North Carolina Medical Board
FORUM
ISSUE NO. 3 | FALL 2017

FROM THE PRESIDENT

Making public outreach a priority

Eleanor E. Greene, MD, MPH

This summer I had the opportunity to do a presentation on the Medical Board to a group of about 100 people at my family reunion in Salisbury. I regularly present to medical professionals about the Board, but it was a rare treat to speak directly with the public (even if they were relations) and see firsthand how NCMB's message is received. I spent 15 minutes or so describing the Board's public protection mission and discussing the ways NCMB fulfills it. I also highlighted the main resources NCMB offers to the public, including our online "Look up a doctor or PA" tool. I was pleasantly surprised with how attentive my audience was, and even more so to note that the assorted aunts, uncles, siblings and cousins picked up all the NCMB literature I brought with me.

Reaching the public NCMB is sworn to protect is among the greatest challenges the Board faces. More than 10 million people live in North Carolina and, although NCMB offers a tremendous amount of information on its website, the agency does no advertising to build public awareness of the Board. Last fall, NCMB did a public market research survey that confirmed what many Board Members and staff already suspected: Most North Carolinians have no idea who we are. Our public survey found that only about one out of every 10 individuals who responded (we only accepted responses from state residents who are not licensed physicians or PAs and/or do not work in the medical profession) had heard of the North Carolina Medical Board. Of these, only a handful of respondents had any direct experience with the Board. Clearly, NCMB has some work to do if it is to fulfill its goal to serve as a resource for both the profession and the public.

With this in mind, NCMB added public outreach to its strategic priorities for 2017. So far this year, Board Members and staff have presented to 11 different community groups representing patients and the public (including Rotary Clubs,

Continued on pg 2

IN THIS ISSUE

SPOTLIGHT

As of Sept. 30, NCMB had issued 1,082 resident training licenses (RTL) to physicians who are completing postgraduate training in North Carolina. NCMB's Licensing Department processed 86 percent of these applications during the months of May and June – Whew!

931

RTLs issued May-June 2017

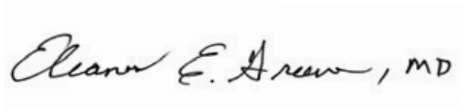
1,082

RTLs issued through Sept. 30, 2017

senior centers, caregiver groups and even a few business networking gatherings), reaching a little over 300 people. This is a modest start, to be sure, but NCMB has appreciated the opportunity to speak, and listen, with people at these events. Board staff have used feedback received during these public events to assess interest in NCMB's information and to develop ideas for future projects.

I'm told by staff that NCMB had, historically, shied away from presenting to the public because some Board Members and staff feared speakers might face heckling from dissatisfied complainants, or that NCMB would spark concerns among licensees that it was trying to solicit more complaints from patients. So far, the experience of speaking to public audiences has been nothing but positive. Our audiences have received Board speakers with polite interest. Many have told us that they're glad they now know about NCMB, and that they are glad to know we are here for the benefit and protection of the people of North Carolina. That is, after all, our job.

Be well,



Eleanor E. Greene, MD, MPH
Board President*

*Dr. Greene's term ended October 31st

NEED A SPEAKER?

The North Carolina Medical Board is pleased to provide Board Members and/ or Board staff to speak to professional groups and other audiences.

To schedule a speaker please contact the Board's Communications Director, Jean Fisher Brinkley at 919-326-1109 x230 or jean.brinkley@ncmedboard.org

North Carolina Medical Board Forum Credits VOLUME XXI | No. 3

Contact Us

Street Address:
1203 Front Street
Raleigh, NC 27609

Telephone:
(800) 253-9653

Fax:
(919) 326-1130

Website:
www.ncmedboard.org

Email:
info@ncmedboard.org

Have something for the editor?
forum@ncmedboard.org

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.

Protocols for co-prescribing naloxone

Emergency room visits due to opioid overdose jumped nearly 27 percent statewide between July and August 2017, prompting the NC Division of Public Health (NCDPH) to issue guidance to clinicians on co-prescribing rescue naloxone to patients who may be at risk.

There were 646 opioid overdose visits to emergency departments across NC in August 2017, up 136 visits from July. Overdoses from heroin, fentanyl and fentanyl analogues accounted for most of the increase in opioid overdose visits, according to NCDPH. Increased use of these drugs, in addition to widespread use of prescription opioids, underscores the need for prescribers to be aware of current recommendations for prescribing naloxone. Naloxone blocks or reverses the effects of opioids from all sources and can be administered in emergency situations to prevent death from overdose.

NC Division of Public Health recommends clinicians take the following steps:

- Prescribe/dispense naloxone to patients discharged home after an opioid overdose to prevent death from future overdose.
- Per CDC Guidelines, clinicians should consider offering naloxone for patients with a history of overdose, history of substance use disorder, on higher dosages (more than 50 morphine milligram equivalents/day) or with concurrent benzodiazepine use.
- Educate patients and their family and friends that naloxone can be dispensed at participating pharmacies under NC's standing order for naloxone. Information on participating pharmacies and use of naloxone can be found at *www.naloxonesaves.org*.
- Provide information on syringe exchange. Syringe exchange programs are effective in decreasing transmission rates of HIV and hepatitis C, as well as connecting users to treatment. Information available at *www.ncdhhs.gov/divisions/public-health/north-carolina-safer-syringe-initiative/syringe-exchange-programs-north*.
- Screen patients to determine risk for or presence of opioid use disorder, and connect to treatment services. Information on 24/7 crisis lines can be found at *www.ncdhhs.gov/providers/lme-mco-directory*.

