North Carolina Medical Board
# FORUM
ISSUE NO. 1 | Second Quarter 2018

FROM THE PRESIDENT

## Getting at the root causes of physician burnout

Timothy E. Lietz, MD

Recently, the Charlotte emergency medicine group of which I am president agreed to be the first medical practice in the state to try out a new program offered by the NC Physicians Health Program (NCPHP). Over the next several months we will open the practice up to NCPHP's team, which will do a top-to-bottom analysis to assess how "burned out" our physicians are, and how "burnout inducing" our organization is. We'll receive a report and recommendations for improvement, and a check-in after one year to see how things have changed (hopefully, for the better). With emergency medicine perennially at or near the top of the list of specialties most affected by burnout, it was an easy decision to debut NCPHP's new service.

Discussions of physician resilience so often focus on self-care – taking vacations, getting regular rest and exercise, eating well, building healthy relationships. And while those things are critically important, they are not the only solution. To really make progress towards resilience, it's time to start addressing the root causes of burnout, as well as dealing with the symptoms.

Think of it this way: If you keep stepping on tacks, you wouldn't just pull them out and treat the wounds, you'd clean up the floor so you stop stepping on tacks. Identifying challenges and solutions at the practice and system levels is a similar preventive approach. When you consider that as much as 90 percent of burnout may be driven by factors outside of the physician's control, this approach makes even more sense. The most common drivers include staffing levels, long shifts/work hours, mounting administrative duties, electronic health records and a general sense of loss of autonomy over patient care (due to system- or practice-level policies).

Now, I happen to think that my practice is already doing a lot of things right when it comes to confronting systemic drivers of burnout. Over the years we have been thoughtful and deliberate in building a professional environment that frequently results in long, productive

Continued on pg 2

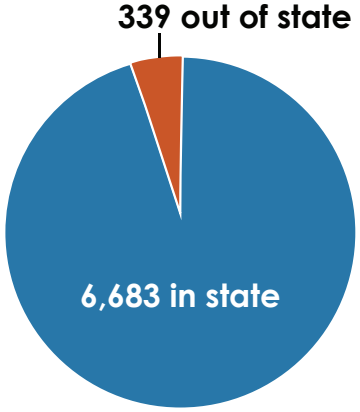
## IN THIS ISSUE



## SPOTLIGHT

**A new high for PAs!**

The number of licensed physician assistants crossed a new milestone in March 2018. The Board now more than 7,000 PA licensees!



and healthy careers. For example, we have maintained local control over staffing and compensation decisions so our physicians have direct input into their workload, shift length and pay formula (e.g. how much is based on productivity and how much is based on a set hourly rate). But no organization is perfect. I'm looking forward to receiving an independent assessment of what we're doing well, and where there may be opportunities to improve. As president of the practice, I'm hopeful working with NCPHP will identify blind spots, lead to strategies that set us up for even greater success, and improve our relationships with the hospitals we staff.

Over time, I believe the practice's commitment to setting its clinicians up for success may even help us recruit and retain talent in one of the state's most competitive physician labor markets.

I am glad to say that NCMB also recognizes the need to look beyond self-care to make headway in physician resilience. The Board is in the process of planning, with the NC Medical Society (NCMS), NCPHP and other partners, a wellness summit that will bring together hospitals, health systems, and other large physician employers to discuss ways to reduce systemic drivers of burnout. This meeting will take place immediately before NCMS's LEAD Health Care Conference in Raleigh Oct. 18-19.

The Board can't fix the root causes of burnout, or compel organizations and employers that have a more direct role in those causes to improve their processes. What we can do is acknowledge the problem and be a catalyst for discussion and change. NCMB is committed to filling this role whenever possible.

Be well,

Timothy E. Lietz, MD
Board President

## Did you know…

**…NCMB offers free annual renewal to licensees who are currently serving active duty within any branch of the U.S. armed services?**

**To request the renewal fee waiver, a licensee must be in good standing with the Board and actively deployed during his or her annual renewal period. Contact the Board prior to renewing at *registration@ncmedboard.org* or 919-326-1100 to request a waiver.**

**NCMB is grateful to all licensees who serve our country.**

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### Forum Staff

**Publisher**
NC Medical Board

**Editor**
Jean Fisher Brinkley

**Designer**
Sylvia French-Hodges

### Contact Us

**Street Address:**
1203 Front Street
Raleigh, NC 27609

**Telephone:**
(800) 253-9653

**Fax:**
(919) 326-1130

**Website:**
www.ncmedboard.org

**Have something for the editor?**
forum@ncmedboard.org

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

# TRENDING AT NCMB

## Physician obligation to complete death certificates

The continuing issue of timely completion of death certificates was again before the Board in July, when a dispute between two licensees who both declined to certify a mutual patient's death reached NCMB's Disciplinary Committee. Committee members were dismayed to hear that the physicians' unwillingness to certify the death led to the deceased being held by the funeral home, making it impossible for the family to proceed with funeral rites. After voting to send a confidential letter urging the primary care physician to certify the death, the Board directed staff to clarify NCMB's position on physician responsibility to complete death certificates.

**Some history:** NCMB has repeatedly addressed the issue of certifying deaths in the *Forum* and has developed an online information sheet that states NCMB's belief that physicians should complete death certificates when asked. However, in instances where a physician may not have recently examined the decedent, some clinicians continue to decline to certify deaths.

**The crux of the problem:** Based on NCMB's experience with this issue, the most common reason for a clinician to refuse to certify a death is the clinician's belief that he or she simply has no idea what caused the patient's death. Believe it or not, it is OK to certify a death with your best educated guess. Such a "guess" should be based on a review of the decedent's available medical records and your knowledge of that patient's history.

**What did the Board decide?** The Board voted to develop a position statement that states NCMB's expectation that clinicians complete death certificates, to the best of their ability and in good faith, when asked – even in situations where the patient has not been seen recently. It is the Board's hope that elevating this expectation to the level of position statement will encourage more licensees to perform this final service for patients and families.

**What else can be done?** The Board also directed staff to explore the option of seeking an amendment to state law to explicitly state that a physician or other clinician authorized to certify deaths (such as a PA or a NP) is immune from prosecution for certifying a cause of death based on the best available evidence, provided the death certificate was completed in good faith.

