FORUM
NORTH CAROLINA MEDICAL BOARD
FOR THE BENEFIT AND PROTECTION OF THE PEOPLE OF NORTH CAROLINA
NO. 2 SUMMER 2015

The looming epidemic of physician burnout - Pg. 8

Who is responsible for quality of care in an era of diminished provider autonomy?

I entered the practice of medicine at a time when physicians could more or less count on being masters of their professional domains. Most either worked in solo practice, where their authority was absolute, or in group practices with the expectation to eventually earn partnership. Both settings afforded the almost unquestioned ability to make independent decisions about patient care. Of course, being in control of care also meant being willing to assume responsibility for care-associated outcomes, good and bad.

NCMB President Cheryl Walker-McGill, MD, says "the traditional model of holding licensees responsible as "captains of the ship"... is not always appropriate"

Today, decisions about patient care are increasingly subject to factors outside the treating provider's control, creating challenges for licensees and the Board alike. This evolution in health care delivery presents this quandary: How can the NCMB effectively hold individuals accountable in situations where the licensee's true impact on patient care cannot be easily determined? The answer is neither obvious nor simple.

We practice medicine in an environment where managed care policies dictate which studies, procedures and medications should be used. Economic and regulatory pressures have led more licensees to choose hospital or corporate employment (just over a quarter of physicians work in practices owned in part or in full by a hospital or health system, according to a survey by the American Medical Association released in July) over partnership or solo practice. With this comes increased pressure to follow corporate, system or department protocols that may conflict with provider judgment. The trend toward team-based medical practice, despite its many potential benefits, also dilutes the physician's ability to control decisions about care. Finally, the prevalence of electronic health records and system communication breakdowns add additional layers of complexity that can lead to mistakes and poor care.

Frequently, Board review of a disciplinary case suggests some factor outside the licensee's control played a significant role in the case. The NCMB's mission is clear: we have a duty to protect patients. But the circumstances of these cases are not clear. Sometimes Board Members conclude that a poor outcome is truly more of a team failure or system failure, but we do not regulate teams or health systems. The Board licenses individuals and its disciplinary process is designed to hold individuals accountable. At times it seems that we are trying to fit a proverbial square peg in a round hole.

IN THIS ISSUE

I'll share some examples of the types of cases that regularly challenge the Board:

When following established protocols fails patients

Case study: *A licensee treats a patient who presents in the hospital emergency room with symptoms suggestive of a serious underlying medical problem, but test results do not meet thresholds established in hospital protocols for admission. Protocol recommends discharge to home and follow up as an outpatient. The patient is discharged home. The patient's condition worsens, and they present to another emergency department the following day with similar symptoms and die within 24 hours of admission.*

Discussion points: Health care institutions have written and unwritten policies for managing patients and resources. These guidelines are in place to ensure consistent quality of care and prevent overconsumption of resources. A licensee is in the difficult position of having to follow policy while having the skill and intuition to tailor care to meet the unique needs of their patients. When licensee judgment runs counter to established policy, what responsibility does the licensee have to buck the system? The clinician members of the Board understand that it's not reasonable or realistic to expect licensees to argue for exceptions every time their gut tells them that, this time, the protocol isn't right and the patient does need to be admitted. The Board does expect licensees to learn from bad outcomes and work constructively with department and system administrators to make changes that improve care. At the same time, we appreciate this is only possible when department and system administrators are willing to work with the licensee to make necessary changes in policies and procedures.

Case study: *A licensee accepts a position with a medical practice that manages a large population of chronic pain patients. The practice follows a written protocol that directs opioid prescribing and other aspects of patient management. The protocol does not meet accepted and prevailing standards of care. A patient's family members file a complaint, after the patient is admitted to the hospital for opioid poisoning.*

Discussion points: It's difficult to come into an established practice group and question the way things are done. At the end of the day, however, licensees are held individually accountable for practicing care that meets accepted standards. If you agree to follow established protocols, you have a responsibility to ensure you will still be able to provide quality care. If you discover that you cannot, finding an employment situation that does is the best way to protect yourself and your patients. If it comes to it, the explanation of, "I was just following my practice protocol" will not prevent the Board from voting to take action, if warranted.

Complications of the healthcare delivery system

Case study: *A licensee performs emergency abdominal surgery on a patient with a burst appendix. The patient lives alone and will require outside assistance with recovery and follow up care. The licensee orders home health services for the patient during discharge planning, but home health is not in place when the patient*

North Carolina Medical Board Forum Credits

Volume XX | No. 2 2015

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) 326-1130

Website:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

Have something for the editor?
forum@ncmedboard.org

is discharged home, and antibiotic therapy is not continued as directed by the licensee. Two days after discharge, the patient calls for an ambulance after developing a fever, shortness of breath and chest pain. The patient is diagnosed with abscess, sepsis and pneumonia and is readmitted.

Discussion points: This is the sort of case we often refer to as a "system failure." Who is ultimately responsible for the bad outcome? Should the licensee be held accountable for ensuring that orders have been properly executed or is his or her duty discharged simply by ordering the correct course of treatment? In these types of case, one approach the Board might use is to hold the licensee accountable (by issuing a Public or Private Letter of Concern, for example) while acknowledging the system failures that contributed to the poor outcome.

