FORUM
NORTH CAROLINA MEDICAL BOARD
PRIMUM NON NOCERE
SUMMER 2011

Pg. 8 — Practicing medicine in the Facebook age

The doctor is (always) in:
Treating oneself and one's family

It's the third day of your vacation on the Outer Banks. The kids are running between the pool and the ocean, for once not annoying each other. You and your spouse have put aside your everyday stresses and are having fun reconnecting. As a spectacular sunset paints the horizon, you think, "I could get used to this."

Then your son comes up.

"My ear hurts when I touch it." A quick exam reveals typical otitis externa.

Does the personal relationship between practitioner and patient bias medical judgment?

"You've got swimmer's ear. Not surprising with all the time you've spent in the water this summer."
"Can you make it better? It really hurts."

The nearest urgent care is more than an hour's drive. And even if you make the trip, by the time you are done, the pharmacy will be closed. Treating swimmer's ear is not part of your everyday practice, but it is fairly simple with little potential for complications. You call in some drops to a nearby pharmacy, pick up some ear plugs and the rest of the vacation goes swimmingly (sorry about the pun!)

Did the practitioner/parent in this scenario do the right thing? This was a minor, acute illness that most likely required one-time treatment. The "patient" started therapy faster than he would have if the family had sought medical attention from an unrelated practitioner. It made life easier for several people. I think most physicians and physician assistants would agree that Dr. Mom (or Dad) acted appropriately.

The NC Medical Board would also consider the conduct described above to be generally acceptable. While the Board's current position statement on treatment of self and family cautions against treating family members, it recognizes that it may be appropriate or even necessary to do so for minor, acute illnesses, and in emergencies. One thing that would improve the encounter described in the example: the creation of a brief note indicating the date, patient's name, chief complaint, therapy recommended and drugs prescribed. Creating such a record would ensure full compliance with the Board's position statement.

IN THIS ISSUE

QUESTIONS TO ASK

Researchers suggest that physicians ask themselves the following questions when they are asked to treat family members in nonemergent, discretionary cases:

- Am I trained to address this medical need?
- Am I too close to obtain intimate history and to cope with bearing bad news if need be?
- Can I be objective enough not to overtreat, undertreat or give inappropriate treatment?
- Is my being medically involved likely to cause or worsen family conflicts?
- Is my relative more likely to comply with an unrelated physician's care plan?
- Will I permit any physician to whom I refer a relative to treat that relative?
- Am I willing to be accountable to my peers and to the public for this care?

Source: American Medical Association; La Puma et al, N Engl J Med. 1991;3251290-1294

The Board is currently reviewing the rather awkwardly entitled position statement, *Self-treatment and treatment of family members and others with whom significant emotional relationships exist*. A Board task force I established to head up this review held a public meeting in late June, during which it received comments and suggestions from interested parties. All position statements of the Board are reviewed on a regular basis in an effort to keep the Board's guidance as clear and up-to-date as possible. (One of my personal goals for the task force: Come up with a new title that is both clear and concise!)

If you didn't attend the task force meeting or submit written comments, it's not too late to tell the Board what you think. Look for instructions on taking a brief, anonymous online survey on treating self and family at the end of this article.

The Board's licensees confront the possibility of diagnosing and treating immediate family, loved ones or themselves on a daily basis, in situations that often are far more complex than the vacation scenario described in my example. Invariably, deciding to treat someone "in the family" (I use the phrase broadly to include romantic interests, in-laws and perhaps even close friends) raises questions.

Does the personal relationship between practitioner and patient bias medical judgment? Does doing a cursory, one system exam, if an exam is done at all, prevent the patient from receiving more thorough medical care that might uncover other problems? Should it ever be OK to prescribe controlled substances to yourself or to family? Is it appropriate to treat chronic conditions or give preventive care? When treating family, will the practitioner be more inclined to treat outside of his or her area of training/practice and, thus, be more likely to provide substandard care? What happens if there is a bad outcome?

Then, too, there is the problem of over-diagnosis. A colleague of mine recently underwent several biopsies due to a troubling blood test, which turned out to be falsely elevated. My colleague drew the test on himself not because of symptoms, but out of curiosity and expediency. The result was unnecessary cost, discomfort and anxiety.

The answers to these questions, like many things in medicine, are complicated and, to a large degree, subjective. If you ask 10 of your colleagues you are likely to get 10 different perspectives. There is wide diversity of opinion even among the members of the Board. That's why, when the time came to review the Board's self-treatment position, I knew a quick and quiet internal discussion would not be sufficient.

About a dozen guests, most of them representing professional organizations for physicians, physician assistants, nurse practitioners and pharmacists, attended the task force meeting at the NCMB's offices in Raleigh on June 28. The task force will consider their suggestions, as well as comments from readers of this article and the results of the online survey, as it proceeds. The group hopes to present a revised draft of the position statement to the

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"The Board's licensees confront the possibility of diagnosing and treating immediate family, loved ones or themselves on a daily basis. . ."

Board no later than November.

I know there are some licensees of this Board that believe —some of them vehemently—that medical boards have no business telling licensed, competent physicians and PAs who they can treat and under what circumstances. But the NCMB didn't invent this dilemma. In truth, medicine has been grappling with it for a long time.

