FORUM
NORTH CAROLINA MEDICAL BOARD
FOR THE BENEFIT AND PROTECTION OF THE PEOPLE OF NORTH CAROLINA
SPRING 2013

Year in Review — Pg. 10

Teamwork: In medicine, more than ever, patient safety demands it

NCMB President Dr. William A. Walker, says "By engaging everyone on the team, we support each other and make errors much less likely."

In 2009, The Joint Commission (TJC) called attention to the "disruptive physician" and required hospitals to develop a process for identifying and dealing with doctors who seemed to have problems working with others. As usual, TJC did not dictate how hospitals should do this. Rather, TJC simply required hospitals to create procedures to deal with the problem. As a result, licensees and others contacted the NCMB to ask it to issue a formal position on "disruptive physicians." In response, the Board published the position entitled, "Collaborative care within the health care team" on January 1, 2010. The position statement outlines the Board's expectation for licensee conduct (among physicians and others such as PAs) in the context of working with others to provide patient care. We purposefully avoided the term "disruptive physician" in the title, choosing to emphasize the most important part of our professional lives—care of the patient—by everyone involved. We did define disruptive behavior, noted that the behavior may result from other underlying causes, and indicated that such behavior may be grounds for discipline.

Almost always, it is physicians who are singled out as "disruptive" and it's not terribly difficult to understand why. In medicine, physicians have traditionally been at the top of the power structure and, consequently, have the greatest potential to impact those around them, including patients and other members of the health care team. This phenomenon is commonly referred to as "power distance." Defined simply, power distance occurs when individuals in positions of less power are reluctant to challenge those with greater authority. In some environments, such as the battlefield, there are very good reasons for strict adherence to the established power structure. But in other environments, power distance may actually result in harm.

The aviation industry is rife with examples that tragically demonstrate this. If the captain intimidates crew members or the culture of the airline allows the captain an absolute authority, crew members may not speak up appropriately. Examples of this include the 1977 KLM crash in Tenerife, in which hundreds of people lost their lives essentially because the flight crew did not contest a poor decision made by the captain. Similarly, the crash of Korean Air Flight 801 in 1997 was attributed primarily to the rigidly hierarchical power structure in the cockpit, which prevented crew from speaking up until it was too late to avoid catastrophe.

Similarly hierarchical cultures exist in medicine, and the implications are clear. If a

IN THIS ISSUE

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physician or surgeon (the captain) intimidates or disrespects others who help care for the patient (the crew), bad or even fatal outcomes may occur. In an airplane crash, however, the captain and flight crew often perish with the passengers. In the context of health care, only the patient suffers the consequences.

Just as in the aviation industry, health care organizations such as TJC and the Accreditation Council for Graduate Medical Education have started to understand the effects of poor team performance. Still, not everyone agrees that personal behavior can impact care.

During a confidential interview at the NCMB that I helped conduct, an attorney for a physician argued that his client was an excellent physician and that his behavior had no effect on the quality of care he provided. I felt compelled to explain that physician behavior can have a very large impact on quality. If a nurse has been verbally abused by a physician, that nurse will be understandably reluctant to call the physician when concerns arise. Who would, knowing that the likely result would be a rude, belittling response? So in ambiguous circumstances, a nurse might wait until a patient's condition has worsened further before alerting the physician, potentially increasing the risk of complications. It was a simple but compelling example that I hope helped the attorney understand that medicine is more than just technical knowledge.

In 2003, the Institute for Safe Medication Practices surveyed 1,565 nurses and 354 pharmacists about their experiences with physicians. Eighty-eight percent of respondents reported that a physician had spoken to them with condescending language or tone; 87 percent reported that physicians had been impatient with questions; and 79 percent said physicians had demonstrated reluctance to, or had refused to, answer questions or phone calls. In other words, a significant majority of nurses and pharmacists had experienced this treatment. Nearly half of those surveyed—48 percent—said they had experienced strong verbal abuse from a physician; and 42 percent reported they had experienced threatening body language. Aside from the potential for patient harm, how many of us would want our sons, daughters or other family members to be treated in such a fashion?

We've all heard the same excuses to explain poor behavior by physicians, but in reality, there are no excuses. Treating people poorly is never right, especially if there is even a chance that our patients might suffer as a result. While physicians have certainly seen a substantial change in their roles over the last several years, they remain the leaders of the team. As such, the physician must set the example and welcome the engagement of the other team members.

How do physicians successfully lead the team? Most physicians can probably appreciate the value of a calm, professional, deliberate atmosphere. But many of us don't remember that we play a huge part in setting that tone. As team leaders, physicians should encourage communication from all members of the team, regardless of level of training or role. Many of my surgical colleagues have questioned the part of the surgical checklist that requires team members to introduce themselves. It might seem unnecessary, since many of us have worked with the same nurses, techs and nurse anesthetists for years, but the action of actually speaking up empowers people to continue speaking if concerns arise. Physicians should encourage members of the team to express concerns without fear of retribution, sarcasm or bullying. It sounds pretty fundamental, but we've all seen those behaviors from our colleagues. Some of us may even have

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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.

Contact Us

Street Address
1203 Front Street
Raleigh, NC 27609

Mailing Address
PO Box 20007
Raleigh, NC 27619

Telephone / Fax
(800) 253-9653
Fax (919) 326-0036

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

Have something for the editor?
forum@ncmedboard.org

participated in them. By engaging everyone on the team, we support each other and make errors much less likely.

At a session presented by the health care safety consulting firm HPI, the speaker quoted data published in 2004 about perceptions of teamwork. In a survey of operating room personnel about teamwork, 75 percent of surgeons rated teamwork as "high" (e.g. surgeons felt the team worked well together.) You may be reading this thinking, 'I've seen bad behavior in others but I'm one of the good ones—my team works like a well-oiled machine.' Just remember that we are not always the best and most accurate judges of how we are perceived by others. The responses of other team members to the same survey question are telling. Thirty-nine percent of anesthesiologists surveyed reported that teamwork was "high." Just 28 percent of surgical nurses rated teamwork as "high" and nurse anesthetists came in at a slightly less enthusiastic 25 percent. Surgical residents were the toughest critics, with just 10 percent of residents describing the level of teamwork as "high."

The same study gives some hints as to what might influence team members' perceptions of the team. The survey found that 50 percent of surgeons felt junior team members should not question senior physicians (though, as a surgeon, it pains me to share this finding.) That attitude probably reflects the failure of physicians to understand that working as part of a team doesn't mean rule by committee. No one suggests that surgery should be done by consensus after discussion by all members of the team. Teamwork does require mutual trust and respect and a shared expectation that any member of the team has an obligation to speak up if he or she believes an error is imminent or sees some potential for patient harm. It should be clear to all that good communication is not a challenge to anyone's authority.

