

FROM THE PRESIDENT

A Medical Board of action: how the NCMB works to anticipate and address challenges in medicine

The work of the Medical Board falls in three main areas: discipline and remediation, licensing and, finally, policy.

Our disciplinary work is complaint driven and, consequently, a mostly reactive process. The Board investigates complaints and reviews information about the cases to determine what action, if any, is needed. If the Board decides to take action in a case, it does so to protect the public by addressing areas of concern so that similar occurrences may be avoided in the future.

Licensing also involves the review of information submitted to the Board in the form a license application, but it is not a purely reactive process. In fact, in many ways it is a proactive way for the Board to protect patients. By maintaining high standards for licensure and a rigorous application review process, the Board protects patients by issuing licenses only to those applicants it believes can practice safely.

The third main type of Medical Board work—policy—provides the most opportunity for the Board to be proactive, and the NCMB has become increasingly so in recent years.

Nonetheless, some observers apparently look on the Medical Board as slow to act, a point that came up during a recent Board retreat. A consultant hired to assist with strategic planning interviewed groups and individuals to solicit comments and critiques of the NCMB. Some, it seems, think the Medical Board doesn't act to address problems, but instead reacts as issues arise. I would like to correct the perception that the NCMB is unwilling or unable to anticipate challenges. I would like to correct that perception.

Transparency and inclusion

Over the past few years the Board has worked to become a far more open and transparent organization that routinely engages in dialogue with its constituencies. The NCMB is not content to consider only those issues it decides are important—the Board reaches out in numerous ways to ask stakeholders for their thoughts and ideas. For example, the NCMB now regularly conducts group policy discussions that include both Board Members and interested parties outside the NCMB before decisions are made. The Board conducts licensee surveys on important topics, invites—and answers—comments to online *Forum* articles and has become far more proactive about seeking out opportunities for Board Members to speak and present. We are also on Facebook and Twitter and engage with followers there.



NCMB President Dr. Paul S. Camnitz, says "The Board does not want to make decisions regarding policy in isolation."

FOR THE BENEFIT AND PROTECTION OF THE PEOPLE OF NORTH CAROLINA

FALL 2014

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“Over the past few years the Board has worked to become a far more open and transparent organization that routinely engages in dialogue with its constituencies.”

Including stakeholders in policy discussions is perhaps the change that has had the most impact in how the NCMB does its policy work. This method of engaging with parties interested in and affected by the Board's work is far more proactive than the traditional process of accepting oral and written comment via public hearings, which typically garner low or no attendance. Participants literally have a seat at the table and discuss the issues at hand with sitting members of the Board.

An early example of this is the special task force on physician scope of practice issues (aka “practice drift”) the Board convened in October 2010. This task force discussed the growing incidence of licensees practicing outside of the areas in which they completed formal postgraduate training and led the Board to adopt a position statement on this issue. The task force process was inclusive and the subject was forward thinking, enabling the Board to get in front of the issue of “practice drift.”

Since 2010, the Board has hosted numerous other policy discussions that follow the same basic model as the physician scope of practice task force. Issues examined by these Board-stakeholder groups include treatment of self and close family members, prescribing of controlled substances for the treatment of chronic pain, the collateral consequences of NCMB actions and, most recently, telemedicine.

In recent years, the Board has used this newsletter as a means of engaging in dialogue with licensees. Through the *Forum*, the Board has conducted multiple surveys that received an unprecedented response rate. Surveys on

prescribing to self and family and on licensee use of opioids in their current practice setting each received more than 1,000 responses and hundreds of narrative comments. In both cases, these results were considered by the Board as part of major policy decisions.

Comments to the online version of *Forum* newsletter articles are another small way the Board can engage in two-way communication with licensees and other readers. For example, a reader of the Hepatitis C article that appeared in the Summer 2014 issue noted that it failed to discuss the cost of the new treatments examined in the piece. The *Forum* editor forwarded the comment to the article's author, who provided a response that was then posted in answer to the reader comment (the response is also published in this issue of the newsletter, on p.3.)

More than just discipline

As noted earlier in this article, the Board's disciplinary function is complaint driven and, by definition, reactive. Over time, however, as the NCMB reviews cases that involve different licensees but contain similar facts, opportunities for intervention and outreach become obvious.

Problems with opioid prescribing are a prime example. In recent years, excessive or otherwise inappropriate opioid prescribing has been a factor in approximately 20 percent of all public adverse actions for a given year. In response, the Board has found numerous ways to address this problem outside the traditional disciplinary case review process.

North Carolina Medical Board Forum Credits

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

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

I have mentioned the roundtable discussion on opioid prescribing. This group's work informed the Board's review and sweeping revision of its position statement on prescribing controlled substances for the treatment of chronic pain earlier this year. Based on feedback from roundtable participants and others, the Board took a different approach with the new position statement, which was adopted in May. For the first time in a position statement, the Board provided detailed, specific clinical guidance to prescribers. The Board hopes that this new approach will be more effective at helping prescribers avoid problems with prescribing that have brought licensees to the Board's attention in the past.

The NCMB has been busy on less obvious fronts to improve opioid prescribing as well. Last year, the Board cosponsored with the NC Medical Society and other organizations, a continuing medical education session on responsible opioid prescribing. It was the Board's first time cosponsoring a CME event, but we hope to do more. This year, the Board secured a grant that will help cover the costs of a CME event on opioid prescribing at a meeting of the NC Academy of Family Physicians in December.

The NCMB has also collaborated with the state agency that administers the NC Controlled Substances Reporting System to make it easier to register for access. Licensed physicians and physician assistants can now register for access to the NCCSRS, the statewide database that tracks all controlled substances dispensed in outpatient settings, through the same NCMB portal they use to update their information. The Board hopes this effort will encourage more licensees to use the system.

Now, the Board's continued collaboration with the NCCSRS is expanding to include regular reports on the state's most prolific prescribers of controlled substances. The Board will review this information and investigate, as appropriate. This initiative will help the Board be truly

proactive in its investigative work by enabling the NCMB to address prescribing issues before licensees come to the Board's attention due to a death or adverse incident.

Other ways the Board is being proactive

Another effort that is worthy of mention is the Outreach Committee. I established this standing committee of the Board last fall as one of my first acts as Board president. The Outreach Committee works to improve relations with the professional and public constituencies by engaging them in dialogue about the Board's policy and work. This dialogue is critical since it implies a two-way interchange. The Board does not want to make decisions regarding policy in isolation.