Case study: *A licensee who practices family medicine sees an established patient with a remote history of depressive illness for a routine visit. The licensee's practice recently implemented an electronic health records system and the licensee is using a scribe to handle documentation of the visit. The licensee takes the patient history and conducts an examination and no issues are noted. Later that night, the patient presents in a hospital emergency room with an acute grief reaction and an acute overdose of Tylenol. Later, the patient tells the licensee that she is going through a painful divorce and had been feeling down for weeks prior to her check up, but did not feel comfortable bringing up the divorce and related feelings in the presence of the scribe.*

Discussion points: This is an example of one way that changes in the health care delivery system (routine use of EHR and medical scribes) have the potential to impact care in unpredictable ways. Licensees must strive to remember that patients are as affected by changes to the health care delivery system as the providers who are struggling to adapt to new processes and tools, and be sensitive to their patients' needs.

Where do we go from here?

I'd love to say that the Board has discovered a foolproof way of analyzing complex cases that always results in determining who is accountable in a way that is fair to both licensees and to patients. However, that just isn't the case. I can tell you that the Board is fully cognizant that the traditional model of holding licensees responsible as "captains of the ship" regardless of extenuating circumstances outside the licensee's control is not always appropriate. We recognize that the health care delivery system has changed and that we cannot ignore how this impacts the licensee's control over outcomes and other aspects of care. We also recognize that the NCMB's traditional processes need to evolve to match modern circumstances. This will not happen overnight and it will not happen easily.

For now, I and my colleagues on the Board consider the facts of each case and do the very best we can to come to a resolution that holds the licensee accountable for decisions and actions that he or she can reasonably be held responsible for while noting the influence of external factors. This is an uphill battle, but one that must be aggressively pursued to ensure that the NCMB is able to effectively fulfill its mission in a way that is fair to licensees.

Best Regards,

Cheryl L. Walker-McGill, M.D.

Cheryl L. Walker-McGill, MD, MBA

Send comments to forum@ncmedboard.org

Protect Yourself

Licensees can avoid putting themselves in professional situations that may expose them to sanction by the Board by going into any new employment situation with their eyes open.

Points to consider when entering a new work environment:

- Understand the organizational structure/ownership – to treat patients lawfully in NC, practices must be owned at least in part by someone with an active NCMB license
- Be familiar with the written policies for healthcare delivery
- Be familiar with the unwritten policies for care
- Anticipate problems before you commit. Ask yourself, will I be working in an environment that meets the standard of care and reflects your personal standards for care
- Recognize that your obligation to provide care that meets accepted standards may require you to walk away from a situation that does not allow this

Source: Dr. Walker-McGill

NCMB Leadership Team for 2015-2016

The NC Medical Board elected officers for the coming year at the July meeting of the Board. Officers begin their terms November 1. Pascal Osita Udekwu, MD, of Raleigh, will serve as Board President; Eleanor Greene, MD, of High Point will serve as President-elect and Timothy E. Lietz, MD of Charlotte, will act as Secretary/Treasurer. Michael J. Arnold, a public member from Raleigh, was elected as an at-large member of the Executive Committee, which sets Board priorities and handles governance responsibilities. Outgoing Board President Cheryl Lynn Walker-McGill, MD, will continue to serve on the Executive Committee as Immediate Past President of the Board. Officer terms end on October 31, 2016.

Board President
Pascal Osita Udekwu, MD, MBA/MHA

Dr. Udekwu has practiced at WakeMed Health & Hospitals in North Carolina since 1991. He completed residency training in pediatrics and in general surgery at the University of Chicago, a fellowship in trauma and surgical critical care at the University of Pittsburgh and earned a master's degree in business administration and health administration from Pfeiffer University in Meisenheimer, NC.

Board President
Pascal Osita Udekwu, MD

Dr. Udekwu holds multiple leadership roles including Director of Trauma, Vice Chairman of Medical Staff Quality Improvement and Director of Surgical Critical Care, all at WakeMed. He is also Associate Director of the Surgical Residency Program at the University of North Carolina, Chapel Hill.

Dr. Udekwu currently serves as a professor at UNC-CH and is an adjunct professor at Campbell University's College of Pharmacy and Health Sciences. He is triple-board certified with certifications from the American Board of Pediatrics, the American Board of Surgery and the American Board of Surgery - Surgical Critical Care.

Dr. Udekwu has authored numerous papers and abstracts for scholarly journals and is a member of several professional organizations. He is a fellow of both the American College of Surgeons and of the American College of Chest Physicians.

In addition, Dr. Udekwu served in the United States Army Reserve from 1988-2005 deploying to Bagram Afghanistan as Chief of Surgery in 2003. He currently serves as a Colonel in the United States Air Force Reserve at Joint Base Andrews, Maryland.

Dr. Udekwu was appointed to the Board in November 2012. He currently chairs the Licensing Committee and serves on the Executive and Policy Committees.

President-elect
Eleanor E. Greene, MD, MPH

Dr. Greene, of High Point, is an OB/GYN who practices in High Point. Dr. Greene earned a BS degree in medical technology from the former Bowman Gray School of Medicine (now Wake Forest University School of Medicine). She received her MD and a Master of Public Health in Maternal and Child Health from the University of North Carolina, Chapel Hill, and completed residency in obstetrics and gynecology at the Ohio State University.

Dr. Greene is a member of the North Carolina Medical Society, Doctors for America, North Carolina Obstetrics and Gynecology Society, and the National Medical Association, where she served on the Board of Directors, Finance and Health Policy Committees. She serves on the Piedmont Health Services and Sickle Cell Agency. She served on the North Carolina Advisory Committee on Cancer Coordination and Control, on the Board of Directors of the Healthy Start Foundation, completing two terms on each. Dr. Greene is past president of the Old North State Medical Society, and continues to serve on its current Executive Committee. She is a fellow of the American College of Obstetrics and Gynecology.

