

## Keeping the momentum: making outreach an integral part of NCMB's work

A year ago my colleague, Dr. Cheryl Walker-McGill, used her first President's Message to make the case that increasing outreach to the profession is essential for the Board to strengthen its relationship to licensees and enhance its ability to regulate for the benefit and protection of the people of North Carolina. Now, I am using mine to tell you that the Board was successful in implementing its goal to dramatically expand outreach in 2015. Presentations to professional groups, including medical students and residents, more than tripled last year, allowing the Board to reach an unprecedented number of current and potential licensees.



NCMB President Pascal Udekwa, MD, says "licensees, given good information, will make the right decisions for their patients"

My own take on the value of outreach to licensees is decidedly practical. The longer I serve on the Board, the more obvious it is to me that many of the physicians and physician assistants who come to the Board's attention for alleged misconduct do so because they are uninformed about policies, rules or laws governing the profession. Engaging with licensees through frequent presentations opens a conduit through which the Board can deliver important information that will, hopefully, lead to good decisions and avoid preventable mistakes.

## NCMB Position Statements: 2015 changes and year in review

Each year, in the Winter issue of the *Forum*, NCMB highlights recent changes to the Board's official position statements. Position statements are an important resource for licensees that provide guidance on a range of subjects, including direct clinical practice, professional ethics, legal and policy matters and other practice related topics. This article focuses on position statements that were either revised in 2015 or that were reviewed and approved with no changes. The Board did not adopt any new position statements last year.

A downloadable pdf copy of the complete position statements is available online. Individual statements are also posted online. Access them by visiting [www.ncmedboard.org](http://www.ncmedboard.org) and selecting "Find a position statement" in the bottom left corner of the home page, under Resources. **Continued on pg 5**

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## FROM THE PRESIDENT

I believe that most licensees, given good information, will make the right decisions for their patients and practices. Put another way, if more licensees knew the boundary lines existed, and where they are, perhaps fewer would ever cross them.

Operating ignorant of the rules of conduct, as it were, is especially risky today amid the tumultuous changes occurring in the health care finance and delivery systems. Major shifts such as the rapid expansion of telemedicine into primary and acute care and the rising prevalence of employed physicians accountable to hospital or corporate policy are just two examples that frequently challenge licensees' efforts to meet professional obligations to patients. Regularly discussing these and other issues with licensees through outreach helps keep the Board informed of conditions "in the trenches" and gives licensees the opportunity to raise concerns or ask specific questions.

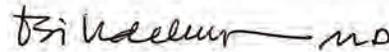
Over the next year, the Board and its staff will work diligently to firmly integrate outreach into the culture of the Medical Board, building on last year's progress. It is my hope and expectation that outreach be thought of as an essential component of the Board's work, rather than a temporary initiative to be achieved and supplanted by some new priority.

To that end, one of the major priorities of my Board Presidency will be a new outreach program focused on medical students and other early career professionals. This program is still in the planning stages, but my vision is to bring medical professionals to the Board's offices in Raleigh for an intensive mini-residency that will deepen participants' understanding of the Board, its mission and duties. This is different from the Board's current outreach activities in a few important ways. First, instead of taking our message to the audience, this program will bring learners to the Board for an up close look. Second, the program will include mock proceedings, role-playing or some

other type of participatory learning, in addition to more traditional lecture-based learning. Finally, we will focus on students and residents in an effort to establish a productive relationship with these potential and current licensees early. Our hope is to infuse an understanding of medical regulation into these young professionals as they enter the practice of medicine and establish an expectation that they will reach out to the Board with concerns and questions over the course of their careers. Ideally, individuals selected for the mini-residency will go back to their schools and training programs to share what they have learned about the Board. Over time, I hope we will see more licensees using the Board as a resource that can help them avoid trouble. I am working with Board staff now to finalize the details. Our goal is to enroll the initial class of participants before my term as President concludes in October.

It is something of a tradition to end one's first President's Message with a statement of gratitude. It is an honor to serve as Board President, and one not many physicians are afforded. I am thankful for the opportunity to serve and will do my utmost to honor the medical profession with my efforts.

Sincerely,



Pascal O. Udekwu, MD

## A Look at NCMB's 2015/2016 Board President

**Name:** Pascal Udekwu, MD

**Term ends:** October 31, 2017

**City:** Raleigh, NC

**Specialty:** General Surgery

**Certification:** American Board of Surgery

**Practice:** Wake Specialty Physicians - General Surgery and WakeMed's emergency medicine

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Volume XXII | No. 4 2016

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

## Keeping the Board apprised of changes to the PA-physician team

Most physician assistants are aware that they must submit an Intent to Practice form indicating their choice of primary supervising physician before beginning clinical practice in NC. It is important for PAs to remember that keeping the Board informed of changes, by removing former supervisors and adding new ones, is an ongoing obligation as long as they remain licensed in the state.

Administrative rule 21 NCAC 32S .0203 requires PAs to notify the Board every time there is a change in primary supervising physicians. This information is communicated to the Board using the online Intent to Practice form on NCMB's website. Forms may be submitted 24 hours a day, seven days a week.