One major area of emphasis has been increasing the number of talks and presentations given by the Board to professional groups and associations, as well as other audiences such as medical students and residents. The Board believes informing licensees and prospective licensees about Board expectations, applicable laws, rules and other policies as early in their careers as possible will lead more licensees to make good professional decisions. We hope, over time, sustained outreach will result in fewer regulatory problems. The Board also sees value in helping students, residents and licensees develop a productive relationship with their regulator. Our goal is for licensees to see the NCMB as a resource that wants them to be successful in practice.

These are just a few of the ways the Board has become more strategic and proactive in its efforts to protect patients and improve the quality of medical care provided in North Carolina. I've no doubt the NCMB will become even more active on this front in the years to come. Increasing outreach was one of a handful of major priorities identified during the NCMB's recent retreat and the Board will soon discuss ways to make this happen.

As someone who, as of Nov. 1, will again be a rank-and-file licensee, I look forward to seeing what's in store.

From our readers...

A reader of the email edition of the Summer 2014 *Forum* took issue with the fact the article, "Hepatitis C: everyone deserves a chance at a cure," did not discuss the cost of treatment. We asked the author, Michael C. Fried, MD, to address this concern. Here is Dr. Fried's response:

"The true costs of treatment are difficult to characterize since many factors affect final drug pricing for the payers and patients. A 12-week course of Sofosbuvir costs approximately \$84,000. The cost for the newest all-oral medication has not been released (These drugs won't be approved for another few weeks). With such high rates of cure, the costs of these medications must be weighed against the myriad benefits of cure for those patients living with HCV infection."

Medical Board complaints against physicians due to communication:

Analysis of NC Medical Board Data, 2002–2012

By Phil Davignon, PhD; Aaron Young, PhD; David Johnson, MA

ABSTRACT: Anecdotal evidence suggests that communication issues are one of the primary reasons for physician complaints, but quantitative studies have yet to examine this assertion. The North Carolina Medical Board's Complaint Department maintains data on physician complaints and categorizes each complaint based on its primary cause. Using data from 2002–2012, our research focused on complaints against physicians licensed by the North Carolina board to determine the extent to which communication issues contribute to complaints against physicians. An analysis of this data reveals that physician complaints based on communication issues are consistently the most prevalent reason for complaints against physicians in the state of North Carolina. In addition, communication-based complaints account for more than one in five complaints made against North Carolina physicians. These results are discussed in light of their implications for the field of medicine as it seeks to improve patient care.

Introduction

In 2012, the 69 state and territorial medical boards of the United States took 9,219 actions against the licenses of 4,479 physicians.¹ The vast majority of these actions originated as a complaint reported by patients or their family members. The literature addressing the bases for patient complaints leading to disciplinary actions by state medical boards is minimal as the focus to date has been on state-specific and aggregate actions.² Several studies, however, have examined communication as a factor in negative outcomes. One study found “significant differences” in the communication behaviors of primary care physicians that aligned with malpractice claims history.³ A study of obstetricians showed that those physicians sued more often were cited for the “interpersonal care” they provided.⁴ Similarly, one study found that scores on the communication and clinical decision-making components of Canada's licensing examination were predictive of later complaints to that country's medical regulatory authorities.⁵

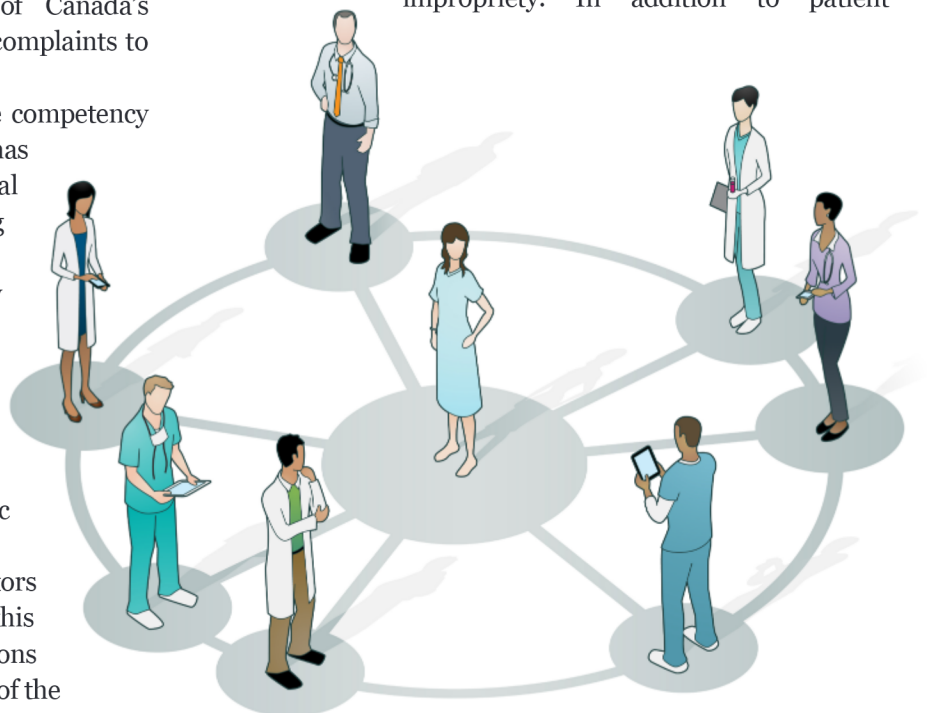
The importance of communication as a core competency critical to physicians' effectiveness in practice has been affirmed across the continuum of medical education by accrediting, certifying and licensing bodies. Communication and interpersonal skills have been identified as a critical competency for physicians in graduate medical education,^{6,7} specialty board certification,^{8,9} and since 2004, for inclusion in the examinations accepted for medical licensure in this country (United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination).