President-elect
Eleanor E. Greene, MD

Dr. Greene is the first physician from High Point, NC, and the first African American female physician to serve on the NC Medical Board. She speaks on the topic of Women's Health and Women in Medicine at numerous church and community forums. Dr. Greene recently served as moderator for a conversation on Women's Health and the Affordable Care Act featuring the Department of Health and Human Services Director, Secretary Kathleen Sebelius.

Dr. Greene was appointed to the Board in November 2012. She currently serves on the Disciplinary and Executive Committees of the

Board, and on the Board of Directors of the NC Physicians Health Program.

Secretary/Treasurer Timothy E. Lietz, MD

Dr. Lietz currently practices emergency medicine in Charlotte with Mid-Atlantic Emergency Medical Associates, where he serves on the Board is also President and CEO. In addition to treating patients in the emergency department, he is co-chair of the Novant Health Emergency Department Shared Governance Council and serves as Medical Director for Novant Health Event Medicine.

Secretary/Treasurer Timothy E. Lietz, MD

Dr. Lietz earned his medical degree from the Ohio State University School of Medicine. He completed an internship with the Eastern Virginia Medical School Department of Internal Medicine and residency training with the same institution's Department of Emergency Medicine.

Dr. Lietz is a fellow of the American College of Emergency Physicians and is board-certified by the American Board of Emergency Medicine. He is a member the North Carolina College of Emergency Physicians and the American College of Emergency Physicians.

Dr. Lietz was appointed to the Board in November 2013. He currently chairs the Board's Disciplinary Committee and serves on the Executive and Policy Committees.

At-large member Michael J. Arnold, MBA

Mr. Arnold, of Wake Forest, has worked as a policy, research and public affairs professional at high levels of state government for more than two decades. He served nine years as a university administrator and on faculty at the University of North Carolina at Wilmington and then later as a high-ranking senior official in the Executive branch of state government.

Mr. Arnold serves as Senior Advisor for Policy & Government Relations with Secretary of State Elaine Marshall. Additionally, he serves as an adjunct faculty member in the Terry Sanford School of Public Policy at Duke University. Prior to that, Mr. Arnold served as Senior Advisor for Policy and Research to the Governor and Lt. Governor's Office.

At-large member Michael J. Arnold, MBA

Mr. Arnold has also worked as Senior Research Director for the NC Health and Wellness Trust Fund, which was one of three entities created by the NC General Assembly to invest North Carolina's portion of the Tobacco Master Settlement Agreement. Prior to that, he served in a public affairs and development role for the Alice Aycock Poe Center for Health Education in Raleigh, one of the state's largest health education centers.

Mr. Arnold earned a bachelor's degree in Communication Studies from the University of North Carolina, Wilmington, and a master of business administration from the same institution. He also earned a certification in Nonprofit Management, with an emphasis on communications and strategic planning from Duke University.

Mr. Arnold was appointed to the Board as a public member in November 2012. He currently chairs the Board's Policy Committee and serves on the Disciplinary and Executive Committees. he represented the Board and helped draft national guidelines on the Federation of State Medical Board's Telemedicine Workgroup.

NEED A SPEAKER?

The North Carolina Medical Board is pleased to provide Board Members and/or Board staff to speak to professional groups and other audiences; medical students, residents, professional meetings and conferences, hospital grand rounds and practice meetings or retreats.

If you are interested in scheduling a speaker please contact the Board's Communications Director: Jean Fisher Brinkley, 919-326-1109 x230 or *jean.brinkley@ncmedboard.org*

Treating children of divorce: Obtaining custody documents and setting clear ground rules are key

Currently over 1 million children experience divorce each year and up to 61% of children in this country will experience their childhood in single-parent homes. The process of separation and divorce strains relationships and erodes communication. The negative emotions associated with this can impact professional relationships within the healthcare setting. The licensee who cares for minor children will likely have to manage some aspect of the controversies attendant to divorce and separation. Licensee entanglement in the legal battles that erupt is not unusual. Review of complaints against licensees presented to the NCMB confirms this.

Karen Burke-Haynes, MD
Assistant Medical Director

In this article, I've attempted to address some of the administrative challenges that may arise in the office in high conflict scenarios. Intensified relational dynamics typically characterize the first two or three years after separation/divorce. Much of this resolves after this time. There is, however, a group of parents (eight to 15%) for whom conflict continues for years after divorce. Licensees caring for minor children in the primary care setting as well as other areas of specialization would benefit from formulating strategies to manage the fallout of these bitter interactions. It is important to note that these dynamics not only negatively impact the physician-patient care relationship but also the administrative staff who are most often the front-line negotiators of parental hostilities.

The American Academy of Pediatrics position statements provide insight and guidelines for addressing the emotional, developmental and physical needs that arise in divorce and separation. However, there is little mention of strategies for assisting practices and institutions in mitigating risks that stem from high conflict scenarios.

Careful consideration and development of a systematic response is warranted and can be extremely important to licensees. Consider the following malpractice case reviewed recently by the Board:

