North Carolina Medical Board
FORUM
ISSUE NO. 4 | WINTER 2017

FROM THE PRESIDENT

Resolve to fight burnout and reclaim satisfaction in life, work

Eleanor E. Greene, MD, MPH

The Board recently surveyed a random sample of its licensees to get input on a range of topics related to the practice of medicine, including professional burnout. About 45 percent of survey respondents indicated they have experienced symptoms of burnout that lasted more than three months, which is consistent with national trends. More eye-opening was a related question that asked licensees with burnout to say whether they had sought assistance. Some 67 percent indicated that they did nothing to alleviate their burnout. When asked why, the most common response was that burnout is "just part of the job."

A few years ago, I would probably have agreed with that statement. As an obstetrician and gynecologist, I worked long hours and was frequently called to the hospital at night to deliver babies. I rarely got enough sleep, didn't have time to exercise and wasn't eating well. I'd started noticing that my knees and back ached if I spent more than an hour or so on my feet, and I was pretty sure surgery was in my future. My blood sugar level and blood pressure were creeping up. I started to ask myself, "How do I get off this merry-go-round?"

I knew I needed to make some changes. I did not want to continue on a path to burnout and further deterioration of my physical and emotional health. So, I took three months off to self-reflect, travel and put my desires and interests first for once. I knew I had to put my own health first – advice I often gave my patients but was not, in fact, following. I got a personal trainer and started to work out regularly and make healthier meal choices. I made the difficult decision to give up obstetrics, to make it possible to get better sleep. After three months, I reopened my practice but changed the focus to women's health and wellness, and I reduced to part time hours. With the help of my doctor,

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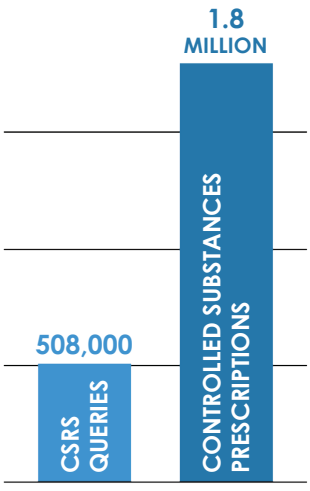
SPOTLIGHT

According to the NC Controlled Substances Reporting System, during the 4th Quarter of 2016 prescribers ordered a prescription history 28 percent of the time when prescribing controlled substances.



NORTH CAROLINA MEDICAL BOARD

Dr. Greene was sworn in as President by Immediate Past President Pascal O. Udekwu, MD, in November.

I was able to lose 50 pounds over a period of three years. Losing weight and exercising resolved the knee and back pain, returned my blood sugar and blood pressure to normal and my sleep apnea went away. Most important, I'm enjoying practicing medicine again, and I'm much happier.

I recognize that I'm fortunate that I am at a point in life where it was possible to make drastic changes to improve my life and practice. Not everyone can do that. At the same time, I want to encourage you, my colleagues, to reject the notion that burnout is inevitable and inescapable.

NCMB hosted a roundtable discussion on physician wellness in 2015, in response to rising rates of physician burnout. One of the actions the Board took after that meeting was to collect and post wellness resources, particularly resources related to identifying and addressing symptoms of burnout, on its website, as *www.ncmedboard.org/wellness*. I hope you'll take a few minutes to review them. You may just find something that inspires you to make some positive changes.

Also in 2015, NCMB joined the NC Consortium for Physician Resilience and Retention, which brings together stakeholders, including the NC Medical Society, Cone Health, the NC Physicians Health Program, and other organizations that deal with the impact of rising physician burnout. The Consortium is committed to identifying opportunities to address mental health, wellness, and burnout among medical professionals in the state. Participation in the Consortium influenced NCMB's recent decision to stop asking licensees completing annual renewal to disclose medical conditions that might impair or limit ability to practice. NCMB hopes this change will encourage licensees who need help to obtain it, without fear of attracting Board scrutiny.

If you're interested in viewing summary results from the recent licensee survey, you'll find a feature on page 6 of this issue of the newsletter.

Be well,

Eleanor E. Greene, MD

Eleanor E. Greene, MD, MPH
Board President

North Carolina Medical Board Forum Credits VOLUME XX | No. 4

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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.

APPAHC Chairperson Jerri L. Patterson, NP, with fellow Board Member Ralph A. Walker, JD

Board updates committee name

The Board voted in January to accept the Allied Health Committee's recommendation to change its name to Advanced Practice Providers and Allied Health Committee (APPAHC).

The committee is responsible for reviewing matters involving physician assistants, nurse practitioners, midwives, clinical pharmacist practitioners, emergency medical service (EMS) providers, anesthesiologist assistants and perfusionists who are regulated, directly or indirectly, by NCMB. The Committee also handles matters related to polysomnographic technologists or "sleep techs". Sleep techs are not licensed by the Board but are required to register with NCMB annually.

The name change more accurately reflects the range of medical professionals who fall under the scope of the committee's work. The APPAHC meets during each Board Meeting.