While I hope I've argued persuasively that physicians play a critical role in nurturing true collaboration, I also want to be clear that I think it's time to move beyond simplistic and pejorative terms such as "disruptive physician." Anyone can disrupt the smooth functioning of the team and potentially harm the patient, and anyone disrupting good care should be held accountable. No individual has all the knowledge required to take care of patients in an exceedingly complex medical care environment. Rather than resenting suggestions about care or questions that clarify issues, we should all welcome support from our teammates and offer such support in kind.

Send comments to *Forum@ncmedboard.org*

Collaborative care within the health care team

Created: January 1, 2010

The North Carolina Medical Board ("the Board") recognizes that the manner in which its licensees interact with others can significantly impact patient care.

The Board strongly urges its licensees to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Licensees should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care.

Disruptive behavior is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that disruptive behavior is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, disruptive behavior may reach a threshold such that it constitutes grounds for further inquiry by the Board into the potential underlying causes of such behavior. Behavior by a licensee that is disruptive could be grounds for Board discipline.

The Board distinguishes disruptive behavior from constructive criticism that is offered in a professional manner with the aim of improving patient care. The Board also reminds its licensees of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a licensee's health and performance. Licensees suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

Finally, licensees, in their role as patient and peer advocates, are obligated to take appropriate action when observing disruptive behavior on the part of other licensees. The Board urges its licensees to support their hospital, practice, or other health care organization in their efforts to identify and manage disruptive behavior, by taking a role in this process when appropriate.

Hospital suspensions related to failure to complete medical records (yes, those are actions too)

Since the fall of 2009, the NCMB has been implementing and refining the expanded licensee information system mandated by the North Carolina General Assembly. As part of this work, last fall the Board began posting on its website hospital privilege suspensions related to failure to timely complete medical records. Hospitals are currently required by state law to report these actions to the Board when a licensee receives three suspensions of this type in a calendar year. These actions have been available to the public through the NCMB for several years. Until relatively recently, however, the NCMB did not post them on the Board's website. Only privilege suspensions and revocations that stemmed from concerns about clinical competence or willful misconduct were posted to the site.

From the Office of the Medical Director

SCOTT G. KIRBY, MD

This column will discuss the recent change in Board policy regarding suspensions related to failure to complete medical records and highlight some resulting changes to how those actions are displayed on the NCMB's website.

What changed?

Last year, the NCMB spent some time carefully considering its handling of hospital privilege suspensions related to failure to timely complete medical records. The Board analyzed the seriousness of these suspensions compared to others. Part of the analysis included a discussion of how the NCMB might differentiate medical records-related suspensions from those related to competence or misconduct. Ultimately, it was decided that suspensions for failure to complete medical records should be published on the Board's website and the relevant staff were directed to come up with a means of differentiating between adverse actions and administrative actions such as the records-related hospital suspensions.

Staff began posting newly reported hospital privilege actions in this category in the fall. To be fair, and to ensure the accuracy and completeness of information on each individual's Licensee Information (LI) page, the Board staff also began the process of reviewing all privilege actions that had been previously reported to ensure that all actions that meet criteria are posted.

As Board staff began posting records-related suspensions from the last few years, it notified licensees of the changes. We quickly heard back from a number of licensees who weren't happy to see a suspension for failure to timely complete medical records on their otherwise clean public record. As a former hospital-based physician (before joining the Board's staff, I practiced emergency medicine in Raleigh) I can understand licensees' frustrations. The vast majority of suspensions related to late medical records are temporary —many are resolved within a day or two—and they rarely, if ever, involve concerns about patient care. Yet a public report of a hospital "suspension" can have adverse effects on a physician or PA that may include real or perceived dings to professional reputation or difficulties with recredentialing.

Why records are important

I don't want to minimize in any way the importance of timely completion of medical records. The Board believes that accurate, current and complete medical records are an essential component of patient care. Significant delays in the completion of medical records diminish both the accuracy and credibility of the records, and may create confusion among others treating the patient. The Board expects licensees to properly document medical care in an accurate and timely manner.

When the Board receives information that a licensee's hospital privileges have been limited, suspended or revoked (a Change in Staff Privileges or CISP), it has a duty to investigate. Depending on the seriousness of the allegation and corresponding level of concern, the Board may conduct a field investigation or require the licensee to respond in writing with an explanation that provides their side of the story. The licensee conduct that led to a CISP may or may not result in a disciplinary action by the Board (most often it does not). In the case of a CISP related to failure to timely complete medical records, the licensee is expected to notify the Board, in writing, within 30 days that all delinquent medical records have been completed and that privileges have been restored.

NCMB's duty to publish

Pursuant to NCGS 90-5.2 (a) (8), (b) the Medical Board is required to publish actions by health care institutions that suspend or revoke a licensee's privileges. Corresponding rules state that these actions are to be displayed on the Board's website (they appear on the individual's LI page) for a period of 7 years.

The rules do not differentiate between hospital actions related to medical records as opposed to actions related to clinical competence or quality of care. However, the Board

recognizes that there is a qualitative difference between them. Consequently, the Board recently modified how these actions are displayed on licensee information pages. The revised page layout now includes a section for administrative actions, including hospital suspensions related to failure to timely complete medical records. The administrative actions section is labeled to indicate that the actions listed are considered non-disciplinary by the Board and involve issues such as failure to meet certain statutory requirements or failure to follow correct administrative procedures. The Board and its staff hope that these changes will prevent confusion about the nature of posted actions and prevent undue negative consequences to licensees.

Note to hospitals

Finally, it must be noted that it is clear to the Board that some CISP reporting requirements are being unevenly applied by health care institutions. In reviewing suspensions related to failure to timely complete medical records, it quickly became apparent that some hospitals are reporting these suspensions in accordance with the law and some, it seems, are not. If you are a hospital administrator or chief of staff reading this article, please understand that the Board expects you to equitably and fairly comply with reporting requirements as outlined in this article. The Board accepts change in staff privilege (CISP) reports via its website at: *www.ncmedboard.org/professional_resources/report_cisp/*

Send comments to *Forum@ncmedboard.org*

LICENSEE TIP

Licensees are sometimes confused about what information they are required to disclose to the Board regarding hospital actions. Licensees are required to report ANY limitation, suspension, revocation or other action by a hospital or health care institution at the time of annual renewal. This is true even if the licensee is aware that the hospital has already reported the action to the Board.

Out and about

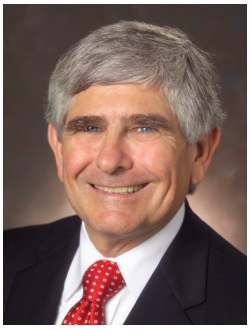
The North Carolina Medical Board regularly sends Board Members and staff to speak to and engage with licensees, community organizations and other groups. Here are some of the venues our speakers have visited recently.