## National praise for NCMB's work on opioids

NCMB recently won a national award recognizing its comprehensive efforts to address inappropriate opioid prescribing and improve the quality of pain management care in North Carolina. The "Best in Boards" award from Administrators in Medicine (AIM) recognizes a state medical board for an outstanding project or initiative that demonstrates the agency's commitment to finding creative and innovative ways to tackle challenges in medicine or medical regulation. NCMB received the award during AIM's annual meeting in Charlotte in late April.

Awards are given based on how well a project or initiative reflect the Board's support for its public protection mission, commitment to educating both the public and medical professionals, and ability to work with partners to solve the identified problem. Specifically, NCMB was recognized for its Safe Opioid Prescribing Initiative, which encompasses several components, including:

- A proactive investigative program that, using data from the NC Controlled Substances Reporting System and NC Medical Examiner's office, identifies potentially unsafe prescribers;
- Development and implementation of a CME requirement for controlled substances prescribers and a related statewide campaign that connected thousands of NC prescribers with free high-quality opioid prescribing CME; and
- Broad efforts to inform and engage with the public and licensed medical professionals on the topic of responsible opioid prescribing through live presentations, online resource pages, social media campaigns, development of FAQs, bill summaries, notices and other resources.

**Safe Opioid Prescribing Initiative Resources**

- **NCMB on Opioid Prescribing**
  ***www.ncmedboard.org/safeopioids***
- **Understanding the STOP Act**
  ***www.ncmedboard.org/STOP***
- **Prescribing CME requirement**
  ***www.ncmedboard.org/prescribingCME***

# NCMB's Parker tapped to serve in national role

Shawn P. Parker, JD, MPA

Congratulations to NCMB Public Member Shawn P. Parker, JD, who was recently elected to the Board of Directors for the Federation of State Medical Boards. Mr. Parker will complete a partial term on the FSMB Board.

FSMB is a national nonprofit organization representing all medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals.

Mr. Parker was appointed to NCMB in 2016. He practices law at Smith Anderson in Raleigh, where he is a member of the Health Care team, advising clients on health care policy, legislative advocacy, executive strategy, and regulatory guidance concerning business planning of organized medicine. Previously, Mr. Parker served as a managing partner for a public policy consulting firm working with clients in government agencies and the private sector. He has also worked for the NC General Assembly, most recently as a senior staff attorney.

# Accolades for two of NCMB's own

Two NCMB leaders, one former and one current, won national honors during FSMB's annual meeting in Charlotte in late April.

## Lifetime Achievement Award – Bryant Galusha, MD

Dr. Galusha, a Charlotte pediatrician who served 12 years on NCMB, was recognized with FSMB's highest honor. This award is presented on rare occasions to individuals who have demonstrated extraordinary and sustained service and commitment to the field of medical licensure and discipline.

Dr. Galusha, a former longtime Director of Medical Education for Charlotte Memorial Hospital, began his service in medical regulation on the North Carolina Medical Board, to which he was appointed in 1968. Dr. Galusha went on to serve as President of FSMB and, upon completing his term, took the top staff position with FSMB, serving as President and CEO from 1984 until 1989. Dr. Galusha laid the early groundwork that culminated in the United States Medical Licensing Examination. He led a major initiative to computerize FSMB's records and establish a database of disciplinary actions that medical boards could remotely query, which exists today as FSMB's Board Action Data Bank.

Congratulations to a true luminary in medical regulation!

Bryant Galusha, MD

R. David Henderson, JD

## FSMB Distinguished Service Award – R. David Henderson, JD

This award recognizes the highest level of service and commitment to FSMB, advancement of the profession of medical regulation, and the strengthening of public protection. Mr. Henderson, NCMB's current CEO, has strongly supported FSMB's mission for many years, making key contributions through his service on the Special Committee on Strategic Positioning, the Committee to Examine the Composite Action Index, the Advisory Council of Board Executives, and the Workgroup on Education About Medical Regulation. He also supported the United States Medical Licensing Examination (USMLE) program through his service as a chair and member of the USMLE Committee on Individualized Review.

Mr. Henderson also has made many contributions to the medical regulatory community as a member of Administrators in Medicine, providing vital leadership to the organization as its Treasurer since 2014. Congratulations!

# Pathbreaking opioid investigative program marks second anniversary

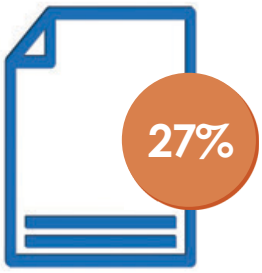
In April 2016, NCMB launched a first-of-its-kind investigative program to increase the Board's oversight of opioid prescribing. Using data from the NC Controlled Substances Reporting System and the state Medical Examiner's office, the program identifies potentially unsafe prescribing for investigation by the Board. Here are some of the lessons learned so far, with two full years of investigations in the books.

1. **SOPI investigative criteria are effective at identifying prescribing of concern** – In 39 percent of all SOPI cases to date, NCMB's investigation found evidence of substandard prescribing sufficient to warrant either public or private action. Public action was the least common outcome, with about 8.5 percent of cases resulting in public action or issuance of a notice of charges & allegations (which sets a disciplinary hearing in motion).
2. **Meeting SOPI criteria for investigation is NOT evidence of substandard practice** – As of May 2018, 61 percent of all cases opened through SOPI were closed with no action against the physician or PA, because the Board did not find evidence that care/prescribing was below accepted clinical standards. Investigative criteria are useful in focusing the Board's oversight of opioid prescribing – it is the results of the investigation that determine whether care is substandard.
3. **SOPI and NCMB's typical complaint-driven system achieve comparable results** – Based on years of history, complaints received from patients and the public typically break down this way: 10 percent result in public action; 25 percent receive private action and 65 percent are closed with no formal action. Results to date suggest that SOPI is slightly more likely to identify cases that involve substandard care than the traditional complaint-driven system, but only by a slim margin. NCMB sees both investigative methods as useful ways of monitoring licensee conduct.
4. **NCMB is still learning, and SOPI continues to evolve** – The Board broke new ground when it implemented SOPI, and did not know what to expect when it established initial investigative criteria. NCMB always anticipated that the program might have to be adjusted to ensure best results. For example, after reviewing SOPI results at the one-year mark, the Board added additional "filters" to ensure that cases opened based on multiple opioid overdose deaths only proceeded with investigation if prescribers authorized 30 or more tablets of an opioid to the patient within 60 days of the death. NCMB is currently proceeding with plans to add additional SOPI investigative criteria that track certain patient and prescriber behaviors to identify potentially unsafe prescribing practices (See article, "New SOPI investigative criteria proposed" on page 10). NCMB will continue to refine its criteria to ensure that the investigative reports it receives are as specific and sensitive as possible.
5. **SOPI is an extremely targeted program** – As of May 2018, 109 cases had been opened through SOPI, directly touching approximately 0.2 percent of licensed physicians and PAs. Prescribers are urged to remember that clinical decisions about treatment should be based on the patient's medical needs and current standards of care, not concern that authorizing a prescription that exceeds the level specified in NCMB's investigative criteria will automatically trigger an investigation. The Board's expectation has always been, and remains, that clinicians provide care that is prudent and appropriate, regardless of the specific medication or dose prescribed.