However, NCMB staff members regularly receive requests from licensees to remove inactive supervisees, typically because the supervisee failed to properly notify the Board that the supervisory relationship was terminated. Please review NCMB's process for adding and changing supervising physicians and make sure your practice information is up to date. Here's what you need to know:

### **Q: Under what circumstances must the PA notify the Board of a change in primary supervising physician?**

A: PAs must submit a new Intent to Practice form any and every time the PA adds a primary supervising physician. This includes PAs who will practice with multiple primary supervising physicians and PAs who transfer from one supervisor to a different primary supervisor.

### **Q: How soon must the PA notify the Board after a change in supervisor occurs?**

A: Administrative rules require the PA to submit a new Intent to Practice form notifying the Board of the change within 15 days.

### **Q: How does a PA notify the Board that a supervisory relationship has ended?**

A: Visit [ncmedboard.org](http://ncmedboard.org) and select "Add/change my supervising physician (submit Intent to Practice)" under Resources, from the bottom left corner of the Home Page. Log in to the Intent to Practice form. After confirming your personal and practice information, check the box next to "Make an existing active supervisor inactive." Complete all remaining steps and submit the form.

### **Q: What happens if the PA does not submit an ITP form to remove a former primary supervising physician?**

A: The Board's records will continue to reflect that the former primary supervising physician is an active supervisor, even if this is not the case. The PA's name will continue to display as a supervisee on

the former primary supervising physician's licensee information page.

### **Q: Will the PA receive a letter confirming the addition or removal of a primary supervising physician?**

A: No. The Board no longer sends letters to confirm receipt of Intent to Practice form. To confirm receipt of the ITP, use the Board's online licensee search to look up the PA or supervisor. Current supervisees and supervisors are listed.

### **Q: May a physician remove him- or herself as a primary supervising physician?**

A: The supervising physician may not complete the ITP form – this is the PA's responsibility. Physicians may contact the Board for assistance in having a former supervisee removed if the physician is unable to have the PA do it.

### **Q: Can NCMB help me have a former nurse practitioner supervisee removed from my licensee information page?**

A: No. Collaborative relationships between physicians and NPs are managed by the NC Board of Nursing, which provides NCMB with this information. If a NP is incorrectly listed as a current supervisee, please direct the NP to go to [www.ncbon.org](http://www.ncbon.org) and complete the online process to remove a physician supervisor, or contact the nursing Board at 919-782-3211.



*Send comments to [forum@ncmedboard.org](mailto:forum@ncmedboard.org)*



## Board Meeting Summary: November 2015

This is a condensed version of the meeting summary. The full version is available online at <http://goo.gl/mEEODq>

### Allied Health

#### CPP rule change

The Board approved changes to the CPP rules, 21 NCAC 32T. The Clinical Pharmacist Practitioner (“CPP”) Joint Subcommittee met in September to discuss amendments to these rules. The joint subcommittee discussed and approved two categories of amendments. The first changes pertain to creating a primary supervising physician model for CPPs similar to what is in place for nurse practitioners and physician assistants. The second set of changes move administration of processing applications and renewals from the Medical Board to the NC Board of Pharmacy.

#### 2015 PA random compliance review results

Board investigator Don Pittman provided an annual report on the board’s compliance review of physician assistant. Among physician assistants reviewed in 2015, 66 percent were found in full compliance with applicable laws and rules, 31 percent had minor discrepancies that were corrected by the PA, and 3 percent had discrepancies that were brought to the Board’s attention. During the discussion, the committee Chair inquired about the possibility of performing the compliance reviews by mail. To date, there is no plan to do compliance reviews by mail.

### Executive

#### Appointment of PHP Compliance Committee

The Executive Committee is responsible for nominating a former Board member to the NC

Physicians Health Program Compliance Committee for service from January 1, 2016, until December 31, 2018. The Board voted to appoint former Medical Board member Dr. Karen Gerancher to the NC PHP Compliance Committee.

#### Voluntary Licensee Information request added to online renewal

In 2016, NCMB will launch a public awareness campaign to highlight information found via the Board’s online licensee search. The Committee discussed the best way to increase the quality and quantity of the information provided on the licensee information pages, particularly by increasing the information reported in the voluntary information fields. The Committee discussed concerns about adding additional questions to the license renewal application. The Committee stated that it must be communicated clearly that providing this information is voluntary. It is important to be transparent to the licensees and the public regarding this voluntary information.

The Board voted to:

1. Add a page to the license renewal application with questions for the voluntary fields.
2. Put at the top of the form information that makes it clear to licensees that completion of this portion of the renewal application is voluntary.
3. Explore adding additional information to the licensee page to alert licensees and the public

that the information is audited but that it is a limited audit.

4. Proactively communicate with licensees and the public the intent behind the voluntary information found on the website.

## Licensing

### USMLE/COMLEX 3 attempt limit retained

The Board voted to retain its requirement that applicants for licensure demonstrate they have passed each step of the USMLE within three attempts per step (“the 3 attempt limit”).

