FORUM
NORTH CAROLINA MEDICAL BOARD
FOR THE BENEFIT AND PROTECTION OF THE PEOPLE OF NORTH CAROLINA
NO. 3 FALL 2015

Responding to "trivial" complaints - Pg. 8

The elephant in the room: It's time to start talking about ways to cope with the needs of our most experienced physicians

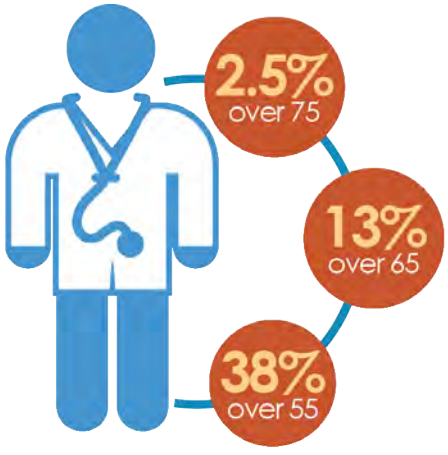
A few weeks ago, I spent a weekend visiting with my cousins, Dan Gasby and Barbara Smith, best known as B. Smith. Over the last few years, I've watched them make a difficult and delicate transition, shifting from their very active and often glamorous public life to a still active, though more private, mindful existence made necessary by the emergence of Barbara's early-onset Alzheimer's Disease. It has been moving, if not a little heartbreaking, to watch this wonderful couple adjust with as much grace as possible to the reality of Barbara's illness and diminished executive capacity and memory. In spending time with them, I found myself appreciating the small moments of connection, even as I recognized how very different their lives are now.

The personal experience of watching a loved one change to accommodate an unrelenting illness has caused me to think on professional transitions in a new way. All medical professionals who practice clinical medicine will eventually transition from active practice to something else, whether that is a part time schedule, a nonclinical professional position or some other role. Some will make the transition by choice and some will make it by necessity. Even licensees fortunate enough to enjoy perfect health into their 60s and beyond will eventually need to wind down their clinical practices to travel or just to slow down and enjoy life.

Inspired by my cousins, I decided it was time for NCMB to initiate a discussion about how licensees can take control of their own destinies and make decisions about career longevity on their own terms. In October, I convened a roundtable discussion at the Board's offices in Raleigh entitled, "Switching Gears: Longevity in Practice." Board Members and a panel of invited guests representing interests from across the spectrum in medicine

Demographic Snapshot

As of Nov. 1, NCMB had 36,197 active physician licensees (MD/DO). More than half are 55 or older.



IN THIS ISSUE

4 Sept. Board Meeting summary
5 Opioid position adopted statewide
6 Guide to new compliance program
10 New CME requirement
11 Quarterly board actions report
15 PA, NP Board applicants sought

NCMB's roundtable discussion on Longevity in Practice revealed strong stakeholder interest in developing strategies to support licensees.

met for an open discussion. Guests were asked to respond to two questions: Is there a role for NCMB in addressing the issue of longevity in practice? If so, what ways could the Board get involved or otherwise support licensees?

This is a timely issue in medicine worldwide. It almost always gets distilled down to a discussion about the aging physician, although the matter is significantly more complex than the question of age alone. This June, for example, the American Medical Association (AMA) voted during its 2015 annual meeting to develop recommendations for assessing the competence of older physicians, noting that about one in four physicians in the U.S. are age 64 or older. AMA specified that such guidelines are to include recommendations for what age it is appropriate to begin assessments, and the content of examinations used to gauge competence.

Unlike industries such as aviation, where pilots must be regularly assessed from the age of 40 on, there are currently no national or state-based standards for when physicians should be subject to screening. Some hospitals and health systems in the U.S. require physicians who reach a certain age to pass cognitive assessments in order to maintain clinical privileges, though not surprisingly this has been somewhat controversial. NCMB has monitored these developments and tried to keep abreast of resources that may be useful. Board Members feel strongly that there should be compelling objective evidence that cognitive assessments for our most experienced physicians are needed before NCMB embraces the concept of screening.

Whatever AMA comes up with may be a useful resource as NCMB and others move ahead in dealing with what some call the "gray tsunami" of aging physicians. I know I'm not alone in thinking it important not to limit the discussion in North Carolina to age, as there is no clear evidence that age alone has a direct relationship to clinical ability. It's also important that we don't sit on the sidelines and wait for others to work through these challenging issues.