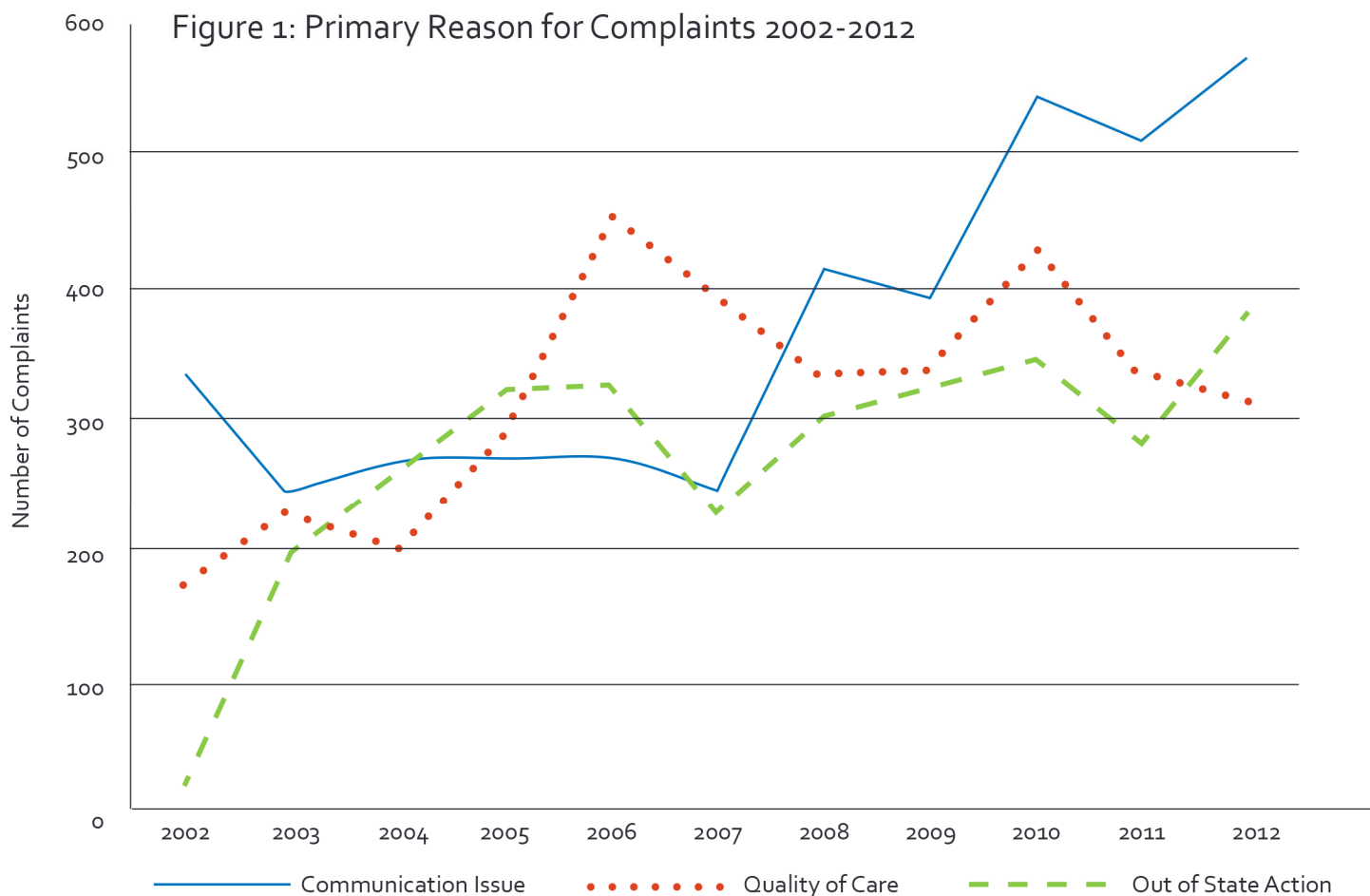
Conversations with various executive directors and members of state medical boards on this subject routinely include personal observations that communication issues are a factor in many of the

complaints received by state medical boards each year. Our objective is to begin moving the discussion beyond anecdotal evidence by examining complaints against physicians received by the North Carolina Medical Board since the year 2002, and the extent to which communication issues are identified as a reason for the complaint.

Methodology

The North Carolina Medical Board's Complaint Department maintains records on complaints filed against physicians licensed in the state. The departments vital to the North Carolina Medical Board's mission to protect the public through physician discipline, as complaints submitted by patients and/or family members are the primary means by which the board learns about physician impropriety. In addition to patient





complaints, the department also receives complaints that originate from other sources, including disciplinary actions from other states. Complaints are received and evaluated by staff within the department, who review each case and determine whether the complaint relates to a violation of board policy or state law, thereby warranting a formal investigation and possible disciplinary action against the physician. According to state law, individuals who file complaints against physicians licensed in North Carolina are entitled to learn the outcome of their complaint. Thus, decisions to open an investigation (or a determination not to) are communicated to the party making the original complaint.