Presentations to professional groups

Dr. Gumber

American Association of Physicians of Indian Origin, Carolinas Chapter
Spring Governing Meeting
Charlotte, NC | March 22-24

Board Member Subhash C. Gumber, MD, a Cary gastroenterologist, and Board President William A. Walker, MD, a Charlotte colorectal surgeon, presented a general overview of the Board and spoke about current and future initiatives.



Dr. Walker

North Carolina Academy of Family Physicians
2013 Spring Family Physicians Weekend
Greensboro, NC | April 4-7

Board President William A. Walker, MD, presented a talk entitled, "Fear Factor—Myths and Reality about the NC Medical Board." The talk featured a special emphasis on the Board's disciplinary work related to inappropriate prescribing of controlled substances and provided practical advice to attendees on avoiding problems.

Presentations to consumer and community groups/organizations

Ms. Brinkley

The Leisurettes, National Association of University Women
Raleigh, NC | February 28 | April 27

Jean Fisher Brinkley, the NCMB's director of public affairs, presented talks to two Raleigh-area groups, a group of retired teachers, the Leisurettes, and a Raleigh chapter of the NAUW. The talks gave an overview of the NCMB's mission/duties and emphasized how the Board protects the public.

Ms. Konkel

Citizen Advocacy Center
Public Outreach Meeting
Washington, D.C. | April 9

Dena Konkel, the NCMB's assistant director of public affairs, presented on the Board's public outreach efforts. The Citizen Advocacy Center (CAC) is dedicated to improving the efficacy of health regulatory oversight boards by offering training and resources to public members, Board staff and other interested parties.

LICENSEE INFORMATION

WHO'S REPORTING AND WHAT ARE THEY SAYING?

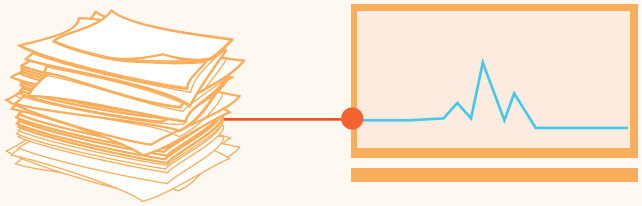
In 2009 the NCMB expanded its online Licensee Information pages. This infographic explores the many new, optional categories that licensees have reported information in.

Why report optional information? The NCMB's "Look Up a Licensee" tool is the most popular feature on the Board's website.. Many users are patients researching specialists they have been referred to, or people scouting out new primary care providers.

Licensees may not think that it matters whether they have provided content for optional categories, but consumers notice when it's not there. Don't miss out on an opportunity to make a positive first impression.

3,612 Total licensee population reporting **PRACTICE WEBSITE** address on LI pages

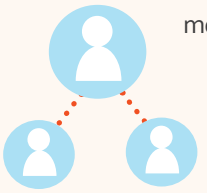
Total licensee population reporting use of **ELECTRONIC HEALTH RECORDS** **10,111**



MEDICARE AND MEDICAID

- Participates in Medicare: **13,495**
- Accepting new Medicare patients: **11,874**
- Participates in Medicaid: **13,231**
- Accepting new Medicaid patients: **11,046**

MEMBERSHIPS



Total number of licensees who have reported membership in one or more professional groups

19,482

- Medical Societies
- Specialty Societies
- American Medical Association

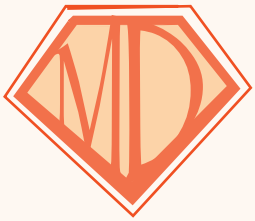
AWARDS AND RECOGNITION

Total number of licensees who have reported receiving one or more awards

5,337

- Academic Excellence
- America's Top Doctors
- Military Honors

PUBLIC SERVICE



Total number of licensees who have reported public service

2,741

- Medical Missions
- Non-profit organizations
- Community Clinic Volunteer

PRACTICE PHILOSOPHY

Total number of licensees who report a practice philosophy **11,820**

"I treat patients of all ages. I emphasize prevention and wellness. I have special interests in geriatrics, pediatrics,sports medicine and public health"

LANGUAGES

5 MOST COMMONLY SPOKEN LANGUAGES

1. SPANISH: **3,453**
2. HINDI: **286**
3. FRENCH: **173**
4. RUSSIAN: **84**
5. ARABIC: **65**

378 report utilizing a translation service to communicate with patients

IT'S EASY TO UPDATE YOUR LI PAGE

Visit *www.ncmedboard.org* and click on "Update Licensee Info Page" in the green Quick Links box on the home page. Follow the prompts to log in. Set aside some time to make sure you've made the most of our optional categories. Need some incentive? Check out our LI page contest on the opposite page!

ENTER NOW: Win a chance to be featured in an upcoming NCMB campaign!

The NCMB challenges licensees to make the most of their Licensee Information pages by providing content for the many optional categories available to them. This information helps patients and others who use the NCMB's website to look up physicians and physician assistants get a better sense of a licensee's unique professional background, education and training. Besides, it's free marketing—why wouldn't you want to take advantage of that?

OUR GOAL:

To encourage more licensed physicians and physician assistants to provide optional content for their Licensee Information pages.

HOW TO ENTER:

Go to *www.ncmedboard.org* and click on Update Licensee Info Page from the green Quick Links box on the home page. Log in and provide content for applicable optional categories (practice philosophy, memberships, languages spoken, etc.) When you have finished entering information, email *forum@ncmedboard.org* with your full name and indicate you are entering the contest. Entrants must complete updates by end of business July 1.

RULES:

Licensed physicians and PAs may enter. You must have an active license, be practicing medicine at least part time and have no history of public discipline for at least 10 years. Information reported in optional Licensee Information categories must be accurate and relevant to each individual category for which information is provided. Winning entries will be determined at the sole discretion of the NCMB's Public Affairs department.

PRIZES:

Depending on the number and quality of entries, the NCMB's Public Affairs department will select up to 10 licensees, who will be offered the opportunity to be featured in an upcoming NCMB public awareness campaign. Examples of upcoming campaigns include print media/display advertisements, radio spots and/or video public service announcements. Winners will also be featured in the *Forum*.

QUESTIONS?

Contact Jean Fisher Brinkley, Director, Public Affairs at *jean.fisher@ncmedboard.org* or 919-326-1109 x230

We still care about the required information too

North Carolina law requires physicians and physician assistants to state their area of practice. Many licensees responded with enthusiasm and listed multiples areas of practice. Trouble is, nearly 40 percent did not indicate a PRIMARY area of practice as requested. The Board needs licensees to do this to enable the NCMB to accurately measure the number of licensees practicing in each primary AOP.