## SOPI investigations so far: A breakdown of cases to date

### Cases opened

NCMB has opened **109** cases based on SOPI criteria affecting **0.2%** of active licensees.




Percent of cases opened based on prescribing criteria


Percent of cases opened based on 2+ patient deaths due to opioid poisoning

# Do you understand the STOP Act's prescribing limits?

North Carolina's first-ever limits on opioid prescribing took effect Jan. 1, 2018, as part of the state's new opioids law, the STOP Act of 2017. The limits apply only to certain prescriptions for postoperative and other types of acute pain, which the law defines as pain that the prescriber expects to last no more than three months.

**Test your knowledge**

**Take a short quiz at:**
***www.ncmedboard.org/limits***

The STOP Act's prescribing limits are designed to ensure that patients with acute pain do not receive excessive supplies of opioid pain medication. The law attempts to balance the need for patients to receive adequate pain relief against the desire to prevent situations in which patients are left with large supplies of unused, unneeded pills available for misuse, abuse or diversion.

To help licensees understand and comply with the prescribing limits, the Board has updated and expanded its FAQs on this topic. Brush up on the new limits by reading a sampling of our prescribing limit FAQs below, then take our short online quiz to test your knowledge.

**Q: Does the STOP Act limit prescriptions for chronic pain?**
A: No. The Act limits certain prescriptions for acute pain (this includes post-operative pain). Prescriptions for chronic pain are not affected.

**Q: How does the STOP Act define "acute pain"?**
A: Pain from disease, accident, intentional trauma, or other cause that is expected to last for three months or less. However, NCMB does not consider acute pain stemming from an established chronic condition to be "acute pain" as contemplated by the STOP Act. For example, the Board does not consider a patient with rheumatoid arthritis who experiences an acute flare of the disease to be subject to the Act's 5-day prescribing limit.

**Q: How does the STOP Act limit opioid prescriptions for post-operative pain?**
A: Pain medication administered in a health care facility (e.g. hospital or surgery center) is not subject to the STOP Act's prescribing limits. Upon discharge, initial prescriptions for Schedule II and Schedule III opioids are limited to no more than a 7-day supply for all types of procedures.

**Q: How does the STOP Act limit opioid prescriptions for non-surgical acute pain?**
A: The Act limits prescriptions for Schedule II and Schedule III opioids to no more than a 5-day supply when the prescription is issued after an initial consultation for acute pain.

**Q: What medications are subject to the 5- and 7-day limits imposed by the STOP Act?:**
A: The limits apply ONLY to Schedule II and Schedule III opioids listed in N.C. Gen. Stat. § 90-90(1), (2) and 90-91(d), only when prescribed for acute pain as described above, and in the Act. Find a complete list of affected drugs at *www.ncmedboard.org/STOP*.


**Q: Is it the initial prescription for opioids written for acute pain that is limited or is it any opioid prescription written after the initial consultation?**
A: The STOP Act states that a prescriber may not prescribe more than a 5- or 7-day supply of opioids following "initial consultation and treatment" of a patient for acute pain. Therefore, the limits apply when a Schedule II or Schedule III opioid is written after an "initial consultation" for acute pain.

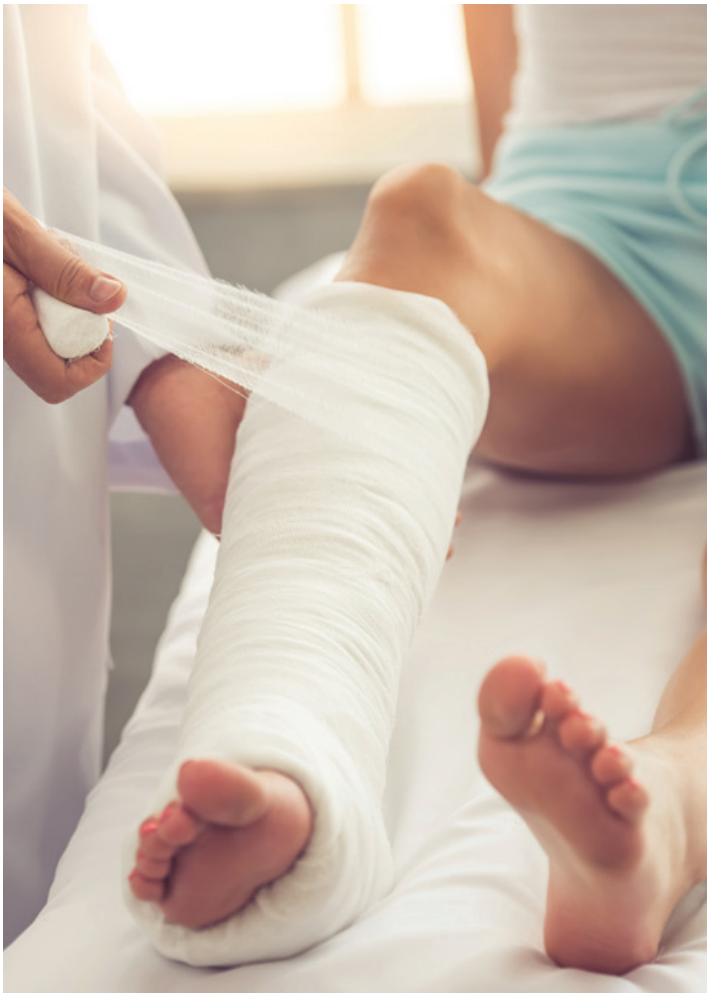
**Example:** A patient presents with severe shoulder pain resulting from a sports injury. After the initial consultation, the clinician recommends ibuprofen, ice and rest. The patient comes back the following week with continued complaints of severe shoulder pain. The clinician recommends treatment with opioids. Because the opioid prescription is issued after a "subsequent consultation for the same pain" the prescriber may lawfully issue a prescription for any amount, consistent with current accepted standards of care. Note: If the clinician in the shoulder pain scenario prescribed opioids

after seeing the patient for the first time (e.g. following the initial consultation) then the STOP Act limits would apply and the prescription would be limited to no more than a 5-day supply.