There was universal agreement among the parties who gathered for NCMB's roundtable that there is a

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Volume XXI | No. 3 2015

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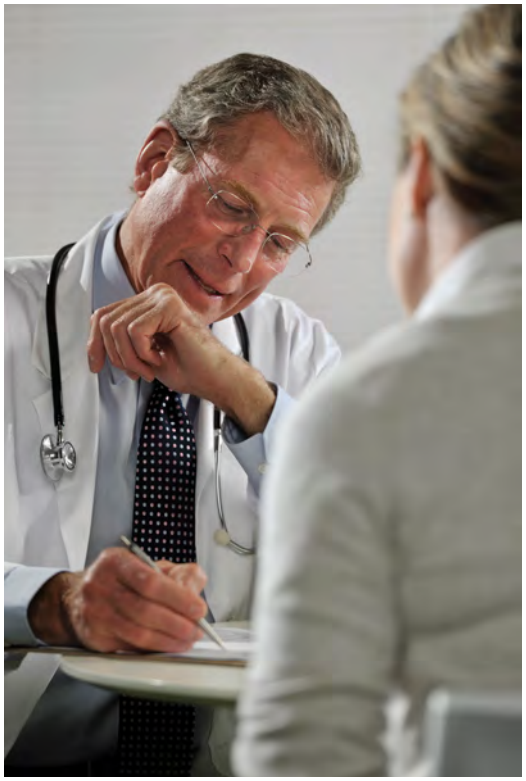
The *Forum* of the North Carolina Medical Board is published four times a year. Articles appearing in the *Forum*, including letters and reviews, represent the opinions of the authors and do not necessarily reflect the views of the North Carolina Medical Board, its members or staff, or the institutions or organizations with which the authors are affiliated. Official statements, policies, positions, or reports of the Board are clearly identified.

We welcome letters to the editor addressing topics covered in the *Forum*. They will be published in edited form depending on available space. A letter should include the writer's full name, address, and telephone number.

Primum Non Nocere

role for the Board to play in helping licensees to navigate late career pathways. Many expressed gratitude that the Board had extended the invitation to discuss this.

How NCMB should get involved is a more difficult question, but one the Board is committed to answering. Acting as a convenor and moderator, and as a gatherer of resources, are natural roles and ones I see the Board continuing as it pursues ongoing conversations on this subject. One comment that several roundtable participants made is that some experienced physicians may "hold on" to their clinical careers longer than they want to or is appropriate because it is all they know. Being a physician is not just a job. For many of us, it is an integral part of identity. It makes sense that individuals who have dedicated their lives to the practice of medicine may not want to let it go. I am intrigued with the idea of helping licensees envision new professional roles that are less demanding than long days in the clinic. Many roundtable participants and audience members suggested that experienced physicians would be valuable as mentors to physicians who are just starting out or who are in an early stage of their careers.



The "graying" of the physician workforce has medicine pondering ways for doctors to remain clinically active as long as they choose while ensuring patient safety

The Board will keep licensees informed as it moves ahead with this initiative. NCMB's licensees work every day to ensure that patients have long and healthy lives. The Board will do what it can to help licensees do the same.

On a personal note, I am about to make a transition of my own, from Board President back to regular Board Member (as Immediate Past President I will continue to serve on NCMB's leadership team for the next 12 months). As I pass the gavel to my colleague, Pascal O. Udekwu, MD, I want to call one last Board President's privilege and take a moment to thank the many people and institutions that helped to bring me to this point in my career, from my high school guidance counselor, the late Mrs. Shirley Freeman in Burlington, to my Chair of Medicine at Northwestern University in Chicago, the late Dr. Roy Patterson. I have had the privilege of knowing people who believed in me and encouraged me to pursue my dreams. I also wish to thank the many leaders I've encountered while serving with NCMB, who have led with vision, dedication and strength. These individuals include recent past Board Presidents Janice Huff, MD, Ralph Loomis, MD, Will Walker, MD, and Paul Camnitz, MD.

Finally, I would like to extend a very special thank you to my husband, Paul, for taking this journey with me, my mother for her never ending support, and my cousins, Dan and Barbara, for being great examples of living life with purpose. Since Barbara's diagnosis, they have been working with the Alzheimer's Foundation to increase awareness about the disease and have used their influence to help raise funds to support Alzheimer's research.

I have worked in several different healthcare environments over the course of my working life. Serving on the Medical Board has been and continues to be one of the highest honors of my career.

Best Regards,

Cheryl L. Walker-McGill, M.D.

Cheryl Walker-McGill, MD, MBA, completed her term as Board President on October 31. She will continue on the Board's leadership team as Immediate Past President. Her term on the Board ends Oct. 31, 2017.

Send comments to forum@ncmedboard.org

Board Meeting Summary – September 2015

NCMB meets during odd numbered months (January, March, May, etc.) Due to this schedule, Board meeting minutes are not available until approximately two months after the covered meeting. To keep licensees informed, NCMB publishes a summary of select events from each meeting. The meeting summary is generally limited to action items that have been finally approved or decided by the Board. Items that are presented for information only or that make only incremental progress toward completion are not reported. The summary also includes new business and special presentations made by visitors. Business is organized by committee. The meeting summary is available online at *http://goo.gl/mEEODq*

Allied Health

- **Board approves proposal for EMS Advisory Group:** The Board accepted the Committee's recommendation to establish an EMS Advisory group to advise and make recommendations to the Board on EMS requests for Scope of Practice changes. The advisory group would include representatives of the NC College of Emergency Physicians, the NC Chapter of the National Association of EMS Physicians, the NC Committee on Trauma, the NC Association of EMS Administrators, and one outside/unaffiliated physician. The State Medical Director would chair the Committee. The Advisory Group would bring together all the major EMS stakeholder organizations to evaluate and initiate requests for scope of practice changes. The Advisory Group would also perform periodic reviews and audit Scope of Practice and Formulary documents. The Advisory Group's opinions and recommendations would be presented to the Allied Health Committee (AHC).
- **NC CSRS data sharing with NC Board of Nursing:** The Board approved plans to amend administrative rules (21 NCAC 32Y.0101) that would allow the Department of Health and Human Services to provide certain data from the North Carolina Controlled Substance Registry System to the Board of Nursing regarding the prescribing practices of nurse practitioners.