The American Medical Association first addressed the subject of treating loved ones in 1847 in its initial "Code of Medical Ethics," which advised the physician against the practice because "the natural anxiety and solicitude which he experiences at the sickness of a wife, a child, or anyone who by the ties of consanguinity is rendered peculiarly dear to him, tend to obscure his judgement and produce timidity and irresolution in his practice." And you have no doubt heard the famous comment of Sir William Osler (1849-1919), who said, "A physician who treats himself has a fool for a patient."

The NCMB adopted the original version of its position statement on self treatment in 1991 and it has been reviewed and/or modified several times over the years, most recently in 2005. If you are not familiar with the position statement, it is published in the box below.

As best the Board's administrative staff can tell, the NCMB was among the first state medical regulatory boards to adopt a formal position on self treatment. But it seems the Board's thinking was timely. In 1993, the AMA issued its Opinion 8.19, *Self-Treatment or Treatment of Immediate Family Members*. Like the NCMB's existing position statement, the AMA opinion cautions against treating oneself or one's immediate family members, except in certain circumstances, such as emergencies or when no other qualified practitioner is available.

As part of its work to support the NCMB's task force on self treatment, Board staff conducted an informal survey of medical regulatory authorities to see where others stand on the issue of treatment of self and family. The Board gathered information on about 25 boards.

Some indicated that they rely on AMA Opinion 8.19 as their guideline. Others have their own formal policies restricting or prohibiting treatment of self and family. Prescribing—especially prescribing of controlled substances—is a particular area of emphasis for most boards that have laws, rules, policies or other guidelines. Even boards that indicated they have no formal laws or other policies reported that they have prosecuted cases involving the

The NCMB is currently reviewing the position statement printed below. A task force charged with updating this position expects to propose a revised version for consideration by the Board no later than November.

SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS AND OTHERS WITH WHOM SIGNIFICANT EMOTIONAL RELATIONSHIPS EXIST

It is the position of the North Carolina Medical Board that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. The Board strongly believes that such treatment and prescribing practices are inappropriate and may result in less than optimal care being provided. A variety of factors, including personal feelings and attitudes that will inevitably affect judgment, will compromise the objectivity of the physician and make the delivery of sound medical care problematic in such situations, while real patient autonomy and informed consent may be sacrificed.

When a minor illness or emergency requires self-treatment or treatment of a family member or other person with whom the physician has a significant emotional relationship, the physician must prepare and keep a proper written record of that treatment, including but not limited to prescriptions written and the medical indications for them. Record keeping is too frequently neglected when physicians manage such cases.

The Board expects physicians to delegate the medical and surgical care of themselves, their families, and those with whom they have significant emotional relationships to one or more of their colleagues in order to ensure appropriate and objective care is provided and to avoid misunderstandings related to their prescribing practices.

*This position statement was formerly titled, "Treatment of and Prescribing for Family Members".
Created: May 1, 1991 Amended May 1996, May 2000, March 2002, September 2005

treatment of self or family. Clearly, this is an active issue for medical boards.

But we already knew that in North Carolina.

The Board's staff receives calls about the self treatment position statement on a regular basis. Whenever I give a presentation about the Board, I know prescribing to self and family is the one subject I can count on getting questions on. Some licensees are curious about why the position statement exists. Others have noticed disciplinary actions based on prescribing to self or family and want reassurances that they won't soon see their own names in the back pages of the *Forum*. Everyone has an opinion on the subject.

Now, I want to hear yours.

There are a few ways to submit feedback. Visit the Board's website and click on the "Treating Self and Family" survey as a featured item in the bottom left corner of the Home Page. Or, use a smartphone camera to go directly to the survey. Finally, if you prefer to submit comments the old-fashioned way—in writing—please send an email to me at the address below.

I look forward to hearing your thoughts.

Email comments to forum@ncmedboard.org

WE WANT TO HEAR FROM YOU!

Complete a brief, anonymous online survey on treating self and family. Visit *www.ncmedboard.org* or scan the QR code at right.

[Scan a QR code using an application on your smartphone (*www.redlaser.com*) and your phone's camera.]

Janice E. Huff, MD.

Dr. Huff, of Charlotte, practices part-time at Presbyterian Urgent Care and Mecklenburg Health Care Center. She was appointed to the Board in 2007. In 2010, she became the fourth female president of the NCMB.

The American Medical Association published an updated opinion on treatment of self and family in 1993, as part of its Code of Medical Ethics. An informal survey conducted by the NCMB found that many medical regulatory boards that lack formal policies of their own use the AMA opinion as a guide.

AMA OPINION 8.19
SELF-TREATMENT OR TREATMENT OF IMMEDIATE FAMILY MEMBERS

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV)

When everyone is supervising, is anyone?

More PAs listing multiple primary supervising physicians

The NC Medical Board has noticed that an increasing number of licensed physician assistants are designating five or more physicians as their "primary" supervisors. The NCMB has had at least one documented case in which a PA had as many as 17 primary supervising physicians. The Board is concerned that PAs and physicians in these types of practice arrangements may not be meeting the Board's requirements with regard to supervision. The Board voted at its meeting in March to ensure that, effective January 2012, PAs with five or more primary supervising physicians are included in the NCMB's PA site visit program, which verifies compliance with supervision rules.