Finding controlled substances CME courses

Now that 2017 is here, many physicians and physician assistants (PAs) are actively looking for continuing medical education (CME) courses that can help them satisfy the new requirement for controlled substances prescribers. Any prescriber whose CME cycle renews on or after July 1, 2017, will be expected to have met the new requirement.

Physicians who prescribe controlled substances (including non-opioids) must complete three hours of eligible CME during each cycle and PAs must complete two hours. These hours are part of the licensee's total CME requirement for the cycle, not in addition to it.

One CME provider physicians and PAs should be aware of is the U.S. Centers for Disease Control and Prevention, which currently offers seven free prerecorded modules on safe opioid prescribing. CME credit can be obtained after viewing or listening to any CDC module by completing an online evaluation and post-test. Titles offered include, *"Assessing Benefits and Harms of Opioid Therapy," " Dosing and Titration of Opioids," "Risk Mitigation to Reduce Opioid Overdose," "Effectively Communicating with Patients about Opioid Therapy,"* and *"Overview of the CDC Guideline for Prescribing Opioid for Chronic Pain."* Courses are certified for credit through December 2017.

Find the series of CDC opioid modules at
https://emergency.cdc.gov/coca/calls/opioidresources.asp

Additional CME courses and information about the new controlled substances requirement can be found at:
www.ncmedboard.org/prescribingCME

To support physicians and PAs, the Board has partnered with Wake AHEC to create free CME that will cover the required topics. CME will be available this spring and will consist of a webinar and four live panel sessions. NCMB will publish details about how to access this CME once details are set.

Will my CME qualify?

To count towards the new requirement, a course must:

- Be Category 1 certified
- Cover one or more of the following education topics:
    1. Controlled substances prescribing practices
    2. Controlled substance prescribing for chronic pain management
    3. Recognizing signs of the abuse or misuse of controlled substances

Note: Each education topic must be covered at least once during each CME cycle. In other words, every course completed need not cover all three topics.

Position statement review: what changed in 2016?

The Board reviews position statements at least once every four years, or more frequently if new information or issues come to light that may necessitate reconsideration, expansion or revision of an existing NCMB position. Here's what the Board worked on in 2016:

New position statements

The Board adopted one new position statement in 2016, entitled, *Corporate practice of medicine*.

As a general rule, the North Carolina Professional Corporations Act (N.C. Gen. Stat. § 55B, et. seq.) requires corporations that provide certain professional services to be owned entirely by licensees of that profession. As a rule, medical practices must be owned by licensed physicians. Under some circumstances, a medical practice may be jointly owned by a combination of other authorized clinicians as listed in N.C. Gen. Stat. § 55B-14(c). NCMB recognizes medical practices owned by hospitals or health maintenance organizations as exceptions because state law authorizes these licensed and regulated entities to provide direct patient care.

Why was this position statement needed?

Often, NCMB will investigate situations where a licensee is employed to work in a practice owned by medical professionals who are not licensed in NC or that is owned by individuals who are not medical professionals. Another common pitfall NCMB sees frequently is the problem of "straw ownership" of medical practices. A straw ownership arrangement is one in which a licensed physician is made the sole shareholder of a practice controlled and operated by a nonphysician. The new position statement can help licensees better understand the Board's expectations with regard to practice ownership and, potentially avoid regulatory problems that arise from becoming involved in an inappropriate practice arrangement.

Amended position statements

The Board approved revisions to the following position statements:

- *The Physician-Patient Relationship*
- *Medical Testimony*
- *End-of-life Responsibilities and Palliative Care*

The Physician-Patient Relationship

What Changed?

The position statement was updated to reflect circumstances faced by employed physicians. For example the position clarifies the Board's expectation that, if an employer terminates a physician, either the physician or the employer provide patients with the physician's new contact information. In addition, patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer.

Medical Testimony

What changed?

The position was updated to include most recent version of the AMA Ethics Opinion on medical testimony.

End-of-life Responsibilities and Palliative Care

What Changed?

The position statement was expanded to state that physicians and physician assistants should address Advanced Care Planning, including the establishing of a Health Care Power of Attorney and Advanced Directives, as appropriate.

Position statements available online

All position statements as well as a downloadable pdf copy of the complete position statements are available online at: *www.ncmedboard.org/positionstatements*

Reviewed, no changes

The Board reviewed all of the following position statements and determined that no changes are needed at this time.

- *Advanced Directives and Patient Autonomy*
- *Availability of licensees to their patients*
- *Office-based procedures*
- *The Retired Physician/Licensee*

Repealed

The Board voted to repeal its position statement entitled, *Competence and Reentry to the Active Practice of Medicine*.

Why was this repealed?

This statement is no longer relevant due to changes to 21 NCAC 32B .1370, which took effect January 1, 2016. Applicants who have not actively practiced clinical medicine for two or more years are required to demonstrate their competence to practice medicine upon application for a North Carolina license. Applicants may be required to complete a program of reentry before a license is issued. Overall, reentry is now a more individualized process developed on a case-by-case basis depending on the strengths, weaknesses, needs and practice plans of the individual seeking reentry. Learn more about reentry to the practice of medicine on NCMB's website: *www.ncmedboard.org/licensure/reentry*.

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.