Regardless of whether the STOP Act limits on acute pain prescriptions apply, prescribers are urged to avoid authorizing excessive amounts of opioids for acute pain.

**Q: Is it acceptable to prescribe less than a 5- or 7-day supply of opioids for acute pain?**
A: Yes, as long as the decision to prescribe less than a 5- or 7-day supply is consistent with good medical practice. The CDC Guideline for Prescribing Opioids for Chronic Pain, for example, recommends prescribing opioids no more than three days for acute pain and five days for post-surgical pain. The Board recognizes that such guidelines may not meet the needs of all patients.

**Q: What if the patient is still experiencing severe pain after finishing a 5- or 7-day prescription?**
A: The STOP Act states that "upon any subsequent consultation for the same pain" the prescriber may issue "any appropriate renewal, refill or new prescription" for opioids. That is, if the patient is still experiencing pain from the same surgery/accident/injury/illness after finishing an initial 5- or 7-day prescription, the prescriber may provide a refill for any appropriate amount.



**Q: Do I need to physically see the patient back in the office in order to renew/refill the prescription or to issue a new prescription for a different amount and/or different drug?**
A: Not necessarily. "Follow up consultation" may not require an in-person visit for the same issue before a refill/renewed prescription or before a new prescription may be authorized, depending on the specific circumstances. In some instances (e.g. when symptoms of infection are reported by the patient, or when a patient reports worsening pain or other symptoms that are not indicative of healthy recovery), the prescriber may need to see the patient in person. Prescribers should determine these situations in a manner consistent with current accepted standards of care and good medical practice.

In situations where an in-person consultation is not indicated, a patient might submit a request for a prescription for the same pain via phone or online portal. The patient or patient representative would still need to come to the office to pick up Schedule II prescriptions unless the practice has the capability to e-prescribe controlled substances.

Find an extended set of prescribing limit FAQs and more STOP Act information at *www.ncmedboard.org/STOP*.

## When do the limits apply?

**Both of the following must be true for the STOP Act prescribing limits to apply:**

**1. The prescription is for a Schedule II or Schedule III opioid or narcotic; AND**

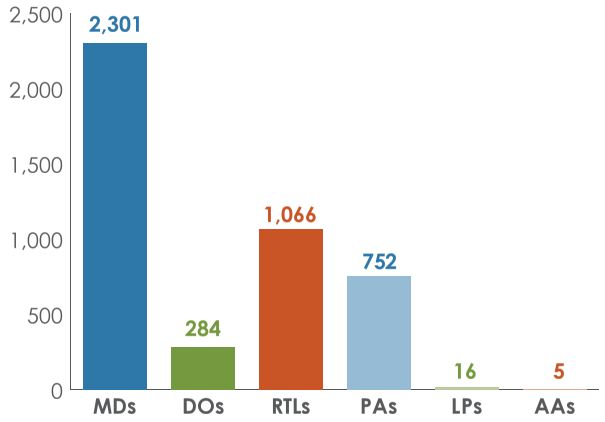
**2. The prescription is written after an initial consultation for acute pain. If writing for post-operative pain, the limit applies to the initial prescription written at discharge.**

# **Year in Review:** A look back at data from 2017

Data reflect information for the calendar year beginning Jan. 1, 2017 and ending Dec. 31, 2017

**ABBREVIATIONS:** MD: Allopathic Physician, DO: Osteopathic Physician, RTL: Resident Training License, PA: Physician Assistants, CPP: Clinical Pharmacist Practitioner, LP: Licensed Perfusionist, AA: Anesthesiology Assistant

## TOTAL LICENSES ISSUED IN 2017



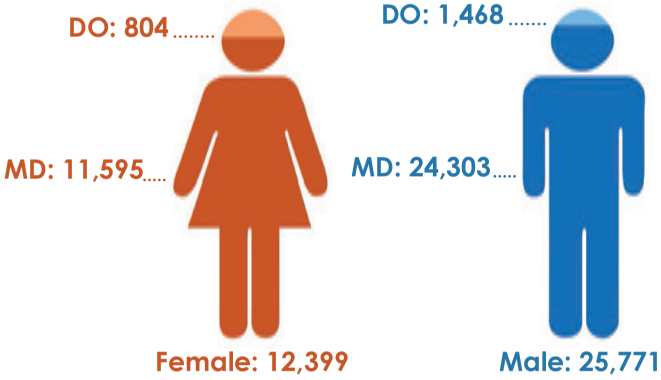

## TOTAL LICENSEE POPULATION

**48,238**

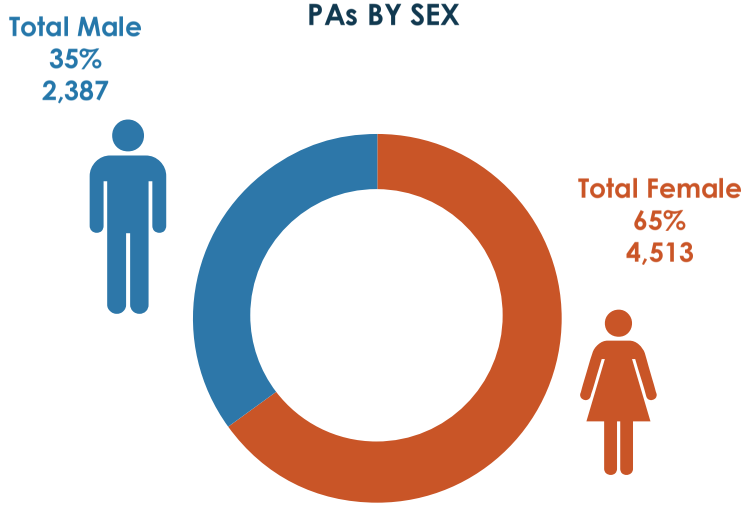
**75.5% IN STATE**

MD: 35,898 | PA: 6,900 | RTL: 2,972
DO: 2,272 | LP: 155 | AA: 41

## PHYSICIANS BY SEX




## PAs BY SEX




## TOP CASES OPENED BY PRIMARY ALLEGATION

- Quality of care: 615
- Communication issues: 423
- Out of state action: 362
- Prescribing issues: 180
- Medical records/ alleged HIPAA violation: 118