More than 250 prescribers attended a panel discussion in October at Duke

Pain management and addiction medicine experts needed for NCMB panel discussions

NCMB and Wake AHEC have scheduled eight CME-eligible controlled substances prescribing panel discussions between fall 2017 and spring 2018 in locations across North Carolina and are planning several more. About 250 prescribers attended a session held at Duke University on Oct. 12. The Board still needs additional subject matter experts with relevant experience in primary care, psychiatry, addiction medicine and pain management to serve as faculty for upcoming panel discussions.

This project is a collaboration between NCMB and Wake AHEC and is supported by a grant from NC AHEC, with additional support from the Governor's Institute. Panel discussions are programmed to cover the educational topics required by NCMB's new CME requirement for controlled substances prescribers and each offer two hours of **AMA PRA Category 1 CME** credit at no cost to attendees.

An initial series of four panel sessions held in spring 2017 reached about 400 prescribers in the greater Triangle area. The current phase of this project will include up to 20 additional panel sessions. A free one hour companion webinar developed by NCMB with Wake AHEC has been viewed more than 3,000 times.

If you are interested in serving as a panelist for sessions held in your region, please email the Board at *PrescribingCME@ncmedboard.org*. To see an up-to-date listing of panel discussions, visit *www.ncmedboard.org/prescribingCME*.

Sitting Board Members reappointed

Congratulations to Board Members Dr. Bryant A. Murphy and Judge Ralph A. Walker on their recent reappointments to the North Carolina Medical Board. Their second and final terms on the Board began on Nov. 1 and will end on Oct. 31, 2020.

Bryant A. Murphy, MD, MBA

Bryant A. Murphy, MD, MBA

Dr. Murphy practices medicine at UNC Health Care in Chapel Hill in the Department of Anesthesiology, where he serves as Vice Chairman for Clinical Operations. He is also an Associate Professor at the UNC School of Medicine in the Department of Anesthesiology. Dr. Murphy was initially appointed to the Board in November 2014 and was recently selected by his colleagues on the Board in to serve as Secretary/Treasurer for the 2017-2018 program year.

Dr. Murphy earned his BS degree from Duke University and his MD from the former Bowman Gray School of Medicine at Wake Forest University. He completed postgraduate training in anesthesiology at Wake Forest University Baptist Medical Center, and also completed a fellowship there in cardiothoracic and vascular anesthesiology. He is certified by the American Board of Anesthesiology, completing recertification in 2012. The same year, Dr. Murphy earned his MBA from George Washington University. Dr. Murphy is a NC delegate to the American Society of Anesthesiologists.

Ralph A. Walker, JD, LLB

Ralph A. Walker, JD, LLB

Judge Walker is the former director of the N.C. Administrative Office of the Courts. He was first appointed as a public member of the Board in November 2014. A former trial lawyer, prosecutor, and county attorney, Judge Walker served as a Guilford County Superior Court judge and as a judge on the North Carolina Court of Appeals. In addition, he has served as chair of the North Carolina Dispute Resolution Commission and currently is a member of the Rules Review Commission.

Judge Walker received his BBA degree from Wake Forest University and his LLB and JD degrees from Wake Forest School of Law, and attended the National Judicial College.

Judge Walker serves on the governing board of Carolina Dispute Settlement Services, and is a member of the Wake County and Guilford County Bar Associations.

Raleigh pediatrician appointed to NCMB

Gov. Roy Cooper recently appointed pediatrician Dr. John W. Rusher of Raleigh to a seat on the Board. His term began on Nov. 1 and will run through Oct. 31, 2020.

John W. Rusher, MD, JD

John W. Rusher, MD, JD

Dr. Rusher practices with Raleigh Pediatric Associates in Raleigh, where he is a partner. He is also an Associate Clinical Professor in the Department of General Pediatrics of the University of North Carolina at Chapel Hill/ NC Children's Hospital. Prior to entering the practice of medicine, Dr. Rusher was an attorney, practicing in solo practice and, earlier in his law career, with the Raleigh law firm of Hatch, Little & Bunn.

Dr. Rusher earned his BA degree from Wake Forest University and received his law degree from the Wake Forest University School of Law. After completing premedical studies at NC State University, Dr. Rusher earned his medical degree from the School of Medicine at the University of North Carolina at Chapel Hill. He went on to complete postgraduate training in pediatrics at UNC Hospitals in Chapel Hill.

Dr. Rusher is a fellow of the American Academy of Pediatrics (AAP) and currently serves on AAP's Committee on Medical Liability and Risk Management. He is a current member of the Advisory Committee of the NC Immunization Branch and currently chairs the State Government Affairs Committee of the NC Pediatric Society, an organization he led as President in 2012-2014. Dr. Rusher is also a member of the North Carolina Medical Society.

Licensee feedback helps shape new position statement

Licensees may wonder if their input can make a difference when the Board seeks feedback while developing new policies. The Board's recent work to establish a position statement regarding the use of video and still photography in the examination room clearly shows that it can. NCMB adopted a position statement on this topic in July, after considering feedback received from licensees and stakeholders. Constructive criticisms of the draft language NCMB published in the *Forum* helped the Board avoid adopting a policy that would likely have been unduly burdensome and may have been incompatible with current clinical practices.