NCMB adopts CDC opioid guidelines

NCMB voted at its January Board Meeting to replace its existing position statement on the use of opiates to treat pain with the *CDC Guideline for Prescribing Opioids for Chronic Pain*.

The Board was motivated by a desire to offer licensees who prescribe opioids a comprehensive and current resource to assist them in providing appropriate care to their patients with pain. NCMB's *Policy for the Use of Opiates for the Treatment of Pain* was adopted in 2014, while CDC's opioid guidance was released in March 2016.

Please follow the link to the right to read the Board's formal comments, which note that the recommendations contained in the CDC policy may not meet the needs of all patients. The Board encourages licensees who prescribe opioids to familiarize themselves with the CDC policy and use it to guide - but not dictate - their treatment decisions.

NCMB's primary goal relative to opioid prescribing is to prevent inappropriate prescribing, not to disrupt the treatment of patients with a legitimate need for pain management. It is up to each clinician providing patient care to develop treatment plans that are both clinically appropriate and in the best interest of their patients.

Website

Access the *CDC Guideline for Prescribing Opioids for Chronic Pain* on the Board's website:

www.ncmedboard.org/CDCpolicy

Licensee survey: here's what you told us

In October, NCMB sent emails to 10,000 randomly selected licensees requesting their input on topics impacting the practice of medicine, including physician wellness/burnout, longevity in practice, and issues facing employed physicians versus those in private practice. We also shared the survey with several groups to distribute to their members, including NC Medical Society, NC Osteopathic Medical Association, NC Academy of Physician Assistants, and the Old North State Medical Society.

NCMB staff will be working over the next few months to see what else can be gleaned from the data and to determine how representative the information is for physicians and PAs in North Carolina. The Board is grateful to the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, Chapel Hill, and to the NC Physicians Health Program, which have both offered assistance in further analyzing the information. Thank you to all physicians and PAs who participated in the survey! If you have any questions or comments, send them to *forum@ncmedboard.org*.

1,855 licensees responded, and much of the information provided mirrors national trends. The initial findings included the following:

The Basics

40%

Of those who responded Indicated they have plans to retire in the next 10 years.

Employed physicians, PAs, and 35-54 year olds reported higher dissatisfaction with work/life balance than other age groups.

60%

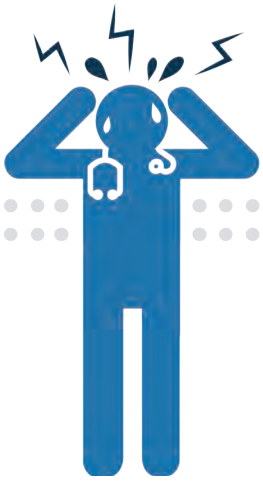
Of employed physicians reporting dissatisfaction regarding work/life balance were women.

For physicians/PAs in private practice, pay was listed as both a top 5 benefit (#5) and a top 5 challenge (#3).

When breaking down the data, the more experience a physician/PA has, the less rewarding the pay in private practice becomes

Professional Burnout

Nearly 45% indicated they have **experienced burnout** that lasted more than 3 months



Burnout was about the same between employed physicians and those in private practice

67% of those who reported experiencing burnout DID NOT seek assistance. The most frequent reason cited was that burnout is just part of the job.

Common side effects of burnout were negativity, exhaustion, self-doubt and anxiety, although 6% indicated they have had suicidal thoughts.

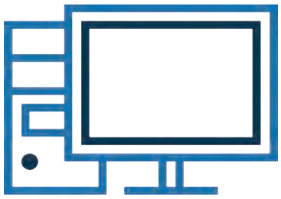
Interactions with NCMB

45% Good

20% Excellent

65% of those that responded rated their overall experience with NCMB on a 5 point scale as "good" or "excellent"

The top three forms of interaction reported by 1,811 licensees includes:



Visiting the NCMB Website: 65%

Accessing the Licensee Page: 45%

Reading articles in the Forum: 42%

How can the Board better serve patients and public education?

Responses included:

"More education around controlled substances"

"Educate the population on the importance of high quality physicians and the danger of losing high quality physicians"

How can the Board better serve licensees?

Responses included:

"License renewal that lasts longer than 1 year" or "streamline the 23 step process for renewal"

"Offer solutions to burnout, real solutions. Things people can do to help themselves and change their practice if that is even possible. "

View the full survey: scan the QR code with your smartphone or go to http://tinyurl.com/jh2dxjh

Call for applicants: physicians needed to serve on NCMB

Applicants are needed for two physician seats on the Board, for terms beginning Nov. 1.

Two seats must be filled by the process set down in statute (N.C. Gen. Stat. 90-2 and 90-3), which requires interested parties to apply via the Review Panel. The Review Panel is an independent body that nominates candidates for consideration by the Gov. Roy Cooper. By law, the Review Panel must nominate two candidates for each open seat.

Applications will be accepted online through July 1, beginning March 1. For more information visit: *http://www.ncmedboardreviewpanel.com/*

The Review Panel will consider only physicians (MDs or DOs) who hold active, unrestricted NC medical 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.