The Board decided to retain the rule based on the following:

1. A plurality of other state medical boards use the 3 attempt rule.
2. The multistate compact has chosen to use the 3 attempt rule.
3. A previous Board considered this matter with deliberation and care and instituted the 3 attempt rule.
4. The current rule was instituted to alleviate multiple problems with a time-based rule.
5. Increasing the number of USMLE passing attempts does not assure that this would improve the flow of well-qualified physicians to North Carolina.
6. While it is acknowledged the current 3 attempt rule is not based on hard outcome data, attempts to obtain this information have not proven conclusive. Additionally, other entities that do have resources to analyze the information available have not been able to come to a firm conclusion on what is the best practice.
7. With very minimal exception the current rule has worked well since it was implemented, and there is no compelling reason to change the current rule.

## Policy

### Physician supervision of other licensed health care providers

At the July 2015 Policy Committee meeting, Committee members discussed concerns about: (1) the potential for boundary violations between supervising physicians and their health care supervisees; and (2) the need to clarify the prohibition on supervisees owning a practice

and employing their supervising physician. The Committee recommended, and the Board approved, bringing the position statement back to the Committee in September 2015 with proposed language to address both concerns.

The Committee discussed the proposed language previously submitted to the Committee. The Committee also asked the guests in the audience for their input and Ms. Cathy Fields of the NC Academy of Physician Assistants indicated that they had no further concerns.

The Board voted to approve the position statement as amended.

### Involuntary departure from hospital-owned practice

The Board received an inquiry from a licensee regarding a recent termination from a hospital-owned physician network. The licensee felt that the termination was handled in a way that prevented her from following guidelines for patient notification and for safe continuity of care.

The Committee noted that this particular scenario is likely to occur again in future. The Committee discussed the best way to hold hospital-owned practices accountable for continuity of care. The Board’s Chief Medical Officer mentioned that the American Medical Association has an ethics opinion related to this particular topic and pointed out the proliferation of hospital-owned practices. The Committee also discussed how this issue is intertwined with the corporate practice of medicine.

The Board voted to take the following steps to address the issue:

1. Organize roundtable to discuss this particular issue with various stakeholders.
2. Develop corporate practice of medicine position statement with a section addressing hospital-owned practices.
3. Refer licensee complaint to the appropriate department.

## Upcoming Board Meetings Dates

March 16 - 18, 2016

May 18 - 20, 2016

July 20 - 22, 2016

September 21 - 23, 2016



# High Point OB/GYN reappointed to NCMB

Congratulations to President-elect Eleanor E. Greene, MD, MPH, on her recent reappointment to the Board. Gov. Pat McCrory notified NCMB of Dr. Greene’s reappointment in January. Her term on the Board will end October 31, 2018.

Dr. Greene is an OB/GYN who practices with Triad Women’s Center 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.

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.

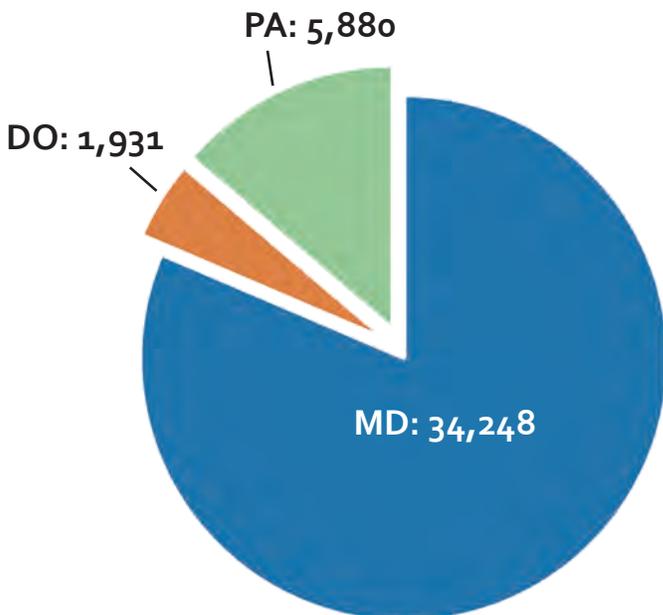
Dr. Greene was appointed to her first full term on the Board in November 2012. She currently serves on the Disciplinary, Executive and Licensing committees of the Board. She will assume the role of Board President on Nov. 1, 2016.