ARTICLE SUMMARY

- More PAs are designating five or more "primary" supervisors
- This practice concerns NCMB
- PAs with five or more primary supervisors may receive a site visit
- NCMB believes limiting primary supervisors is best

The Board recognizes that it may be desirable for a variety of reasons to have multiple physicians share the responsibility of acting as a midlevel practitioner's primary supervisor. The Board does not consider this situation optimal, even if it is possible for multiple primary supervising physicians and their supervisee(s) to be in compliance with supervision rules. Designating a large number of physicians to act as primary supervisors may, in fact, prevent the midlevel practitioner from developing a meaningful clinical partnership with his or her primary supervisor(s), which is the Board's ultimate goal.

For example, administrative rules require PAs to have detailed written scope-of-practice agreements that clearly state the medical duties and tasks to be delegated by each primary supervising physician. When a large number of primary supervising physicians take responsibility for a single PA, practices may be more inclined to use prepared, generalized documents to meet this requirement. In the Board's view, using pro forma documents decreases the quality of the supervision because the PA and his or her primary supervisor(s) are less likely to carefully consider each practitioner's skills, training and experience and create individualized documents that state the medical tasks that may be safely delegated.

On another note, the Board expects each primary supervising physician to hold regular, meaningful quality improvement meetings with each midlevel practitioner under his or her supervision. In an established supervisory arrangement, rules require that a PA meet with each primary supervising physician at least once every six months. A PA with 17 primary supervising physicians would need to participate in, at minimum, 34 QI meetings a year. Even if a PA could manage to attend such a large number of meetings, the Board questions whether the quality of theses interactions would meet its expectations for meaningful quality improvement.

A BETTER MODEL

There is no specific restriction that requires PAs to limit the number of physicians they designate as primary supervisors. However, the Board prefers that PAs structure their practice arrangements such that they have an opportunity to develop close working relationships with their primary supervisors. This is most likely to occur when there is one primary supervisor. In a situation where that is not feasible, the Board believes it is best when supervision is shared among the smallest number of primary supervising physicians possible. If other physicians in the practice wish to have a role in supervising midlevel practitioners, they may participate as back-up supervising physicians.

SUPERVISION REQUIREMENTS: ITEMS TO HAVE AT YOUR PRACTICE SITE

- Proof of licensure and registration
- Statement of supervisory arrangement with each primary supervising physician (This document provides a detailed description of the PA's scope of practice)
- Signed and dated record of Quality Improvement meetings between each primary supervising MD and PA relevant to clinical problems and QI measures
- List of all back-up supervising physicians, signed and dated by MDs (primary and backups) and PA
- Written prescribing instructions to include written policy for periodic review of these instructions by each primary supervising MD
- DEA registration and pharmacy permit, if applicable

To learn more and to view NCMB rules for PAs, visit the Board's website at *www.ncmedboard.org* and click on "Professional Resources," then "Rules."

Janelle A. Rhyne, MD, installed as FSMB Chair

Janelle A. Rhyne, MD, who served as NC Medical Board president in 2007-2008, is now the senior physician leader in medical regulation. Dr. Rhyne, who lives in Wilmington, was installed as Chair of the national Federation of State Medical Boards in late April during the organization's 99th annual meeting in Seattle. She will lead the FSMB during 2011-2012.

The FSMB is a national not-for-profit organization comprised of the 70 state medical and osteopathic boards of the United States and its territories. Its mission is to improve the quality, safety and integrity of health care by developing and promoting high standards for physician licensure and practice.

As FSMB Chair, Dr. Rhyne has pledged to help raise the organization's national profile, especially by establishing a more visible presence in Washington, DC, with leaders involved in medical regulation and health care reform. Health care workforce issues and timely quality of care issues including maintenance of licensure, continued competence and pain control will also be priorities. Finally, Dr. Rhyne hopes to promote the FSMB as a resource with expertise beyond physician licensing and discipline.

Dr. Rhyne got involved in the FSMB in 2005 and she has served on its Finance Committee, Sexual Boundary Workgroup and Emergency Preparedness Ad Hoc Committee. Since winning election to the FSMB's Board of Directors in 2008, she has co-chaired the Readiness and Response Workgroup and served on the Maintenance of Licensure Advisory Group among other committees.

Dr. Rhyne received her medical degree from Wake Forest University School of Medicine. She did her internship in internal medicine, her residency training and a fellowship in infectious diseases at Wake Forest University Baptist Medical Center. She was in private practice at Wilmington Health Associates for 18 years before taking a position with the New Hanover County Health Department in 2007. She was appointed to the NCMB in 2003 and completed her service with the Board in October 2009.

Janelle A. Rhyne, MD, is installed as Chair of the FSMB in April in Seattle.

FSMB urges medical boards to move on MOL

At its recent annual meeting in Seattle, the Federation of State Medical Boards adopted a detailed blueprint intended to guide state medical boards as they consider whether to adopt "maintenance of licensure" programs.

Maintenance of licensure (MOL) is an emerging trend in medical regulation that aims to ensure the continued competence of licensed physicians. Once implemented, MOL would require, as a condition of license renewal, that physicians demonstrate their participation in programs of practice-specific professional development, with an emphasis on continuous improvement.

MOL requirements recommended by the FSMB include: enhanced continuing medical education standards that emphasize training specific to area of practice; licensee use of health care IT to produce data to assist in identifying knowledge gaps and learning opportunities; and required licensee use of comparative data and other tools to align medical practices with recognized quality standards.

The report of the FSMB's MOL Implementation Group urges state medical boards to move decisively, as a group, to implement MOL at the state board level. The report states FSMB's commitment to helping state boards fully implement MOL within 10 years.