Board votes to modify opioid investigations program

After evaluating preliminary results from its opioid investigations program, the Safe Opioid Prescribing Initiative (SOPI), the Board voted in January to refine the selection criteria that determine who will be investigated. Any changes to the rules for this program will be submitted to the Rules Review Committee after the public comment period (now through May 1).

Currently SOPI, which was implemented in April 2016, investigates NCMB licensees who have had multiple patient deaths due to opioid overdose AND licensees who write large numbers of high-dose opioid prescriptions (See "Current SOPI investigative criteria" below). The Board has proposed rule changes to amend the existing selection criteria. The Board is also contemplating new selection criteria to identify prescribers whose medical practices display characteristics associated with potentially inappropriate opioid prescribing.

NCMB welcomes feedback on the proposed rule changes. A public hearing is scheduled for May 1 at the Board's Raleigh offices. Written comments may be submitted to *rules@ncmedboard.org*.

How does NCMB want to change the "patient deaths" criteria?
Currently, the Board opens investigations into physicians or PAs who have had two or more patient deaths due to opioid poisoning within a 12-month period. NCMB wants to modify these criteria so that investigations would only be opened if the prescriber a) authorized 30+ tablets of an opioid to the decedent AND b) the opioid prescriptions were written within 60 days of the patient's death.

Why does the Board want to make changes to the "patient deaths" criteria?
In the vast majority of cases where the prescriber authorized some type of controlled substance in the

Current SOPI investigative criteria:

- Top one percent prescribing 100 milligrams of morphine equivalents (MME) per patient per day.
- Top one percent prescribing 100 MMEs per patient per day in combination with any benzodiazepine and within the top one percent of all controlled substance prescribers by volume.
- Prescribers with two or more patient deaths within a 12–month period due to opioid poisoning.

Revised SOPI investigative criteria:

- Top two percent prescribing 100 morphine milligram equivalents (MME) per patient per day.
- Top two percent prescribing 100 MMEs per patient per day in combination with any benzodiazepine and within the top one percent of all controlled substance prescribers by volume.
- Prescribers with two or more patient deaths within a 12–month period due to opioid poisoning AND authorized 30+ tablets of an opioid to the decedent AND scripts were written within 60 days of the patient's death.

12 months preceding the death, the prescribing did not contribute to the death. Adding filters to ensure that opioids were prescribed in close proximity to the death will ensure that cases are only opened on physicians or PAs who authorized recent opioid prescriptions.

How does NCMB want to change the "high-volume, high-dose" criteria?
Currently NCMB investigates the top ONE percent of licensees prescribing 100 morphine milligram equivalents (MMEs) per patient, per day. The Board also looks at prescribers who meet this criteria and also prescribe in combination with a benzodiazepine. The Board wants to begin opening cases into the top TWO percent of such prescribers.

Why does the Board want to expand the "high-volume, high-dose" criteria?
A majority of cases opened based on these criteria resulted in either private or public action, based on Board findings of substandard practice or other concerns regarding quality of care. The Board believes expanding these criteria to the top TWO percent of clinicians prescribing 100 MMEs per patient, per day, will likely identify additional prescribers who may not be practicing consistent with current accepted standards of care.

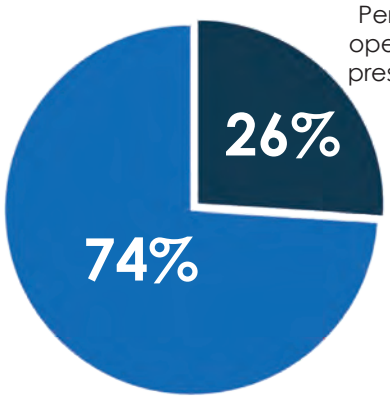
What other changes to the selection criteria is NCMB considering?
The Board is interested in creating a new set of selection criteria to identify prescribers whose practices display certain characteristics (See "Potential SOPI investigative criteria" below). The Board voted in January to test the proposed criteria before seeking rule changes to formally establish them.

How will these proposed changes affect the number of SOPI cases opened?
The Board expects to open fewer cases based on patient deaths than it did under existing criteria. It expects an increase in the number of cases related to the changes to the "high-volume, high dose" criteria.

As the vast majority of SOPI cases to date have been opened based on the patient deaths criteria, the Board expects the net effect of the rule changes to be a smaller but more specific and sensitive report of licensees meeting any investigative criteria.

Cases Opened

As of January 2017 NCMB has completed 62 based on SOPI criteria. These cases have directly impacted .2% of the licensee population.



Potential SOPI investigative criteria *

NCMB would investigate prescribers who meet at least three of the following criteria:

1. At least 25 percent of the prescriber's patients receiving opioids reside at least 100 miles from the prescriber's practice location;
2. The prescriber has more than 30 patients receiving the same opioid and benzodiazepine combination;
3. A majority of the prescriber's patients receiving opioids self-pay for the prescription;
4. Prescriber allows an early opioid prescription refill more than twice in the last 12 months;
5. More than 50% of the prescriber's patients receive opioid doses of 100 MME or greater per day; or
6. The prescriber has more than ten patients who use three or more pharmacies within a year to obtain opioids.

