinitely suspended.
MCINTOSH, Margaret Gloria, MD (000036117) Charlotte, NC	02/07/2012	Improper prescribing to self/spouse; prescribing controlled substances without valid DEA registration. MD has history of Board discipline for improper prescribing and for the unlicensed practice of medicine.	Indefinite suspension of NC medical license.
MEEHAN-DE LA CRUZ, Kathleen, MD (009900813) Norwalk, OH	03/12/2012	MD entered into a romantic relationship with a patient; she issued three prescriptions to the patient. On one occasion, MD wrote a prescription to the patient for a medication she used to treat herself.	MD's license is suspended for 30 days, immediately stayed.
MOORE, Michael Christopher, DO (009701826) Chapel Hill, NC	04/4/2012	Inappropriate care/controlled substance prescribing to a person with whom DO had a personal relationship. Deficiencies in the care of two patients. DO ordered for assessment; surrendered license in January 2012.	DO's license is indefinitely suspended.
NUNN, Michael Kermitt, DO (000036123) New Bern, NC	02/14/2012	MD pled guilty as an organizational defendant (e.g. medical corporation) to money laundering/healthcare fraud.	MD's license is suspended for 12 months, stayed; $5,000 fine.
PARUCHURI, Vamsee Prasad, MD (201001537) High Point, NC	02/14/2012	MD obtained Ambien for personal use by writing prescriptions in the names of others and forging the name of another physician on the prescription; arrested for obtaining controlled substances by fraud/forgery	Indefinite suspension of NC medical license.
RAO, Shiva Kumar, MD (009401479) Roanoke Rapids, NC	3/27/2012	MD submitted an online application and was interviewed for a position on the NC Medical Board. MD failed to provide truthful information in regards to three questions during the application process.	MD's license is suspended for six months, stayed all but 30 days; beginning 4/30/12 and ending 5/29/12.
ULLAH, A.B.M. Enayet, MD (009801790) Smithfield, NC	02/16/2012	MD inappropriately prescribed controlled substances to coworkers. Medical records were inadequate and not created contemporaneously with treatment provided.	MD's license is indefinitely suspended.
URBAN, Edward John, DO (000027410) Asheville, NC	0/05/2012	DO inappropriately prescribed controlled substances without an appropriate physical exam and without appropriate medical justification.	Order of partial suspension of medical license; may not prescribe controlled substances per DEA/Controlled Substance Act.
WASHINGTON, Clarence Joseph, MD (000032295) Fayetteville, NC	03/13/2012	Patients treated at HRC Medical of NC received substandard care according to a Board review of records for Patients A-H.	MD's license is suspended for 12 months, stayed all but 90 days beginning 5/1/12 to 7/30/12.