CPP Joint Subcommittee

- **Rule changes to amend CPP supervisory model:** The Board approved plans to amend administrative rules regarding supervision of clinical pharmacist practitioners (CPPs) to create a primary and back-up supervising physician model similar to that involving physician assistants and nurse practitioners.
- **Shift of primary CPP registration, approval and tracking to the NC Board of Pharmacy:** Presently, both the NC Board of Pharmacy and NCMB both process applications for approval of Clinical Pharmacist Practitioners (CPP). The Board approved minor rule changes to transfer primary responsibility for processing applications and renewals to the NC Board of Pharmacy.

Licensing Committee

- **Misdemeanor charges or convictions that do not require legal review:** In July 2014, the Board voted to allow the Licensing Department to process otherwise clean

applications where the applicant truthfully reports one minor misdemeanor charge and/or conviction that occurred more than five years ago and prior to professional school without the need for the application to be reviewed by the Legal Department or Senior Staff Review Committee. Additionally, these applications would not be reviewed by a Board Member. If the applicant does not truthfully report the charge or conviction or if there are any other issues on the application, the application still requires Legal Department and/or Office of Medical Director review. The Board approved an additional type of misdemeanor (specifically, "open container" charges/convictions) to the "applicable misdemeanors" list.

Upcoming Board Meetings Dates

- November 18 - 20, 2015
- January 20 - 22, 2016
- March 16 - 18, 2016

Physician Assistant Advisory Council

- **Record Retention Rule for PAs:** The Committee discussed whether the requirement that records of PA and physician quality improvement meetings be maintained for a minimum of three years be added to Board Rule 21 NCAC 32S.0213. Currently, nurse practitioners (NPs) retain records of Quality Improvement meetings for five years. The Board approved the Committee's recommendation to add this item to the Allied Health Committee agenda in November.

Executive Committee

- **Proposed Budget (FY 2015-2016)**: The Board approved NCMB's operating budget for fiscal year 2015-2016. The proposed budget includes funds requested by the Policy Committee in July to use professional consulting services, if needed, to review the Office Based Procedures position statement.

NCMB opioid position statement to be adopted statewide by July 2016

A provision of the 2015 state appropriations act, which the Governor signed into law in September, will make NCMB's policy on the use of prescription opiates for the treatment of chronic pain the statewide standard for responsible prescribing of these medications.

Section 12F.16.(a) of Session Law 2015-241 requires certain state health provider licensing boards and health agencies within state government to adopt the NCMB policy by July 1, 2016. This decision was motivated in part by a 2014 report to the Joint Legislative Program Evaluation Oversight Committee. The report concluded that NC needs to strengthen its monitoring and prevention of prescription opioid abuse and specifically noted that North Carolina prescribers lack clear, authoritative standards for treating pain with prescription opioid medications.

The NCMB opioid prescribing policy, adopted in June 2014, provides detailed guidance for clinicians seeking to provide appropriate patient care to individuals with a legitimate need for treatment while following accepted best practices to prevent abuse, misuse and diversion of opioid painkillers.

By July 1, 2016, the following State health agencies and health care provider licensing boards are required to adopt NCMB's *Policy for the Use of Opiates for the Treatment of Pain*:

- NC Board of Dental Examiners
- NC Board of Nursing
- NC Board of Podiatry Examiners
- NC Division of Public Health
- NC Division of Medical Assistance
- NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
- NC Division of Public Safety (Medical, dental and mental health services)

Access the position statement online:
http://goo.gl/xTMFW1

New compliance program encourages complete online licensee profiles

North Carolina law requires licensed physicians and physician assistants (PAs) to report certain information, such as practice address and current area of practice, to the Board for publication on NCMB's website. To ensure that required information is accurate and complete, NCMB has established a new compliance program to review and verify the details reported by licensees.

Another important objective of the new Licensee Information Compliance program is to raise awareness of the Board's Licensee Information pages while encouraging physicians and PAs to provide a broad range of content in their NCMB profile. NCMB has planned a public outreach campaign for 2016 that will drive additional visitors to the Licensee Information pages, so now is a good time to make your page as complete as possible.

The Board recognizes that licensees are busy, so we have designed the new compliance program to be virtually hassle-free.

Here's how it works:

1. Each week, Board staff will randomly select licensees from among physicians and PAs who recently completed annual renewal.

2. Staff will review and independently verify, where applicable, licensee information required under state law, including: medical/professional education, postgraduate training, Board certification, practice address and telephone number, hospital affiliations, out-of-state medical licenses, and primary area of practice.

3. Staff will also review optional information categories and note whether the licensee has provided content.

4. Upon completion of the review, Board staff will notify the licensee via email with the results. The first emails went out in early November to licensees who have been reviewed.