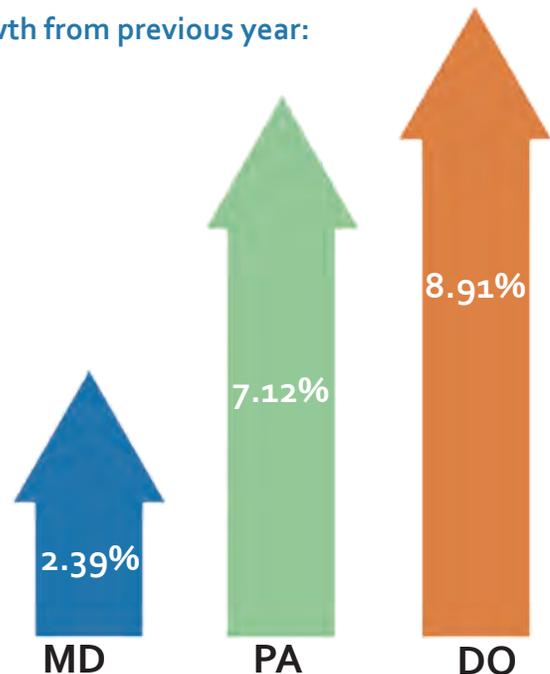
## 2016 Demographic Update

Here’s where physician and physician assistant population totals stood as of January 1, 2016.

2016 physician/PA population:



Growth from previous year:



## NCMB Position Statements: 2015 changes and year in review, continued from cover

### Advisory statement

What are the position statements of the Board and to whom do they apply?

The North Carolina Medical Board's Position Statements are interpretive statements that attempt to define or explain the meaning of laws or rules that govern the practice of physicians,\* physician assistants, and nurse practitioners in North Carolina, usually those relating to discipline. They also set forth criteria or guidelines used by the Board's staff in investigations and in the prosecution or settlement of cases.

When considering the Board's Position Statements, the following four points should be kept in mind:

- In its Position Statements, the Board attempts to articulate some of the standards it believes applicable to the medical profession and to the other health care professions it regulates. However, a Position Statement should not be seen as the promulgation of a new standard as of the date of issuance or amendment. Some Position Statements are reminders of traditional, even millennia old, professional standards, or show how the Board might apply such standards today.

- The Position Statements are not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. Therefore, the absence of a Position Statement or a Position Statement's silence on certain matters should not be construed as the lack of an enforceable standard.

- The existence of a Position Statement should not necessarily be taken as an indication of the Board's enforcement priorities.

- A lack of disciplinary actions to enforce a particular standard mentioned in a Position Statement should not be taken as an abandonment of the principles set

forth therein.

The Board will continue to decide each case before it on all the facts and circumstances presented in the hearing, whether or not the issues have been the subject of a Position Statement. The Board intends that the Position Statements will reflect its philosophy on certain subjects and give licensees some guidance for avoiding Board scrutiny. The principles of professionalism and performance expressed in the Position Statements apply to all persons licensed and/or approved by the Board to render medical care at any level.

\*The words "physician" and "doctor" as used in the Position Statements refer to persons who are MDs or DOs licensed by the Board to practice medicine and surgery in North Carolina.

### Position statements revised in 2015

- *Contact with patients before prescribing:* This position statement was revised to address needed exceptions for hospice care providers
- *HIV/HBV infected health care workers:* This position statement was revised to reflect the most current version of the relevant administrative rule
- *Physician supervision of other licensed health care practitioners:* This position statement revised to include paragraph on maintaining proper boundaries.

The full text of the revised versions of each position statement is published below.

## Contact with patients before prescribing

It is the position of the North Carolina Medical Board that prescribing drugs to an individual the prescriber has not examined to the extent necessary for an accurate diagnosis is inappropriate except as noted in the paragraphs below. Before prescribing a drug, a licensee should make an informed medical judgment based on the circumstances of the situation and on his or her training and experience. Ordinarily, this will require that the licensee perform an appropriate history and physical examination, make a diagnosis, and formulate a therapeutic plan, a part of which might be a prescription. This process must be documented appropriately.

Prescribing for a patient whom the licensee has not

personally examined may be suitable under certain circumstances. These may include admission orders for a newly hospitalized patient, interim medication orders or prescriptions, including pain management, from a hospice physician for a patient admitted to a certified hospice program, prescribing for a patient of another licensee for whom the prescriber is taking call, continuing medication on a short-term basis for a new patient prior to the patient's first appointment, an appropriate prescription in a telemedicine encounter where the threshold information to make an accurate diagnosis has been obtained, prescribing an opiate antagonist to someone in a position to assist a person at risk of an opiate-related overdose, or an appropriate

## ANNUAL POSITION STATEMENT REVIEW

prescription in anticipation of a diagnostic test consistent with the standard of care in that particular specialty . Established patients may not require a new history and physical examination for each new prescription, depending on good medical practice.

Prescribing for an individual whom the licensee has not met or personally examined may also be suitable when that individual is the partner of a patient whom the licensee is treating for gonorrhea or chlamydia. Partner management of patients with gonorrhea or chlamydia should include the following items:

- Signed prescriptions of oral antibiotics of the appropriate quantity and strength sufficient to provide curative treatment for each partner named by the infected patient. Notation on the prescription should include the statement: “Expedited partner therapy.”
- Signed prescriptions to named partners should be accompanied by written material that states that clinical evaluation is desirable; that prescriptions for medication or related compounds to which the partner is allergic should not be accepted; and that lists common medication side effects and the appropriate response to them.
- Prescriptions and accompanying written material should be given to the licensee’s patient for distribution to named partners.
- The licensee should keep appropriate documentation of partner management. Documentation should include the names of partners and a copy of the prescriptions issued or an equivalent statement.