Name/license#/location	Date of action	Cause of action	Board action
PROBATIONS			
CALOGERO, Thomas John, III, MD (20050187) Mount Olive, NC	04/20/2012	MD's treatment and care of six patients fell below accepted standards of medical practice. MD's medical records were "disjointed and inadequate."	MD's license is placed on probations; must comply with conditions
ROGERS, Benjamin Michael, MD (RTL) Winston-Salem, NC	04/20/2012	MD was arrested for misdemeanor charges of Assault on a Female, Communicating Threats and Breaking and Entering. During the pendency of the criminal charges, the District Court entered domestic violence protective orders against MD.	MD's license is placed on probation; must comply with conditions
THOMPSON, Joel Wesley, PA (000101018) Charlotte, NC	04/20/2012	PA was charged/cited with a hit and run on two occasions. Charges were dismissed. PA did not disclose on his license application a 1987 arrest for DWI. Subsequent to the arrest, PA was arrested on three more occasions for DWI, two of which resulted in convictions. PA has undergone treatment for alcohol dependence.	PA is reprimanded and placed on probation for two years; conditions on license.
REPRIMAND			
ACOSTA, Daniel, MD (200100499) Greenville, NC	03/13/2012	MD's care of a psychiatric patient who requested assistance in discontinuing the use of Xanex was below standards.	MD is reprimanded; must attend courses in medical record keeping and prescribing medicines approved by NCMB
ARNOLD, Gordon Bruce, MD (000016565) High Point, NC	04/20/2012	MD treated family members not in accordance with NCMB position statement on treating self/family. Care of several patients was below standards; concerns focused on treatment of chronic pain and controlled substance prescribing.	MD is reprimanded, conditions and restrictions on license
BABALOLA, Olufemi Abiola, MD (200901598) Atlanta, GA	12/16/2012	An independent expert reviewer's assessment of two patient charts revealed that MD's performance of cholecystectomy was substandard in each case. MD currently practices in Georgia.	MD is reprimanded.
BARKER, Joseph David, MD (000036648) Linville, NC	12/17/2012	Inappropriate prescribing of controlled substances for pain; poor documentation.	MD is reprimanded and placed on probation for 12 mos.
CHRISTENBURY, Jonathan David, MD (000026210) Charlotte, NC	04/09/2012	MD had a personal relationship with a patient of his practice. The patient received medical treatment performed by a PA.	MD is reprimanded, and fined $3,000. Conditions on license.
GAFFNEY, Mary Elizabeth, DO (009601319) Charlotte, NC	04/19/2012	A reviewing expert concluded that DO's diagnosis and treatment of a patient was below standard.	DO is reprimanded with conditions placed on license.
GOOTMAN, Aaron Harvey, MD (200200534) Fayetteville, NC	04/03/2012	MD supervised four PAs. MD or PAs signed prescriptions for controlled substances for a patient seen by a clinician who did not have the ability to prescribe controlled substances without independently examining the patient.	MD is reprimanded
KIRBY, Daniel Lee, MD (009900083) Davidson, NC	12/16/2012	MD purchased Canadian versions of two prescription drugs over the Internet for use in his NC practice; Consent forms indicated that the drugs were the FDA-approved American versions.	MD is reprimanded; $10,000 fine.
THOMPSON, Joel Wesley, PA (000101018) Charlotte, NC	04/20/2012	PA was charged/cited with a hit and run on two occasions. Charges were dismissed. PA did not disclose on his license application a 1987 arrest for DWI. Subsequent to the arrest, PA was arrested on three more occasions for DWI, two of which resulted in convictions. PA has undergone treatment for alcohol dependence.	PA is reprimanded and placed on probation for two years; conditions on license.
DENIALS OF LICENSE/APPROVAL			
SHAH, Mian Mohsin, MD (denied) Tustin, CA	02/27/2012	MD was placed on provisional disciplinary probation during residency training; MD failed to report on application. In addition, there was a discrepancy with one of MD's submitted references.	Denial of application for NC medical license.
SURRENDERS			
ADKINS, Paula Clark, MD (00009900745) Pinehurst, NC	04/19/2012		Voluntary surrender of medical license
BOGGALA, Vijaya Prakash, MD (RTL) Greensboro, NC	02/01/2012		Voluntary surrender of resident training license
COLEMAN, Adam C., PA (001001168) Durham, NC	04/16/2012		Voluntary surrender of PA license