The NCMB has participated in national discussions about MOL over the past several years. As with other important issues in the past, the Board is committed to seeking feedback and participation from licensees and other interested parties as it considers MOL.

For more information visit the FSMB's Maintenance of Licensure Information Center at *www.fsmb.org/mol.html*

Save a Life: Know the Facts about North Carolina's Safe Haven law

By Kimberly Licata

North Carolina, like many states, allows a parent, or parents, to give up an infant under seven days of age to a "safe haven," no questions asked and without facing arrest or other penalties for abandonment.

The law is intended to save the lives of infants that might otherwise be abandoned in garbage dumpsters or toilets. For the Safe Haven law to save lives, however, physicians and other health care practitioners need to know about the law and help spread the word.

Safe Haven informational brochure and poster.

Here are the basics:

North Carolina law (N.C.G.S. § 7B-500) recognizes the following locations as "safe havens":

- Hospitals
- Health departments
- Community health centers
- Police and sheriff's departments
- Social services departments
- Fire or emergency stations.

In addition to these locations, any adult may (but is not required to) accept temporary custody of an infant. Health care practitioners, law enforcement officers, social workers and certified EMS workers who are on duty are required under state law to accept surrendered infants. Parents are not required to provide any information upon surrendering a newborn, but may be encouraged to provide medical history to assist in the child's care. The surrendering parent must be told that he or she is not required to give any information.

The parent's age does not matter. The law requires that the parent "not express an intent to return for the infant." A parent who surrenders a baby may change his or her mind and reclaim custody of his or her child. However, if the infant is abandoned for 60 days, parental rights may be lost.

Anyone accepting an infant from an individual believed, in good faith, to be the parent is generally protected from civil and criminal liability. Any person who accepts an infant must protect the child's health and wellbeing, and must immediately contact social services or law enforcement.

The Safe Haven law does not replace adoption, but rather provides a process for parents who feel that they have no other choice but to surrender their child.

Additional information about the Safe Haven law, including brochures and other materials, is available at: *http://healthlaw.ncbar.org/resources/safe-haven.aspx*

Please consider displaying brochures or a poster about the Safe Haven law in your exam rooms or waiting areas to help others learn about this law. This information is provided as a public service of the Health Law Section of the North Carolina Bar Association.

Ms. Licata is an attorney at Poyner Spruill, practices health law, and may be reached at klicata@poynerspruill.com *or 919-783-2949. This information is not intended to establish an attorney-client relationship and is not intended to be legal advice.*

Registry targets off-label prescribing of antipsychotics

NC Medicaid, Community Care of NC and child psychiatrists at the state's four medical schools have partnered on a registry to gather information about off-label prescribing of antipsychotic medications to children.

Antipsychotics—Keeping it Documented for Safety (A+KIDS) aims to ensure that children who are prescribed antipsychotics for off-label indications are monitored according to generally accepted guidelines. The first phase of the program applies to Medicaid eligible children up to 12 years old. The second phase will expand the registry to include Medicaid enrollees aged 13-17.

As of mid-April, NC Medicaid requires prescribers to register patients when:

- The antipsychotic is prescribed for an indication that is not approved by the federal Food and Drug Administration
- The antipsychotic is prescribed at a higher dosage than approved for a specific indication
- The prescribed antipsychotic will result in concomitant use of two or more antipsychotic agents

Upon issuing a new prescription, prescribers go online to *www.documentforsafety.com* and enter basic information about the patient, medication, dose, diagnosis, etc. It is necessary to preregister for access.

Practicing medicine in the Facebook age: Maintaining professionalism online

From the Office of the Medical Director

SCOTT G. KIRBY, MD

Medical Director

In April 2011 a Rhode Island emergency physician was fired by her employer and reprimanded and fined by her state medical board for posting what she thought was anonymous information about a patient on her Facebook page. The NC Medical Board has yet to publicly discipline a physician or other licensee for similar unprofessional behavior. However, the Board has sent at least two private letters of concern to physicians who disclosed information that they obtained during a physician-patient encounter on social media sites. Both licensees indicated to the Board that they considered the information to be anonymous and amusing. In fact, these disclosures were breaches of patient trust.

The informality of social media sites may obscure the serious implications and long term consequences of certain types of postings. Otherwise careful and ethical physicians may inadvertently drift into unprofessional behavior. It is anticipated that the number of disciplinary cases (which usually start with complaints from patients) related to social media will increase as the use of such sites increases among health care professionals. When physicians fail to carefully consider the implications of their online activities, it may be harmful to individual patients, the medical profession and, not least, the physician.

Why is the use of social media a particular concern for health care practitioners? It is not necessarily fair or reasonable, but the fact is, health care practitioners are held to a higher standard than others with respect to social media, as they are in other areas of life. This is because health care professionals, unlike members of the lay public, are bound by ethical and professional obligations that extend well beyond the exam room.

The Board does not currently have a formal position on licensee use of social media. However, the Board believes the physician-patient relationship should be considered sacred. Aspects of the NCMB's existing position statement on *The Physician-Patient Relationship* are relevant in the social media context. The position states that any act by a physician that violates patient trust places the physician-patient relationship at risk. In November 2010, the American Medical Association issued a policy on *Professionalism in Social Media*, signaling rising awareness of potential problems with physician use of these sites.

Let me be clear: The Board recognizes that social media has increasing relevance to professionals and encourages its responsible use. In fact, the NCMB recently established its own Facebook page as a way to get its news and information to a broader audience.