NCMB's Policy for the use of audio or visual recordings in patient care originated from the Board's review of an enforcement case that involved a medical practice's use of video cameras for security, both in patient examination rooms and in public spaces such as the waiting and parking areas. A patient complained to the Board about this practice, stating specific concerns that no private area had been provided for undressing and dressing. The Board's primary goals in drafting the position statement were to ensure that 1. Patients have a private area in which to disrobe or redress and 2. Files are stored in a secure manner that is compliant with HIPAA privacy rules.

The Board's Policy Committee developed a draft position statement in Spring 2017 that included guidance on obtaining informed consent from patients before capturing still or video images. The text of the draft position was published in the Spring 2017 issue of the *Forum*, with an invitation to readers to submit feedback on the proposed text to the Board. NCMB received several comments from licensees and professional organizations representing specialists who regularly use photography for clinical purposes. Their comments noted that it would be impractical or even impossible for licensees to obtain informed consent in a manner that would satisfy the requirements stated in the draft position. For example, still or video images are captured before, during and after certain surgical procedures, and in emergency situations, when the patient may not be conscious or otherwise capable of giving consent. Additional feedback pointed out that consent to photo or video photography is already part of the general consent forms used by surgeons and others who regularly use it for clinical purposes, thus making the informed consent protocols outlined in the draft statement redundant. This feedback influenced the Board's decision to strike detailed recommendations regarding informed consent from the final version of the position statement.

Thank you to all licensees and stakeholders who took the time to provide feedback!

Position Statement

Policy for the Use of Audio or Visual Recordings in Patient Care

The Board recognizes that there may be valid reasons for licensees to make audio or visual recordings of patients during a healthcare encounter. However, such recordings must be made for appropriate professional reasons and should employ safeguards that protect a patient's autonomy, privacy, confidentiality, and dignity. In instances where a patient may be asked to disrobe, the patient should be provided an opportunity to disrobe beyond the view of any camera.

Recordings that could lead to disclosure of the patient's identity constitute protected health information and must be managed and transmitted in a manner that complies with HIPAA requirements.

Prior to an audio or visual recording being made of a patient, licensees should ensure that they have obtained the patient's informed consent. The informed consent should be documented in the medical record and should allow the patient an opportunity to discuss any concerns before and after the recording.

Adopted July 2017

Licensee obligation to complete death certificates

NCMB continues to receive regular calls from funeral directors, families and others who report physician refusals to complete death certificates. When physicians (or other medical professionals authorized to certify deaths) refuse to perform this final essential service for a patient, the result is needless delays and complications with funeral arrangements, estate proceedings and other legal and personal matters that are of paramount importance to the decedent's loved ones.

It is the Board's view that, if requested to certify a death, physicians and/or physician assistants have an obligation to complete the death certificate for their patient to the best of their ability and in a timely manner. This article updates guidance from Associate Medical Director Scott G. Kirby, MD, which was originally published in the Fall 2013 issue of the *Forum*.

Q: What types of patient deaths/cases are most likely to result in licensee refusals to complete a death certificate?

A: Most instances NCMB has heard about arise from unattended deaths from natural causes. Typically, these decedents had an established relationship with the physician or PA, but for a variety of reasons, the identified provider is reluctant to certify the death. The decedent may not have been seen for several months, or the individual may have been under treatment for stable conditions that posed no apparent immediate threat to his or her life (hypertension, diabetes, etc.). Often, when asked, the physician or PA indicates that he or she feels that they have no idea why the patient died.

Q: What types of medical professionals may lawfully complete death certificates?

A: In North Carolina, death certificates must be completed by a licensed physician or by a physician assistant or nurse practitioner who has been specifically authorized by his or her supervising physician to certify deaths. PAs and NPs have been legally able to certify deaths since fall of 2011.

Q: What steps must a supervising physician take to delegate completion of death certificates to a PA or NP?

A: Amendments to NCGS 90-18.1 require that PAs and NPs be explicitly authorized to complete death certificates by the supervising physician in the written supervisory arrangement or collaborative practice agreement. As with any other delegated tasks, the supervising physician is responsible for ensuring that death certificates are properly filled out and filed.

Q: Who determines which medical professional should complete the death certificate for an unattended death?

A: In situations where a person dies at home and is brought by ambulance to a hospital emergency department, it is common practice for hospital staff to check the person's medical records to determine if he or she had an established relationship with a primary care doctor or other physician. If so, the hospital will generally ask the decedent's physician to certify the death. It is the Board's view that this is a reasonable practice, as physicians or other professionals who have examined and treated a patient in the past are arguably in the best position to make an educated guess about the probable cause of death, even if the patient had not been seen recently.

Q: How accurate must the clinician's conclusion about cause of death be when certifying a death?

A: A death certificate is a legal and not a scientific document. As such, physicians are NOT required to establish a specific anatomical reason that caused the death. The requirement for death certification is a statement of the condition most likely responsible for death. The patient's medical history should provide adequate information to state a reasonable cause of death that meets legal requirements. Clinicians are expected to exercise their best clinical judgment under the circumstances, just as they would in diagnosing treatment for a living patient. It is acceptable to use

terms such as "probable" or "presumed" to identify a suspected final cause of death.

Q: Why can't the decedent be referred to a state Medical Examiner if a clinician is uncertain of the cause of death?

A: The function of the North Carolina Medical Examiner system is to investigate deaths due to injury or violence, as well as natural deaths that are suspicious or unusual. Understand that, before a physician or other clinician is contacted about signing the death certificate, an assessment of the circumstances has almost always been made by EMS, law enforcement, or a medical examiner. If a death falls within the Medical Examiners' jurisdiction, it will be referred accordingly.