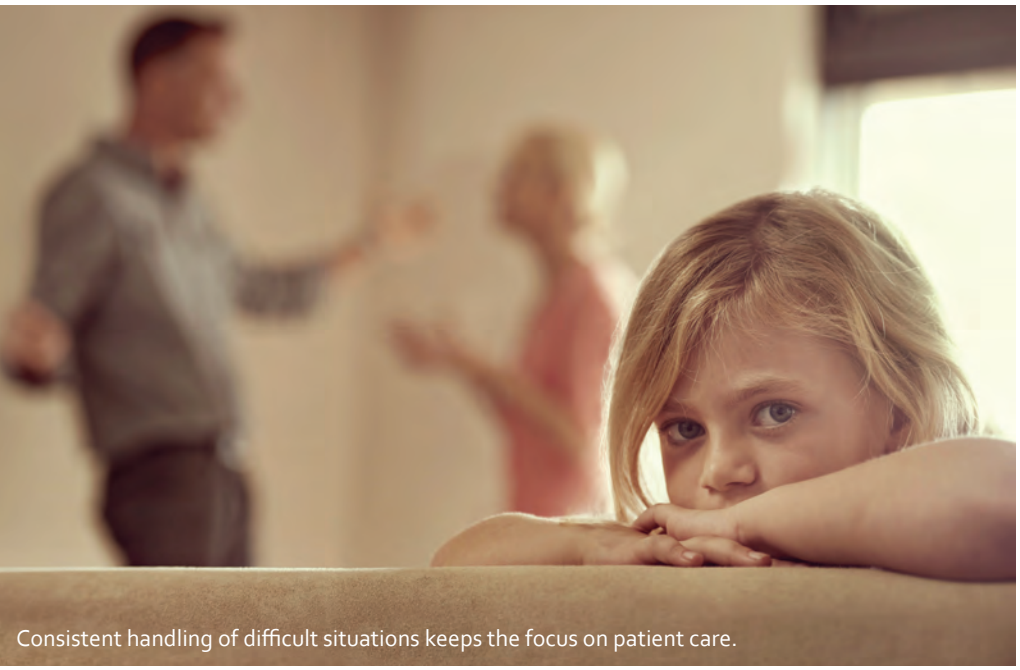
Case Study: Appropriate care, inadequate consent

The Board received a malpractice payment report regarding a payment made on behalf of a board certified pediatric specialist with no prior history of actions against his license. The licensee was successfully sued by a parent in spite of having provided medically relevant and appropriate care to the minor child. The patient was brought in for care by the father, who had physical custody and shared legal custody. The setting was one of ongoing conflict after an extremely contentious divorce. The clinician was consulted by a major academic center to assist in supporting the psychological needs of the patient. Care was arranged by the father and assumed by the clinician to have been confirmed with the mother. Care was delivered over a two-year period. Records documented that the child did well under the physician's care. Review of records confirmed competent and appropriate care of the patient. However, the licensee was accused by the mother of being a biased advocate. The physician's clinic notes were used to support the mother's case. The Board determined that there was no violation of the Medical Practice Act involved in the case and no board action was taken. However, because a payment that met criteria established by state law was made on the physician's behalf, the payment is public information. As a result, there is now a public malpractice payment reported on the licensee's information page on the NCMB's website.

Practical guidance on protecting your practice and avoiding problems

Conversations with local attorneys familiar with high conflict divorce dynamics and a review of complaints presented by custodial and noncustodial parents to the Board suggest the need to support licensees with practical advice on managing these cases to mitigate potential risks.

One of the first steps for a medical office is to ensure that the practice has access to all relevant legal documents that state the terms of custody and care of the minor(s) involved. Parental and custodial relationship disclosure should be standard for all pediatric patients. In shared custody arrangements, documents should be requested from both parents. If parents are unwilling or unable to provide copies, these documents can also be obtained from the Clerk of Court office that has jurisdiction over the case. These are public documents and are available if the case number is provided. To ensure consistent access to custody documents, there may be benefit to using



Consistent handling of difficult situations keeps the focus on patient care.

the Clerk of Court as the standard source of custody information. Front office staff should be informed of the importance of obtaining custody documents and trained to request and maintain them.

I offer the following advice, based on more than 25 years of pediatric practice in academic and private practice settings:

Establish terms of custody: Custody may refer to both physical and legal rights. The decision to treat a minor child based on input of one parent in the setting of joint legal custody should be based on medical necessity and be clearly documented in the record.

Set office policies: Develop standard office policies for obtaining information on custody arrangements for all new patients prior to establishing care. Clarify marital status and gather all addresses.

Use a healthcare contract: Develop a written, signed informal contract that states the parents' commitments regarding healthcare decision making for the patient and communication with the office. This may be used as a reference point when conflict arises. It is not intended to be a legal document, but rather to serve as a behavior contract.

Be proactive: Once conflict is identified, declare a timeout. Attempt to meet with parents separately or together to present the practice's position and outline policies regarding authorization for treatment and other matters.

Set clear boundaries: Avoid playing the role of peacekeeper. Your focus should be on your patient and avoiding barriers to quality patient care.

Remain neutral: Avoid being pulled into the dynamic of acting as a character witness - no taking sides. If there is clear evidence of abuse or neglect, document, follow the law and report or refer to appropriate community agencies.

Set clear goals: For example- providing quality care with minimal disruption of normal office workflows and mitigation the risk of litigation or other unfavorable action on the part of a disgruntled parent.

Establish consequences: Clearly inform parents of the possibility of patient dismissal from the practice early in communication if there is evidence of unwillingness to accept boundaries. The priority of rendering good care cannot be achieved if there is no agreement on the process by which this is to be done. The responsibility for this rests with the parents.

Understand the legal process: Clinicians may be called to testify as a fact witness or an expert witness in custody or other legal proceedings. A fact witness is generally used to establish matters such as a parent's level of concern regarding the child, and general observations of the pediatrician of parental dynamics, while expert witnesses typically provide information solely on medical facts and aspects of medical care. Fact witnesses may not receive compensation for their time unless there is a contract specifying that time will be compensated. It may be prudent to include a standard statement in your policies that the parent agrees to compensate for services should a subpoena be issued, regardless of the licensee's designation as a fact or expert witness.

These points should serve as general guidelines for developing individualized protocols depending on the unique needs of the practice. The sooner a practice develops clear policies, documents and procedures for handling cases involving shared custody, the better protected and prepared its providers will be.