Make sure we have your primary AOP. Visit *www.ncmedboard.org* and click on "Update Licensee Info Page." **Thank you** for your help in making the NCMB's licensee information accurate and complete.

Position Statement update

The NCMB regularly adopts new position statements and reviews and, where appropriate, revises the existing official position statements of the Board to ensure that they remain relevant. We periodically publish a summary of recent revisions to position statements to help licensees stay abreast of changes. Full position statements may be found online in the Professional Resources section of the Board's website.

Statement: **Advance directives and patient autonomy**
Date revised: November 2012
Changes: Minor changes only (changing physician to licensee throughout).

Statement: **Referral fees and fee splitting**
Date revised: January 2013
Changes: Changed physician to licensee throughout; The statement is revised to address licensee use of voucher advertising programs (e.g. Groupon, Living Social, etc.) The new section on voucher advertising reads:

It is the Board's position that, so long as certain conditions are followed, advertising involving the utilization of vouchers does not constitute unethical fee-splitting or a prohibited solicitation or referral fee under North Carolina law. Those conditions include: (1) ensuring that the negotiated fee between the voucher advertising company and the licensee represents reasonable compensation for the cost of advertising; and (2) incorporating the following terms and conditions in a clear and conspicuous manner in all advertisements:

(a) A description of the discounted price in comparison to the actual cost of services;
(b) A disclosure that all patients may not be eligible for the advertised medical service and that decisions about medical care should not be made in haste. Determinations regarding the medical indications for individual patients will be made on an individual basis by applying accepted and prevailing standards of medical practice; and
(c) A disclosure to prospective patients that, if it is later decided that the patient is not a candidate for the previously purchased medical service, the patient's purchase price will be refunded in its entirety. If the patient does not claim the service, then the patient's purchase price must still be refunded in its entirety. In the event that the voucher advertising company does not refund the purchase price in its entirety, it will be the sole obligation of the licensee to refund the entire purchase price.

Statement: **End-of-life responsibilities and palliative care**
Date revised: January 2012
Changes: Revises definition of palliative care; changes physician to licensee throughout.

Statement: **Drug overdose prevention**
Date revised: March 2013
Changes: Broadens the scope of the position statement to indicate Board support of all programs that attempt to prevent deaths from drug overdose through making available or prescribing an opioid antagonist such as naloxone to someone in a position to assist a person at risk of an opiate-related overdose.

New Position Statement: **Professional Use of Social Media**
Date adopted: March 2013

Professional Use of Social Media
The Board recognizes that social media has increasing relevance to professionals and supports its responsible use. However, health care practitioners are held to a higher standard than others with respect to social media because health care professionals, unlike members of the lay public, are bound by ethical and professional obligations that extend beyond the exam room.

The informality of social media sites may obscure the serious implications and long term consequences of certain types of postings. The Board encourages its licensees to consider the implications of their online activities including, but not limited to, the following:

- Licensees must understand that the code of conduct that governs their face to face encounters with patients also extends to online activity. As such, licensees interacting with patients online must maintain appropriate boundaries in accordance with professional ethical guidelines, just as they would in any other context.
- Licensees have an absolute obligation to maintain patient privacy and must refrain from posting identifiable patient information online.
- A licensee's publicly available online content directly reflects on his or her professionalism. It is advisable that licensees separate their 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.).
- Because privacy is never absolute, considerations of professionalism should also extend to a licensee's personal accounts. Posting of material that demonstrates, or appears to demonstrate, behavior that might be considered unprofessional, inappropriate or unethical should be avoided.

- The online use of profanity, disparaging or discriminatory remarks about individual patients or types of patients is unacceptable.
- Licensees should routinely monitor their own online presence to ensure that the personal and professional information on their own sites is accurate and appropriate.

The Board also endorses the Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice adopted by the Federation of State Medical Boards (www.fsmb.org/pdf/pub-social-media-guidelines.pdf). Further discussion of this issue by the Board's Medical Director can be found at *www.ncmedboard.org/articles/detail/practicing_medicine_in_the_facebook_age_maintaining_professionalism_online*.

NCMB on the road: At the Federation of State Medical Boards Annual Meeting, April 18-20

Each year members of the Board and a delegation of Board staff attend the annual meeting of the Federation of State Medical Boards (FSMB) to discuss current and emerging issues in medical regulation. This year's meeting found Board Members and staff in Boston, just days after the bombing at the city's iconic Boston Marathon. A day into the meeting, law enforcement put the city on lockdown as they circled in on the surviving bombing suspect. The NCMB delegation was confined to the hotel for almost two days.

Fortunately, there was no shortage of medical regulatory business to attend to. Ralph C. Loomis, MD, a recent former Board member and past president of the Board, continued the proud NCMB tradition of service on the Federation's Board of Directors by winning a seat on that board. Loomis, an Asheville neurosurgeon who completed his final term on the NCMB in October, is one of many former NCMB members to serve in this capacity.

Dr. Loomis

North Carolinians, including members of the NCMB staff and others who work closely with the Board, led and participated in panels at the FSMB meeting, and at the annual meeting of the Administrators in Medicine (the professional organization for medical board executives and staff). The AIM meeting took place in Boston on April 17.

- Michael C. Sheppa, MD, the NCMB's associate medical director, led the Medical Board Staff Roundtable, which brings together staff from medical boards across the nation and territories to discuss the scope of their administrative work, issues they may have in common and challenges that they face.
- Warren Pendergast, MD, medical director of the NC Physicians Health Program, participated in a panel offered as part of a Joint Session of the FSMB and the Federation of State Physicians Health Programs, of which Pendergast is the current president. The panel discussion, entitled "Aging and Misbehaving: Two Special Topics in Physician Health" explored trends related to the aging of the physician workforce and the rise in "disruptive" behavior among physicians. The emphasis of the panel was on how PHPs can assist with aging and disruptive physician licensees.

Dr. Pendergast waits to speak during a panel presentation titled "Aging and Misbehaving: Two Special Topics in Physician Health"

- Thom Mansfield, the director of the NCMB's Legal Department and its primary liaison to the NC legislature, co-presented a session on the Federal Trade Commission's emerging interest in licensing board regulatory practices to attendees of the AIM annual meeting. The FTC has a particular interest in licensing boards' efforts to limit unauthorized practice (In FTC's view, potential "restraint of trade" activity). The session explored lessons from the recent FTC action against the North Carolina Board of Dental Examiners, which is currently under appeal. The session provided practical advice on steps boards can take to minimize the risk of FTC scrutiny and tips on responding to an FTC investigation, if one is initiated.

Year in Review:
A look back at data from 2012

It's that time again: Year in Review time. This feature highlights a selection of Board data in a two-page graphic spread that, we hope, illustrates some interesting facts about the NCMB's work and licensee population.