Q: What are some consequences of refusing to sign a death certificate and forcing a case to be accepted by the state Medical Examiner system?

A: Deflecting a case to the Medical Examiner will result in delays and unnecessary hassle for the decedent's family, and costs the county about $300 per case. It is NOT likely to result in an autopsy being done to determine the specific cause of an unattended natural death. In most cases, the Medical Examiner will not perform an autopsy but will simply certify the death based on review of available patient medical records, just as the decedent's established provider could have done.

Q: Could a physician or PA be disciplined by the Medical Board for inaccurately identifying a patient's cause of death?

A: There is no precedent for this. The Board is not interested in pursuing disciplinary action against licensees who complete death certificates in good faith to the best of their abilities. The chance of facing investigation by the Board, or other adverse legal consequences, related to the completion of a death certificate in good faith is remote and should not deter a physician from performing this duty.

Q: How quickly must death certificates be completed?

A: In North Carolina, state law (NCGS §130A 115) specifies that death certificates must be completed within three days of receipt of the request. However, the Board has received reports of families waiting for several weeks to have a loved one's body released due to a physician's unwillingness to certify the death.

Q: How can clinicians educate themselves about certifying deaths?

A: The U.S. Centers for Disease Control and Prevention booklet, The Physician's Handbook of Medical Certification of Death, is an excellent resource that provides detailed guidance to clinicians. This can be accessed at *www.ncmedboard.org/DeathCertificates*.

Proposed rule defines "consultation" for PAs, supervisors

At its September meeting, the Board tentatively approved rule changes that define "consultation" between a physician assistant and his or her primary supervising physician, for the purpose of complying with certain provisions of NC's new opioids law, the STOP Act of 2017. The proposed rule will be submitted to the NC Rules Review Commission for final approval in late November.

A provision of the STOP Act that has been in effect since July 1 requires PAs and nurse practitioners (NPs) who work in pain clinics to consult with their primary supervising physicians before issuing a prescription for a Schedule II or Schedule III opioid where therapeutic use is expected to last for 30 days or longer. Subsequent consultations between the PA or NP and the supervising physician must occur every 90 days for as long as treatment with the Schedule II or Schedule III opioid continues.

NCMB will accept public comments on the proposed rule through March 1, 2018, and will hold a hearing on the rule the same day. The proposed text is published at right. Send comments to *Rules@ncmedboard.org*.

PROPOSED RULE

21 NCAC 32S .0225 DEFINITION OF CONSULTATION FOR PRESCRIBING CONTROLLED SUBSTANCES

For purposes of N.C. Gen. Stat. § 90-18.1(b), the term "consult" shall mean a meaningful communication, either in person or electronically, between the physician assistant and a supervising physician that is documented in the patient medical record. For purposes of this Rule, "meaningful communication" shall mean an exchange of information that allows the supervising physician to make a determination that the prescription is medically indicated.

History Note: Authority G.S. 90-5.1(a)(3)

Happy 50th birthday to the Physician Assistant profession

This year the physician assistant (PA) profession celebrates 50 years of serving patients in North Carolina and beyond. North Carolina is proud to be the birthplace of the PA. The profession originated in the mid-1960s when a Duke University physician realized his vision of training former medics and hospital corpsman to perform basic medical tasks. The very first class of three PAs graduated from Duke in 1967; Today PAs are the fastest-growing group of medical professionals licensed by NCMB, accounting for nearly one out of every six licenses issued. In recent years the number of PAs in NC has increased by about 7 percent each year, and the total number of PAs licensed by the Board is on pace to reach 7,000 by the end of 2017. NCMB congratulates PAs everywhere on their contributions to patient care!

PAs in North Carolina

LICENSES ISSUED in 2016

760

POPULATION BY SEX*

4,256 2,291

*As of March 30, 2017

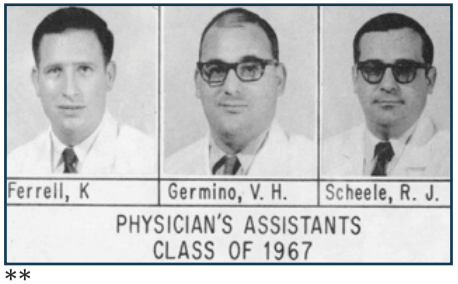
A timeline of significant events in the history of PAs

1965

*

Dr. Eugene A. Stead, Jr. established a 2-year certificate program at Duke University to formally educate former medics and hospital corpsmen as physician assistants (PA). He envisions the role of the PA to be similar to that of Henry "Buddy" Treadwell, informally trained and used by Dr. Amos Johnson in his general practice in rural Garland, NC.

1967



**

The first PAs graduated from Duke University Medical Center (DUMC) establishing the first formal education program in the USA to educate PAs. In 50 years, the profession has grown to include 115,000 clinically active PAs and 225 accredited educational programs.

1968

*

Prentiss Harrison, PA-C becomes first African-American PA.

1968

AAPA

The American Academy of Physician Assistants (AAPA), the national organization for PAs, was first incorporated in North Carolina.

1970

*

Joyce Nichols, the first woman to be formally educated as a PA, graduated from Duke University in 1970. Not only was she the first female PA, she was the first African-American woman to become a PA. She practiced in one of the first satellite clinics in rural North Carolina.