However, physicians and other licensees must understand that the code of conduct that governs their face to face encounters with patients also extends to their online activity. The licensee has a responsibility to maintain professionalism online. This responsibility includes absolute obligations not to disclose or violate patient privacy. In the context of social media, this specifically extends to online posts of anonymous or de-identified information or material acquired while providing patient care.

Even the posting of information for which patient permission has been obtained should be carefully scrutinized for improprieties, or the appearance of improprieties. The unequal relationship between a physician and patient may result in an unappreciated violation of trust. The patient may give consent to online posts that they would not or could not otherwise agree to, out of a sense of obligation to the physician. Another potential area of concern is the practice of posting pictures taken during international medical mission trips. These photos often include patients who have been seriously injured or have unusual conditions. Most ethicists believe it is improper for physicians or other clinicians to display such pictures on social media sites. Recent technological advances,

Social media has increasing relevance for health care professionals.

including the use of face-recognition software to identify individuals in posted photos, increases the peril of sharing images of patients online.

The blurring of the line between a physician's professional identity and private life represent an additional area of hazard. A physician's publicly available online content directly reflects on his or her professionalism. It is advisable to separate your professional and personal identities online (maintain separate email accounts for personal and professional use; establish a social media presence for professional purposes and one for personal use, etc.) This practice is sometimes referred to as establishing "dual citizenship" online.

Privacy, however, is never absolute and considerations of professionalism should also extend to your personal accounts. Do not use social media to disclose information you would not want your patients or public to know. Posting of material that demonstrates, or appears to demonstrate, behavior that might be considered unprofessional, inappropriate or unethical should be avoided. Would a patient who is dissatisfied with the results of his or her surgery who then finds a picture of their apparently inebriated surgeon on Facebook be more likely to file a malpractice suit? I don't know, but it is worth thinking about. Venting frustrations through the online use of profanity, disparaging or discriminatory remarks about individual patients or types of patients is unacceptable.

There's no doubt that online networking encourages personal expression, but health care practitioners would do well to remember that their presence on the Internet makes their personal attitudes and activities infinitely more visible. Public discussions about frustrations and work related activities may reach unintended audiences, causing others to make unfavorable judgments about your professional demeanor. This includes not only patients and colleagues, but prospective employers. Posts you find humorous may be offensive to others.

It's complicated, to say the least. Although I am a strong proponent and frequent user of information technology, the issues discussed in this article are daunting enough that I have made a personal decision not to use social media.

If you do use social media, now is a good time to examine each post on your various accounts and delete anything that is questionable. Unprofessional material could be defined as any content that might be interpreted as possible evidence of substance abuse, sexism, racism or lack of respect for patients. Be sure to include online organizations, groups or sites that you "like," follow or participate with in the review of your online social media presence. Many patients search for their physician's social media presence and may draw unflattering conclusions if they find that their health care provider is associated with groups that have disparaging or deroga-

AMA POLICY: Professionalism in the Use of Social Media

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar Internet opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

(a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.

(b) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

(c) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just, as they would in any other context.

(d) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.

(e) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

(f) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession.

> **"Health care professionals. . . are bound by ethical and professional obligations that extend well beyond the exam room."**

tory titles or inappropriate pictures. Again, publicly accessible sites should not contain information you would not disclose to patients directly during a doctor-patient encounter.

One dilemma physicians with a social media presence may encounter is "friend" requests from patients. Unless you maintain a separate site for patient specific information, it's generally not appropriate to include patients as personal, social connections. Health care practitioners must maintain the same boundaries in the online context that they would follow in accordance with established professional ethical guidelines in a more traditional physician-patient setting.

Above all, health care professionals must be sensible of the ubiquitousness and durability of Internet posts. An online indiscretion will have far more widespread and long lasting impact than an unguarded comment to a colleague that is inadvertently overheard. When physicians or other health care practitioners discover posts by colleagues that appear to be unprofessional, they have a responsibility to bring that content to the attention of the persons involved. If appropriate action to remedy the situation—by removing an inappropriate post, for example—is not forthcoming, the matter should be reported to appropriate authorities.

The NCMB is considering whether it should develop a position statement to give formal ethical guidance and to provide a framework of standards of online professionalism. The Board welcomes your comments on this subject.

Email comments to forum@ncmedboard.org.

PHYSICIAN USE OF SOCIAL MEDIA

There is little research on physician attitudes about social media sites, and how they use them. A recent survey gives some intriguing hints.

- 40 percent of physicians surveyed have a page on a social networking site such as Facebook or Linked In.
- 84 percent of physicians disagreed with the statement, "I am willing to connect with my patients on social networking sites, such as becoming "friends" on Facebook."
- 43 percent of physicians disagreed that "Patients can learn a lot of helpful information about their health conditions by communicating with other people over the Internet." 28 percent of physicians said they were "neutral" and 29 percent agreed with the statement.

Source: Markle Foundation, January 2011. Results are based on survey responses from 779 physicians drawn from a national sample that is generally reflective of the U.S. physician population. Younger physicians may be somewhat underrepresented.

FIND THE NCMB ON FACEBOOK

Access the Board's Facebook page one of two ways:

- Visit *www.facebook.com* and search for North Carolina Medical Board. Click the 'Like' button to receive news and information.
- Scan the QR code below using your smartphone's camera (If you do not have a bar code reader, download a free application such as Red Laser or Quick Mark.