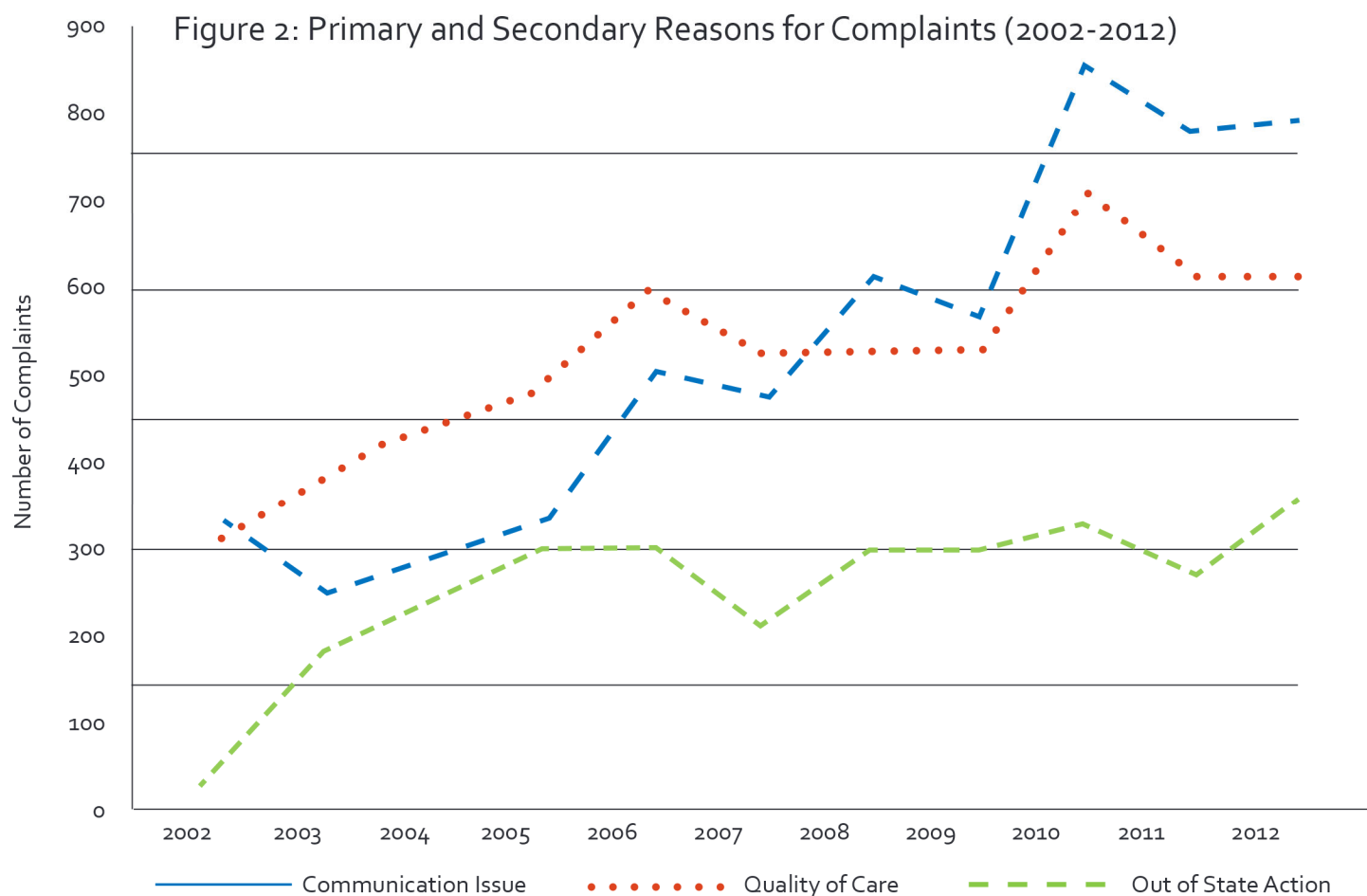
The North Carolina Medical Board began compiling, categorizing, and maintaining its current database of information about complaints towards physicians in 1978, and by the late 1980s, the board began to accumulate significant data that might be useful for longitudinal analysis. Complaints have steadily risen since the turn of the century, an increase that can be partly attributed to the board beginning to accept complaints by email in 2006. The North Carolina Medical Board categorizes complaints into nearly 100 categories, reporting the primary reason, as well as up to four secondary reasons for the complaint. Using data from 2002 to 2012, our research focuses on complaints against physicians licensed by the North Carolina Medical Board, to determine the extent to which communication

issues contribute to complaints against physicians.

Results

An examination of the data revealed communication issues, out-of-state actions and quality of care are the top three reasons for complaints against physicians licensed in North Carolina. As demonstrated in Figure 1, communication issues have frequently been the top reason for complaints against physicians. In the mid 2000s, out-of-state actions* and quality-of-care complaints surpassed communication complaints as the most prevalent reason for complaint, but from 2008 to 2012 communication issues were again the top reason for physician complaints. Between 2010 and 2012, more than 500 complaints made to the North Carolina Medical Board involved communications with the physician as the primary reason for the complaint.

Communication issues are also the top reason for complaints against physicians when examining both primary and secondary reasons. Since 2008, communication issues have been the top reason for physician complaints, being a primary or secondary reason for more than 800 physician complaints in 2012. Communication issues also represent a sizeable proportion of the total number of complaints made against physicians each year in North Carolina. Since 2008, more than one in five complaints made to the North Carolina



Medical Board were related to communication issues. It should also be noted that the prevalence of communication-based complaints may even be understated, as communication may have also played a role in complaints that are categorized as out-of-state actions.

The nature of the communication complaints against physicians varied markedly. Frequently cited reasons included the following: failure by the physician to consider the patient's unique intellectual or cultural background; failure of the physician to maintain an appropriate level of professionalism when confronted with a difficult or contentious patient; lack of timely follow-up communication with patients about abnormal laboratory studies; and the insufficient attention to properly communicating appropriate details of the physician's plan of care or treatment decisions.

Discussion

This analysis suggests that communication issues may be one of the most prevalent reasons for complaints against physicians to state medical boards. Communication skills are vital for physicians to effectively provide patient care, and poor communication skills are tied to negative outcomes such as malpractice claims.³ In addition, a comprehensive analysis of studies examining the effects of physician-patient communication found a strong relationship to patient

outcomes,¹⁰ while another meta-analysis revealed that communication is highly correlated with patient adherence to treatment.¹¹

Medical schools, specialty boards, and assessment organizations such as the National Board of Medical Examiners and the National Board of Osteopathic Medical Examiners recognize the importance of communication skills to the successful practice of medicine, as they require physicians to demonstrate competency in clinical skills such as communication. This paper lends further support to the idea that clinical skills such as communication are vital to effective medical practice, perhaps suggesting that healthcare entities should focus on physician communication skills as they seek to improve patient care and decrease patient complaints.

**The North Carolina Medical Board resolved a backlog of formal out-of-state actions between 2003 and 2004, resulting in a temporary spike in complaints during that time frame.*

References

1. Federation of State Medical Boards. 2014.
2. Federation of State Medical Boards. Summary of 2011 Board Actions. www.fsmb.org/pdf/2011-summary-of-board-actions.pdf. Accessed February 24, 2014.
3. Levinson, W, Roter, DL, Mullooly, JP, et. al, "Physician-Patient Communication: The Relationship with Malpractice