1971

In July, the General Assembly of North Carolina enacted NC Statutes: Section 1. GS 90-18 to allow a physician licensed by the Board of Medical Examiners to supervise a person approved by the Board as one qualified to function as a physician assistant in accordance with rules and regulations promulgated by the Board. The model legislation was developed by lawyers and health policy makers at Duke University and became the standard used by other states during the adoption of similar legislation during the remainder of the century.

1976

The North Carolina Academy of Physician Assistants (NCAPA) was incorporated. NCAPA currently occupies a building in Durham, NC, dedicated to Dr. Eugene Stead, the founder of the PA profession.

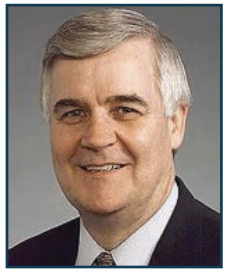
1986

Medicare Reimbursement for PAs, the Omnis Budget Reconciliation Act, is signed.

1994

PAs were granted controlled substance prescriptive authority. MDs were given the ability to supervise multiple PAs and PAs were approved to practice without a supervisor on-site. A "physician extender" seat was added to the North Carolina Medical Board, to be filled by a PA or NP.

1999



A PA, Wayne VonSeggen, was appointed to the North Carolina Medical Board in 1999 and became president of the Board, the first physician assistant to hold such a position in the United States.

*

2015

HB 724 designated a PA-only seat on the NC Medical Board.

Reamer Bushardt, PA Pharm. D, was the first to hold the seat.

*Photo Credits: PAHx Digital Repository
**Photo Credits: Duke University Medical Center Library & Archives

Bringing Wellness, Resilience and Recovery

By Joseph Jordan, PhD

WELLSPRING BY NCPHP

When I first meet with a physician or PA, I usually begin our conversation with a question: What does the individual know about the North Carolina Physicians Health Program? Most often, my query is answered with another question – "Aren't you the group that helps alcoholic doctors?" In more than a decade of asking this question, I have yet to hear an answer that, I believe, truly gets to the heart of what we do. NCPHP helps medical professionals address difficult issues that affect their ability to practice safely so they can get back to doing what they most want to do – taking care of patients.

In this new column in the *Forum*, I and my colleagues at NCPHP will share some of the ways we are working to improve the lives of medical professionals. NCPHP has made a lot of changes and much progress over the last several years, and I am excited to offer physicians and PAs a clearer understanding of the services we provide. Did you know, for example, that approximately one third of the medical professionals referred to NCPHP each year come to us for reasons other than alcohol or substance use? We are much more than just "the people who work with alcoholic doctors."

In future columns, NCPHP will discuss topics such as recognizing when a colleague's conduct is serious enough to warrant intervention (this may or may not involve reporting the colleague to NCPHP). We will offer guidance on understanding boundary crossings and violations and how to safeguard yourself and your organization. We look forward to sharing the differences between substance use, substance misuse and substance use disorders. This column will also explore many aspects of professional burnout, such as how to know the difference between burnout and other problems that may mimic its symptoms. One of the significant changes NCPHP has made in recent years is bringing in national expertise in recognizing and effectively treating physician burnout (NCPHP's current Medical Director is Dr. Clark Gaither – *www.drburnout.com*). We have a lot to say and, I believe, a lot to offer, on this subject. A few months ago, there was a tragic event in New York involving a physician who took his own life after shooting and killing another physician and seriously wounding six bystanders. I am not familiar with the specifics of this case and cannot offer any wisdom about what caused this individual to act out in such a violent manner. However, I can tell you the morning this news broke nationally, my email and phone lit up with messages from PHP Directors across the country. My colleagues wanted to discuss what had happened and what, if anything, could be done to prevent a similar tragedy.

I offer this anecdote because I believe it provides important insight into what motivates people who work in PHP organizations. At our core, we are compassionate health care providers seeking to help physicians and PAs figure out what is causing their problems and, wherever and whenever possible, address them. In this way, we are not that different from the physicians and PAs we serve.

It is rarely a joyful day when a physician or PA takes the critical step of getting in touch with NCPHP, either because they have decided it is time or because someone else – a colleague, a practice partner, hospital administration, or the North Carolina Medical Board – has required it. The work we do with our participants, and the work these individuals must do personally, is by no means easy. However, it is tremendously rewarding when a professional struggling with life and work because of the issues that have brought them to NCPHP's door is able to move forward in a constructive way.

Every day when I go to work, I see anguish in the eyes of NCPHP's physician and PA clients, and it only strengthens my determination to guide them to the help they need. I hope you will keep an open mind about NCPHP as this column develops. We welcome suggestions for topics to be addressed in this space. Please send them to *forum@ncmedboard.org*.

Joseph Jordan, PhD

Joseph Jordan, Ph.D, is Chief Executive Officer of the North Carolina Physicians Health Program. He has more than 25 years of experience working with persons experiencing substance abuse and co-occurring disorders.

Updated STOP Act FAQs

NCMB has added additional questions and answers about the state's new opioids law, the STOP Act of 2017, to the FAQs document available on the Board's website: *www.ncmedboard.org/safeopioids*. New additions to the list include:

- Information about NCMB's definition of "consultation" between a PA or NP and his or her supervisor prior to prescribing Schedule II/III opioids (see article on p. 7)
- Clarification as to whether a primary care practice that offers pain management as part of a full spectrum of primary care services is considered a "pain clinic"
- Guidance on how limits on initial prescriptions for acute pain apply when the patient being treated for acute pain is also a chronic pain patient.

Reminder: Limits on initial prescriptions for acute and post-operative pain (no more than five days or seven days, respectively) will be in effect January 1.