## ENFORCEMENT ACTIVITY IN 2017

**2,372** cases opened

**2,391** cases closed

**95** average # days to close a case

## ENFORCEMENT ACTIVITIES BY TYPE

**320** private letters

**156** public actions, adverse

**25** public actions, non-adverse

## TOP CAUSES OF PUBLIC ACTION in 2017

**59** Quality of care

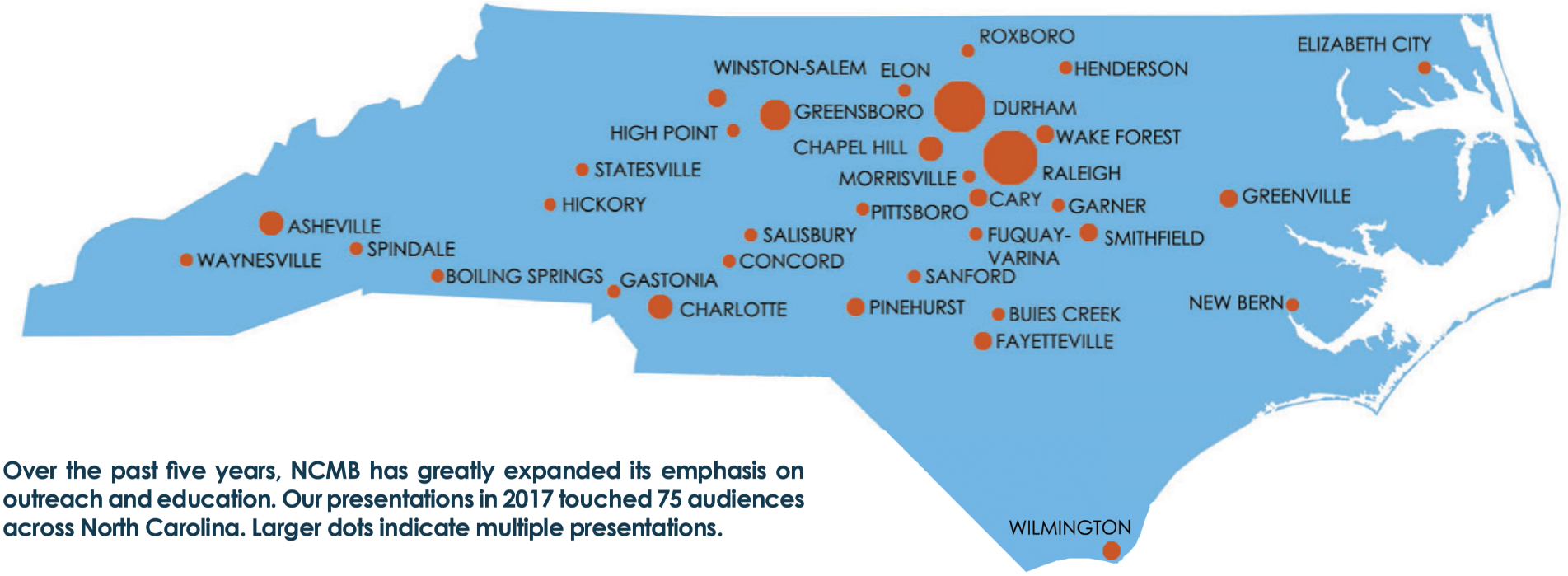
**56** Issues with prescribing

**34** Alcohol/ substance use

**25** Action by out of state medical authority

**13** Sexual misconduct/ boundary

## THE REACH OF NCMB'S OUTREACH




**Over the past five years, NCMB has greatly expanded its emphasis on outreach and education. Our presentations in 2017 touched 75 audiences across North Carolina. Larger dots indicate multiple presentations.**

### PROFESSIONAL OUTREACH

NCMB presented to 50 professional audiences - nearly one per week - during 2017.

The Board's professional outreach program aims to get accurate information about NCMB's policies and expectations for conduct to licensed medical professionals and stakeholders in medicine.

Audiences include medical schools, PA programs, residency programs, private medical practices, hospitals and health systems, and other professional meetings and conferences. Request a speaker for your practice or meeting by emailing *jean.brinkley@ncmedboard.org*.

### PUBLIC OUTREACH

NCMB presented to 17 public audiences in 2017.

In recent years, NCMB has expanded its outreach and education efforts to include more public audiences. This program seeks to raise public awareness of the Board's mission and responsibilities, as well as resources and services available to the public.

Public audiences include civic and community groups, including senior centers, patient support groups, clubs, business networking groups and local government meetings, which provide NCMB the opportunity to engage with staff who interact with patients and members of the public.

### OPIOID PRESCRIBING CME

NCMB co-sponsored eight opioid prescribing CME panel sessions in 2017.

In 2017, NCMB launched a collaborative initiative with Wake AHEC to provide opioid prescribing CME to controlled substances prescribers. This project resulted in a statewide training series, providing two hours of CME credit per session.

In combination with a one-hour opioid prescribing webinar also produced through this project, attending a panel session provided sufficient training hours to satisfy NCMB's CME requirement for controlled substances prescribers.

# New SOPI investigative criteria proposed

NCMB is seeking approval for rule changes to establish a third set of investigative criteria for the Safe Opioid Prescribing Initiative, which screens opioid prescribing data from the NC Controlled Substances Reporting System to identify potentially unsafe prescribing practices. The new criteria would look at a variety of patient and prescriber characteristics and behaviors commonly associated with inappropriate opioid prescribing to identify additional licensees for investigation. The Board will accept written feedback through end of business hours on Aug. 17 at *rules@ncmedboard.org*. NCMB will hold a public hearing at its offices in Raleigh at 10 a.m. on Aug. 17 to receive feedback on the proposed investigative criteria.