Results and follow up

If the licensee is found to have incomplete or inaccurate required information, he or she will be notified of the area of noncompliance and informed of any actions that may be required to become compliant. All licensees will be encouraged to provide content for optional information categories if they have not already done so.

If you have questions about the Licensee Information Compliance program, please contact the Board's Licensee Information Coordinator, Michelle Yanik, at *li@ncmedboard.org* or 919-326-1109 x260.

Update your Licensee Information now

Licensees can update their information with the Board online, 24 hours a day. Here's how:

- Visit *www.ncmedboard.org*
- Under "Resources" (bottom left corner of Home Page), click on "Update my licensee information page"
- Click on "Update my Info – Online Form" at the right side of the screen and follow prompts to log in to the Licensee Information portal.
- Review each category and verify that information is correct. Update existing information or report new information as needed.
- Be sure to click "Apply" to ensure that changes or new information are captured.

Note: changes to licensee information (a new practice address, for example) should be reported to the Board within 60 days.

NCMB's Licensee Information page and Board Certification

When choosing a doctor, patients are taught to look for Board Certification as evidence of a physician's demonstrated expertise in his or her area of practice. The Board's new Licensee Information Compliance program will include independent verification of information reported about Board Certification.

NCMB's policy on what certifications may be listed on the licensee information page has evolved over the years. Certifying boards must meet criteria established by NCMB if the licensee wishes to list the certification on his or her page, or if the physician wants to refer to him- or herself as "Board Certified" in marketing materials.

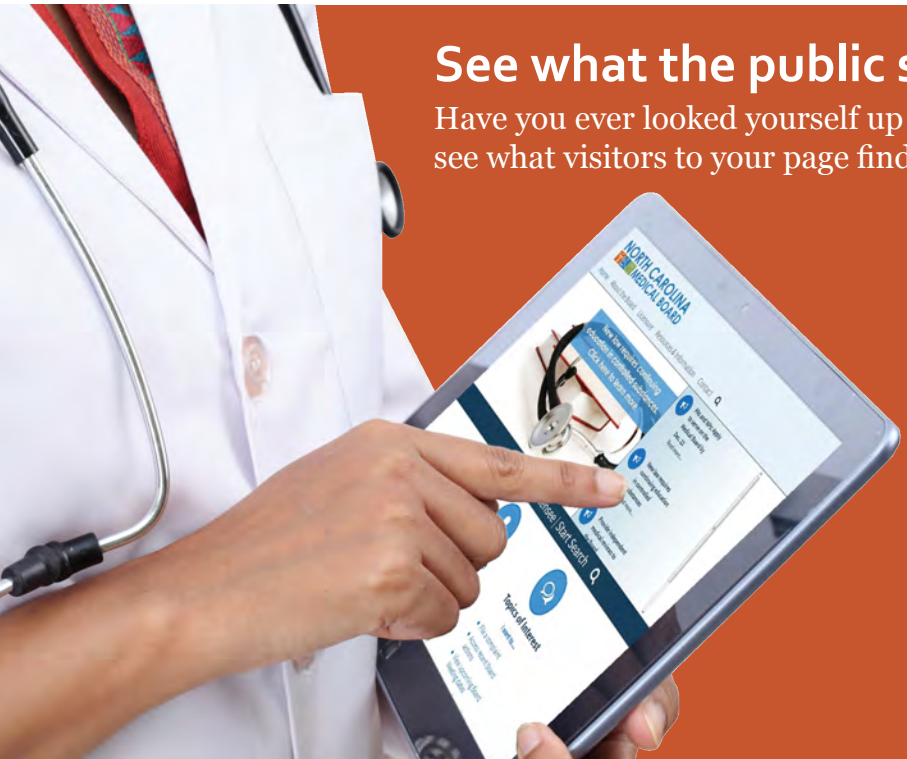
Initially, the Board recognized only certifications conferred by boards affiliated with the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA) or the Royal College of Physicians and Surgeons of Canada (RCPSC). In 2012, NCMB completed a comprehensive review of certifying bodies active in medicine, including several that are not affiliated with any Board-approved entity. The Board concluded that some certifying boards outside the ABMS, AOA and RCPSC systems maintain standards that are sufficiently rigorous to merit recognition by NCMB.

Article summary:

- NCMB's position on Board Certification has evolved over time
- Boards not affiliated with ABMS, AOA or RCPSC may be included on the licensee information page if they meet NCMB criteria
- If you are unsure if your certification meets NCMB criteria, check with the certifying board

The Board revised its position statement, *"Advertising and Publicity"* in 2012 to reflect the specific standards a certifying board must maintain in order to be recognized by NCMB. The section of the position statement relevant to Board Certification is excerpted below.

The Board does not maintain a list of certifying boards that have been approved for use in advertising or inclusion on the licensee information page. If you are certified by a board that is not affiliated with ABMS, AOA or RCPSC and want to know if your board meets NCMB criteria, it is recommended that you check with the certifying board.



See what the public sees

Have you ever looked yourself up on NCMB's website? It can be illuminating to see what visitors to your page find when they view your information.