Back by request (really, we get frequent inquiries) is the Physician Population by County table. This data is also available for Physician Assistants (our space is limited here, so it is not published—look for it online in the Data Center). PAs are currently the NCMB's fastest growing licensee group. Notable: PAs account for 11.5 percent of the total licensee population in 2012 but made up more than 14 percent of licenses issued for the year.

And, for the first time, we took a look at fines issued by the NCMB in 2012. Fines are a relatively recent addition to the range of tools used by the Board to address disciplinary and administrative matters. Good to know: the NCMB does not benefit financially from the issuance of fines. All funds go to the NC Department of Education.

SUMMARY OF THE 2012 BOARD ACTION REPORT

PREJUDICIAL ACTIONS*

Annulment:
None

License Denied:
5 Actions (3 Physicians, 2 PAs)

Revocations:
5 Actions (5 Physicians)

Reprimand:
32 Actions (26 Physicians, 5 PAs, 1 LP)

Suspensions:
46 Actions (37 Physicians, 8 PAs, 1 NPs)

Summary Suspensions:
4 Actions (4 Physicians)

Miscellaneous Actions:
2 Actions (2 Physicians)

Surrenders:
25 Actions (20 Physicians, 4 PAs)

Public Letters of Concern:
74 Actions (64 Physicians, 8 PAs, 1 NP, 1 LP)

Temporary/Date Licenses Issued to Expire:
8 Actions (7 Physicians, 1 PA)

Temporary/Dated Licenses Allowed to Expire:
None

Conditions on License

PHYSICIAN POPULATION BY COUNTY

COUNTY	TOTAL	COUNTY	TOTAL	COUNTY	TOTAL	COUNTY	TOTAL	COUNTY	TOTAL
Alamance	277	Clay	6	Harnett	63	Nash	179	Stokes	24
Alexander	17	Cleveland	172	Haywood	112	New Hanover	741	Surry	122
Alleghany	11	Columbus	60	Henderson	268	Northampton	5	Swain	32
Anson	18	Craven	254	Hertford	40	Onslow	241	Transylvania	63
Ashe	25	Cumberland	812	Hoke	13	Orange	1,535	Tyrrell	0
Avery	21	Currituck	10	Hyde	2	Pamlico	8	Union	178
Beaufort	64	Dare	58	Iredell	335	Pasquotank	108	Vance	67
Bertie	10	Davidson	122	Jackson	85	Pender	26	Wake	2,439
Bladen	24	Davie	36	Johnston	130	Perquimans	4	Warren	4
Brunswick	121	Duplin	37	Jones	19	Person	31	Washington	7
Buncombe	1,078	Durham	2,367	Lee	88	Pitt	804	Watauga	135
Burke	199	Edgecombe	41	Lenoir	104	Polk	30	Wayne	199
Cabarrus	452	Forsyth	1,874	Lincoln	79	Randolph	125	Wilkes	74
Caldwell	83	Franklin	24	Macon	71	Richmond	46	Wilson	119
Camden	0	Gaston	407	Madison	11	Robeson	158	Yadkin	23
Carteret	130	Gates	1	Martin	19	Rockingham	107	Yancey	19
Caswell	13	Graham	4	McDowell	43	Rowan	251		
Catawba	414	Granville	130	Mecklenburg	2,927	Rutherford	84		
Chatham	90	Greene	10	Mitchell	25	Sampson	57		
Cherokee	37	Guilford	1,295	Montgomery	10	Scotland	69		
Chowan	31	Halifax	71	Moore	321	Stanly	82		

In State	23,867
Out State	9,616
GrandTotal	33,483

TOTAL BY SEX

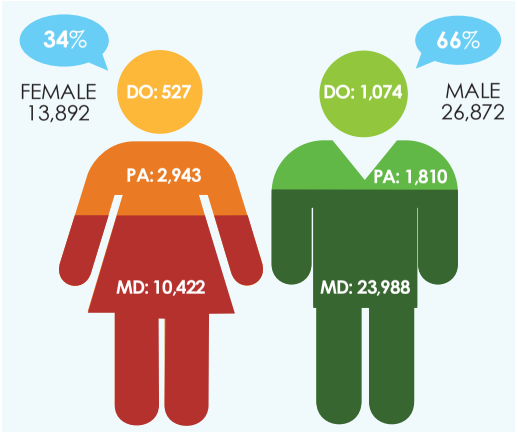
TOTAL LICENSEE POPULATION

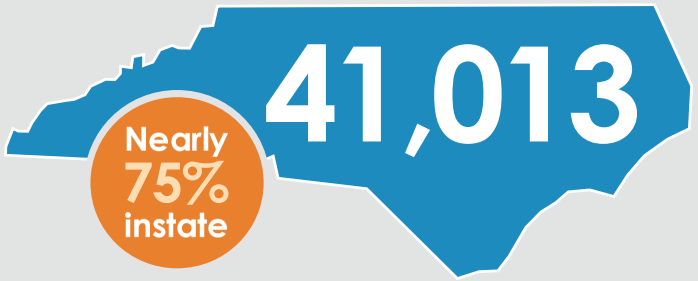
41 Actions (34 Physicians, 6 PAs, 1 LP)

Limitations/Restrictions on License
7 Actions (5 Physicians, 2 PAs)

TOTALS:
Prejudicial actions in 2012 related to 192 persons (164 physicians; 24 PAs; 2 NPs, 2 LPs)
Prejudicial actions in 2011 related to 213 persons (187 physicians; 19 PAs; 7 NPs)

*Prejudicial Action: A "prejudicial action" is adverse in nature and reflects a violation of the Medical Practice Act by the practitioner.





Physicians: 36,006 | **Physician Assistants:** 4,751
Perfusionists: 134 | **Clinical Pharmacist Practitioners:** 107
Anesthesiology Assistants: 15

LICENSING

Total licenses issued by the NCMB in 2012.

LICENSE TYPE	TOTAL
Physicians	2,188
Resident Training License	898
Physician Assistants	512

Length of time to process an application assuming the Board has received all materials from the applicant.