Under the proposed rule change, licensees would be investigated if they meet three or more of the following criteria, when there are at least five patients for each criterion:

(1) At least 25 percent of the prescriber's patients receiving opioids reside at least 100 miles from the prescriber's practice location;

(2) The prescriber had more than 25 percent of patients receiving the same opioids and benzodiazepine combination;

(3) The prescriber had 75 percent of patients receiving opioids self-pay for the prescriptions;

(4) The prescriber had 90 percent or more of patients in a three-month period that received an opioid prescription that overlapped with another opioid prescription for at least one week;

(5) More than 50 percent of the prescriber's patients received opioid doses of 100 MME or greater per day excluding office-based treatment medications; and

(6) The prescriber had at least 25 percent of patients who used three or more pharmacies within a three-month period to obtain opioids, regardless of the prescriber.

## GETTING TO KNOW THE PEOPLE OF THE NC MEDICAL BOARD

# Five Questions: JERRI L. PATTERSON, NP

APPOINTED 2016 | PAIN MANAGEMENT | NP BOARD MEMBER | WEST END, NC

**Q: What do you find most rewarding about practicing medicine?**
**A:** I love my job of working with pain patients. Every day I am humbled to see how wonderful, courageous and resilient people are. By the time a pain patient gets to me, they are often angry, distrustful and sometimes feeling hopeless. Together, we formulate a plan and work to get them back to the best possible place. It is rewarding to see them hope again and watch them progress in their goals.

**Q: What do you do to recharge/prevent burnout?**
**A:** After what may have been a horribly draining day, I try not to focus on the negative. Instead I think over the day and focus on at least one positive outcome that I achieved. Sometimes this requires some digging but I don't give up until I find one, no matter how small. To prevent burnout, I try to make sure that I take time for me, and am now able to do with without feeling selfish. I enjoy sitting down with a good book, listening to music, splurging on a massage or facial or planning an outing with friends.

**Q: What do you like to do in your leisure time?**
**A:** When the weather is good, I am an avid glamper. No tents for me! I have all the conveniences of home. Picture this- a lounge chair, a fan, a good book, SPF30 sunscreen and a margarita! If I can't do that, then I enjoy gardening, reading and shopping online.

**Q: Who inspires you?**
**A:** I would have to change this question to who *inspired* me. The answer is my two daughters, who are both deceased - one from breast cancer and the other from an asthma attack after suffering with the disease since infancy. During their illnesses they both exhibited a continued zest for life, courage and a determination to live their lives to the fullest, without any regrets. I was humbled and proud to be their mother and they are wonderful examples for their children.

**Q: What has surprised you about serving on the Board?**
A: I have been astonished by the expertise, commitment and dedication of every staff member. Because of this, Board Members are able to navigate their way through license applications, policy and position statements and disciplinary hearings with an expediency that I would never had imagined possible.

# North Carolina Medical Board

## Quarterly Board Actions Report | November 2017 - January 2018

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** | | | |
| **CAMPBELL**, James Stewart, MD (000020380) Clemmons, NC | 12/04/2017 | MD prescribed controlled substances excessively and failed to document the rationale of prescriptions and/or substantial increases in opiate prescriptions. MD wrote overlapping prescriptions and failed to practice appropriate pharmacovigilance to ensure patients were taking medications as directed. These cumulative practices may have contributed to the deaths of three patients. | Revocation of NC medical license |
| **DAVIS**, Dantre, PA-C (001006112) Greensboro, NC | 01/23/2018 | Board action based on felony conviction of PA in United States of America v. Dantre Davis, 1:17-CR-00136-1, for receipt of child pornography. Board served PA with a Notice of Revocation in November 2017 and having received no request for a hearing, the Board has revoked the PA's license. | Revocation of NC medical license |
| **OKIE**, Frederick T, MD (201200464) Woodstock, MD | 11/08/2017 | Action based on March 2016 action by the Board of Healing Arts for the State of Kansas, which revoked MD's license to practice medicine in Kansas due to substandard care of a pregnant patient. Specifically, MD; a) delayed involving other specialists to assist in patient's care; b) MD failed to acknowledge patient's proteinuria and high blood pressure; c) MD placed patient at an increased risk for placental abruption, seizures, renal damage, and stroke; and d) MD delayed patient's transfer to a facility that could care for her and her premature infant. | Revocation of NC medical license |
| **SMITH**, Michael Alson, MD (000033467) Charlotte, NC | 12/15/2017 | MD engaged in forced or coerced sexual acts, sexual contact, and/or vaginal intercourse with patients in an examination room at his practice. | Revocation of NC medical license |
| **SUSPENSIONS** | | | |
| **BLOCK**, Matthew, MD (200100308) Laurinburg, NC | 11/01/2017 | MD has a history of alcohol and drug abuse as well as prescribing controlled substances to himself, employees, and relatives, which is prohibited by Rule 21 NCAC 32B .1001. MD has history of inadequate record keeping. | Suspension of NC medical license for 24 months, immediately stayed. MD is prohibited from prescribing Schedule I, II/IIN, III/IIIN, and IV controlled substances. MD is to keep all medical records up to date. MD is to maintain his current contract with NCPHP and abide by its terms. |
| **DEHGAN**, Robert Bahman, MD (009600425) Ponte Vedra Beach, FL | 01/23/2018 | Action taken by another state medical board; In a Final Order dated November 22, 2016, the Florida Board suspended MD's license for a period of three years followed by five years of probation. Additionally, MD received a reprimand, was assessed a $30,000.00 administrative fine, and was permanently restricted from treating any female patients. The Florida Board found that MD committed sexual misconduct with three patients. | Indefinite suspension of NC medical license. |