** NCMB will study this criteria to determine its feasibility and value before pursuing rule changes.*

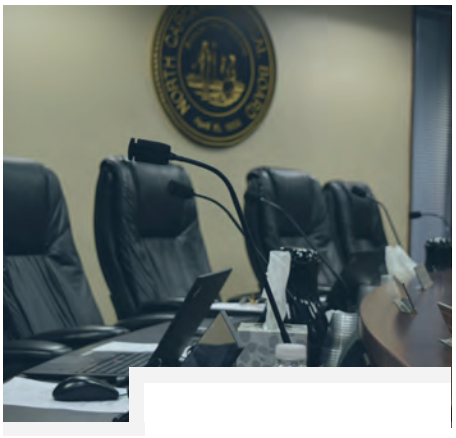
The SOPI rule changes are available on the NCMB website in the Rule Change Tracker:
www.ncmedboard.org/SOPIRules

Update on PA Board Member appointment

The Review Panel for the NC Medical Board interviewed several candidates for the open physician assistant (PA) seat on the Board on Jan. 28.

The Panel, which under state law is responsible for nominating candidates for NCMB seats for consideration by the Governor, is expected to select two candidates sometime in February. Barring any unforeseen delays, NCMB hopes to have a new PA Board Member seated in time to attend the meeting scheduled for March 15-17.

NCMB has a total of 13 members, including eight seats held by physicians, one seat held by a nurse practitioner, one seat reserved for a PA and three seats held by members of the public.



GETTING TO KNOW THE PEOPLE OF THE NC MEDICAL BOARD

Five Questions: Timothy E. Lietz, MD

EMERGENCY MEDICINE | MID-ATLANTIC EMERGENCY MEDICAL ASSOCIATES | APPOINTED 2013 | PRESIDENT ELECT

What do you wish the public or other medical professionals understood about the Board?

A: For medical professionals, I want them to really think about our mission of protecting the public. Medical professionals need to understand that by protecting the public we are protecting the integrity of our profession. The public needs to understand we are here for their protection and that we are a resource when they encounter questionable professional behavior or questionable clinical competence.

What is the biggest challenge facing medicine or medical regulation?

A: That more physicians are working for large health care organizations in an employed model. Physicians are measured by productivity and by metrics that have been placed on them by the organizations and the federal government. Physicians are increasingly measured and graded by best business practices and these often do not measure the value of the patient-physician relationship. Since their paychecks come from the larger organization, physicians are not working for their patients and business partners as they did in the past, but for the corporation. I believe this is causing collegiality between physicians and the doctor-patient relationship to be compromised.

What is the best lesson you have learned from your personal or professional life experiences?

A: To always work on being a good listener. Early in my career I had a respected colleague counsel me about not listening well to the concerns of our nursing leadership. It was a wake-up call. You cannot be a good leader or mentor if you do not listen to others. I think by working on listening to others' ideas and positions I have become more balanced in my decisionmaking and understand that my ideas, concerns and solutions are not the only way things can be accomplished.

What is the last book you read?

A: In high school I was not much of a reader so most of the classic literature did not receive the time and effort it deserved. I thought that I would go back and start reading now that I have no pressure to finish in a relatively short period of time. I have read the *Count of Monte Cristo*, *All Quiet on the Western Front*, *In Cold Blood*, *Catcher in the Rye*, and I am currently reading *The Grapes of Wrath*.

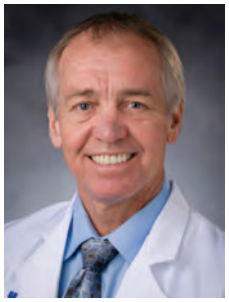
Who inspires you?

A: My wife. She has had a full time OB/GYN practice for 22 years, raised three children, and is a supportive spouse and a great cook. She is now is starting a new practice with additional training in Functional Medicine and Wellness. She has done all this with a dignity and grace that I admire and try to emulate.

Using NCCSRS to improve opioid prescribing

Tips from the director of Duke Health's Medical Pain Service

This year, the NC Controlled Substances Reporting System (CSRS) will celebrate its 10th anniversary. The system is a valuable resource that can help prescribers monitor patient behavior and avoid issuing prescriptions to patients who may be abusing or misusing the medications. Yet CSRS remains an underused resource in NC, with less than half of prescribers with a valid DEA registration currently signed up for access. *Forum* editor Jean Fisher Brinkley asked Dr. Steven D. Prakken, director of the Medical Pain Service for Duke Health and an early adopter of CSRS, for his thoughts on why – and how – prescribers should use the system.



Dr. Steven D. Prakken

Q: How long did it take for you to fully incorporate CSRS into your patient care?

A: Probably about a year. It's a process. The most important thing is not to give up. Of the patients dying from prescription opioids, 85 to 90 percent have obtained them from a physician, directly or through family members. You want to make sure you are not contributing to the problem without knowing it.

Q: Many prescribers comment that they just don't have time to add checking CSRS to the list of things they do before or during a patient visit. What do you say to people with this view?

A: That I understand. A lot of physicians don't want to do another bloody thing. But they don't have to–have someone else do it. One the great things about CSRS is that you can delegate access. Assign a staff member to learn the system and do the queries for you. They can have them waiting for you in the patient's chart.