Have a question about the new law? Send it to *forum@ncmedboard.org*. We'll take a look and determine if it should be added to our FAQs.

GETTING TO KNOW THE PEOPLE OF THE NC MEDICAL BOARD

Five Questions: Venkata Jonnalagadda, MD

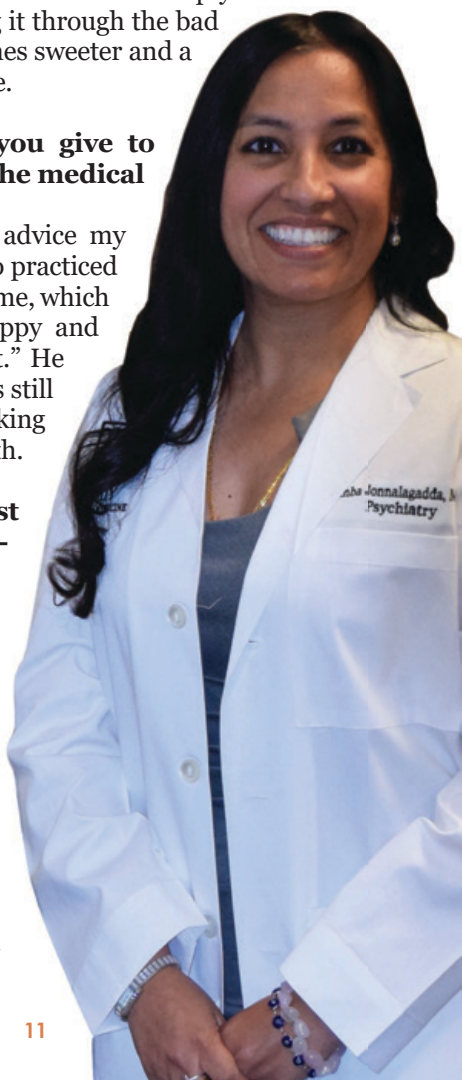
APPOINTED 2016 | CHILD & ADOLESCENT/ GENERAL PSYCHIATRY | BOARD MEMBER | GREENVILLE, NC

Q: What do you wish other medical professionals understood about the Medical Board?
A: Board Members are their colleagues, their neighbors and their partners in navigating the ever-changing landscape of medical regulation and healthcare reform. A great example of this is the free opioid CME developed by NCMB and Wake AHEC. These trainings help our licensees meet the new requirements for controlled substances prescribers, which NCMB adopted at the direction of the executive branch. I also wish more licensees understood that NCMB truly is a resource for them. You see this in our increased level of activity on Twitter, and in the information we publish in the *Forum* newsletter. We are always offering information to help providers be successful and stay on top of all the changes.

Q: What do you find most rewarding about serving on the Board?
A: The opportunity to serve the people of my home state and to be part of the system that ensures all physicians and APPs receive unbiased due process from this regulatory board. More important to my heart is the ability to be part of protecting the people of North Carolina.

Q: What has surprised you about serving on the Board?
A: NCMB is so much more than the Board Members. When I first joined the Board I was surprised by the efficiency and the lean manner in which the limited staff work to fulfill the mission for the people of NC. I also hadn't realized that NCMB is nationally recognized for its progressive and innovative strategies to help physicians and communities.

Q: What is the best lesson you've learned from your personal or professional life?
A: That life is a cycle of good moments and bad moments. The skills you learn during the good moments help you survive the bad ones. Making it through the bad moments makes the good times sweeter and a real reason to live in gratitude.



Q: What advice would you give to someone starting out in the medical profession?
A: I'd give them the same advice my personal hero – my Dad, who practiced medicine for 50 years – gave me, which is, "Do what makes you happy and everything else will work out." He was right, and I believe this is still good advice for anyone looking for his or her professional path.

Q: What do you find most rewarding about practicing medicine?
A: I genuinely love caring for patients of all ages. I tell my patients that my goal each working day is to provide them with the same quality and standard of care I would want my family to receive. I love the children in my practice – they are our futures. I also love my adult patients, who teach me every day to be a better doctor.

North Carolina Medical Board

Quarterly Board Actions Report | May 2017 - July 2017

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			
NONE			
REVOCATIONS			
NONE			
SUSPENSIONS			
ACOSTA, Daniel, MD (200100499) Washington, NC	05/24/2017	Boundary violations; the Board received information that MD engaged in personal relationships with two patients who were under his psychiatric care. The Board received information that MD also pursued and made sexual overtures to additional patients who were under his care. MD denies all allegations.	Indefinite suspension of NC medical license
FERNANDEZ, Sander, MD (201401596) Winter Garden, FL	05/09/2017	Boundary violation; MD attempted to inappropriately touch and kiss two female hospital staff members.	MD's NC medical license is suspended for a period of 24 months, all but 180 days of which is stayed. The period of active suspension shall begin 30 days from the date of this order. MD shall also pay an administrative fine of $5,000 and shall submit himself for a comprehensive assessment by Acumen Assessments or a comparable assessment center approved by the Board. MD must schedule this assessment within 14 days of the date of this order.
GERLACH, David Campbell, MD (9500591) Greensboro, NC	06/15/2017	MD violated NCPHP contract from December 2014 Consent Order by testing positive for controlled substances in May 2017; History of alcohol and substance abuse.	Indefinite suspension of NC medical license
HOWARD, Chad Daniel, MD (200200125) Elizabeth City, NC	06/26/2017	MD was arrested for DWI in October 2016. MD reported to NCPHP and was referred for a comprehensive assessment, which indicated MD suffers from severe Substance Use Disorder (alcohol). MD presented for inpatient treatment and voluntarily surrendered his medical license in December 2016.	Indefinite suspension of NC medical license
LOVIN, Jeffrey Douglas, MD (39641) Bakersfield, CA	06/05/2017	Action taken based on another state medical board action; The Colorado medical board took action against MD in July 2016 based on findings that MD 1. Failed to report multiple charges, arrests and a conviction for spousal battery in California; 2. Failed to report his release from his position with his employer due to alleged inaccuracies in radiology reports and reports of inappropriate behavior; and 3. Provided substandard care to multiple patients.	MD's NC medical license is suspended but immediately stayed; MD must comply with the terms of his CO order.
PHILLIPS, Timothy John, PA (103731) Fort Bragg, NC	07/12/2017	PA admitted to self-prescribing opioids using the identity and DEA number of a colleague. PA was suspended from patient care, contacted NCPHP for an assessment and was referred for treatment, which he successfully completed in March 2017. PA was approved to return to work in an administrative capacity with a gradual assumption of clinical duties.	PA's license suspended for 120 days; the period of active suspension ran from October 20, 2016, until February 17, 2017. PA must maintain contract with NCPHP and abide by all terms.