| Name/license #/location | Date of action | Cause of action | Board action |
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| **HOWER**, David Kemp, MD (201401610) Burlington, NC | 01/03/2018 | In August 2016, the Orange County Child Protective Services substantiated allegations that MD engaged in improper discipline of his fourteen-month-old child which resulted in significant injuries to the child. MD suffers from Major Depressive Disorder and Mild Alcohol Use Disorder. MD was presented to the NCPHP, which recommended a two-year monitoring contract which the MD has signed. | Suspension of NC medical license for 24 months, immediately stayed except for a period of 60 days. MD shall maintain a contract with NCPHP and abide by its terms. |
| **KHAN,** Farouk Yusaf, MD (200000488) Dothan, AL | 11/27/2017 | Action based on the action of another state medical board related to MD's prescribing practices; On April 14, 2017, the Alabama Board resolved this matter with MD through a Joint Stipulation and Consent Order that revoked his pain management registrations and his authority to order, manufacture, distribute, possess, dispense, administer, or prescribe Schedules II, III, IV, and V controlled substances under his Alabama Controlled Substances Certificate (ACSC) number. The AL Board agreed to suspend the revocation of MD's ACSC and placed him on probation for a minimum of 18 months, subject to conditions. | Indefinite suspension of NC medical license; Immediately stayed on the condition that MD complies with his April 2017 Joint Stipulation and Consent Order with the Alabama Board of Medical Examiners. Additionally, MD's April 2017 Interim Non-Practice Agreement with the NC Board is hereby immediately dissolved. |
| **LOWE**, James Richard, MD (200901841) Marion, NC | 01/24/2018 | In April 2011, MD was referred to the North Carolina Physicians Health Program by the Board after he was charged with Driving While Impaired. In June 2014, MD was again referred to NCPHP by the Board after he was charged with a second DWI. MD agreed to enter into a five-year monitoring contract with NCPHP which requires MD to abstain from consuming alcohol. MD consumed alcohol in violation of his monitoring contract in April 2017 and again in August 2017. | Indefinite suspension of NC medical license |
| **RAMPONA**, Douglas Mercer, MD (000018823) Virginia Beach, VA | 01/08/2018 | Board action based on June 2017 action taken by the Virginia Board of Medicine, in which the Virginia Board accepted MD's voluntary and permanent surrender of his license to practice medicine and surgery in the Commonwealth of Virginia. The Virginia Board had concerns regarding MD's substance use and his filing of fraudulent prescriptions. | Indefinite suspension of NC medical license (In February 2017, MD placed his license in retirement status, limiting him to only voluntarily practicing medicine in indigent clinics.) |
| **TAYLOR**, Latimer Anthony, MD (009801527) Charlotte, NC | 12/06/2017 | MD has a history of professional sexual misconduct. In May 2017, the Board received information that MD had been engaged in a personal relationship with a patient starting in 2015 that became intimate between August 2016 and March 2017, while a physician-patient relationship existed between them. | Indefinite suspension of NC medical license |
| **PROBATION/CONDITIONS** | | | |
| **MCGRATH**, Timothy John, MD (200200571) Mebane, NC | 12/06/2017 | MD has a history of substance use disorder and of relapses in his recovery. After his most recent relapse in May 2017, in which MD voluntarily surrendered his medical license, the Board decided to indefinitely suspend MD's license in August 2017. MD entered into substance abuse treatment, progressed in his recovery and the NCPHP advocates for his return to practice. | MD's license is reinstated; Prior to resuming practice, MD must notify the Board and obtain practice site approval from the Board's Office of Medical Director. MD to maintain his current contract with NCPHP and abide by its terms. |
| **SAPPINGTON**, John Shannon, MD (009400628) Casper, WY | 01/03/2018 | MD has a substance use disorder and has struggled with relapses in the past. He has been without his NC medical license since he surrendered it in August 2002. MD reports being clean and sober since 2012 and has submitted a reinstatement application to the Board. The NCPHP advocates for his safety to practice. | MD's license reinstated; MD to maintain his current contract with NCPHP and abide by its terms. |

| Name/license #/location | Date of action | Cause of action | Board action |
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| **REPRIMANDS** | | | |
| **AFLATOONI**, Saeed, MD (200501671) Greensboro, NC | 12/08/2017 | MD, a psychiatrist, treated a patient while also engaging in a social and business relationship with the patient. This is contrary with the ethics of the medical profession. | Reprimand |
| **DIMKPA**, Okechukwu, MD (200501338) Concord, NC | 01/26/2018 | Quality of care, substandard prescribing of controlled substances. MD failed to conduct a detailed history or verify an inherited patient's chronic back pain. MD did not have a basis to continue prescribing high doses of narcotic pain medications. Additionally, MD's medical records for patient's treatment were inadequate. | Reprimand; MD to complete CME in prescribing and medical record keeping within six months of the date of Consent Order. |
| **DENIALS OF LICENSE/APPROVAL** | | | |
| **CARLSON**, James Lennart, MD (200200010) Cerro Gordo, NC | 12/07/2017 | Board denied MD's application for reinstatement of his NC medical license based on MD's previous history of misconduct, alcohol and substance use. Additionally, MD has not actively practiced medicine for the eight-year period immediately preceding the filing of the reinstatement application. | Denial of application to reinstate NC medical license |
| **SHANTON**, Gregory Damon, PA (000101943) Newport, NC | 01/26/2018 | In September 2017, the Board received PA's request for a formal hearing on the Board's denial of his Physician Assistant Reinstatement Application from August 2017. After review of the PA's history of substance use and diversion, and the fact that PA had not actively practiced as a physician assistant for the two-year period immediately preceding the filing of the reinstatement application, the Board has decided to deny reinstatement of his license. | Application for reinstatement of NC PA license denied |
| **SURRENDERS** | | | |
| **BARNETT**, Kari Chappell, AA (100000265) Fayetteville, NC | 01/26/2018 | | Voluntary surrender of NC Anesthesiologist Assistant license |
| **CHRISTENBURY**, Jonathan David, MD (000026210) Charlotte, NC | 11/29/2017 | | Voluntary surrender of NC medical license |
| **SCOTT**, Gregory Earl, MD (009400142) Salisbury, NC | 01/05/2018 | | Voluntary surrender of NC medical license |
| **WILEY**, Jerry William, MD (000021616) Raleigh, NC | 11/14/2017 | | Voluntary surrender of NC medical license |
| **PUBLIC LETTERS OF CONCERN** | | | |
| **LOPEZ NEGRETE**, Hugo Manuel, MD (201702486) Flint, MI | 11/21/2017 | Quality of care; Board is concerned about a February 2012 incident that occurred during a frontoparietal craniotomy and craniectomy MD performed. | Public Letter of Concern; MD is issued a license to practice medicine in NC. |
| **PATEL**, Shil Kiritkumar, MD (201500970) New Bern, NC | 11/16/2017 | Board is concerned that during a surgery MD preformed, a small nasal macular intraretinal hemorrhage occurred for which intra-ocular diathermy was applied. The Board's reviewing expert noted that MD's decision to utilize intra-ocular diathermy deviates from the standard of care and expressed concern regarding the absence of documentation outlining the associated risk of bleeding, stating that, "the standard of care would require a clear discussion of risks, benefits, and alternatives to surgery to include a specific mention of bleeding risk associated with anti-coagulant therapy."<br><br>Board is also concerned that during the patient's postoperative course, the patient inadvertently received a copy of another patient's medical records. This constitutes a HIPAA violation. | Public Letter of Concern; MD required to complete six hours of Category 1 CME for intraoperative surgical risks of patients on anticoagulant intraocular surgery and a review of the indications and cautions in the use of diathermy for the management of intraocular hemorrhage and four hours of Category 1 CME for medical record documentation. MD to get advanced approval for the courses by Board's Office of the Medical Director and shall complete the CME within six months from the effective date of the public letter of concern. |