Pristine: one week or less
With issues*: up to two months

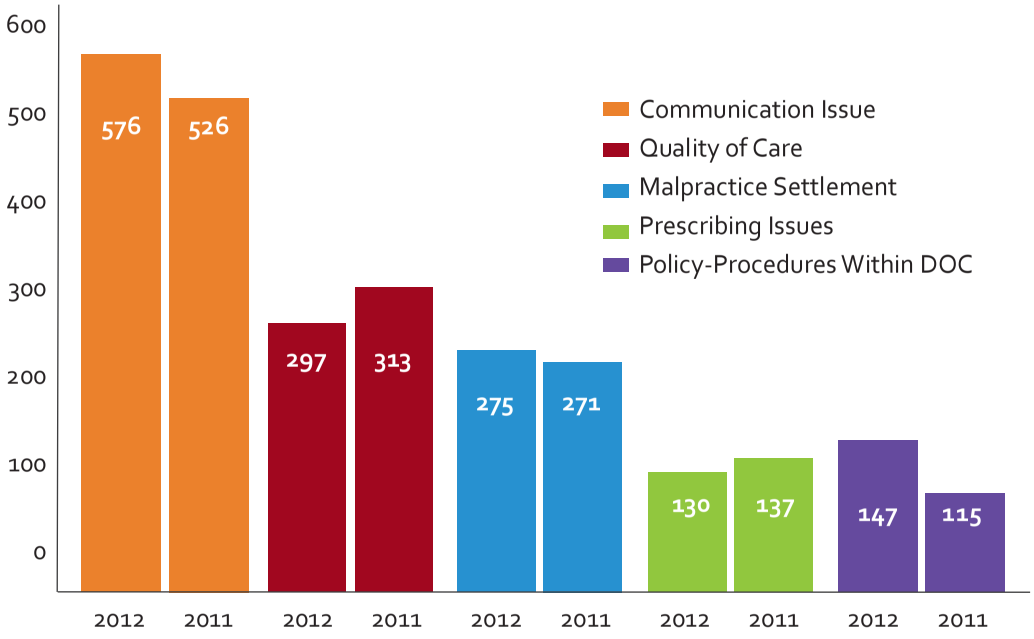
*Non-disclosures, discrepancies, etc.

FINES RECEIVED BY NCMB IN 2012

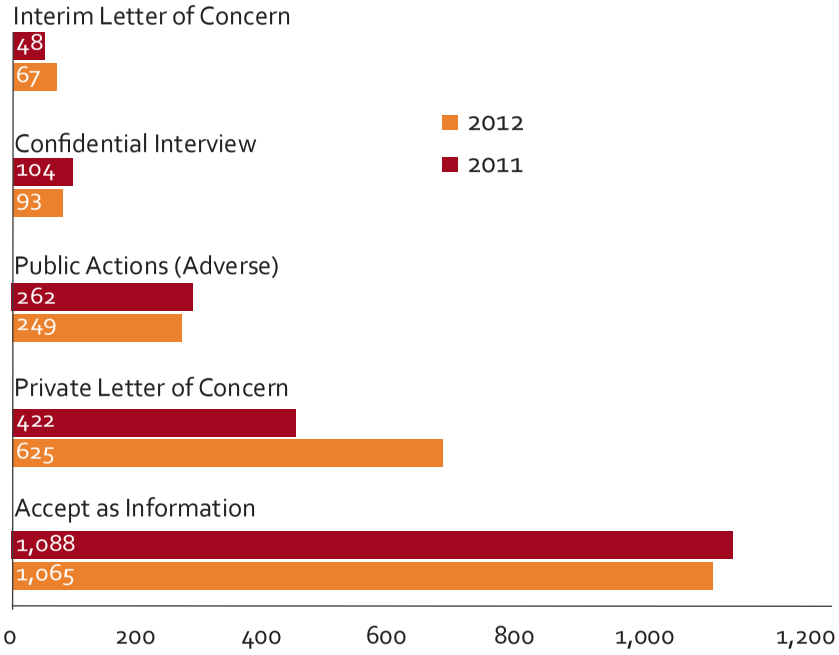
Total: 46
Total amount of all fines received in 2012: $57,350
Rate of fines per 1,000 licensees: 1.1
Average fine amount: $1,235
Minimum fine: $350 | **Maximum fine:** $10,000
Fines between 0-$500: 43%
Fines between $501-$1,000: 37%
Fines greater than $1,001: 20%

Fines collected benefit the NC Department of Education.

TOP FIVE COMPLAINT ALLEGATIONS 2011-2012



PUBLIC AND PRIVATE ACTIONS 2011-2012



North Carolina Medical Board

Quarterly Board Actions Report | November 2012 - January 2013

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			
BLACK, Laura Ann, MD (009701305) Charlotte, NC	12/20/2012	MD saw as many as 60 patients a day and wrote prescriptions for controlled substances for many of them while working at a clinic whose physician owner was serving an indefinite license suspension. MD was unaware of the suspension. MD's care of patients fell below accepted and prevailing standards.	MD's license is suspended for one year, stayed all but 30 days, which shall be served in two 15 day increments (12/21/12 to 1/4/2013 and 2/17/13 to 3/3/13).
CADE, Jerry David, MD (000019787) Spruce Pine, NC	12/12/2012	History of substance abuse/alcohol dependency; MD admitted taking Ambien that he obtained over the Internet without a prescription; he admitted that he had drunk alcohol in violation of his NCPHP contract.	Indefinite suspension
CASSIDY, John Francis, PA (000103164) Raleigh, NC	01/17/2013	PA had an inappropriate relationship with a patient. PA inappropriately prescribed controlled substances to this patient, even after she was no longer a patient of the practice. Prescriptions were not documented.	PA's license is indefinitely suspended; PA may not apply for reinstatement for one year from the date of this order.
FENN, James David, MD (201000133) Moyock, NC	11/07/2012	October 2011 arrest for DWI; January 2012 arrest for assault on a female; Failure to report for treatment for alcohol dependence.	Indefinite suspension; MD may not apply for reinstatement until his meets certain conditions,
FREDE, James Richard, MD (201001726) Kahului, HI	11/14/2012	MD entered into a consent order with the Illinois Board that indefinitely suspended MD's license because he issued prescriptions over the Internet.	Indefinite suspension
MUNCHING, Aaron Albert, PA (001000016) Raleigh, NC	01/30/2013	History of cognitive dysfunction. PA also relapsed and drank alcohol and took Vicodin.	Indefinite suspension
VANSTORY, Ashley Nowlan, PA (001001770) High Point, NC	11/29/2012	History of alcohol/substance abuse; Following a dental procedure, PA was prescribed Norco for pain. She was permitted by NCPHP to take the medication for three days. PA continued to take the medication in violation of her NCPHP contract.	Indefinite suspension
WEISS, Allen Charles, MD (000031404) Milford, DE	01/11/2013	MD's Delaware license was suspended based on unprofessional conduct, including: failure to appropriately prescribe controlled substances, failure to document patient care, bizarre behavior, verbal abuse of patients/pharmacists and physical abuse of a patient.	Indefinite suspension
ZIMMERMAN, Mark Woodrow, MD (09401104) Raleigh, NC	11/19/2012	History of alcohol dependence; MD self-reported that he relapsed in July 2012	Indefinite suspension
PROBATIONS			
[None]			
REPRIMANDS			
ALEX, Vicki May, PA (000102576) Taylorsville, NC	12/18/2012	PA engaged in an inappropriate relationship and inappropriate prescribing with Patient A and his wife, Patient B. PA prescribed narcotic controlled substances to Patients A and B, while engaging in a sexual relationship with Patient A.	Reprimand; Simultaneously, PA's license is suspended for 120 days but immediately stayed.
DRISCOLL, William Barry, MD (200200022) Charlotte, NC	01/03/2013	MD prescribed controlled substances to himself and to his wife, in violation of the Board's position statement and corresponding administrative rules.	Reprimand