It is the position of the Board that prescribing drugs to individuals the licensee has never met based solely on answers to a set of questions, as is common in Internet or toll-free telephone prescribing, is inappropriate and unprofessional.

*(Adopted: Nov 1, 1999) (Modified: February 2001; November 2009, May 2013, November 2014, March 2015, July 2015)*

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## CHIV/HBV infected health care workers

The North Carolina Medical Board supports and adopts the following rules of the North Carolina Department of Health and Human Services regarding infection control in health care settings and HIV/HBV infected health care workers.

10A NCAC 41A .0206 INFECTION PREVENTION – HEALTH CARE SETTINGS

(a) The following definitions apply throughout this Rule:

(1) “Health care organization” means a hospital; clinic; physician, dentist, podiatrist, optometrist, or chiropractic office; home care agency; nursing home; local health department; community health center; mental health facility; hospice; ambulatory surgical facility; urgent care center; emergency room; Emergency Medical Service (EMS) agency; pharmacies where a health practitioner offers clinical services; or any other organization that provides clinical care.

(2) “Invasive procedure” means entry into tissues, cavities, or organs or repair of traumatic injuries. The term includes the use of needles to puncture skin, vaginal and cesarean deliveries, surgery, and dental procedures during which bleeding occurs or the potential for bleeding exists.

(3) “Non-contiguous” means not physically connected.

(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens each health care organization that performs invasive procedures shall implement a written infection control policy. The health care organization shall ensure that health care workers in its employ or who have staff privileges are trained in the principles of infection control and the practices required by the policy; require and monitor compliance with the policy; and update the policy as needed to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens. The health care organization shall designate one on-site staff member for each noncontiguous facility to direct these activities. The designated staff member in each health care facility shall complete a course in infection control approved by the Department. The Department shall approve a course that addresses:

- (1) Epidemiologic principles of infectious disease;
- (2) Principles and practice of asepsis;
- (3) Sterilization, disinfection, and sanitation;
- (4) Universal blood and body fluid precautions;
- (5) Safe injection practices;
- (6) Engineering controls to reduce the risk of sharp injuries;
- (7) Disposal of sharps; and
- (8) Techniques that reduce the risk of sharp injuries to health care workers.

(c) The infection control policy required by this Rule shall address the following components that are necessary to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens:

- (1) Sterilization and disinfection, including a schedule for maintenance and microbiologic monitoring of equipment; the policy shall require documentation of maintenance and monitoring;
- (2) Sanitation of rooms and equipment, including

cleaning procedures, agents, and schedules;

(3) Accessibility of infection control devices and supplies; and

(4) Procedures to be followed in implementing 10A NCAC 41A .0202(4) and .0203(b)(4) when a health care provider or a patient has an exposure to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV or hepatitis B.

(d) Health care workers and emergency responders shall, with all patients, follow Centers for Disease Control and Prevention Guidelines on blood and body fluid precautions incorporated by reference in 10A NCAC 41A .0201.

(e) Health care workers who have exudative lesions or weeping dermatitis shall refrain from handling patient care equipment and devices used in performing invasive procedures and from all direct patient care that involves the potential for contact of the patient, equipment, or devices with the lesion or dermatitis until the condition resolves.

(f) All equipment used to puncture skin, mucous membranes, or other tissues in medical, dental, or other settings must be disposed of in accordance with 15A NCAC 13B .1200 after use or sterilized prior to reuse.

*History Note: Authority G.S. 130A-144; 130A-145; 130A-147; Eff. October 1, 1992; Amended Eff. January 1, 2010; December 1, 2003; July 1, 1994; January 4, 1994.*

## Physician supervision of other licensed health care practitioners

The physician who provides medical supervision of other licensed healthcare practitioners is expected to provide adequate oversight. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise the appropriate amount of supervision over a licensed healthcare practitioner which will ensure the maintenance of quality medical care and patient safety in accord with existing state and federal law and the rules and regulations of the North Carolina Medical Board. What constitutes an “appropriate amount of supervision” will depend on a variety of factors. Those factors include, but are not limited to:

- The number of supervisees under a physician’s supervision

- The geographical distance between the supervising physician and the supervisee
- The supervisee’s practice setting
- The medical specialty of the supervising physician and the supervisee
- The level of training of the supervisee
- The experience of the supervisee
- The frequency, quality, and type of ongoing education of the supervisee
- The amount of time the supervising physician and the supervisee have worked together
- The quality of the written collaborative practice agreement, supervisory arrangement, protocol or other written guidelines intended for the guidance of the supervisee
- The supervisee’s scope of practice consistent with the supervisee’s education, national certification and/or collaborative practice agreement

Physicians should also be cognizant of maintaining appropriate boundaries with their supervisees, including refraining from requesting medical treatment by the physician’s supervisee. Physician assistants and nurse practitioners are specifically prohibited from prescribing controlled substances for the use of their supervising physicians.