- Visit *www.ncmedboard.org*
- Click on Look up a licensee – Start Search on the blue bar the runs across the center of the Home Page
- Enter your last name and first name in the search fields. This typically yields the best search results.
- Click through the various information tabs to view your information.
- If information is incorrect or incomplete, update your information as soon as possible (See Update your Licensee Information now)

Responding to "trivial" complaints: Frustrating but necessary

A while back, Board Members asked me to write an article to address a question often received from licensees who find themselves the subject of a patient complaint: Do I really have to respond to this (possibly) frivolous allegation?

Put simply, the answer is, "If the Board asks you to, yes." However, some deeper explanation is in order.

Review process filters out truly frivolous cases

Each year the Board opens about 2,500 cases based on complaints from patients and other sources. To manage this influx of information, some of which includes allegations of actionable misconduct or substandard care, NCMB staff members assess and filter cases so that licensees and Board Members alike are spared the need to respond to complaints that are truly without merit.

In fact, up to 25 percent of complaints received annually are clearly inconsequential, incoherent, trivial, or simply outside of the Board's authority to investigate. In these cases the licensee is advised of the complaint, but not asked to respond in writing to the allegations or to provide medical records for review. The complainant is advised in writing that their complaint is not appropriate for Board investigation. That's roughly 500 cases per year handled solely by Board staff.

In the remaining cases, however, it simply cannot be determined upon initial review of the complaint whether the allegations are valid without input from the licensee. The complainant will often paint a picture that is of sufficient potential concern that the Board is obligated to investigate. While it might seem reasonable to expect Board staff to simply call the licensee to discuss the matter this is expressly prohibited under the law. North Carolina General Statutes §90-14(i) prohibits any agent of the Board from contacting a licensee by telephone who is the subject of a complaint or investigation. The first communication is required by law to be in writing and to provide the licensee with mandatory notifications.

Scott G. Kirby, MD
Medical Director

Preserving the public trust

It must be noted that the Board has a statutory duty to treat all complaints seriously, and to thoroughly investigate allegations where there is a reasonable possibility that a violation of the Medical Practice Act has occurred. Similarly, the licensee has a responsibility (and, in fact, a keen self-interest) to ensure that the Board has all the information it needs to reach a fair decision about the complaint. North Carolina physicians and physician assistants are fortunate to enjoy the privilege of self-regulation. This privilege is based on public trust. It will only continue as long as the Board, with full cooperation by licensees, can demonstrate it is willing and able to faithfully carry out its obligation to investigate and resolve complaints that are brought to its attention.

Article summary:

- NCMB staff handle about 25 percent of patient complaints per year without the need for a written licensee response
- In many cases, NCMB cannot tell if a patient complaint has merit without a response from the licensee
- State law prohibits NCMB from obtaining a licensee response via telephone
- Complaints must receive thorough consideration and investigation in order to preserve public trust in the Board

The Board recognizes that some patients may have unrealistic expectations about what can be achieved by filing a complaint. Over the last few years, NCMB has sought to educate patients and the public about the Board's complaint resolution process to encourage appropriate use. These efforts include brochures and an online tutorial that spells out what the Board can and cannot do through the complaint process. In addition, the Board's Complaint Department staff counsels patients and the public directly, fielding about 40 phone calls each business day. In each of the past two calendar years (2013-2014) the Board observed decreases in the number of complaints received from patients and the public. Although we cannot say for sure what is driving this decline, it's possible that the Board's efforts may have deterred some inappropriate use of the complaint process.

Responding to patient complaints can be stressful, especially when the licensee believes allegations to be trivial or without merit. Licensee responses are essential, however, for the Board to fulfill its mission and appropriately resolve cases.

Preparing an appropriate response

The Board is well aware that requiring a physician to respond to a complaint is time-consuming and, particularly if the allegations are untrue, frustrating. Contrary to what licensees may believe neither Board staff nor Board Members ever consider licensees to be guilty until proven otherwise, and there is no arbitrary assignment of blame. In a typical year, just 10 percent of all disciplinary cases (out of the approximately 2,500 cases opened) result in any type of adverse public action.

Licensees often wonder if they should hire an attorney to help them respond to a patient complaint. This is ultimately a matter of personal choice, determined by the circumstances of you particular situation. A thoughtful, well organized response, adequately supported by the medical record, is generally sufficient and can be prepared without the aid of an attorney. It is not helpful to submit a response that is emotional or dismissive or that makes sarcastic or derogatory comments about the complainant, the complaint, or the Board. Your response to the Board should be a professional, succinct, and objective answer to the specific allegations in the complaint. Any complaint that relates to quality of care should be carefully considered. Licensees may want to contact their malpractice carriers for advice in these situations.

In closing, regardless of your opinion of the complainant or the complaint you are required, when asked, to provide the Board a timely and professional response. Think of it as an opportunity. There is almost no complaint that cannot provide a licensee some useful information about his or her practice or patient interactions. You might consider, even briefly, reflecting on the allegations from the complainant's point of view and look for ways to, hopefully, avoid similar issues in future.

What would you like to see from the Office of Medical Director?