Q: Some prescribers are aware of CSRS but aren't sure how it can be used to improve the care they provide. Can you offer some guidance?

A: CSRS is designed to help me understand what other prescribers have done and what I have actually done with this particular patient. You know what you've prescribed, but do you know what the patient has actually done? For example, let's say I authorize three one-month scripts. Are the scripts filled early? Does the patient fill one and then nothing for six weeks? You can start to see patterns and develop a better understanding of what's actually occurring.

Q: Can you offer some specific advice about when prescribers should check CSRS?

A: The first time you write an opiate for a patient, you need to check CSRS. After that, at a minimum, check CSRS every six months. Every time I do a urine drug screen, I check CSRS – they go together. And finally, I check whenever my gut tells me to. It's going to be different for every patient.

Mandatory Registration for CSRS

A 2016 state law will eventually require all licensees who hold a valid DEA registration to register for access to the NC Controlled Substances Reporting System. The requirement will not be in effect until DHHS makes technical upgrades and meets performance targets; however, NCMB encourages licensees to register now. Here's what you need to know:

- NCMB offers a streamlined online registration process for CSRS here: *www.ncmedboard.org/LicenseeInformation* Log in and select Training & CSRS to find the form.
- Current law requires registration only, not use.
- Problems or questions about registering for access via the NCMB website? Call 919-326-1100.
- Questions about using CSRS? Call 919-733-1765.

Delegate access

NC General Statute 90-113.74 (c) 1 authorizes licensed medical professionals to designate a delegate who may retrieve NC CSRS data for review by the prescriber. Some basics:

- The delegate can be any licensed or non-licensed person who is supervised by the prescriber.
- The prescriber is responsible for all delegate activity
- Delegates may not use the prescriber's login information to access CSRS; They must have their own accounts.

North Carolina Medical Board

Quarterly Board Actions Report | August 2016 - October 2016

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. A complete listing of recent Board actions is available at *www.ncmedboard.org/BoardActions*.

Name/license #/location	Date of action	Cause of action	Board action
ANNULMENTS			
NONE			
SUMMARY SUSPENSIONS			
HAMEL, John David, MD (009300141) Nebo, NC	10/10/2016	MD violated his August 2014 consent order by performing certain surgical procedures prohibited by the order; MD performed cosmetic surgery in a manner that does not meet current accepted standards and that resulted in patient harm and subjected patients to unnecessary risk; MD falsified medical records to conceal that he was performing procedures prohibited by his consent order; and finally, MD has a history of alcohol abuse and was recently arrested for DWI.	Summary suspension of NC medical license.
REVOCATIONS			
WILSON, Wayne Vincent, MD (000033444) Hickory, NC	09/13/2016	MD was convicted of two counts of felony health care fraud in United States of America vs. Wayne Vincent Wilson, M.D., case number 5-15cr57.	Entry of Revocation
SUSPENSIONS			
CLARKE, Michael Thomas, MD (200700737) Dewitt, NY	08/04/2016	Action based on another jurisdiction's disciplinary action; While practicing in New York, MD made comments of a sexual nature to operating room staff and hospital staff; MD is also alleged to have physically struck patients on the hip area prior to operating, for the purposing of determining that they were fully under anesthesia, in a manner not consistent with standards of care.	MD's license is suspended for three years, immediately stayed; $3,000 fine. MD must comply with the terms of his New York order. MD is placed on probation, to run concurrent with the terms of his New York order.
HERNANDEZ, Mario Augusto, MD (201000567) Charlotte, NC	09/02/2016	Allegations of professional sexual misconduct; MD was arrested and charged in December 2015 with three counts of 2nd degree sexual offense.	Indefinite suspension of NC medical license
KPEGLO, Maurice Kobla, MD (000029314) Greensboro, NC	10/13/2016	Quality of care; inappropriate prescribing of controlled substances for the treatment of pain. In addition, MD was convicted of DWI on February 21, 2016. MD was previously convicted of DWI in 1992 and has a prior diagnosis of alcohol use disorder.	Indefinite suspension of NC medical license
LASSITER, Paulette Denise, MD (200001401) Derby, KS	10/19/2016	MD engaged in a romantic relationship with a patient she treated for alcoholism, depression and anxiety. This is a violation of professional boundaries and of the ethics of the psychiatric profession.	Indefinite suspension of NC medical license
WELLS, Wendell D'Alton, MD (000026479) Rockingham, NC	09/26/2016	MD inappropriately prescribed controlled substances to a patient with whom MD was engaged in an inappropriate relationship with. This relationship included personal texts with the patient and touching not related to any medical treatment.	Indefinite suspension of NC medical license
PROBATION/CONDITIONS			
MCQUEEN, (Jr.), Fred Douglas, MD (000019375) Hamlet, NC	09/21/2016	History of substance use/abuse.	MD must maintain NCPHP contract and abide by all terms.
ZELLER, Kathleen Elizabeth, MD (200700068) High Point, NC	09/08/2016	History of alcohol abuse; MD has completed both inpatient and intensive outpatient treatment and is under a monitoring contract with NCPHP.	MD must maintain contract with NCPHP and abide by all terms.