The suggestions I've presented above are certainly not exhaustive, however, they highlight major areas that should be addressed as individual offices and programs develop protocols.

I welcome feedback and suggestions that might be helpful to share with colleagues regarding this challenging subject.

Send comments to forum@ncmedboard.org

The looming epidemic of physician burnout

The NCMB hosted a roundtable discussion on Physician Wellness, with particular emphasis on burnout, on June 17. The event brought together medical professionals and other interested parties across medicine to discuss the subject and brainstorm ways for the Board to support licensees. This productive meeting confirmed that finding ways to nurture personal and professional resilience while guarding against the destructive phenomenon of burnout should be a priority for any organization invested in the future of medicine and quality patient care. The Board's ultimate concern is to protect the public from the negative effects of burnout.

Burnout is defined as "emotional and physical exhaustion resulting from a combination of exposure to environmental and internal stressors and inadequate coping and adaptive skills," according to the Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health. The person with burnout exhibits an "increasingly negative attitude toward his or her job, low self-esteem, and personal devaluation."

What's more, the problem seems to be getting worse for American physicians. The 2015 Medscape Physician Lifestyle Report, a survey of approximately 20,000 US physicians, found a significant increase from the 2013 survey in the percentage of respondents who described themselves as burned out (46 percent in 2015, compared to 40 percent in 2013). This feature excerpts key findings from the 2015 Medscape survey.

Findings are published with permission: Peckham C. Physician Burnout: It Just Keeps Getting Worse; Medscape Family Medicine; January 26, 2015. Available at: www.medscape.com/viewarticle/838437

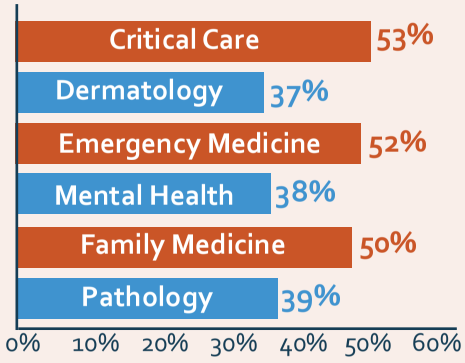
Nearly half of all physicians burned out

46% of Medscape survey respondents reported burnout

Total burned out, by gender

51% **43%**

Most (and least) burned out specialties



Burnout starts early

44% of physicians age 35 and under reported burnout

Leading contributors to burnout

#1 Too many bureaucratic tasks

Pretty simple math here. Too much compliance and documentation related work and too little time actually providing patient care – you know, the reason most people become physicians.

#2 Too many hours at work

Get physicians some work-life balance, stat.

#3 Not enough income

Increasing from 5th to 3rd from 2013 to 2015. Prospects aren't looking up, with significant Medicare payment cuts on the horizon and, for the first time this year, penalties for failing to show the federal government "meaningful use" of electronic health records (EHR).

#4 Increased computerization

Lots of physicians are singing the EHR blues, citing steep learning curves and frustration associated with adopting new systems and a corresponding loss of face-to-face time with patients.

#5 Impact of the Affordable Care Act

Related to #1, but big enough on its own to warrant a specific mention from Medscape survey respondents. The ACA dropped from 3rd in 2013 to 5th in 2015.

Protective factors against burnout

Time off Specifically, vacations. 70 percent of physicians who reported they were not burned out indicated they took more than two weeks of vacation a year. Physicians reporting burnout were less likely to take the same amount off (just 59 percent did).

Maintaining a healthy weight Which came first, the weight gain or the burnout? Not sure, but physicians who describe themselves as burned out are more likely to be overweight or obese. (46 percent compared to 39 percent, according to the Medscape survey.)

Excellent Health 70 percent of physicians who are not burned out report they are in excellent health. Just 54 percent of doctors who are burned out say the same. 68 percent of non burned-out physicians and 56 percent of burned-out physicians report exercising at least twice a week.

Marriage The highest rates of burnout among respondents occurred in physicians who had never been married and lived alone. The lowest rates of physician burnout were seen among widows and widowers at 37 percent, followed by physicians who are either remarried (44 percent) or in a first marriage (45 percent).

Resources: ways to focus on the positive

Three good things A popular way to help ward off professional burnout is the "Three Good Things" exercise. Developed by psychologist Martin Seligman, Ph.D, this simple but effective activity takes the individual's focus off the negative and redirects it to specific things that are working well in that individual's life and work.

Completing the exercise is simple:

1. Each night, before going to sleep, think about the good things that happened that day. Any good thing works – it could be having a positive interpersonal interaction with a colleague or something as simple as enjoying a perfect peach.
2. Write down three good things. Reflect on the factors that allowed these good things to happen. Write down explanations for why these good things happened – e.g. "I took the time to visit the Farmer's Market over the weekend, where they have the best fruit."
3. Repeat this exercise every night for at least a week. Over time, you will begin to focus on the positives in your life more easily.

Watch a one minute video of Seligman describing the exercise:
www.youtube.com/watch?v=ZOGApgdw8Ac
Want more depth? Watch a TED talk by Seligman on the power of positive psychology:
http://www.ted.com/talks/martin_seligman_on_the_state_of_psychology?language=en

AMA offers free online CME on battling burnout, developing resilience

The American Medical Association recently launched a series of online interactive modules to address common practice challenges, including burnout. Physicians may access the free modules online at *www.STEPSForward.org*

There are two modules that specifically address physician wellness. Each completed module earns the participant a half-hour of Category 1 CME credit:

- Improving physician resilience
- Preventing physician burnout

FREE CME

www.STEPSForward.org

The AMA plans to continue adding modules to the collection. More than 25 modules are expected to be available by the end of 2015.