Send questions, comments and suggestions to forum@ncmedboard.org

New law mandates controlled substances CME for physicians and other prescribers

The NC budget appropriations act signed into law in September includes a new requirement for licensed physicians and physician assistants and other licensed medical professionals to complete at least one hour of the total continuing education hours required in controlled substances prescribing.

Boards have discretion under the new law to determine how best to implement the CME requirement. The Board will consider the new law and discuss how to implement it for physician and PA licensees at its January meeting.

Current CME rules for physicians require 60 hours of Category 1 CME over a three year period.

A physician assistant must complete at least 100 hours of continuing medical education (CME) every two years, at least 50 hours of which must be American Academy of Physician Assistants Category I CME.

New CME Requirements

A provision signed into law this fall makes CME in controlled substances prescribing mandatory for all who prescribe them.

CONTINUING EDUCATION REQUIREMENTS

SECTION 12F.16.(b)

The following health care provider occupational licensing boards shall require continuing education on the abuse of controlled substances as a condition of license renewal for health care providers who prescribe controlled substances:

1. North Carolina Board of Dental Examiners.
2. North Carolina Board of Nursing.
3. North Carolina Board of Podiatry Examiners.
4. North Carolina Medical Board.

SECTION 12F.16.(c)

In establishing the continuing education standards, the boards listed in subsection (b) of this section shall require that at least one hour of the total required continuing education hours consists of a course designed specifically to address prescribing practices. The course shall include, but not be limited to, instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management.

Reader Survey Results

Thanks to all *Forum* readers who took the time to complete our recent content survey. Your feedback is greatly appreciated!

The results indicated that most *Forum* readers view the newsletter favorably. About 75 percent of survey respondents were either satisfied or very satisfied with the *Forum*. About 70 percent of respondents indicated that they like the quarterly publication schedule, though a solid 20 percent indicated that a bimonthly schedule would be welcome. For now, we've decided to keep the *Forum* a quarterly newsletter.

On the content front, readers were clear in indicating a preference for articles that provide information and insight into Board policy, changes to state law and other content that helps licensees stay informed and in compliance with all applicable rules and other standards. We will continue to strive for content that is practical and relevant.

We are beginning the process of redesigning the look and feel of the print and email editions of the *Forum*. We expect the new version to debut in Spring 2016. One change you will see is the use of NCMB's new logo (below), which was adopted earlier this year.

Reader feedback is always welcome. Please continue to send comments to the editor at *forum@ncmedboard.org*

NORTH CAROLINA MEDICAL BOARD

North Carolina Medical Board

Quarterly Board Actions Report | May - July 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			
ZARATE, Enrique, MD (000031224) Tracy, CA	06/30/2015	MD entered into an agreement with the California medical board wherein he accepted a revocation, stayed, and agreed to have his license placed on probation for five years related to allegations about MD's quality of care and opioid prescribing.	Revocation of NC license, stayed; license placed on probation for five years.
SUSPENSIONS			
BIANCO, Salvatore Franco, MD (201200768) Cornelius, NC	06/25/2015	Aiding the unlicensed practice of medicine through violation of NC corporate practice of medicine laws; Inadequate supervision of a nurse practitioner.	One year suspension, immediately stayed. MD must pay a $5,000 fine and sever ties to HealthMed of Charlotte, NC.
CORRIGAN, Francis Charles, MD (000034839) Pinehurst, NC	07/14/2015	Arrest for DWI on October 2, 2014; MD completed inpatient treatment from Oct. 27, 2014, through Jan. 23, 2015.	MD's license is indefinitely suspended, immediately stayed. MD must maintain his NCPHP contract and abide by all terms.
GETTINGS, Justin Luke, MD (RTL) Chapel Hill, NC	05/27/2015	History of substance abuse	MD is issued a resident training license. The license is indefinitely suspended, immediately stayed upon conditions. MD must refrain from use of mind and mood altering substances.
HAAHS, Michael M., MD (009400515) Mooresville, NC	06/01/2015	Arrest for DWI on Dec. 7, 2014; History of illicit drug use.	Indefinite suspension
LE, Mark Tuan, MD (09700088) Cornelius, NC	05/08/2015	On June 25, 2014, MD was convicted of felony health care fraud conspiracy, health care fraud and tax evasion.	Indefinite suspension
MITCHELL, Rajan, DO (200900432) Winston-Salem, NC	06/17/2015	Quality of care; DO terminated from practice on suspicion of participating in a kickback scheme.	Indefinite suspension of NC medical license, stayed on conditions. DO must undergo a comprehensive competency assessment and complete an ethics course.