Name/license #/location	Date of action	Cause of action	Board action
REPRIMANDS			
FUENTES, Edwin Laserna, DO (009701749) Danville, VA	10/02/2016	Action taken by another state medical board; An audit of DO's billing practices conducted by the Virginia board found that 68 percent of DO's billing was inappropriate or excessive.	Reprimand
HUSSEIN, Diaa Eldin, MD (200000467) Morganton, NC	08/16/2016	A patient complained to the Board that MD touched her inappropriately during an examination, made inappropriate comments regarding her appearance and offered her his personal cell phone number. MD states that it is his normal practice to provide patients with his personal cell phone number. MD denies that he touched the patient inappropriately and states that he did not make inappropriate comments. MD acknowledges that he may have done or said things during the course of the examination that the patient perceived to be inappropriate.	Reprimand; MD must use a female chaperone who has read this Board order, be present any time MD is in an examination room with a female patient.
MILLER, Bruce Loring, PA (001004644)	09/08/2016	PA prescribed a variety of medications, including controlled substances, to his fiancee, using prescription blanks from a former employer's practice in NY but written on the authority of his NC license.	Reprimand
STONECIPHER, Karl Gene, MD (000034914) Greensboro, NC	09/19/2016	MD prescribed controlled and non-controlled drugs to family members and to a co-worker without performing or documenting an appropriate medical examination. Administrative rules specifically prohibit the prescribing of controlled substances to family members.	Reprimand
DENIALS OF LICENSE/APPROVAL			
NONE			
SURRENDERS			
BECERRA, Gonzalo Daniel, MD (201101599) Goldsboro, NC	08/02/2016		Voluntary Surrender of License
MITCHELL, James Alistair, MD (200400921) Stillwater, OK	09/08/2016		Voluntary Surrender of License
PUBLIC LETTERS OF CONCERN			
BULLARD, Dennis Eugene, MD (000026088) Raleigh, NC	10/17/2016	The Board is concerned that MD's care of a patient who underwent decompression surgery with placement of an interbody cage for treatment of symptomatic spondylolisthesis may have been below accepted standards.	Public letter of concern
CRAWFORD, (Jr), Clifford Addison, MD (201001488) Duluth, GA	08/10/2016	Action taken by Georgia medical board; The Board is concerned that MD's license was suspended by the Georgia board for defaulting on his federal student loans; MD's Georgia license was reinstated after MD showed evidence that he had entered into a repayment plan.	Public letter of concern
COOK, John Edmund, MD (000026647) Dakota Dunes, SD	10/21/2016	MD entered into a public agreement with another state medical regulatory board; While practicing in Nebraska, MD allowed medical radiographers to administer Propofol intravenously for sedation purposes. MD agreed not to do this.	Public letter of concern
HAGA, Edward Wayne, MD (201602223) Jacksonville, NC	10/11/2016	The Virginia medical board took action against MD due to the fact that MD engaged in a sexual relationship with a patient in 2004.	MD is issued a NC medical license, with a Public Letter of Concern.
HEIMBINDER, David Allan, MD (201601792) Shelton, CT	08/01/2016	Action taken by Connecticut medical board, based on wrong-side application of nerve block anesthetic.	Public letter of concern
LYNCH, Christopher Robert, MD (201601803) Tulsa, OK	08/03/2016	The Board is concerned about MD's history of substance use, which it learned of due to a board order issued by the Oklahoma medical board. MD has entered a monitoring contract with NCPHP and is obliged to abide by all terms.	Public Letter of Concern
MANDHARE, Vijaysinha Ashok, MD (200800275) Raleigh, NC	08/15/2016	MD performed epidural injections on a family member with chronic pain caused by severe spinal stenosis. The fifth procedure performed resulted in complications that necessitated a hospitalization for the family member.	Public letter of concern; MD is urged to read the Board's position statement on Self Treatment and Treatment of Family Members.