The NCMB's goal is to persuade at least 100 individuals to 'Like' its Facebook page by the end of the calendar year. At press time, nearly 60 individuals had 'Liked' the Board's Facebook page.

The NCMB believes its Facebook page is a convenient way for licensees to stay on top of important issues that may affect their practices.

He likes us. . .

In the last issue of the *Forum*, the NC Medical Board announced that it had established a Facebook page. Dr. K. Patrick Ober, Associate Dean of Medical Education at Wake Forest University School of Medicine, was the first licensee to 'Like' the NCMB. Dr. Ober spoke to *Forum* Editor Jean Fisher Brinkley about using social media to enhance his professional life.

Q&A

How do you use Facebook professionally?

I'm exploring that. I use it professionally, I guess, as an observer and a watcher. Basically what I've done is I've identified organizations in which I have an interest and I click the 'Like' button. This has been primarily medical, professional journals, organizations, where I went to college, where I went to medical school. Places like that. It's mainly just to see, is it useful? Is it not useful?

Do you use Facebook primarily on a desktop computer or a laptop, or do you use it on a Smartphone?

I mainly use it on my iPad. I go home in the evening and look at some emails and some other stuff, and it's actually very easy to click on Facebook and scroll through and see what's been going on the last day or so.

What made you 'Like' the NCMB page?

It actually is a very colorful page. There's a lot of stuff there. I looked at it and it dawned on me that it's probably stuff that I ought to be keeping up with or at least ought to be aware of.

Has the NCMB Facebook page met your expectations?

What I expected to be there is there. There's a part of me that's always curious about the people who got into trouble, not so much who messed up, but how did they mess up and how did they get into trouble? In teaching professionalism to medical students, it's useful for them to know the common ways that physicians get themselves into a bind. So [the disciplinary reports], as a teaching instrument, are useful.

Have you learned anything new about the NCMB through the Facebook page?

I actually have. I've been impressed by the scope of what the Medical Board is responsible for and the number of people involved and the fact that it's actually a very active organization. I think most of us might think of the Medical Board as a thing that's just there and it's very staid and it's very traditional and nothing too much happens. But now it's quite clear to me that there are all sorts of things going on in a very dynamic fashion.

Dr. Patrick Ober

Office-based procedures position revised

The NC Medical Board adopted a reorganized and revised version of its position statement entitled, *Office-based procedures* at its meeting in May.

During its review, the Board's Policy Committee solicited input from insurance companies and a range of medical specialties including plastic surgery, dermatology, obstetrics and gynecology and gastroenterology. Based on the committee's review and comments received, the statement was reorganized to make it easier to read. In addition, the term "reasonable proximity" was added to the definitions list. Other changes of note include defining 30 minutes as an appropriate distance from a hospital in situations when a licensee must arrange for emergency transfer of a patient during a procedure.

Also at the May meeting, the Board reviewed and accepted, without changes, the position statement entitled, *Sale of goods from physician offices*.

The Policy Committee discusses position statements in public sessions during regularly scheduled Board meetings. The full text of the position statements can be found on the Board's website: *www.ncmedboard.org* Click on "Professional Resources" and then "Position Statements."

North Carolina Medical Board

Quarterly Disciplinary Report | February -April 2011

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			
COOK, Raymond Dwight, MD (009900195) Raleigh, NC	04/11/2011	MD was involved in an alcohol related motor vehicle accident that resulted in the death of a young woman. MD was charged with felonious death by vehicle, driving while impaired, failure to reduce speed to prevent an accident and careless and reckless driving. On 09/28/2011, MD was indicted for second degree murder.	Revocation of NC medical license
POULIN, Ronald Francis, MD (009400976) Virginia Beach, VA	03/18/2011	MD was convicted of felony health care fraud.	Entry of revocation
SUSPENSIONS			
BREWER, Ann Rose, MD (000030782) Albemarle, NC	04/12/2011	MD prescribed narcotics without clear medical indications and failed to manage patients who had been prescribed narcotics in a way that did not meet accepted and prevailing standards.	MD's license suspended for six months, immediately stayed. MD must complete CME on prescribing medications; comply with other conditions.
DILL, Gregory Oran, MD (200300462) Tampa, FL	04/12/2011	History of substance abuse; MD admitted to using methamphetamine twice during the year 2010.	Indefinite suspension of medical license
EARLE, Kristen Renee, MD (009600800) Greensboro, NC	02/22/2011	History of alcohol abuse	Indefinite suspension of medical license
MARSHALL, John Everett, MD (000039646) Lincolnton, NC	02/09/2011	MD wrote controlled/non-controlled prescriptions to NC patients, and occasionally to family members, who lived out of state. He did not always maintain detailed medical records of his prescribing for these patients. In addition, MD is alleged to have engaged in unwelcome touching and inappropriate remarks with a nurse.	Indefinite suspension of medical license
STOCKS, Lewis Henry III, MD (000018344) Raleigh, NC	2/17/2011	Quality of care and poor medical record documentation in the treatment of several patients.	MD's license is suspended for one year; immediately stayed. Conditions placed on license.
YOUNG, Sarah Wistran (200801889) West End, NC	2/22/2011	MD took Oxycodone tablets from three patients in the emergency room of a hospital. Completed treatment at Metro Atlanta Recovery Residences.	MD's NC medical license is suspended indefinitely.
PROBATIONS			
[NONE]			
REPRIMANDS			
KOTZEN, Rene Marlon (200200937) Brooklyn, NY	2/9/2011	Surgery performed on a patient at the wrong level.	MD is reprimanded and must pay a $5,000.00 fine