Name/license #/location	Date of action	Cause of action	
NIEMEYER, Meindert Albert, MD (000030440) Elon, NC	07/01/2015	MD prescribed controlled substances in violation of a prior order with the Board; history of inappropriate prescribing.	MD's license is suspended, immediately stayed except for a period of 60 days to begin on Sept. 1, 2015, and end on Oct. 31, 2015; $10,000 fine. MD must surrender his DEA privileges.
SCALLION, Ralph Michael, MD (000023664) Durham, NC	06/19/2015	Boundary issues; MD engaged in a sexual relationship with a patient.	Indefinite suspension
WATT, Alan Henderson, PA (001000395) Greensboro, NC	06/02/2015	Boundary issue; PA engaged in a sexual relationship with a recent patient he had treated for post traumatic stress disorder, major depressive illness and ADHD.	Indefinite suspension
LIMITATIONS/CONDITIONS			
NONE			
REPRIMANDS			
ALBUQUERQUE, Maria Luiza Coutinho, MD (201200090) Doylestown, PA	06/25/2015	When her regular doctor became unavailable to her due to his own serious illness, MD began prescribing the same controlled substances her physician has been prescribing to herself. MD also wrote prescriptions for controlled substances to close family members. Prescribing controlled substances to oneself or to close family members is expressly prohibited by NC administrative rules.	Reprimand
FOX, Olin Mackay, MD (200901367) Pinehurst, NC	06/18/2015	MD prescribed controlled substances to himself and to an immediate family member, which is against the NCMB's position on treatment of self/family and is expressly prohibited by NC administrative rules. MD immediately stopped this prescribing when notified that it is not acceptable practice.	Reprimand
GROSSLIGHT, Kenneth Russell, MD (200601402) West Columbia, SC	06/02/2015	MD, an anesthesiologist, screened a surgical patient for appropriate pain medication and advised that it would be appropriate for the patient to be prescribed Methadone 10 mg, 1-2 tablets every eight hours for postoperative acute pain. The patient went home with a prescription for Methadone 10 mg and subsequently died of respiratory depression due to Methadone overdose.	Reprimand
LEE, Barry Russell, MD (000036758) Gastonia, NC	06/15/2015	MD prescribed Lomotil, a schedule VI controlled substance to himself and to a close friend in. Administrative rules prohibit prescribing controlled substances to oneself.	Reprimand
DENIALS OF LICENSE/APPROVAL			
NONE			
SURRENDERS			
BAILEY, Scott Allen, MD (200500604) Mebane, NC	05/19/2015		Voluntary Surrender of medical license

Name/license #/location	Date of action	Cause of action	Board action
PUBLIC LETTERS OF CONCERN			
ALEX, Vikki May, PA (000102576) Taylorsville, NC	08/06/2015	PA diverted controlled substances from her employer to treat leg pain. When confronted, PA stated that should could not afford medication to treat her pain.	Public Letter of Concern
BOWLING, (Jr.), Jack Wayne, MD (009601239) Wilmington, NC	07/07/2015	The Board is concerned that MD's care of a patient who presented with signs of infection following a hip surgery did not meet accepted standards. MD failed to timely respond to the patient's symptoms, resulting in complications and a delay in the treatment of the patient's staph infection.	Public Letter of Concern
CRUZ, Leonard Lee, MD (000036335) Asheville, NC	05/20/2015	MD made inappropriate physical contact with a patient during a physical therapy session.	Public Letter of Concern
GILBERT, David Branson, MD (000017131) Fayetteville, NC	07/14/2015	History of arrest for DWI on May 23, 2012; NCPHP assessment at the time concluded MD did not have alcohol abuse problem. History of arrest for DWI on Feb. 5, 2015; MD was referred by NCPHP for a comprehensive assessment and ultimately diagnosed with an alcohol use disorder. MD successfully completed six weeks of intensive outpatient treatment.	MD is issued a Consent Order that shall constitute a Public Letter of Concern; MD must maintain NCPHP contract and abide by all terms.
GODFREY, Joseph Lawrence, MD (009800255) Belmont, NC	05/26/2015	The Board is concerned that MD's diagnosis of ADHD in a three year old patient, and medication choices for this patient, did not conform to accepted standards of care.	Public Letter of Concern
LUTZ, Robert Brian, MD (201202380)	06/17/2015	MD relinquished his SC license to practice in Nov. 2014; MD's NC license is inactive as of June 2014.	Public Letter of Concern
MATSUURA, Ian Makoto, MD (200800125) Eden Prairie, MN	05/27/2015	MD erroneously reported an absence of free intraperitoneal air on the CT scan of a patient who had undergone gastric bypass surgery. The patient subsequently developed sepsis and died.	Public Letter of Concern
MATTHEWS, Charles Joseph, MD (000027245) Raleigh, NC	07/30/2015	The Board is concerned that MD's care of a patient who presented with complaints of recent onset of headache and neck pain was below accepted standards. MD failed to obtain and document a history sufficient to establish the time, course and associated clinical characteristics of the headache and neck pain and to justify MD's decision that brain imaging studies were not indicated. Approximately one month after MD last consultation with the patient, the patient was found at home unresponsive and later pronounced dead. A post-morten examination revealed a third ventricle colloid cyst with enlargement of the lateral ventricles and cerebral edema. Cerebrospinal fluid obstruction by the colloid cyst was cited as the cause of death.	Public Letter of Concern