- Claims Among Primary Care Physicians and Surgeons,” *JAMA* 1997;277(7):553-557.
4. Hickson, GB, Clayton, EW, Entman, SS, “Obstetricians’ Prior Malpractice Experience and Patients’ Satisfaction with Care,” *JAMA* 1994; 272(20):1583-87.
 5. Tamblyn, R, Abrahamowicz, M, Dauphinee, D, “Physician Scores on a National Clinical Skills Examination as Predictors of Complaints to Medical Regulatory Authorities,” *JAMA* 2007; 298(9):993-1001.
 6. Sullivan, G, Simpson, D, et.al., “A Milestone in the Milestones Movement: the JGME Milestones, *Journal of Graduate Medical Education* March 2013 supplement, 1-4.
 7. Tunanidas, AG, Burkhart, DN, “American Osteopathic Association Commitment to Quality and Lifelong Learning,” *JAOA* September 2005; 105(9):404-407.
 8. American Board of Medical Specialties, “MOC Competencies and Criteria,” accessed at www.abms.org/maintenance_of_certification/MOC_competencies.aspx on December 4, 2013.
 9. Journal of the American Osteopathic Association, “Osteopathic Specialty Board Certification,” accessed at www.jaoa.org/content/111/4/280.full.pdf on December 4, 2013
 10. Canadian Medical Association Journal, “Effective Physician-Patient Communication and Health Outcomes: A Review,” accessed at www.ncbi.nlm.nih.gov/pmc/articles/PMC1337906/pdf/cmaj00069-0061.pdf on June 3, 2014.
 11. Medical Care, “Physician Communication and Patient Adherence to Treatment: A Meta-analysis,” accessed at www.ncbi.nlm.nih.gov/pmc/articles/PMC2728700/ on June 3, 2014.

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The authors wish to thank Scott Kirby, MD, Medical Director at the North Carolina Medical Board, and Hari Gupta, Director of Operations, for their contributions to this research project. Dr. Kirby contributed to the authors’ understanding of the medical board’s structure and the administrative protocols for capturing complaints. Mr. Gupta provided the data for this study. Clinical skills such as communication are vital to effective medical practice, perhaps suggesting that healthcare entities should focus on physician communication skills as they seek to improve patient care and decrease patient complaints.

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New position statement addresses obligation to report child abuse and neglect

The Board adopted a new position statement (published below) on recognizing and reporting suspected child maltreatment at its September meeting.

Also at the September meeting, the Board reviewed and approved the following position statement with no changes:

- Advertising and publicity

The complete Position Statements of the Board are available online and in pdf format at www.ncmedboard.org/position_statements.

CHILD MALTREATMENT

It is the position of the North Carolina Medical Board that child maltreatment (abuse and neglect) presents a significant risk to the health and well-being of North Carolinians. The Board’s licensees have a legal responsibility to report as soon as practicable “cases involving recurrent illness or serious physical injury to any child under the age of 18 years where the illness or injury appears, in the physician’s professional judgment, to be the result of non-accidental trauma.” N.C.G.S. § 90-21.20(c1).^{*} This legal and ethical obligation requires a licensee to recognize the signs, symptoms, and etiology of child maltreatment. Licensees are also encouraged to learn how to refer children for expert medical evaluations of possible maltreatment.^{**}

^{*}This obligation specific to physicians is in addition to the legal requirement that any person or institution in North Carolina “who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found.” N.C.G.S. § 7B-301(a).

^{**}Web-based training on “Recognizing and Responding to Suspicions of Child Maltreatment” is available at www.preventchildabusenc.org/index.cfm?fuseaction=cms.page&id=1047.

Board considers revisions to clarify expectations on telemedicine

The NCMB is seeking comment on proposed revisions to two Board position statements that affect the practice of telemedicine. The Board revised the position statements, entitled, “*Telemedicine*,” and “*Contact with Patients before Prescribing*.” Please respond as soon as possible to provide comment, as the Board will consider feedback and vote on the revised position statements during the Board Meeting scheduled Nov. 18-20. Please submit comments to the Board via email to telemedicine@ncmedboard.org or use your smartphone to access a one-question survey on the proposed revisions by scanning the QR code on this page. Full text versions of the draft position statements are published below and on the facing page.

Changes to the position statements include the following:

- The expectation that telemedicine practitioners will engage in practice improvement and outcomes monitoring
- Clarification that telemedicine practitioners are held to the “standard of care” governing their practice specialty and there is no separate (or lower) standard of care for telemedicine practice
- Clarification that the physician-patient relationship need not be established through an in-person encounter so long as a physician may acquire the same or superior information through the use of technology and peripherals
- Additional burdens are placed on the practitioner to ensure he or she verifies identity and location of the patient and provides his or her identity, location and professional credentials to the patient
- A new section clarifies constraints on prescribing
- Telemedicine practitioners are held to the same professional standards concerning communication and transfer of health care records to the primary care physician or medical home
- Contact with patients prior to prescribing need not occur through an in-person encounter, so long as a practitioner has access to the same or superior information through telemedicine technology

Scan with your smartphone to provide feedback to a one question survey on telemedicine.



TELEMEDICINE

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

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

The Board cautions, however, that licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by this Board. It is the Board’s position that there is not a separate standard of care applicable to telemedicine. Telemedicine providers will be evaluated according to the standard of care applicable to their area of specialty.

The Board provides the following considerations to its licensees

as guidance in providing medical services via telemedicine:

Training of Staff — Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

Evaluations and Examinations — Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate evaluation examination prior to diagnosing and/or treating the patient. However, this evaluation examination need not be in-person if the technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face. licensee employs technology and peripherals sufficient to provide an examination that is equal or superior to an in-person examination.

Other examinations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate examination may be a violation of law and/or subject the licensee to discipline by the Board.¹

Licensee-Patient Relationship — The licensee using telemedicine

BOARD NEWS

~~should have some means of verifying that the person seeking treatment is in fact who or she claims to be. The licensee using telemedicine should verify the identity and location of the patient and should inform the patient of the licensee's name, location and professional credentials. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status examination, physical examination and appropriate diagnostic and laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.~~

Prescribing — Licensees are expected to practice in accordance with the Board's Position Statement "Contact with patients before prescribing." Licensees are cautioned that prescribing controlled substances for the treatment of pain via telemedicine is disfavored by the Board. Licensees prescribing controlled substances for other conditions should obey all relevant federal and state laws and are expected to participate in the Controlled Substances Reporting System.

Medical Records — The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate examination of the patient's presenting symptoms, and relevant components of the electronic professional interaction must be documented as with any other encounter.

The licensee must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's record constitute one complete patient record. Licensees practicing via telemedicine will be held to the same standards of professionalism concerning medical

records transfer and communication with the primary care provider and medical home as those licensees practicing via traditional means.