Name/license#/location	Date of action	Cause of action	Board action
RHOLL, Vicky Lee, MD (200000124) Asheville, NC	03/18/2011	Breast biopsy tissue samples for two patients were mistakenly switched, resulting in diagnosis of malignancy in a patient who did not have cancer and a delayed diagnosis of cancer in a patient who did have a malignancy.	Reprimand
STEWART, John Ernest, MD (200601484) Jacksonville, NC	02/08/2011	On a 2006 job application submitted to a hospital, MD provided incorrect information regarding his undergraduate medical education.	Reprimand
THIGPEN, Fronis Ray, MD (000020979) Whiteville, NC	04/13/2011	MD prescribed controlled substances to multiple patients in a manner that did not meet accepted and prevailing standards. MD prescribed opioids without a clear medical indication and continued to prescribe to one patient despite clear evidence the patient was narcotic dependent and that a family member may have been diverting medication.	Reprimand. Must complete CME in prescribing controlled substances.
SMITH, Gregory Eugene, PA (000103971) Dunn, NC	2/17/2011	PA committed boundary violations with several female patients.	PA is reprimanded and shall pay a fine of $500. PA must release all reports from his assessment to the Board and shall follow recommendation made by his assessors.
TROYER, Eric Charles, MD (009500748) China Grove, NC	2/28/2011	MD engaged in an intimate and inappropriate relationship with an employee.	MD is reprimanded and must take CME courses in ethics and maintaining proper boundaries.
DENIALS OF LICENSE/APPROVAL			
GORECKI, John Paul, MD (009400064) Wichita, KS	03/08/2011	MD provided false or incomplete answers to multiple questions on his NC license application	Application for reinstatement denied; Hearing requested
ROLLINS, Curtis Edward, MD (200501895) Redwood City, CA	04/05/2011	MD has criminal history, a history of substance abuse, a prior disciplinary history with the Board, a disciplinary history with the AZ medical board and also failed to accurately answer questions on his license application	Denial of application for reinstatement of NC medical license
SURRENDERS			
MCINTOSH, Margaret Gloria, MD (000036117) Charlotte, NC	03/30/2011		Voluntary surrender of NC medical license
MESA, Gregory Robert, PA (000103090) Hendersonville, NC	03/24/2011		Voluntary surrender of NC physician assistant license
PUBLIC LETTER OF CONCERN			
ALVAREZ, Osvaldo, PA (001000562) Asheville, NC	04/12/11	PA punctured a patient's pulmonary artery during a CT guided biopsy procedure, resulting in pericardial tamponade. The patient subsequently died.	Public letter of concern
ATASOY, Erham, MD (200001460) Raleigh, NC	3/1/2011	MDs treatment of patient A fell below accepted standards.	Public letter of concern.
BRIGHT, Crystal Deon, MD (201100243) Swansboro, GA	02/25/2011	MD incorrectly answered a question on her license application; Indicated she left a residency program because it was "not a good fit" for her. The residency program indicated that MD failed to achieve the competency level needed.	Public letter of concern
CLARKSON, Jenkins Lucas, MD (009800815) Murphy, NC	03/28/2011	The Board is concerned that MD's care of a patient with a left ovarian cyst and significant pelvic adhesions was below accepted and prevailing standards.	Public letter of concern

Name/license#/location	Date of action	Cause of action	Board action
CLEMENT, Wesley Dobbs, MD (000019789) Charlotte, NC	2/18/2011	MD performed "laser body sculpting procedures." Medical records for those procedures were incomplete and lacked accepted components of an operative record.	Non-disciplinary consent order that constitutes a public letter of concern. Limitations on license.
DEFRIETAS, Junior, MD (000038042) Denton, TX	03/01/2011	The Board is concerned that MD entered into an Agreed Order with the Texas Medical Board on 06/14/2010, related to MD's documentation and pre-surgery management of a patient with non-Hodgkins lymphoma.	Public letter of concern
FROELICH, Mary Elizabeth, MD (009300121) Jamestown, NC	03/01/2011	MD's treatment of a patient with a long history of psychiatric illnesses and substance abuse may have been below standards. Patient died from combined drug toxicity.	Public letter of concern
HARPER, Jennifer Lynne, MD (000031993) Ft. Lauderdale, FL	03/04/2011	MD's care of a pregnant woman whose ultrasound showed signs of severe intrauterine growth restriction was below standard. The medical record does not document that MD read the ultrasound in a timely manner. Patient delivered a stillborn fetus.	Public letter of concern
LOWDER, Richard David, II, PA (000103918) Winston-Salem, NC	03/08/2011	PA's care of four patients treated for chronic pain was below accepted and prevailing standards	Public letter of concern
LUE, Alvin Joseph, MD (009500649) Winston-Salem, NC	02/23/2011	MD failed to adequately explore the possibility that a patient's complaints of chest pain and soreness in his upper chest and forearms might be related to cardiac issues. The patient died three days after his encounter with MD of presumed ventricular fibrillation and heart disease.	Public letter of concern
MARTIN, Rebecca Mathilde (201100201) Fort Wayne, IN	2/21/2011	Failed to provide correct information on a license application regarding a letter of warning received by the Iowa Medical Board.	MD is issued a license to practice medicine and shall receive a public letter of concern.
MOSS, John Simpson, Sr., MD (200700158) Roanoke Rapids, NC	03/30/2011	The Board is concerned that MD's care of a patient who presented with signs and symptoms consistent of compartment syndrome was below accepted and prevailing standards.	Public letter of concern
OKONKWO, Ambrose Sunday, MD (009900633) Kinston, NC	04/07/2011	The Board is concerned that MD's care of several patients treated for chronic pain and/or sleep disorders was below accepted and prevailing standards.	Public letter of concern
SHEN, John, MD (000036429) Albermarle, NC	2/17/2011	Communication issues with hospital staff.	MD is issued a public letter of concern and shall pay a fine of $1,000.
SILVER, Danny, MD (009500723) Fort Smith, AR	03/21/2011	MD entered into a consent order with the Arkansas State Medical Board on August 8, 2010, related to charges that he had inappropriately prescribed an excessive amount of controlled substance medications.	Public letter of concern
TOMEU, Enrique Jose, MD (009801097) Kenansville, NC	02/02/2011	MD is an owner of a medical spa. A patient seen at the medical spa for laser hair removal developed an adverse reaction after treatment that was resolved after further treatment. The Board is concerned the patient was not seen and evaluated by a physician prior to medications being administered and the procedure being performed.	Public letter of concern