Practices owned solely by physician assistants or nurse practitioners may not hire or contract with physicians to practice medicine on behalf of the physician assistant or nurse practitioner owned practice. The physician assistant or nurse practitioner may contract with a physician to provide the legally required supervision of the physician assistant or nurse practitioner.

*(Adopted July 2007)(Reviewed September 2012)(Revised November 2015) See also the Board’s position statement on “Self-treatment and Treatment of Family Members.”*

### The following position statements were reviewed in 2015 and approved by the Board with no changes:

- *Competence and Reentry to the Active Practice of Medicine*
- *Laser Surgery*
- *Prescribing Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties*
- *Referral fees and fee splitting*
- *Sale of goods from physician offices*
- *Writing of prescriptions*

## Board seeks comment on rule changes to require controlled substances CME

NCMB has developed draft rules for implementing a new state requirement that all prescribers of controlled substances obtain mandatory continuing medical education in prescribing these medications.

Under the proposed rule, physician licensees would be required to make three hours of the required total of 60 hours of Category 1 CME earned over a three year cycle related to controlled substances prescribing. The proposed rule for physician assistants, who must earn 50 hours of CME over two years, would require PAs to make at least two of

their reported CME hours related to controlled substances.

The rules do not provide detailed guidance on the content of courses to be completed. The only requirement is that course content be related to controlled substances prescribing practices, recognizing signs of abuse or misuse of controlled substances and/or controlled substances prescribing in the context of chronic pain management.

The Board will accept public comments on the proposed rule changes through Feb. 29. Review the draft rules online by visiting [www.ncmedboard.org](http://www.ncmedboard.org) and selecting the CME Rule Change image from the slideshow in the center of the page.

*Comments should be emailed to [PrescribingCME@ncmedboard.org](mailto:PrescribingCME@ncmedboard.org) by Feb. 29.*



The Board proposed changes to the physician and physician assistant CME rules at its January meeting. Proposed revisions to the physician CME rule are published below. Visit [www.ncmedboard.org](http://www.ncmedboard.org) and click on the prescribing CME slide at the center of the page to access the proposed changes to the PA rule.

### **SUBCHAPTER 32R – CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS**

#### **SECTION .0100 – CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS**

#### **21 NCAC 32R .0101 CONTINUING MEDICAL EDUCATION (CME) REQUIRED**

(a) Continuing Medical Education (CME) is defined as education, training and activities to increase knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of healthcare to the public. The purpose of CME is to maintain, develop, or improve the physician's knowledge, skills, professional performance and relationships which physicians use to provide services for their patients, their practice, the public, or the profession.

(b) Each person licensed to practice medicine in the State of North Carolina, except those holding a residency training license, shall complete at least 60 hours of Category 1 CME relevant to the physician's current or intended specialty or area of practice every three years. Beginning on January 1, 2017, every physician who prescribes controlled substances, except those holding a residency training license, shall take at least three hours of CME, from the required 60 hours of Category 1 CME, that is designed specifically to address controlled substance prescribing practices. The controlled substance prescribing CME shall include instruction on controlled substance prescribing practices, recognizing signs of the abuse or misuse of controlled substances, and controlled substance prescribing for chronic pain management.

(c) The three year period described in Paragraph (b) of this Rule begins on the physician's first birthday following initial licensure.

*History Note: Authority G.S. 90-14(a)(15); 2015 Session Law 12F .16(b); G.S. 90-5.1 22  
Eff. January 1, 2000;  
Amended Eff. \_\_\_\_\_ ; August 1, 2012; January 1, 2001.*

# North Carolina Medical Board

## Quarterly Board Actions Report | August - October 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](http://www.ncmedboard.org). Go to Recent Board Actions to view current public actions 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
<b>ANNULMENTS</b>			
NONE			
<b>SUMMARY SUSPENSIONS</b>			
NONE			
<b>SUSPENSIONS</b>			
<b>KRISHNARAJ, Ramesh Loganathan, MD</b> (009901228) Morganton, NC	09/23/2015	History of alcohol use disorder; MD consumed alcohol in violation of NCPHP contract. MD has successfully completed residential treatment.	MD's license is indefinitely suspended, immediately stayed; Must maintain NCPHP contract
<b>MARTINEZ, Paul Armando, MD</b> (00 9300219) Apex, NC	09/24/2015	History of alcohol use; MD consumed alcohol in violation of NCPHP contract. MD has successfully completed residential treatment.	MD's license is indefinitely suspended, immediately stayed; MD must maintain NCPHP contract.
<b>MORRISON, Angela Sharnell, MD</b> (201001402) Rock Hill, SC	10/22/2015	MD aided and abetted the unlicensed practice of medicine by acting as medical director for a Huntersville practice that provided weight loss treatments. The practice was owned by an out of state physician who is not licensed by NCMB as is required by state laws governing the corporate practice of medicine. MD stated that she was unaware that the practice's ownership was in conflict with NC law. Protocols followed by the clinic did not conform to accepted standards of care. Patients initially seen by MD were reassessed by medical assistants and in some cases received medication refills on MD's authority without MD's knowledge or consent.	MD's license is suspended for 12 months, immediately stayed. MD must complete a course in medical record keeping that is approved by the Board; \$5,000 fine.
<b>SPIVEY, David Lee, MD</b> (000030582) Winston-Salem, NC	09/11/2015	History of substance abuse; MD has entered inpatient relapse prevention treatment.	Indefinite suspension, immediately stayed. MD must maintain NCPHP contract and abide by all condition.
<b>THOMPSON, Joel Wesley, MD</b> (RTL) Charlotte, NC	08/27/2015	History of alcohol dependence; Resident was arrested and charged with driving while impaired in March 2015, while under a consent order with the Board that required him to refrain from the use of alcohol.	Indefinite suspension of resident training license (RTL)