Is your licensee information page ready for visitors?

Did you know every licensed physician and physician assistant has a licensee information page on the Board's website? Patients and others access these more than 3,000 times each day on average, making licensee information the most-used resource available at *www.ncmedboard.org*

Maintaining accurate, complete information on every physician and PA is an ongoing challenge for the Board. Despite efforts to make it easy for licensees to update required information such as current practice address or hospital privileges during the annual renewal process or via the Board's website, NCMB staff members regularly receive questions about incomplete or inaccurate pages. Omissions or errors can reflect poorly on the licensee and, in some cases, may even violate state law.

It's easy to update your licensee information page:

1. Visit *www.ncmedboard.org*
2. Select "Update my licensee information page" from the bottom left corner of the Home Page (fifth bulleted item under Resources)
3. Login and update your information.

The NCMB is in the process of establishing a new compliance program to encourage licensees to keep their information current, and to assist those who have not done this in bringing their information up to date. The program is not intended to be punitive. Rather, its purpose is to bring more licensees into full compliance with NCGS 90-5.2-5.3, which specifies information to be provided to the public.

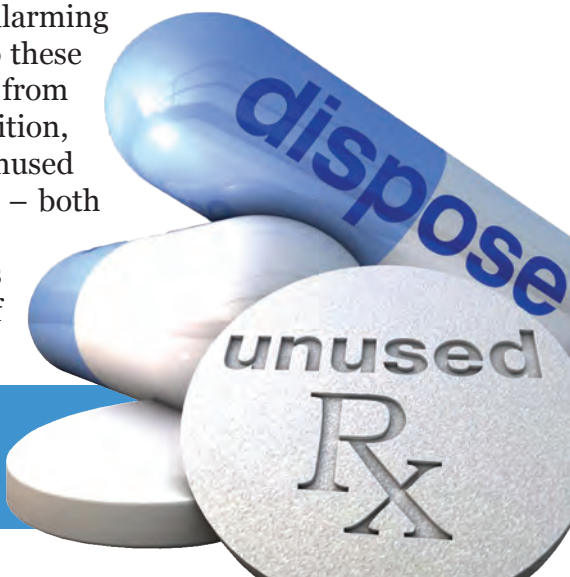
Mark your calendars: Prescription Drug Take-Back Day

The 10th National Prescription Drug Take-Back is set for Saturday, Sept. 26th from 10 am-2 pm. As with the previous nine Take-Back events, sites will be set up throughout communities nationwide to provide local residents with secure drop-off sites to return their unwanted, unneeded, or expired prescription drugs for safe disposal.

Collection sites in every local community can be found by going to the DEA's website. Beginning Sept. 1, this site will be continuously updated with new take-back locations.

National Prescription Drug Take-Back Day addresses a vital public safety and public health issue. Many Americans are not aware that medicines that languish in home cabinets are highly susceptible to diversion, misuse, and abuse. Rates of prescription drug abuse in the U.S. are at alarming rates, as are the number of accidental poisonings and overdoses due to these drugs. Studies show that many abused prescription drugs are obtained from family and friends, including from the home medicine cabinet. In addition, many Americans do not know how to properly dispose of their unused medicine, often flushing them down the toilet or throwing them away – both potential safety and health hazards.

In the previous nine Take-Back events from 2010-2014, consumers nationwide have safely disposed of 4,823,251 pounds, or 2,411 tons of unwanted medication.



For more information visit:
www.deadiversion.usdoj.gov/drug_disposal/takeback/

DEA registration holders: Sign up for access to the state's CSRS today

According to the administrators of the state-run NC Controlled Substances Reporting System (CSRS), less than half of in-state licensees with a DEA registration are registered to use the statewide database of opioid prescription information. The CSRS maintains a searchable record of every controlled substance dispensed in NC outpatient settings. Routine use of the system to monitor patient use of controlled substances can help licensees avoid prescribing to drug-seeking patients.

Increasing the number of registered CSRS users remains an important goal in addressing the serious problems associated with prescription drug abuse/diversion and avoiding mandatory registration. To encourage additional registrations, the Board voted at its July meeting to add a question to the online license renewal form that will ask whether the licensee is registered with the CSRS. If not, the form will provide the licensee with a link to a pre-populated registration form. This change will take several months to implement.

In the meantime, licensees can register for access to the CSRS via the NCMB's website. To do this, licensees must log in to update their licensee information. Follow the instructions in the accompanying box and complete your registration today. The NCMB recommends that all licensees authorized to prescribe controlled substances register for access to the CSRS. Only registered users may access the system's data.

Register for the NC CSRS through the NCMB website:

1. Visit *www.ncmedboard.org*
2. In the bottom left corner of the Home Page, under "Resources", click on "Update my licensee information page"
3. Click on "Update my Info – Online form" (at the right side of the page)
4. Enter FileID# and date of birth. If you do not have your FileID# click the Recover FileID button for an alternate means of login.
5. Select "Training & CSRS" from the menu options and scroll to the bottom of the page to begin CSRS registration.

New law adds dedicated PA seat to the NCMB

The Governor recently signed into law a bill that will add a dedicated seat for a physician assistant to the NCMB, bringing the total number of Board seats to 13.

HB 724, now Session Law 2015-213, amends state law to state that the composition of the North Carolina Medical Board shall include one dedicated seat for a PA and one dedicated seat for a nurse practitioner (NP). Currently, the law specifies that one seat on the Board shall be occupied for a PA or a NP. In accordance with the law, the remaining Board seats are to be occupied by eight physicians and three public members.