Name/license#/location	Date of action	Cause of action	Board action
UNGER, Henry Alan, MD (000020758) Cary, NC	04/19/2011	The Board is concerned that MD did not provide adequate follow-up care to a patient who presented with a retroperitoneal mass, resulting in a delay in diagnosis of the patient's testicular cancer.	Public letter of concern
WALDO, Aikya Fisher, MD (200001482) Laurinburg, NC	03/03/2011	MD's care of a patient with multiple anesthetic risk factors, including smoking, asthma and obesity, may have been below standard. Patient became cyanotic following a procedure during which MD administered general anesthesia. The patient went into respiratory and then cardiac arrest.	Public letter of concern
WEATHERS, Paul Michael, PA (000100876) Nebo, NC	03/08/2011	PA failed to recognize that a patient had symptoms consistent with coronary artery disease, despite the patient's complaints of chest pain and risk factors for CAD, such as being a smoker and having a family history of high cholesterol. The patient's health deteriorated and subsequently died from CAD.	Public letter of concern
MISCELLANEOUS ACTIONS			
REZAI, Reza, MD (200701238) Jamestown, NC	03/25/2011	History of substance abuse.	MD is issued an NC medical license via consent order; must maintain contract with NCPHP and comply with conditions.
CONSENT ORDERS AMENDED			
BASILI, Richard Louis, Jr, MD (009700464) Kinston, NC	2/22/2011	MD has not actively practiced medicine since June 2005.	Amended consent order. MD shall undertake a program of reentry.
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
BROOKS, Michael Lee, MD (000028845) Red Springs, NC	03/17/2011		Temporary physician license extended; expires 04/30/2012
EARLA, Janaki Ram Prasad, MD (200701202) Fayetteville, NC	02/23/2011		Dated physician license issued; expires 02/23/2012
ELLIS, Rickie Wade, MD (200101442) Greenville, NC	03/17/2011		Temporary physician license replaced with full license
GUARINO, Clinton Tom Andrew, MD (009900062) Hickory, NC	2/10/2011	MD has disciplinary history with the Board and has not actively practiced medicine since 2006.	Consent order and remediation agreement and temporary medical license. Conditions on license.
SHUMWAY, David Lucius, MD (000021310) Knoxville, TN	2/14/2011	MD was charged with DWI (dismissed) and convicted of reckless driving. Entered treatment facility for impairment. Contract with NCPHP.	MD is issued a temporary license with conditions.
COURT APPEALS/STAYS			
[NONE]			
DISMISSALS			
MISZKIEWICZ, Steven Craig, MD (009500411) Lake Wylie, SC	04/20/2011		Charges issued February 9, 2011, are dismissed without prejudice

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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

July 20-22, 2011 (Full Board)
August 18-19, 2011 (Hearings)
September 21-23, 2011 (Full Board)
October 20-21, 2011 (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.

Serve as an independent medical expert reviewer

The North Carolina Medical Board needs your help.

The Board evaluates a large number of quality of care issues each year as a result of complaints, malpractice payment reports, etc. The Board draws on the knowledge and experience of independent reviewers from all fields of medicine to help determine if the care provided is within accepted standards of care. Reviewers are asked to analyze patient medical records and report their opinions and conclusions to the Board for its consideration as part of the overall review process.

Physicians selected to review cases are provided a brief summary of the issues involved, relevant patient and prescribing records and prepared forms to guide the physician. All materials and information provided to reviewers are confidential. On rare occasions, a reviewer may be asked to offer testimony at a formal hearing of the Board. North Carolina law (NCGS §90 14 (f))specifically protects individuals who provide expert medical opinions to the Board in good faith, without fraud or malice, from liability in civil proceedings.

The Board asks that reports be completed in four weeks. Although the time required to complete a report varies, a typical review takes approximately one to three hours per patient. Compensation is provided at $150 per hour.

External reviewers should be ABMS or AOA Board certified, have no history of public discipline with the Board and have been engaged in active clinical practice in North Carolina for at least the past two years.

For more information, please call or email Scott G. Kirby, MD, NCMB Medical Director, at (919) 326-1109 ext. 247, or *scott.kirby@ncmedboard.org*.