BOARD ACTIONS REPORT

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<b>PROBATION/CONDITIONS</b>			
<b>BAKKEN, Whitney Jo Dennison, MD</b> (200900784) Greenville, NC	09/14/2015	Inappropriate prescribing of controlled substances for the treatment of pain	MD is limited and restricted from treating any and all kinds of pain (acute or chronic); MD must complete 10 hours of CME in EACH of the following subjects: medical record and prescribing.
<b>BRONSTHER, Rachel Beth, MD</b> (RTL) Greenville, NC	08/27/2015	History of alcohol abuse	Resident must maintain NCPHP contract and abide by all terms, including refraining from the use of any mind- or mood altering substance not lawfully prescribed to her.
<b>HAYES, John David, MD</b> (200201473) Asheville, NC	09/22/2015	Concerns about quality of care provided to patients choosing home birth delivery	MD may perform home birth deliveries, subject to conditions stated in the order.
<b>TYLER, Brian Carey, MD</b> (009601121) Gloucester, VA	08/06/2015	Unprofessional conduct; MD was charged with stalking his wife (dismissed).	MD must maintain NCPHP contract and abide by all terms.
<b>REPRIMANDS</b>			
<b>LAIZURE, Clancy Conde, PA</b> (000100970) Asheboro, NC	09/09/2015	Failure to comply with the terms of the October 16, 2014, consent order, which required PA to have 100 percent of his patient charts reviewed and signed by his supervising physician.	Reprimand
<b>LONNEMAN, Kimberly Watson, PA</b> (102711) Wilmington, NC	11/04/2015	PA prescribed controlled substances to a close family member, in direct conflict with administrative rules that prohibit this.	Reprimand; PA must complete a course in professional ethics.
<b>MCGEE, (Jr.), Thomas Page, MD</b> (200200740) Franklin, NC	09/09/2015	MD performed medical examinations (of the breasts and genitalia) without adequately informing patients beforehand of the location and purpose of the physical examinations.	Reprimand; MD shall have his patient interview skills evaluated by a professional mentor and make improvements to his interview technique based on the mentor's observations and recommendations. MD must maintain NCPHP contract.

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<b>VANDE LUNE, Daniel Wayne, MD</b> (201101889) Iowa City, IA	09/22/2015	Disruptive conduct; MD threw an instrument in the OR and also struck a patient with his fist.	Reprimand; MD must complete a communications course with an anger management component.
<b>DENIALS OF LICENSE/APPROVAL</b>			
NONE			
<b>SURRENDERS</b>			
NONE			
<b>PUBLIC LETTERS OF CONCERN</b>			
<b>ALEX, Vikki May, PA</b> (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
<b>ARENAS, Gilbert Domingo, MD</b> (000035256) Rockingham, NC	10/23/2015	The Board is concerned that MD failed to provide patients timely access to their medical records when he closed his practice and moved to another state. Licensees are professionally obligated to ensure patients are provided with their records in a timely manner.	Public Letter of Concern
<b>GACCIONE, Craig Stephen, MD</b> (009700556) Asheboro, NC	08/18/2015	MD failed to appropriately follow up to confirm whether a patient's 1972 hysterectomy included removal of the ovaries. MD's patient record mistakenly indicated that MD reviewed the 1972 records when, in fact, he had not yet done so.	Public Letter of Concern
<b>GIORDANO, Stephen Robert, DO</b> (200701965) Huntersville, NC	08/12/2015	DO treated at least four family members without maintaining appropriate patient records and in a manner that conflicts with the Board's position on treatment of self/family. In addition, DO failed to comply with a 2014 Board order that required him to obtain an assessment. DO has completed the assessment and is complying with a recommendation to receive treatment.	Public Letter of Concern
<b>HOWARD, Chad Daniel, MD</b> (200200125) Elizabeth City, NC	08/03/2015	MD prescribed controlled substances to an immediate family member from July 2009 until April 2014. Prescribing controlled substances to immediate family members is inappropriate and prohibited by NC administrative rules.	Public Letter of Concern; MD required to take an ethics course.