| Name/license #/location | Date of action | Cause of action | Board action |
|---|---|---|---|
| **SCHNYDER**, Drew David, MD (201200350) Black Mountain, NC | 11/21/2017 | In April 2017, MD experienced a health crisis that affected his behavior and impacted his ability to practice medicine. MDs behavior led to him being evaluated and hospitalized where he was diagnosed with a medical condition that, if left untreated, would render him unsafe to practice medicine. MD has voluntarily undergone treatment for his medical condition and is presently being monitored by the NCPHP who advocates for MD as safe to practice medicine. | MD is issued a Public letter of concern via a Non-Disciplinary Consent Order. MD shall adhere to all numbered conditions listed in order including: MD to maintain monitoring contract with the NCPHP; continue with outpatient treatment and medications; sign waivers and releases so that his healthcare providers can provide reports to the NCPHP and the Board; designate his practice manager to monitor his work hours. MD to work no more than 30 hours per week; MD shall designate his advanced practice providers, nurses, and other clinical staff to monitor his interactions with patients and file quarterly reports with the NCPHP. MD shall authorize the clinical staff and office staff to make immediate reports to the Board and the NCPHP regarding any aberrant behavior by him. |
| **SMITH**, Kathleen Jeanne, MD (200400601) Decatur, GA | 01/22/2018 | The Board is concerned that MD was convicted for felony Breach of Trust with Fraudulent Intent in South Carolina in May 2016 for fraudulently obtaining goods and/or money in excess of ten-thousand dollars ($10,000) from Germain Dermatology for her own use. | Public Letter of Concern |
| **YAGGER**, Scott David, DO (200800677) Lakeland, FL | 01/25/2018 | Action taken by another state medical board; The NC Board is concerned that DO continues to fail to comply with administrative actions by the Florida Board of Osteopathic Medicine stemming from a 2013 Consent Agreement. DO was fined and placed on probation by the Florida DO Board for defaulting on his medical school student loan. In March 2017, DO received a Reprimand, a $3,000 fine and a suspension of his Florida license for failing to pay the fine as stipulated in the 2013 Florida Consent Agreement. | Public Letter of Concern |
| **YING**, Kan, MD (200900156) Honolulu, HI | 12/15/2017 | Action taken by another state medical board; NCMB is concerned that in July 2017, MD entered into a Final Decision and Order for Remedial Education with the Wisconsin medical board based on concerns about the quality of care MD provided to a patient. In February 2014, a patient presented to the emergency department with sudden onset of dizziness and headache. MD ordered a brain CT and his preliminarily interpretation of the CT found no intracranial abnormality or bleeding and the patient was discharged. Another radiologist subsequently interpreted patient's CT as depicting decreased attenuation in the left cerebellar hemisphere and recommended a follow up CT. Based on this treatment, the MD was ordered by the Wisconsin Board to complete six hours of education on the topic of CT interpretation and/or abdominal imaging in the emergency room setting. | Public Letter of Concern |
| **MISCELLANEOUS ACTIONS** | | | |
| NONE | | | |

| Name/license #/location | Date of action | Cause of action | Board action |
|---|---|---|---|
| **CONSENT ORDERS AMENDED** | | | |
| **WARONSKY**, Roy George, PA-C (000102512) Charlotte, NC | 12/05/2017 | In June 2017, the Board and PA entered into a Consent Order wherein PA agreed not to prescribe controlled substances. In October 2017, PA and the Board entered into an Amended Consent Order allowing PA to prescribe Schedule IV and V controlled substances. Upon PA successfully completing certification training to obtain a DATA waiver to prescribe Suboxone® (buprenorphine and naloxone), a Schedule III controlled substance, the Board is allowing PA's request to prescribe Suboxone® for the purpose of treating opioid addiction. | Amended Consent Order; PA may prescribe Suboxone® for the purpose of treating opioid addiction. PA to provide the Board patient charts as requested for review of his care. All other terms and conditions of the June 2017 Consent Order and October 2017 Amended Consent Order remain in effect. |
| **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
1203 Front Street
Raleigh, NC 27609

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# Changes to the *Forum*'s print edition publication schedule

In order to provide more timely updates to the Board's licensees, we are adopting a new publication schedule for the email and print editions of the *Forum*.

Beginning in September, NCMB will move to a bimonthly publication schedule for the email edition of the newsletter. Changes to the *Forum* were motivated in part on NCMB's increased emphasis on education and outreach and desire to share information more frequently with physicians and PAs. Also, nearly 80 percent of licensees who completed a recent Forum survey indicated interest in receiving more frequent updates from the Board.

NCMB will continue to produce a print edition of the *Forum* for the relatively small percentage of licensees who request it, but will reduce the number of issues to two per year. The next print issue will be published in late fall 2018.

Print readers who want to also receive bimonthly email editions of the Forum may sign up at *www.ncmedboard.org/Forum*. Readers who sign up via this link will receive both print and email edition of the newsletter.


## BOARD MEETING DATES

July 18-19, 2018 (Full Board)
Sept. 19-21, 2018 (Full Board)
Oct. 18-19, 2018 (Hearing)
Nov. 14-16, 2018 (Full Board)
Dec. 13-14, 2018 (Hearing)

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

***www.ncmedboard.org***