Name/license #/location	Date of action	Cause of action	Board action
MINIELLY, Richard Wesley, MD (000035991) Roanoke Rapids, NC	06/30/2015	MD care of a patient who presented to the hospital 39 weeks and 4 days pregnant for a scheduled induction did not meet accepted standards. MD failed to report to the delivery room when called by the delivery room nurse, failed to appropriately respond to signs of fetal distress and continued to administer Pitocin when it should have been stopped. The patient's baby died of respiratory failure and hypoxic encephalopathy.	Public Letter of Concern
OLSON, David George, MD (000022799 Clyde, NC	07/15/2015	The Board is concerned about the quality of care MD provided to a patient who presented to the ER with complaints of racing heart, chest tightness, shortness of breath and a history of deep vein thrombosis. Tests, including a d-dimer test, were ordered but the patient was discharged before results of the d-dimer test were available. The d-dimer results indicated a strong possibility of venous thrombosis or embolism. About an hour and half post discharge the patient became symptomatic again and was transported to another facility, where a pulmonary embolism was confirmed and the patient subsequently died. The Board is concerned that MD did not ensure that all tests were completed and documented prior to discharging the patient.	Public letter of concern
RATCLIFFE, (III), Robert Richard, MD (000016152) Rutherfordton, NC	06/29/2015	The Board is concerned that MD prescribed controlled substances to three former patients without appropriate patient examinations or establishing medical records. MD stated that he wrote the prescriptions as a favor to the former patients, each of whom did not have health insurance. MD's license is currently inactive.	Public Letter of Concern
SMITH, Alastair Douglas, MD (200300544) Durham, NC	07/02/2015	Boundary violations; MD admitted inappropriate behavior towards a co-worker and a patient.	Public Letter of Concern; The Board notes that MD has made his NC license inactive.
SUTTON, Jeremy Hunter, MD (201402368) Alabaster, AL	06/04/2015	Failure to disclose criminal charges of cyberstalking and having a concealed weapon after consuming alcohol on NC license application. MD passed a field sobriety test after a Dec. 31, 2014, stop for speeding but was charged with having a concealed weapon while consuming alcohol or after consuming alcohol after the officer smelled alcohol on the MD's breath and was told about MD's concealed weapon. MD also failed to disclose a Feb. 1, 2015, charge of cyberstalking, of which MD was subsequently found not guilty.	Public letter of concern; MD must complete a 2 ½ day course on Problem Based Ethics with 12 months of followup and assessment.
TROJANOWSKI, Zbigniew, MD (200700287) Fayetteville, NC	06/18/2015	Action taken by Ohio medical board	Public Letter of Concern

Name/license #/location	Date of action	Cause of action	Board action
WILLIAMSON, Barry Eugene, MD, (009500477) Lumberton, NC	07/08/2015	The Board is concerned about the quality of care MD provided to two surgical patients. In one case, MD did not discontinue the patient's blood thinning medication prior to surgery. This patient developed significant internal bleeding after surgery and had to be returned to the OR, where approximately three liters of blood were removed. In the second case, the Board is concerned that MD failed to do a confirmatory study to ensure correct placement of a replacement PEG tube. The tube was not correctly placed with the distal tip in the patient's peritoneal cavity and free air was noted.	Public Letter of Concern
MISCELLANEOUS ACTIONS			
NISBETT, Donald A., MD (000026332) Laurinburg, NC	06/19/2015	Quality of care; inappropriate prescribing of opiates; medical knowledge deficiencies documented by CPEP.	MD's license is made inactive; MD may not petition to reactivate his license sooner than 12 months from the date of the order. If MD chooses to petition for reactivation, he must comply with conditions stated in the order.
CONSENT ORDERS AMENDED			
NONE			
STEMPORARY/DATED LICENSES			
NONE			
ISSUED,EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
HARRIS, Benjamin Scott, MD (RTL) Durham, NC	05/21/2015	History of substance use disorder	Temporary/Dated Licenses Issued; Resident must maintain NCPHP contract and abide by all terms.
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			

North Carolina Medical Board
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BOARD MEETING DATES
November 18-20, 2015 (Full Board)
December 10-11, 2015 (Hearing)
January 20-22, 2015 (Full Board)
February 18-19, 2015 (Hearing)

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.

Applicants sought for PA, NP Medical Board seats

The independent body that nominates candidates for the Medical Board to the Governor's Office is seeking applicants for two Board seats, one for a physician assistant (PA) and one for a nurse practitioner (NP). Under North Carolina law, interested parties must apply through the Review Panel of the North Carolina Medical Board. The Review Panel screens applicants, conducts interviews and makes recommendations to the Governor, who then appoints candidates to the Medical Board. The Review Panel will only consider applicants who hold active, unrestricted NC licenses. Applicants must be actively practicing clinical medicine at least part time and must have no history of disciplinary action within the past five years. Applications are due by Dec. 22, 2015 at 4:45 p.m.

The PA seat was established by the NC General Assembly and signed into law by the Governor in September. The addition of the PA seat brings the total number of Board Members to 13.

The NP seat on the Board is currently occupied by a nurse practitioner who is seeking reappointment. However, state law requires sitting Board Members who are seeking reappointment to apply and go through the nomination process.

To find information about applicant qualifications and the application process, or to access the online application, visit *www.ncmedboardreviewpanel.com/?page=openings*

For more information, contact Jerel Noel, the Review Panel Administrator, at (919) 861-4545.