Name/license#/location	Date of action	Cause of action	Board action
EAKINS, Darrin Franklin, MD (009800521) Steamboat Springs, CO	01/11/2013	MD was arrested/charged with unauthorized use of a motor vehicle and larceny. He also took property from his neighbor, resulting in additional charges of possession of stolen goods and breaking and entering. MD was convicted and placed on probation for 36 months.	Reprimand
KIRSCH, Melvin Lee, MD (000019757) Winston-Salem, NC	12/06/2012	MD was arrested and charged with misdemeanor offenses arising out of a confrontation with an individual who accused MD of keying her car. MD failed to report the arrest on his 2011 license renewal. MD failed to file/pay NC income and withholding taxes from 2004-2009 and NC withholding tax for his employees' wages during each quarter of tax year 2009.	Reprimand
REDDY, Ravi Kanth T., MD (200000121) Winston-Salem, NC	12/20/2013	MD's privileges to perform Endoscopic Retrograde Cholangiopancreatography were summarily suspended as a result of an adverse perforation event. A Board review determined that aspects of the care MD provided failed to conform to accepted standards.	Reprimand; MD must provide Board with detailed Delineation of Privileges for each institution where MD holds privileges.
SONYIKA, Chionesu, MD (200700334) Griffin, GA	12/19/2012	MD failed to correctly answer two questions on his application for reinstatement.	MD's NC license is reinstated with a reprimand, $1,500 fine.
STATON, Tara Mills, MD (200301083) Goldsboro, NC	11/07/2012	MD treated a patient who was thought to have had either syncope or a seizure associated with a motor vehicle collision and right wrist fracture. MD administered a rapid escalation of opiate regimen that a medical expert opined decreased the patient's respiratory drive and led to cardiorespiratory collapse, subsequent irreversible neurologic damage and death.	Reprimand; within six months of the date of the order, MD must complete a Board-approved CME course in prescribing
SWEENY, Mark Anthony, MD (009900695) Decatur, AL	11/16/2012	MD entered into a consent order with the Alabama Board that reprimanded MD, fined him and required him to complete 25 credits of CME. The order was based on MD's false certification that he had met CME requirements needed to renew his AL license.	Reprimand
DENIALS OF LICENSE/APPROVAL			
SURRENDERS			
CASSIDY, John Francis, PA (000103164) Raleigh, NC	12/06/2012		Voluntary surrender of PA license
HOOVER, Michael Shane, MD (200800507) Goldsboro, NC	01/09/2013		Voluntary surrender of medical license
MAYES, Kate Barrett, MD (201201391) Aiken, SC	11/29/2012		Voluntary surrender of medical license
RICE, Philip Scott, MD (000031367) Morehead City, NC	01/14/2013		Voluntary surrender of medical license
PUBLIC LETTERS OF CONCERN			
ANDERSON, Jeffery Stuart, MD (000039759) Morehead City, NC	12/04/2012	The Board is concerned that MD's care of a 63-year-old patient with penicillin and sulfa allergies may have failed to conform to acceptable and prevailing standards of medical practice.	Public letter of concern; MD is required to attend CME in evaluation and management of bite wounds.
BOYER, Kevin Louis, MD (200500165) Bradenton, FL	11/13/2012	MD entered into a settlement agreement with the Florida Board related to allegations of practicing below standards on a patient who presented with complaints of paralysis and immobility in his legs.	Public letter of concern
BROOKS, Chad Montgomery, PA (000104187) Memphis, TN	11/19/2012	PA's treatment of a 26-year-old diabetic female who presented in the ER with complaints of dizziness, fainting, chest pain, failed to meet accepted standards.	Public letter of concern; PA must complete appropriate CME courses.
CABORN, David Neil M., MD (000028401) Louisville, KY	11/19/2012	The Board is concerned that MD's care of a patient who presented to his office with a history of chronic right knee pain may have failed to conform to accepted standards.	Public letter of concern
CHAKNIS, Manuel John, MD (201300105) Atlanta, GA	01/23/2013	MD provided an incorrect answer on his application for a NC medical license.	Public letter of concern; $1,000 administrative fine

Name/license#/location	Date of action	Cause of action	Board action
DAVE, Sharda Kiran, MD (201202429) Flushing, NY	12/31/2012	MD entered into a consent order with the New York Board related to charges that he provided improper anesthesia care and falsified the patient's medical records.	NC medical license issued, with a public letter of concern
EASON, Ernest Bernard, MD (000026815) Burlington, NC	12/13/2012	The Board is concerned that MD's care of a patient who was hospitalized for decompensated cardiomyopathy may have failed to conform to accepted and prevailing standards of care.	Public letter of concern
HOFFMAN, Stanley David, MD (200000825) Denver, NC	12/14/2012	MD prescribed medications to himself and his family members in conflict with the Board's position on treating self/family.	Public letter of concern
HUFFMAN, Robert Allen, NP (000200993) Whiteville, NC	01/11/2013	While restricted by consent order from prescribing controlled substances, NP authorized nine prescriptions for Bontril and two prescriptions for testosterone, both of which are schedule III drugs. The Board is concerned that NP relied too early and primarily on drug therapy.	Public letter of concern; must complete CME in medical management of obesity; $1,000 fine for violation of consent order
JREISAT, Khalid Farid, MD (000027377) Jacksonville, NC	12/06/2012	MD self-prescribed testosterone, a controlled substance, in conflict with the Board's position statement and related administrative rules.	Public letter of concern
OVERCASH, William Todd, MD (000038275) Williston, FL	01/22/2013	MD was issued a letter of concern by the Florida Board for complications arising out of two gastric sleeve bypass procedures MD performed.	Public letter of concern
PATTERSON, Dwayne Edward, MD (009700702) Raleigh, NC	11/27/2012	MD's care of a 77-year-old patient who presented with a history of back surgeries and chronic lower back pain may have failed to conform to accepted standards.	Public letter of concern
POWELL, Eddie Nelson, MD (000023962) Roseboro, NC	12/13/2012	MD failed to complete an assessment in the time and manner ordered by the Board.	Public letter of concern
PURCELL, Craig Sumner, PA (000102990) Pinehurst, NC	01/23/2013	PA allowed a nurse to sign his name to prescriptions, and may have missed some early signs that a patient was abusing or diverting medications.	Public letter of concern
SCHWARTZ, Jay Harris, MD (201202287) Philadelphia, PA	12/03/2012	MD entered into a consent order with the New Jersey Board wherein he voluntarily surrendered his license due to issues involving substance abuse.	Public letter of concern
SHUCK, Linda Michele, DO (200500550) Elkin, NC	01/22/2013	DO prescribed a controlled substance to a close family member for weight loss purposes, which is in violation of the Board's position statement and related administrative rules on self/family treatment.	Public letter of concern
WEEMS, Larry Bryan, MD (009300367) Huntersville, NC	11/29/2012	MD prescribed for himself and for a person with whom he has a significant emotional relationship. He failed to keep a medical record for any of the prescriptions. It is a violation of the Board's position statement and related administrative rules.	Public letter of concern
MISCELLANEOUS ACTIONS			
PARIKH, Himanshu Pravinchandra, MD (009600671) Cary, NC	12/06/2012		MD is relieved of certain obligations stated in his 4/2012 consent order. He is relieved of the requirement to obtain work-site approval from the Board president and to use a workplace monitor.
WESTRA, Donald Freeman, Jr., MD (000023891) Bradenton, FL	12/13/2012	MD allegedly engaged in a romantic relationship with a patient. MD acknowledges that he and the patient met outside of practice hours to discuss their business relationship but contends that there was no romantic relationship. MD did prescribe Adipex, a weight loss medication, and other non-controlled medications for this patient, without a physical exam/medical records.	The Board accepts MD's making license inactive.
METHVEN, George Duncan, MD (201300112) El Dorado Springs, MO	01/24/2013	History of alcohol abuse, history alleged domestic assault, alleged sexual misconduct with a patient; MD enrolled in a treatment program for physicians for anger management, alcohol abuse and sexual boundary issues.	MD shall be issued a license; MD shall maintain a contract with NCPHP and abide by all terms and conditions.