Name/license #/location	Date of action	Cause of action	Board Action
SHUCK, Linda Michele, DO (200500550) Dobson, NC	05/24/2017	DO violated the terms of a Dec. 6, 2016, interim partial non-practice agreement wherein DO agreed not to prescribe controlled substances. DO continued to prescribe controlled substances to some of her patients after Dec. 6, 2016.	DO's license is suspended for six months. The period of active suspension shall run from June 23, 2017, until December 23, 2017. DO may return to active practice on December 24, 2017, subject to the provisions contained in the order that specify that DO shall not prescribe controlled substances in any outpatient settings.
PROBATION/CONDITIONS			
HEADEN, Kenneth Jay, MD (9400266) Greensboro, NC	06/09/2017	Quality of care; Inadequate record keeping and billing; Failure to adequately follow standards of care for practice in NC	Indefinite suspension, stayed; MD must complete an assessment with the Center for Personalized Education for Physicians (CPEP) and follow all recommendations for remedial education.
POLLEY, Dennis Charles, DO (000027881) Wilson, NC	07/12/2017	DO had installed security cameras in the public areas of his practice facilities, including hallways, administrative offices, at the front entrance, and in parking areas, as well as in his practice's examination rooms. DO stated this was done to document the appropriateness of his interactions with patients and staff. However, a patient complained about the practice.	DO is hereby prohibited from using any video transmission or recording devices in examination rooms or any area where patients may disrobe or get dressed. DO is expected to attend and successfully complete the Problem-based Ethics (ProBE) course offered by Center for Personalized Education for Physicians (CPEP) within six months of the effective date of this Consent Order and shall submit evidence of completion to the Board.
VERDIN, (III), Thomas Marion, MD (200901427) Calabash, NC	05/15/2017	Quality of care; overuse of antibiotics	MD must obtain a competency assessment to be conducted by Affiliated Monitors Assessment. MD must enroll as a participant with Affiliated Monitors within 30 days of the date of this order and complete all aspects of the assessment within six months of the date of the order. Finally, MD shall follow all recommendations made by Affiliated Monitors and complete all remediation within one year of the date of this order.
REPRIMANDS			
BUNT, Theodore James, MD (201300816) Ferguson, NC	07/25/2017	In January 2017, the Board received information regarding a medical malpractice lawsuit settlement payment related to the care MD provided a patient. A medical expert reviewer opined that MD's diagnosis, treatment, records, and overall management of a patient were below accepted standards of care. Specifically, MD failed to adequately diagnose and aggressively treat a patient's symptomatic, ruptured abdominal aortic aneurysm despite evidence of life-threatening condition.	Reprimand
RICH, Preston Berkeley, MD (200000952) Chapel Hill, NC	06/26/2017	MD displayed unprofessional conduct by engaging in two inappropriate dating relationships with resident trainees who had previously been under his supervision.	Reprimand; Within six months of the order, MD must complete the Problem-based Ethics (ProBE) course offered by the Center for Personalized Education for Physicians (CPEP).
THORP, (Jr.), John Mercer, MD (000029877) Chapel Hill, NC	07/25/2017	Board felt MD displayed unprofessional conduct and failed to conform to accepted standards of medical practice by allowing a NP under MD's supervision to prescribe Suboxone to patients for substance use disorder using his DEA number and DATA 2000 Waiver. MD also failed to conduct required quality assurance. These actions constitute violations of a law involving the practice of medicine.	Reprimand; $500, to be paid within six months of date of Consent Order. MD must meet monthly for 12 consecutive months following the date of Consent Order with all PA and NP staff he supervises for quality assurance meetings pursuant to 21 NCAC 32S .0213 and 21 NCAM 32M .0110. Meetings should be documented and available for Board review if requested. MD shall complete his certification with the American Society of Addiction Medicine within 12 months of the date of the order.