BOARD ACTIONS REPORT

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<b>KAPLAN, Richard David, MD</b> (000023389) Greensboro, NC	10/08/2015	The Board is concerned MD attempted to effectuate vaginal delivery in a patient who presented at 41 weeks gestation by using both a vacuum extractor and then forceps. After these efforts were not successful a fetal scalp electrode was placed and a fetal bradycardia was detected and MD ordered an emergency cesarean section. The Board is concerned that the use of two vaginal operative procedures resulted in a delay in ordering the cesarean section.	Public Letter of Concern
<b>OJIEGBE, Vitalis Ohakwe, MD</b> (200200430) Lanham, MD	10/13/2015	The Board is concerned that MD entered into a consent order with the Maryland medical board related to allegations that MD was overprescribing controlled substances. MD's North Carolina license was made inactive as of February 25, 2015. Should MD seek reactivation, the Board will take the issues involved in the MD order into account in making a decision.	Public Letter of Concern
<b>SCHAEFER, William Dickson, MD</b> (009701583) Fayetteville, NC	11/04/2015	The Board is concerned that MD performed a wrong site surgery on a patient, performing surgery on the right thumb instead of the right index finger as intended. MD immediately acknowledged the error, apologized to the patient and scheduled surgery for the correct finger at no additional charge.	Public Letter of Concern
<b>MISCELLANEOUS ACTIONS</b>			
<b>SPAHN, Kreig, DO</b> (201502151) Cochran, PA	10/08/2015	DO failed to appropriately disclose a consent agreement he entered into with the Pennsylvania medical board related to allegations of substandard care.	DO is issued a medical license via consent order, with a \$2,000 fine.
<b>CONSENT ORDERS AMENDED</b>			
<b>BOGGOLA, Vijaya Prakash, MD</b> (RTL) Greensboro, NC	08/05/2014	History of soliciting sex from a minor online; MD has completed treatment and has been judged by the treatment center and the NCPHP to be safe to practice.	MD is issued a resident training license; MD must enter into a monitoring contract with NCPHP and abide by all terms; MD must also continue treatment.

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<b>EVANS, Michael Allen, MD</b> (200001370) Smithfield, NC	10/24/2014	Restrictions no longer needed.	Consent order dated August 2, 2013, is amended; restrictions on controlled substance prescribing lifted. MD may administer and prescribe controlled substances in any practice setting.
<b>TEMPORARY/DATED LICENSES</b>			
NONE			
<b>ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES</b>			
NONE			
<b>COURT OF APPEALS/STAYS</b>			
NONE			
<b>DISMISSALS</b>			
NONE			

## Request a speaker from the NCMB

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.

Learn more about the Board’s mission and core responsibilities, gain insight into the complaint and investigative process, or get in depth information about specific subjects such as appropriate supervision of mid-level practitioners or responsible opioid prescribing. NCMB will tailor presentations to a group’s specific interests, upon request.

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](mailto:jean.brinkley@ncmedboard.org).

You can also visit [www.ncmedboard.org](http://www.ncmedboard.org) and complete our request a speaker form by going to contact and select request a speaker.



**North Carolina Medical Board**

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**BOARD MEETING DATES**

February 18-19, 2015 (Hearing)  
March 16-18, 2015 (Full Board)  
April 21-22, 2015 (Hearing)  
May 18-20, 2015 (Full Board)

Meeting agendas, minutes and a full list of meeting dates can be found on the Board's website

[ncmedboard.org](https://ncmedboard.org)

## Browse (and contribute to) NCMB's online physician wellness resources

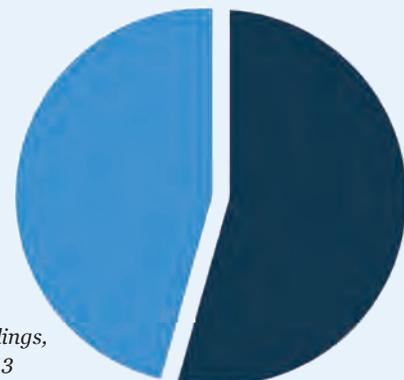
NCMB has assembled an online collection of wellness and burnout resources at the recommendation of Board Members and stakeholders who participated in NCMB's June 2015 roundtable discussion on physician wellness.

Visit [www.ncmedboard.org](http://www.ncmedboard.org), go to Resources & Information and select "Wellness resources: from the options in the center of the page. Many resources are geared towards helping licensees recognize and assess their own symptoms of burnout. Some emphasize ways to combat the signs of burnout and encourage resilience in the face of mounting professional stressors. Although some organizations featured offer paid services, NCMB has tried to avoid posting resources where the primary purpose is to promote commercial products and services.

The Board will expand its collection of wellness resources over time. If you are aware of a resource that might be useful to NCMB licensees, please email [forum@ncmedboard.org](mailto:forum@ncmedboard.org) to suggest it.

A recent study by Tait Shanafelt, MD, and colleagues found that more than half of a sample of nearly 36,000 physicians surveyed in 2014 reported one or more symptoms of burnout. That's a nearly 10 point increase from 2011.

- **Physicians reporting burnout: 54.4**
- **Physicians not reporting burnout: 45.6**



Source: *Shanafelt et al, Mayo Clinic Proceedings, Dec. 2015, Volume 90, Issue 12, Pages 1600-1613*