Name/license#/location	Date of action	Cause of action	Board action
OENBRINK, Raymond Joseph, DO (200901584) High Point, NC	01/04/2013	DO has a medical condition that, left untreated, affects his ability to practice medicine.	DO agrees not to practice clinical medicine or perform any activities that require a license to practice medicine under the terms of this order. Agrees to refrain from consuming mind or mood-altering substances.
CONSENT ORDERS AMENDED			
[None]			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
BOOK, Roy DeWayne, MD (009701700) Greensboro, NC	01/17/2013		Temporary medical license issued to expire 01/31/2014
DUNN, Lawrence Anthony, MD (000030018) Durham, NC	11/15/2012		MD's temporary license is extended; Expires 11/30/2013
EARLA, Janaki Ram Prasad, MD (200701202) Hoover, AL	01/17/2013		Temporary medical license made full and unrestricted
EVANS, Michael Allen, MD (200001370) Smithfield, NC	01/30/2013	Prior history of substance abuse; MD has successfully completed inpatient treatment.	MD is issued a temporary license to expire on 07/31/2013
KAOUD, Hany Aziz, MD (200901680) Greenville, NC	12/06/2012	History of substance abuse; MD's license was indefinitely suspended 8/22/2012. MD has successfully completed inpatient treatment.	MD is issued a temporary license ; Expires May 31, 2013
LOGAN, Melissa Sims, MD (201202224) Shelby, NC	12/12/2012		MD is issued a temporary license; Expires 05/31/2013
LONG, Scott David, PA (000103319) Burlington, NC	01/17/2013		Temporary PA license issued to expire 07/31/2013
MCANALLEN, Terry Joseph, DO (200301013) Henderson, NV	01/17/2013		MD's temporary license is made full and unrestricted.
MOORE, Michael Christopher, DO (009701826) Cary, NC	01/28/2013	History of alcohol abuse/dependence.	MD is issued a temporary license to expire on 07/31/2013. MD shall abide by the terms of his NCPHP contract.
OLIVER, Joseph Andrew, III, (009501366) Rockwell, NC	01/18/2013		Temporary license issued to expire 01/31/2014
PARIKH, Himanshu Pravinchandra, MD (009600671) Cary, NC	11/15/2012		MD's temporary license is made full and unrestricted.
SMITH, Bryan Dorsey, MD (200201531) Pinehurst, NC	01/17/2013		MD's temporary license issued to expire 01/31/2014
YOUNG, Sarah Wistran, MD (200801889) West End, NC	01/17/2013		MD's temporary license is made full and unrestricted.
COURT APPEALS/STAYS			
[None]			
DISMISSALS			
[None]			

FINES

The NCMB issues non-disciplinary administrative fines in certain cases where incorrect and/or incomplete information on a medical licensing application causes Board staff to spend an inordinate amount of time resolving the issue(s),

Date	Reason	Amount
12/28/2012	Failed to provide accurate information on NC license application.	$500.00
12/28/2012	Provided an incorrect response on application for NC medical license.	$1,000.00
12/28/2012	Failed to provide accurate information on NC license application.	$500.00
12/28/2012	Failed to provide accurate information on NC license application.	$500.00
12/28/2013	Provided an incorrect response on application for NC medical license.	$1,000.00

North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609

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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

May 15-17, 2013 (Full Board)
June 20-21, 2013 (Hearings)
July 17-19, 2013 (Full Board)
August 22-23, 2013 (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.

Apply no later than July 1 to serve on the NCMB

Three physician members of the NC Medical Board will complete their second and final terms this year. The independent panel that nominates candidates for the Board is now seeking physicians to fill these seats, for terms beginning Nov. 1. Are you interested in serving the public and the medical profession in this challenging, dynamic role? Do you know someone who might be?

Candidates must have an active North Carolina medical license and must be practicing clinical medicine at least part time. Candidates must have no history of public discipline for the past 10 years. Candidates should also be aware that serving on the Board requires a significant commitment of time and possess both the ability and willingness to dedicate this level of service.

The process established by state law (N.C. Gen. Stat. § 90-2 and 90-3) requires anyone interested in serving on the Board to apply though the Review Panel for the NC Medical Board. This body screens applicants, conducts interviews, and makes recommendations to the Governor, who then makes appointments to the Board. The Medical Board is not involved in the review of applications or the selection of nominees.

Applications must be submitted by close of business on Monday, July 1. All qualified applicants will be invited to participate in a face-to-face interview with the Review Panel on August 24 & 25, 2013, at the Hampton Inn & Suites in Cary, NC.

APPLY ONLINE

Access the Board Member application online:
www.ncmedboardreviewpanel.com

For more information:
Dave Feild
Administrator for the Review Panel
919-861-4533