Name/license #/location	Date of action	Cause of action	Board action
WARONSKY, Roy George, PA (102512) Charlotte, NC	06/09/2017	Quality of care; PA practiced poor pharmacovigilance by failing to examine pain generators in patients before prescribing controlled substances to patients with addiction issues. In addition, PA prescribed controlled substances excessively.	Reprimand
DENIALS OF LICENSE/APPROVAL			
NONE			
SURRENDERS			
ALBRIGHT, Elizabeth Rae Bakisae, PA (001004908) Fayetteville, NC	06/14/2017		Voluntary surrender of PA License
GERLACH, David Campbell, MD (009500591) Greensboro, NC	05/17/2017		Voluntary surrender of NC medical license
MCGRATH, Timothy John, MD (200200571) Greensboro, NC	05/02/2017		Voluntary surrender of NC medical license
PARKER, James Edward, MD (000031350) Birmingham, AL	05/02/2017		Voluntary surrender of NC medical license
PUBLIC LETTERS OF CONCERN			
ATILLA, Mehmet Aydin, MD (009700180) Key West, FL	07/18/2017	The Board is concerned that MD's treatment of a patient who presented with severe, persistent headache did not conform to accepted standards of care in NC. MD did not perform a typical neurological exam. The expert reviewing MD's case found that MD failed to perform a lumbar puncture and repeat imaging or seek Neurology input for patient. Patient ultimately had a CT scan of her head which showed a right temporal lobe hematoma (intracranial hemorrhage). Patient was then airlifted to a tertiary care center and had clipping of brain aneurysm/hematoma removal and ventriculoperitoneal shunt placement.	Public Letter of Concern
DAHNERS, Laurence Earl, MD (27151) Chapel Hill, NC	06/01/2017	Quality of care issue; surgical site error	Public Letter of Concern
DASTOUS, Linh, MD (201701289) Hendersonville, NC	05/30/2017	Action taken by another state medical board; The Board is concerned that MD was publicly reprimanded by the South Carolina State Board of Medical Examiners for prescribing Adipex to two employees and a family member without proper documentation.	Public Letter of Concern
FERNZ, Miriam Minu, MD (9600530) Whiteville, NC	06/01/02017	MD allowed a PA under her supervision to begin performing clinical tasks prior to submitting a mandatory Intent to Practice form with the Board.	Public Letter of Concern
HECKMAN, Eric Christopher, PA (001004006) Charlotte, NC	06/29/2017	Quality of care issue; PA prepared the wrong extremity for surgery.	Public Letter of Concern
LEE, Chee Yan, MD (201701148) Daytona Beach, FL	05/15/2017	Action taken by another state medical board; The North Carolina Board is concerned about actions taken by the Florida Board of Medicine, including a 2006 action related to MD's pre-signing of prescription blanks and a 2014 action related to allegations that MD forged the signature of a fellow physician to obtain two non controlled medications for personal use.	Public Letter of Concern
NICOLINI, Jennifer Croutcher, MD (200400722) Arden, NC	07/18/2017	The Board is concerned that MD wrote a controlled substance prescription for an immediate family member in May 2016, which is prohibited by administrative rule 21 NCAC 32B .1001.	Public Letter of Concern
PITTS, Venus Idette, MD (009900644) Durham, NC	05/25/2017	The Board is concerned about MD's association with a chiropractor, Jeffrey Hodges, DC, who operated several medical practices in North Carolina under the name Superior Healthcare. As a general rule, with few exceptions – none of which are applicable in MD's situation – a business entity that engages in the practice of medicine must be owned by a physician. MD's association with Mr. Hodges may have aided and abetted the unlicensed practice of medicine.	Public Letter of Concern

Name/license #/location	Date of action	Cause of action	Board action
ROBERTS, Virginia Salyer, MD (21163) Asheville, NC	06/29/2017	MD retired from active practice in 2000 and inactivated her license in January 2017 with no plans to return to medicine. The Board is concerned that MD issued prescriptions, including two prescriptions for controlled substances, to herself from November 2014 until October 2016. Prescribing controlled substances to oneself or to family members is prohibited by administrative rule 21 NCAC Rule 32B .1001.	Public Letter of Concern
MISCELLANEOUS ACTIONS			
HARRIS, (Jr.), John Joel, MD (32114) Wilmington, NC	06/15/2017	MD suffers from a medical condition, which if left untreated, renders him unable to practice medicine with reasonable skill and safety to patients.	Interim Non-Practice Agreement; MD will be given a ten-day wind down period, beginning on June 14, 2017, and extending until June 24, 2017.
LEINWEBER, (Jr), Clinton Henry, MD (201200595) Greenville, NC	05/04/2017	On March 16, 2017, MD was charged with three felony counts arising from alleged irregularities regarding controlled substances. MD denies all charges.	Interim Non-Practice Agreement
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
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.

NORTH CAROLINA MEDICAL BOARD
North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609

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

CONNECT WITH NCMB ON SOCIAL MEDIA

Facebook.com/ncmedboard | Twitter: @NCMedBoard

Stay on top of NCMB news between issues

NCMB is testing a digital supplement to the quarterly *Forum* newsletter to keep licensees apprised of the latest Board news. To receive the supplement via email, print readers must provide an email address by visiting *www.ncmedboard.org/enews*.

The first edition of the new digital supplement will be sent in December. A second edition will be emailed in May or June, in between the Spring and Summer issues of the *Forum*. The editorial staff will analyze reader response to the digital supplement and decide whether it should be continued.

Thank you for your help in evaluating the resources NCMB provides to its licensees!

BOARD MEETING DATES

December 14-15, 2017 (Hearing)
January 17-19, 2018 (Full Board)
February 15-16, 2018 (Hearing)
March 14-15, 2018 (Full Board)
May 16-18, 2018 (Full Board)

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

www.ncmedboard.org