The new PA seat will be nominated by the Review Panel, the independent body that currently nominates candidates for a majority of the Board seats held by licensed medical professionals, and appointed by the Governor. The Review Panel is scheduled to meet in late August to select nominees for Board seats that will be open as of Nov. 1.

North Carolina Medical Board

Quarterly Board Actions Report | February - April 2015

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			
FARRINGTON, Bradford Arlin, NP (n/a) Lexington, NC	03/06/2015	Felony convictions for possession with intent to sell/distribute oxycodone and conspiring to obtain controlled substances by fraud.	Revocation of NP license
LEWIS, Randall Eugene, PA (001001908) Monroe, NC	03/16/2015	History of felony arrest for sexual molestation of a minor victim who is related to him; Law enforcement in multiple states have not been able to locate PA and he remains at large.	Revocation of PA license
SUSPENSIONS			
HARRELL, Sampson Emanuel, MD (000017981) Durham, NC	03/10/2015	Inappropriate treatment of patents for opioid addiction; inadequate documentation; inadequate response in the face of evidence of possible opioid abuse.	Six month suspension, immediately stayed
TORRE, Matthew Stephen, DO (201302270) Winston-Salem, NC	02/09/2015	History of substance abuse	Indefinite suspension, applied retroactively to begin Nov. 14, 2013, and to expire upon reinstatement of a new NC license. DO's license is reinstated effective with the date of this order. DO shall refrain from the use of all mind and mood altering substances and all controlled substances, excepting those prescribed to him by someone other than himself.
LIMITATIONS/CONDITIONS			
DIXON, Donovan Dave, MD (201001347) Pembroke, NC	04/06/2015	MD's practice of pain management medicine was found to be substandard. In addition, MD's medical record keeping was inadequate.	MD's license is limited such that he may not prescribe controlled substances of any kind; within six months of the date of the order, MD must complete CME in medical record keeping that includes a preceptorship component.
FINCH, Sudhir Eugene, MD (200101336) Las Vegas, NV	03/31/2015	History of alcohol abuse	MD's license is reinstated; MD must maintain NCPHP contract and abide by all terms.
JONES, Enrico Guy, MD (009700302) Greensboro, NC	03/26/2015	History of diversion and abuse of controlled substances	MD's license is reinstated; MD must maintain NCPHP contract and abide by all terms.
WATFORD, Douglas Elry, MD (000035546) Kinston, NC	03/16/2015	Concerns regarding MD's controlled substances prescribing.	Within six months of the date of the order, MD must obtain a professional assessment from the Center for Personalized Education for Physicians (CPEP) or a similar assessment program approved by the Board.

Name/license#/location	Date of action	Cause of action	Board action
REPRIMANDS			
BIRMINGHAM, William Joseph, MD (009401129) Elizabethtown, NC	02/20/2015	Quality of care; MD's care of a patient who suffered a microperforation of the small bowel after undergoing laparoscopic removal of the gall bladder failed to meet accepted standards.	Reprimand
DELERUYELLE, Laura Jane, NP (n/a) Palmetto, FL	02/19/2015	NP aided the unlicensed practice of medicine by working for a Wilkesboro medical practice that was owned by a licensed chiropractor, rather than a licensed physician or physician assistant as required by NC law. A board review of some of NP's patient charts identified issues with quality of care.	Reprimand; NP shall discontinue all association with Holistic Medical Clinic of the Carolinas and its owner, Dr. Ronald Cohn.
RANDALL, Wendell Lewis, MD (000036016) Wilkesboro, NC	02/19/2015	MD aided the unlicensed practice of medicine by working for a Wilkesboro medical practice that was owned by a licensed chiropractor, rather than a licensed physician or physician assistant as required by NC law. MD also inadequately supervised an NP employed by the practice. A board review of some of NP's patient charts identified issues with quality of care.	Reprimand; MD to discontinue all association with Holistic Medical Clinic of the Carolinas and its owner, Dr. Ronald Cohn.
TAYLOR, Latimer Anthony, MD (009801527) Charlotte, NC	04/24/2015	MD made unprofessional and inappropriate remarks to a female patient.	Reprimand; Within six months of the date of the order, MD must submit himself for a comprehensive assessment and follow all recommendations of the provider.
DENIALS OF LICENSE/APPROVAL			
NONE			
SURRENDERS			
NONE			
PUBLIC LETTERS OF CONCERN			
BELLAMY, Michael Alan, MD (200700283) Huntersville, NC	02/20/2015	Quality of care; The Board is concerned that MD failed to recognize and appropriate respond to the subgaleal hemorrhage suffered by a newborn following unsuccessful vacuum delivery. The case occurred in 2009.	Public Letter of Concern; MD must complete CME in neonatal care and must recertify in Pediatric Advanced Life Support (PALS) and Neonatal Advanced Life Support (NALS)
BENDER, Currin, PA-C, (001003722) Pinehurst, NC	03/04/2015	Prescribing; Between December 2013 and August 2014, PA prescribed controlled substances to a colleague without maintaining a chart, without performing a physical examination and without ensuring the prescriptions were medically justified.	Public Letter of Concern
CHRISTINE, Cybele, PA (001003703) Asheville, NC	02/05/2015	Action taken by another medical board (Colorado) related to PA's failure to perform a follow up evaluation of a patient after radiographic findings suggested cancer. PA also practiced in Colorado with an expired PA license and refused to timely respond to the Colorado board's inquiry about it.	Public letter of concern
DALBY, Richard Hunter, LP (100000471) Durham, NC	03/11/2015	LP consumed alcohol while on call. Consuming alcohol while on call is not appropriate.	Public Letter of Concern