Licensure — The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina.² Licensees need not reside in North Carolina, as long as they have a valid, current North Carolina license.

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

(Adopted July 2010)

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

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

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

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, 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, or prescribing an opiate antagonist to someone in a position to assist a person at risk of an opiate-related overdose. 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.

Created: Nov 1, 1999

Modified: February 2001; November 2009, May 2013 Reviewed July 2010

Striking the right balance:

A former public Board Member's view on self-regulation

By John B. Lewis, Jr, LLB

One of the greatest honors a citizen of North Carolina can receive is appointment to the North Carolina Medical Board. That honor was mine between November 2007 and October 2013, when it was my great privilege to serve as one of the Board's three public members. I served one year of an unfilled term and then was appointed to serve the maximum of two three-year terms. I can honestly say that



John B. Lewis, Jr.

my time on the Medical Board was one of the most enriching and illuminating professional experiences of my life.

The Board's outgoing president, Paul Camnitz, MD, suggested that I share some reflections about my service to the NCMB.

A public member's job is to act as proxy for patients and their loved ones. It is our job to

advocate for their best interests, to ensure that licensed physicians and physician assistants are held accountable for their actions. The Medical Practice Act, the state law that gives the Board its authority, states that the Board is to regulate medicine and surgery "for the benefit and protection of the people of North Carolina." That is the highest duty of the entire Board.

As a public member, fulfilling this mandate requires both principle and courage, as it may involve challenging and questioning those members of the Board who are trained clinicians and, invariably, high performing members of the medical profession. I have been proud to speak up for North Carolinians over the past seven years, and I am even more proud to say that the physicians and other medical professionals on the Board have heard and considered my words and the words of other public members.

It is generally assumed in medical regulation that public members are less inclined to coddle licensees who come before the Board and more inclined to vote for more serious discipline. In some jurisdictions, including the United Kingdom, a system of medical regulation I have become familiar with due to my involvement with the NCMB and my Anglophilic tendencies, medical boards have sought

to shore up their public images by giving greater control to public members. The General Medical Council that regulates medicine in England, Scotland, Wales and Northern Ireland, reserves half its Board seats for public members, for example. In North Carolina, three of the 12—a quarter—of Board seats are held by public members.

Medical Boards are perennially under scrutiny—from the news media, from the public, from elected officials—and the NCMB has always been sensible of the fact that its current practice of physician-led regulation is a privilege. This was acknowledged frequently during my years on the Board and the message was clear: the NCMB must be effective, fair and just in regulating medical professionals or that privilege may be taken away.

Having spent countless hours reading disciplinary case files and participating in complex discussions about missed diagnoses and standards of care in urban settings versus the agrarian areas of North Carolina, I believe this would be a grave error. I did my level best to keep up with the medical discussions, but I am not medically trained. As a lay person, one misses an enormous amount of the intricacies and factors that go into why the licensee might miss a diagnosis. Even with the benefit of independent expert medical opinions to guide the Board—as a retired judge I am well aware that competing opinions are easily found—I do not think lay people are in a position to make the best decisions about cases involving quality of care.

“I have been proud to speak up for North Carolinians over the past seven years, and I am even more proud to say that the physicians ... on the Board have heard and considered my words.”

My conclusion after seven years on the Board is that the NCMB strikes the optimal balance between accountability to the public and fairness to the medical professional. Medicine is constantly evolving and in many ways the pressures have never been greater. The advent of the Affordable Care Act is bringing more people into the health

care system and that may bring even more “business” to the NCMB. The current structure of the Board is best equipped to handle this, and I hope it is preserved.

I could not end this article without some acknowledgement of what the Board has meant to me personally. It is no exaggeration to say that serving on the Medical Board saved my life not once but twice. The first time the Board saved my life it was metaphoric. When I got the call from the Governor’s Office in fall 2007, an offer of a public member seat on the other end of the line, I was deeply grieving the loss of

my wife of 40 years, who died in July 2006. Serving on the Medical Board gave me a new sense of purpose and direction at a time when it was sorely needed.

The second time the Board saved my life was quite literal. The morning of a regularly scheduled Board Meeting in March 2009, I woke up feeling poorly but managed to make it in to the Board’s offices. My physician colleagues on the Board listened to my complaints of headache and dizziness and two in particular, Dr. Camnitz and then- Board President Dr. Charles Saunders, insisted that I

receive emergency medical attention. Hours later I was undergoing surgery for a bilateral subdural hematoma, from which I am happy to say I fully recovered. I shudder to imagine the outcome, however, had I been at a Bar Association meeting instead of the Medical Board that day.

John B. Lewis, Jr. is a retired attorney and former NC Court of Appeals judge. Judge Lewis served as a Court of Appeals recall judge, a temporary administrative law judge and an emergency Special Superior Court judge. His term on the NCMB ended October 31, 2013. He married Margaret “Peg” O’Connell in February 2014.

Board welcomes new Assistant Medical Director

The NCMB’s Office of the Medical Director (OMD) has hired a new Assistant Medical Director, Karen Burke Haynes, MD. Among other things, the OMD reviews all cases related to quality of care and makes recommendations for Board action as part of the Board’s internal case review process. Dr. Haynes joined the Board’s staff in September.

Dr. Haynes, a pediatrician, has more than 25 years of experience working in academic and private practice settings, most recently as the owner and managing physician of Stepping Stones Pediatrics in



Dr. Haynes

Raleigh. Dr. Haynes earned her medical degree from the University of Rochester School of Medicine and Dentistry and completed postgraduate training in pediatrics at Strong Memorial Hospital in Rochester. She is certified by the American Board of Pediatrics.

Can we make a house call?

The North Carolina Medical Board provides Board Members and/or Board staff to speak to professional groups and other audiences: medical students, residents, hospital grand round and practice meetings or retreats.

Programs typically present a general overview of the Board’s structure, mission and responsibilities as well as in depth discussion around important issues in medical regulation. The Board is also able to develop programs tailored to specific audiences and events upon request. Please submit speaker requests at least two months prior to the date of the event.

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



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North Carolina Medical Board

Quarterly Board Actions Report | May– July 2014

The Board actions listed below are published in an abbreviated format. The report does not include non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. Recent Board actions are also available at www.ncmedboard.org. Go to “Professional Resources” to view current disciplinary data or to sign up to receive notification when new actions are posted via the RSS Feed subscription service.