Name/license#/location	Date of action	Cause of action	Board action
GUFFEY, Neal Hamilton, Jr., MD (009500489) Winston-Salem, NC	04/17/2012		Voluntary surrender of medical license
MAYNOR, Michael Lee, MD (000030677) Choctaw, MS	02/15/2012		Voluntary surrender of medical license
PUBLIC LETTERS OF CONCERN			
BLOEM, Josephus TH. J., MD (000024225) Rocky Mount, NC	04/02/2012	MD prescribed controlled substances to a family member, and prescribed/asked others to prescribe with intention of diverting medication for personal use; MD did so on one occasion.	Public letter of concern
CONA, Constantino Dino, MD (009700905) Asheville, NC	04/24/2012	MD and a PA under MD's supervision inserted a biopsy needle into a patient's chest on the left side rather than the right, puncturing the patients pulmonary artery and causing a pericardial tamponade that led to her death.	Public letter of concern issued via Findings of Fact, Conclusions of Law and Order of
CONTRERAS, Jamie Jaqua, MD (201001200) Winston-Salem, NC	04/09/2012	MD failed to register and renew MD's NC medical license within 30 days of his birthday. MD continued to practice with an inactive license, but immediately stopped and applied for reactivation upon realizing his license was inactive.	Public letter of concern
HARRIS, Tasha Jean, PA (009900541) St. Johns, FL	03/20/2012	PA did not appropriately address significantly abnormal laboratory results that may have had an impact on the outcome of a patient diagnosed with anemia and dysfunctional uterine bleeding.	Public letter of concern
JENELLE, Richard Lester Stephen, MD (200101564) Los Angeles, CA	04/04/2012	MD supervised a resident who incorrectly noted that a tumor of a patient was in the left lung, when it was in the right lung. This led the patient to receive 32 treatments of radiation to his left lung, when the patient had lung cancer located in the right middle lobe of his right lung.	Public letter of concern
JOHNSON, John Theodore, Jr., MD (200300816) Morehead City, NC	02/14/2012	MD's care of a patient who developed an anastomotic leak following gastric bypass surgery may have been substandard. The Board is concerned that MD did not suspect anastomotic leak sooner, which may have led to earlier surgical intervention and fewer complications.	Public letter of concern
LANCASTER, David Steven, II, MD (200601330) Charlotte, NC	04/30/2012	MD's care may have failed to conform to acceptable standards. MD failed to properly recognize changes in a patients second ECG and then did not obtain additional diagnostic tests prior to discharging the patient.	Public letter of concern
PETERSON, Carole Jean, MD (2012-00312) Rochester, NY	03/01/2012	MD failed to disclose his involvement in six malpractice claims filed from 1986-2007.	License issued, with a public letter of concern and $1,000 fine.
REID, Kim Purcell, PA (000101039) China Grove, NC	03/29/2012	PA failed to diagnose cirrhosis in a patient even though symptoms were suggestive of liver disease. The patient developed unrecognized non-alcoholic cirrhosis of the liver presumably through long-term use of improperly monitored methotrexate.	Public letter of concern
ROY, James William, MD (200700583) Decatur, AL	04/12/2012	MD interpreted a sleep study and offered his impressions and recommendations for treatment of a NC patient. MD's license has been inactive since 2007. MD was practicing medicine in NC without a license.	Public letter of concern
SHERMAN, Robert Olney, Jr., PA (000103138) Fayetteville, NC	02/01/2012	PA practiced medicine without having required documents in place, including a signed statement of supervisory arrangement, written instructions for prescribing, etc.	Public letter of concern
SHERROD, William Maxwell, MD (200101497) Bolivia, NC	04/17/2012	MD did not appropriately document a thorough evaluation of a patient's injuries following a motor vehicle accident, and did not obtain further tests/CT scan or alternatively document the patients refusal of such recommended tests.	Public letter of concern
SMITH, Yale Robert, MD (201200717)	04/04/2012	MD failed to include an investigation/Board action by the Fl. Board on MD's license application	Public letter of concern
SNOW, Douglas Hardy, DO (200600532) Paducah, KY	04/20/2012	DO's supervision of a PA may have failed to conform to acceptable standards. MD was not appropriately involved in the care the PA provided.	Public letter of concern