Name/license #/location	Date of action	Cause of action	Board action
MCNEEL, Don Frederick, MD (009800634) Greenville, SC	08/19/2016	The Board is concerned that MD prescribed antibiotics to a five year old child who developed ear pain following seven days of head congestion after a telephone consultation. An expert reviewer opined that it is not consistent with standards of care to prescribe antibiotics to every patient with ear pain and cold symptoms.	Public letter of concern
MORSE, Eric Dalton, MD (009901445) Raleigh, NC	09/22/2016	MD prescribed Suboxone to a patient after the patient moved out of state, with only sporadic face-to-face interaction with the patient. The Board is concerned that this is not consistent with current standards of care.	Public Letter of Concern; Within 30 days of the date of this letter, MD must arrange to attend 10 hours of CME in Suboxone prescribing.
OGUNNIYI, Sola Egberanmwen, MD (001003067) Knightdale, NC	08/31/2016	The Board is concerned that MD permitted his brother, who is not a licensed health care professional, to perform range of motion measurements on a female patient that involved placing hands on the patient. The examination was unchaperoned. MD acknowledged to a Board investigator that he permitted his brother to perform these examinations on other patients as well.	Public letter of concern
OKWARA, Benedict Onwukwe, MD (000033878) Monroe, NC	09/07/2016	Quality of care; MD ordered a thyroid function test for a patient and then neglected to make the patient aware that the results were consistent with hyperthyroidism. The patient was subsequently seen by another physician and diagnosed with a grossly enlarged thyroid.	Public Letters of Concern; MD must complete a comprehensive personal assessment in Internal Medicine within six months of the date of this order and complete all recommendations for remediations within one year of the date of the order.
RIZVI, Syed Asif Raza, MD (009401482) Fayetteville, NC	08/22/2016	The Board is concerned that MD prescribed growth hormone at a level that was too high for a pediatric patient and in a manner not consistent with accepted standards of care.	Public Letter of Concern
SUHR, Christopher, MD (000036128) Jacksonville, NC	10/28/2016	The Board is concerned about the circumstances involving an operating room fire resulting in burn injury to the patient. In preparation for removal of a lipoma on the patient's posterior neck, the surgery area and the hairline were treated with an alcohol based antibacterial solution. During the procedure, which was performed using open oxygen under monitored anesthesia care, strands of patient's hair covered with solution residue were ignited from electrocautery. The cause of the fire was multifactorial; however, the Board believes that the surgeon is ultimately responsible for the patient's safety during an operation. The Board believes that MD responded appropriately to the intraoperative emergency and notes that MD sustained second degree burns to his hands trying to extinguish the flames. The Board also acknowledges that the operating team's rapid response minimized the harm to the patient. The Board also acknowledges that MD has since implemented appropriate risk reduction procedures to reduce the risk of future operating room fires.	Public Letter of Concern; $1,000 administrative fine
MISCELLANEOUS ACTIONS			
NONE			
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED			
NONE			

Glossary of Terms

Annulment: Retrospective and prospective cancellation of the practitioner's authorization to practice.

Conditions: Actions or requirements a licensee must complete and/or comply with as a condition of licensure.

Consent Order: An order of the Board that states the terms of a negotiated settlement to an enforcement case; A method for resolving a dispute without a formal hearing.

Denial: Decision denying an application for licensure, reinstatement, or reconsideration of a Board action.

Dismissal: Board action dismissing a contested case.

Inactive Medical License: Licenses must be renewed annually in NC. The Board may negotiate a provider's agreement to go inactive as part of the resolution of a disciplinary case.

Public Letter of Concern (PubLOC): A public record expressing the Board's concern about a practitioner's behavior or performance. A public letter of concern is not considered disciplinary in nature; similar to a warning.

Revocation: Cancellation of authorization to practice. Authorization may not be reissued for at least two years.

Stay: Full or partial stopping or halting of a legal action, such as suspension, on certain stipulated grounds.

Summary Suspension: Immediate cancellation of authorization to practice; Ordered when the Board finds the public health, safety, or welfare requires emergency action.

Suspension: Withdrawal of authorization to practice, either indefinitely or for a stipulated period of time.

Temporary/Dated License: A License to practice for a specific period of time. Often accompanied by conditions contained in a Consent Order.

Voluntary Surrender: The practitioner's relinquishing of authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.

Limitation: A restriction placed on a licensee's practice. When practicing under a restriction, it is not lawful for the licensee to engage in the prohibited activity. Example: Dr. Smith is restricted from prescribing Schedule II and III medications.

2016 PA compliance checks

Three-quarters of all physician assistants (PAs) reviewed during the Board's 2016 PA compliance checks were in full compliance with all applicable laws and rules.

The remaining 25 percent of PAs reviewed were found to be noncompliant with rules related to prescribing medications and with requirements for both frequency and documentation of quality improvement meetings. In all cases, the PAs corrected the deficiencies noted. The Board issued private letters of concerns to both the PA and his or her primary supervising physician in 75 percent of cases where deficiencies were documented.

The Board conducts random site visits at PA practice sites each year to encourage compliance with NC law and administrative rules that govern PA practice in the state. The Board has selected PAs for site visits to be conducted in 2017. PAs will be contacted by a Board field investigator, who will schedule the site visit. During the visit, PAs will be asked to produce certain documents that are required to be kept on file at each of the PA's practice locations.

Are you in compliance?

A complete description of the information PAs should expect to provide during a compliance review is available on the PA Site Visit Checklist. This document, as well as PA rules, FAQs and other information, are available on the Board's website at *www.ncmedboard.org/PAResources*

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Take our *Forum* reader survey

We are in the process of making decisions about the future of this newsletter. Give us your candid feedback and impact the outcome by taking a few minutes to complete a short reader survey. Reader feedback is essential to help NCMB provide its licensees with timely, relevant information.

To complete a brief (five minutes or less) survey scan the barcode to the right with your smartphone's QR code reader or go to *https://goo.gl/TDDLJR*.

Your responses are greatly appreciated!

BOARD MEETING DATES

March 15-17, 2017 (Full Board)
April 27-28, 2017 (Hearing)
May 17-19, 2017 (Full Board)
June 15-16,2017 (Hearing)
July 19-21, 2017 (Full Board)

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

www.ncmedboard.org