Name/license#/location	Date of action	Cause of action	Board action
ANNULMENTS			
None			
SUMMARY SUSPENSIONS			
None			
REVOCATIONS			
None			
SUSPENSIONS			
BRABHAM, Felicia Browne, MD (000031248) Hendersonville, NC	05/09/2014	Failure to cooperate with a Board investigation, failure to respond to a request to appear for an interview with Board members. History of arrest for breaking and entering and theft.	MD's license is indefinitely suspended.
KALDAS, Amir Ishak, MD (201001177) Davidson, NC	06/19/2014	Inappropriate prescribing of controlled substances; prescribing to family members in a manner not consistent with the Board's Position Statement on treatment of self and/or family members.	MD's license is suspended for six months; MD shall comply with the Board's Position Statement on treatment of self/family.
MCGRATH, Timothy John, MD (200200571) Mebane, NC	07/23/2014	MD prescribed controlled substances to three family members in conflict with the NCMB's position on prescribing to family; MD took opiate medication prescribed to a family member for personal use.	Indefinite suspension of NC medical license.
TURBYFILL, Patricia Kay, NP St. Augustine, FL	05/13/2014	NP worked for a practice owned by a naturopathic practitioner who does not have a license to practice in NC. NP's treatment of a patient with ALS departed from accepted and prevailing standards.	12-month suspension, stayed except for a period of 30 days beginning on May 13, 2014, and ending on June 13, 2014.
WESTBROOK, Brent Ashley, PA (001000569) Newton, Grove, NC	06/16/2014	History of prescription opiate abuse	Indefinite suspension of PA license.
WICKE, Susan Holly, MD (000036618) Durham, NC	06/30/2014	MD entered into an intimate relationship with her patient that resulted in marriage; MD prescribed medications to her patient after they began a sexual relationship. MD unlawfully prescribed methadone to her patient and spouse, and to two other patients. MD later falsely stated in a sworn affidavit that she did not have a sexual relationship with her patient.	Indefinite suspension, effective July 18, 2014.
PROBATION			
ROGERS, Rayna Larain, MD (200801709) Fayetteville, NC	05/16/2014	History of alcohol and substance abuse; noncompliance with NCPHP monitoring contract.	MD is placed on probation; must maintain a contract with NCPHP and maintain a relationship with a therapist, must comply with other conditions.

BOARD ACTIONS REPORT

Name/license#/location	Date of action	Cause of action	Board action
<u>REPRIMANDS</u>			
OVERS, Shannon Nicole, MD (201301727) Charlotte, NC	05/27/2014	MD was issued a license with a Public Letter of Concern on 8/6/13, and a \$2,000 fine. MD ordered to obtain an assessment. The assessment came back positive for cannabis, which MD acknowledged using. NCPHP believes MD is safe to practice.	Reprimand; \$2,000 fine; MD must comply with her NCPHP contract.
PELLICORE, Karen M., NP Sherrills Ford, NC	05/27/2014	Inappropriate prescribing of controlled substances; NP concealed chronic pain patients' charts from the supervisor.	Reprimand; NP must complete CME in controlled substances prescribing/medical record keeping.
WEATHERSPOON-CUPID, Melissa Jo-Ann, MD (200301427) Charlotte, NC	05/05/2014	Inappropriate prescribing of controlled substances; MD's treatment of patients with chronic pain was found to be substandard. MD prescribed controlled substances and then diverted pills for personal use.	MD is reprimanded; shall not accept or treat new chronic pain patients; must comply with other conditions.
<u>DENIALS</u>			
None			
<u>SURRENDERS</u>			
LE, Mark Tuan, MD (09700088) Huntersville, NC	06/25/2014		Voluntary surrender of NC medical license
<u>PUBLIC LETTERS OF CONCERN</u>			
BERNSTEIN, Daniel Joseph, MD (000034951) Denver, NC	05/27/2014	The Board is concerned that MD's supervision of an NP supervisee's treatment of chronic pain patients was inadequate. The Board is also concerned that MD agreed to supervise other mid-level providers at other pain clinics in NC, although he is only able to observe their practice on-site periodically. MD is in Charlotte but supervises mid-levels in Mt. Airy, Hendersonville, Asheville and Denver, NC.	Public Letter of Concern; MD must disassociate himself with pain practices owned by Dr. Williams.
DAVIS, Ashley Royal, PA (001000771) Smithfield, NC	07/07/2014	PA's care of a patient who presented with right knee pain may have fallen below accepted standards in some aspects. Laboratory results that suggested the patient may have had an infection were placed in the patient chart but not reviewed before the patient was admitted to a hospital and subsequently diagnosed with methicillin-sensitive staph aureus bacteremia. The patient underwent surgery to address the infection and later died of complications related to bacterial endocarditis and severe mitral regurgitation, which may have been related to the knee infection. The Board is concerned that the failure to review the labs prior to admission created a delay in appropriate treatment.	Public letter of concern
FILIP, Stanley John, MD (000039590) Durham, NC	05/12/2014	The Board is concerned about the quality of care MD provided to two patients, who MD performed laparoscopic procedures on. Patient A died from sepsis associated with peritonitis, right colon perforation and ischemia. Patient B suffered two bladder lacerations, which became infected. The lacerations were repaired and Patient B recovered.	Public Letter of Concern