Name/license#/location	Date of action	Cause of action	Board action
THERIAULT, Joseph Herman, LP (100000066) Raleigh, NC	05/10/2012	LP had a positive drug screen for cannabis and placed perfusionist license on inactive status	Public letter of concern
WATKINS, James Allison, MD (000024954) Charlotte, NC	04/12/2012	MD did not consult with a thoracic surgeon or oncologist intraoperatively after discovering a patient had distal esophageal cancer during a scheduled partial gastrectomy. The patient experienced significant post-surgical complications.	Public letter of concern
WHITESIDES, Daniel Baxter, MD (000029445) Charlotte, NC	3/22/2012	MD did not review the genetic test results of a patient, failing to discover a nurse's error of inaccurately recording "negative" when a patient tested positive as a carrier for cystic fibrosis	Public letter of concern
WHITTED, Matthew Louis, MD (000033199) Chesapeake, VA	02/14/2012	History of boundary issues/disruptive behavior in the hospital setting. Conduct led MD to enter into a consent order with the Va. Board	Public letter of concern
WILLIAMS, James Dewey, MD (200300429) Oxford, NC	04/30/2012	MD did not discontinue a biopsy procedure when anesthesia staff were unable to intubate or otherwise establish a secure airway for a patient.	Public letter of concern
MISCELLANEOUS ACTIONS			
CARR, Emily Kathleen, MD (RTL) Winston-Salem, NC	03/08/2012	MD failed to answer a licensing application question correctly and inform the Board about MD's medical conditions. MD has been assessed by NCPHP and entered into a contract.	MD is issued a resident training license via consent order; $500 administrative fine.
CONSENT ORDERS AMENDED			
HUYNH, Tuan Anh, MD (200300814) Charlotte, NC	12/17/2012	History of inappropriate prescribing of controlled substances.	Amendment to consent order dated 10/15/2010. MD may prescribe controlled substances if he obtains a proper DEA registration. However, MD is still prohibited from prescribing controlled substances for the treatment of pain.
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
OLIVER, Joseph Andrew, III, MD (009501366) Rockwell, NC	03/08/2012	History of alcohol dependence	Temporary medical license issued; expires 03/08/2013
PARKIH, Himanshu Pravinchandra, MD (009600671) Cary, NC	03/23/2012		Temporary license issued; expires 11/30/2012
SHEILDS, Douglas Allen, MD (009400352) Jonas Ridge, NC	4/13/2012	MD has history of alcohol dependence; entered into a consent order with the Board in 06/2010; MD's license was indefinitely suspended; MD has been in a contractual relationship with NCPHP.	Temporary medical license issued; expires 04/13/2012
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			

FINES

The NCMB issues non-disciplinary administrative fines in certain cases where incorrect and/or incomplete information on a medical licensing application causes Board staff to spend an inordinate amount of time resolving the issue(s),

Date	Reason	Amount
March 2012	Failure to respond accurately to a question on license application	$500
March 2012	Failure to report out-of-state investigation and Board action	$1,000
March 2012	Failure to renew license and practiced with and inactive medical license	$1,000
March 2012	Failure to respond accurately to questions on license application	$1,000
April 2012	Failure to timely report CME and respond to audit inquiries from the Board	$500
April 2012	Healthcare fraud and money laundering	$5,000
April 2012	Incorrectly completed the malpractice data section on license application	$1,000

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

August 16-17, 2012 (Hearings)
September 19-21, 2012 (Full Board)
October 18-19, 2012 (Hearings)
November 14-16, 2012 (Full Board)

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.

Rule change alert

Three sets of rule changes won final approval in July, including significant revisions to the rules governing the Board's continuing medical education (CME) requirements.

Revised CME rules (21 NCAC 32R - .0101 - .0105) take effect August 1 and include the following changes:

- The rule eliminates the requirement to document any Category 2 CME hours but maintains the requirement to earn at least 60 Category 1 CME hours over a three-year period. The Board encourages licensees to participate in CME, whether Category 1 or 2, above and beyond the minimum required hours, as their time permits.
- The rule exempts licensees who can document participation in an ABMS- or AOA-approved Maintenance of Certification (MOC) program from reporting any CME hours to the NCMB. This change reflects the Board's acknowledgement of the significant effort and investment in practice-relevant training/education involved in pursuing MOC.

Additional rule changes that take effect August 1 include:

- Revisions to 21 NCAC 32B .1001 and 21 NCAC 32S .0212 (prescribing rules for physicians and for physician assistants) prohibits physicians and PAs from prescribing controlled substances to themselves or to members of their immediate families.
- A revision to the Resident Training License (RTL) application rules (21 NCAC 32B .1402) eliminates the requirement for RTL applicants to submit letters of recommendation. The Board has determined that it very rarely receives useful information via recommendation letters. In addition, this rule change makes the RTL application requirements consistent with requirements for applicants for a full medical license.