Name/license#/location	Date of action	Cause of action	Board action
ESPOSITO, David Anthony, MD (000033647) Wilmington, NC	03/09/2015	MD performed left knee arthroscopy on a patient when the surgery should have occurred on the right knee. MD has made changes to preoperative procedures to prevent similar issues in future.	Public Letter of Concern
LANGSTON, (III), Bernard Leroy, MD (000027938) Shallotte, NC	02/19/2015	MD prescribed controlled substances to patients in a manner not consistent with prevailing and accepted standards (failed to provide a detailed patient history in the medical record, failed to provide an assessment, over-relied on opioids without adequately exploring other modes of pain relief and increased amounts and dosages without proper justification.	Public letter of concern; MD must complete 10 hours of CME in prescribing controlled substances for the treatment of chronic pain.
MCCOY, Travis Wyatt, MD (201500743) Asheville, NC	04/13/2015	The Board is concerned that MD performed myomectomy on a patient when, according to an independent expert medical review, hysterectomy was the appropriate course of action. The patient experienced significant blood loss during the myomectomy and developed disseminated intravascular coagulopathy.	Public letter of concern
SANCHEZ, Alejandro Macias, MD (000020504) West Covina, CA	04/10/2015	Action taken by another state medical board; MD accepted a letter of reprimand from the California Medical Board based on information that he performed surgery to close a large wound on a patient's leg without adequate anesthesia.	Public letter of concern
SEHBAI, Aasim Shaheen, MD (201500755) Lewes, DE	04/13/2015	Action taken by the Delaware medical board; MD drafted a fraudulent letter of recommendation for himself.	Public letter of concern; $1,000 fine
STURDIVANT, Mark Cooper, MD (000039377) Raleigh, NC	03/23/2015	Delay in diagnosis of a patient's breast cancer	Public letter of concern
UYESUGI, Walter Yutaka, DO (200801776) Honolulu, HI	03/24/2015	The Board is concerned that DO failed to correctly interpret a patient's X-ray; this misinterpretation contributed to a delay in timely treatment of the patient's pneumothorax.	Public Letter of Concern
MISCELLANEOUS ACTIONS			
MOGABGAB, Edward Roddy, MD (009501609) Concord, NC	03/03/2015	History of alcohol abuse.	MD's license is reinstated; MD must maintain NCPHP contract and abide by all terms.
SANCHEZ-BRUGAL, Fernando Alberto, MD (009900128) Asheville, NC	03/06/2015	History of arrest for DWI, assault on a female (spouse); Failure to timely report arrests; History of conviction for DWI.	MD's license is reinstated; MD must maintain NCPHP contract and abide my all terms.
SUMROW, Bradley James, MD (201200920) Durham, NC	04/23/2015	History of substance dependence	MD's license is reinstated. For six months following the date of the order, MD shall only practice in settings where he has on-site physician supervision; MD must obtain Board approval of his practice site. MD must maintain a contract with NCPHP and abide by all terms. MD must refrain from the use of all mind and mood altering substances.
CONSENT ORDERS AMENDED			
NONE			

Name/license#/location	Date of action	Cause of action	Board action
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
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
2/27/2015	Error/omission on license application or annual renewal	$500.00
3/25/2015	Error/omission on license application or annual renewal	$500.00
3/30/2015	Error/omission on license application or annual renewal	$1,000.00

The NCMB has a new website!

The new site, which launched in June, was redesigned with two main goals in mind. First, the new site is mobile optimized to give visitors who browse *www.ncmedboard.org* on a smartphone or tablet a better user experience. We hope users enjoy this flexibility. Second, the Board has worked to simplify the site navigation to make it easier for visitors to access the most-used content. In order to accomplish this, the Board consolidated and reorganized much of the site content.

In the interest of helping licensees get to know the new site, here are some quick tips on finding the most-used content:

1. **Annual renewal:** Every physician and physician assistant licensee visits the NCMB's website at least once a year to renew. Many access the site directly from their emailed renewal notification, but it's easy to find on the website should the need arise. Go to the bottom center of the Home Page and find "Renew my license" under "Resources".
2. **Licensee search:** Find this right at the middle of the screen. Click on the navy blue band with white lettering – Look up a licensee – Start Search – to look up any licensee.
3. **Name/address change:** Licensees are required to keep a current practice address and telephone number on file with the Board, as well as an accurate legal name. There are two ways to access the online form used to update licensee information from the Home Page. Go to the bottom left corner of the Home Page and select either "Change my name or home/practice address" or "Update my licensee information page."
4. **(Almost) everything else:** From NCMB Position Statements to Board Meeting and Hearing Schedules to the most recent Public Board Actions, the most used content on the NCMB's website can be accessed from the three columns of quick links at the bottom of the Home Page.

North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609

Prsrt Std
US Postage
PAID
Permit No. 2172
Raleigh, NC

"Like" US ON FACEBOOK
facebook.com/ncmedboard

FOLLOW US ON TWITTER
@NCMedBoard

BOARD MEETING DATES

August 20-21, 2015 (Hearings)
September 16-18, 2015 (Full Board)
October 22-23, 2015 (Hearing)
November 18-19, 2015 (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.

Help make this newsletter better

Help us improve the *Forum*! We are collecting feedback from all our licensees in order to determine how we can make the Forum more readable, relevant and user-friendly. Please take a few minutes to participate in our short reader survey. Thank you in advance for your time and input.

If you prefer to share your feedback by email or telephone, send your comments to the editor at *forum@ncmedboard.org* or call Jean Fisher Brinkley at 919-326-1109.

Access the survey at *http://tinyurl.com/NCMedBoardForumSurvey* or by scanning the QR code with your smartphone.