BOARD ACTIONS REPORT

Name/license#/location	Date of action	Cause of action	Board action
HARRIS, Pamela D., MD (200300671) Wilmington, NC	07/14/2014	The Board is concerned that MD works in a medical spa that is owned by an individual who is not a licensee of the Board as required by NC law; in addition, the Board is concerned that patients treated for weight loss at the medical spa received treatments that did not conform to accepted and prevailing standards.	Public Letter of Concern; MD is required to complete a course in weight loss treatment and a course in medical records documentation.
HEWETT, Krista Newman, PA (000103822) Whiteville, NC	05/28/2014	The Board is concerned that the care PA provided to a patient who was eventually diagnosed with diabetic ketoacidosis and pancreatitis may have fallen below accepted and prevailing standards.	Public Letter of Concern
INGRAM, Alice Michelle, MD (201401274) Houston, TX	06/16/2014	The Board is concerned about care MD provided to patients in Texas. Each case resulted in malpractice and the Texas Board entered into an agreed order with MD requiring she comply with conditions.	Public letter of concern
KLINK, Jaleen Lynn, NP Kernersville, NC	05/27/2014	NP practiced at a medical spa not owned by a licensee of the NCMB; NP provided weight loss treatments to patients that did not conform to accepted and prevailing standards.	Public letter of concern
MARTINEZ, Paul Armando, MD (009300219) Apex, NC	05/29/2014	The Board is concerned that the quality of care MD provided to a patient who presented in the ER with a two day history of nausea, vomiting and diarrhea may have been below accepted and prevailing standards of care.	Public Letter of Concern
SEGREST, Justin Fletcher, NP Hazel Green, AL	06/19/2014	The Board is concerned that NP pre-signed prescription blanks and that he failed to properly secure returned controlled substances.	Public letter of concern
TIMMERMAN, Daniel Steven, DO (200800710) Enka, NC	06/03/2014	The Board is concerned that a patient upon whom DO performed a hemorrhoidectomy may not have conformed to accepted standards.	Public letter of concern; DO agrees to perform three hemorrhoidectomies with a mentor.
WILLIAMSON, Steven Grover, MD (000031694) Hickory, NC	05/16/2014	The Board is concerned that MD's treatment of a patient who presented for treatment after a fall did not conform to accepted standards of care. MD failed to conduct thorough and sequential neurological examinations, which may have contributed in a delay in diagnosis of the patient's central cord syndrome.	Public Letter of Concern; MD must complete a CME course in the evaluation and management of cervical spine injuries.
WRIGHT, Kimberly L., NP Kernersville, NC	05/19/2014	NP practiced at a medical spa not owned by a licensee of the NCMB; NP provided weight loss treatments to patients that did not conform to accepted and prevailing standards.	Public Letter of Concern; NP must complete CME courses in weight loss treatment and in medical record keeping.
MISCELLANEOUS ACTIONS			
JUSTIS, Christopher Morrow, MD (000038991) Edenton, NC	05/30/2014	Prior history of substance abuse	License issued by consent order; Must comply with conditions
ORTON, Jonathan, MD (201401078) Greensboro, NC	05/29/2014	Prior history of substance abuse	License issued by consent order; Must comply with conditions
REACH, Ralph Thomas, MD (201401815) Johnson City, TN	08/12/2014	Prior history of alcohol/substance abuse	License issued by consent order; Must comply with conditions

BOARD ACTIONS REPORT

Name/license#/location	Date of action	Cause of action	Board action
STEINER, Drew John, MD (009901479) St. Michael, MN	07/24/2014	History of alcohol abuse; MD has completed inpatient treatment; MD has not practiced since July 2007.	Amended Consent Order; MD is issued a temporary license to practice medicine. Must comply with conditions
CONSENT ORDERS AMENDED			
None			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
ARTIS, Danielle Lynette, MD (201401194) Greensboro, NC	06/10/2014	On her application for an NC medical license, MD failed to disclose that she was placed on academic probation during medical school; Prior history of substance abuse.	Temporary/Dated Licenses Issued; Expires 06/10/2015; \$250 administrative fine; must maintain NCPHP contract.
CASSIDY, John Francis, PA (000103164) Raleigh, NC	06/11/2014	History of failing to maintain proper boundaries.	Temporary license issued; Expires June 11, 2015. Must maintain NCPHP contract.
COURT APPEALS/STAYS			
None			
DISMISSALS			
None			

FINES

The NCMB issues non-disciplinary administrative fines in certain cases where incorrect and/or incomplete information on a medical licensing application causes Board staff to spend an inordinate amount of time resolving the issue(s).		
Date	Reason	Amount
5/7/14	Error/omission on license application or renewal	\$500.00
5/30/14	Error/omission on license application or renewal	\$500.00
5/30/14	Error/omission on license application or renewal	\$500.00
6/2/14	Error/omission on license application or renewal	\$250.00
6/16/14	Error/omission on license application or renewal	\$2,000.00
6/16/14	Error/omission on license application or renewal	\$500.00
6/23/14	Error/omission on license application or renewal	\$250.00
6/24/14	Error/omission on license application or renewal	\$1,500.00
7/3/14	Error/omission on license application or renewal	\$1,000.00
7/11/14	Error/omission on license application or renewal	\$500.00
7/28/14	Quality of care	\$1,000.00

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1. The photo should be a color head shot (head, neck and shoulders in frame) that is in focus. The individual pictured should not be wearing sunglasses, a hat or any other item that obscures the face or alters his or her normal appearance.
2. The licensee should be the only individual in the photograph. The licensee should be looking straight ahead, with both eyes open and a natural facial expression.
3. The licensee should be in professional dress equivalent to his or her everyday attire for work in a clinical setting.

North Carolina Medical Board

1203 Front Street
Raleigh, NC 27609

EXAMINATIONS

Residents Please Note USMLE Information

United States Medical Licensing Examination

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at www.fsmb.org.

Special Purpose Examination (SPEX)

The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

BOARD MEETING DATES

November 19-20, 2014 (Full Board)
December 11-12, 2014 (Hearings)
January 21-23, 2015 (Full Board)
February 19-20, 2015 (Hearings)

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

ncmedboard.org

Visit the Board's website at www.ncmedboard.org to change your address online. The Board requests all licensees maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 30 days of a move.

Board changes reentry requirements

At its September meeting, the NCMB voted to revise its method of addressing the clinical competency of license applicants without recent clinical experience. The new policy requires these applicants to be assessed by organizations experienced at determining physician competency.

Previously, the Board required physician license applicants who had been out of active clinical practice for two or more years before seeking licensure, or reinstatement of licensure, in North Carolina to design and complete a program of reentry approved by the Board. However, it has been challenging for the Board to determine whether applicants have gaps in their clinical knowledge and skill that should be addressed. In addition, the Board has had little ability to accurately assess whether the approved reentry program meets its goal of safely reintegrating the applicant into active practice.

The new policy will require physician license applicants who have not practiced clinical medicine for two or more years to complete a formal examination or assessment approved by the Board, and follow all applicable recommendations. The Board is unable to determine what type of competency assessment will be required until the complete license application has been reviewed.

Reentry requirements affect a small fraction of license applicants. About 200 licensees have completed programs of reentry since the Board began requiring them about eight years ago.