North Carolina Medical Board
FORUM
ISSUE NO. 1 | Summer 2019

FROM THE PRESIDENT

Clinicians on social media: No taking off the white coat

Barbara E. Walker, DO

It was probably inevitable.

Social media is so entwined with every aspect of our lives that it is becoming an active driver of Medical Board disciplinary work.

One recent case involved the posting of an operating room photo of a licensee and members of the surgical team, a draped patient's naked abdomen visible in the background. The comments on the post included irreverent remarks by the licensee that would have been embarrassing — perhaps humiliating — to the unidentified patient.

Another case stemmed from a negative online review one licensee wrote disparaging a colleague's competence after a contentious interaction over a mutual patient. In responding to the Board's inquiry, the licensee who wrote the review refused to delete it, evidently seeing nothing wrong with medical professionals airing dirty laundry via Facebook recommendation.

Negative incidents involving physicians and social media most often flow from a failure to recognize that professionalism and the ethics of the medical profession extend to social media. The expectation of professional conduct does not end when a shift is over, or when the white coat comes off. There's simply no walking away from one's status as a medical professional.

To have any hope of maintaining this standard, medical professionals must actively question their words and actions, including on social media, to ensure they uphold an appropriate standard of professionalism. NCMB has no interest or intention to dictate what may or may not be appropriate, but the Board does have a position statement that provides general guidance on protecting oneself from inadvertent lapses on social media.

A relatively simple and straightforward way to self-regulate is to ask (ideally before posting anything on social media): Would I say this in front of a patient if we were face-to-face? Would I want my own physician to post something like this? Do I want to explain this to the medical board? If in doubt, just don't post. Nothing is private on social

Continued on pg 2

IN THIS ISSUE

SPOTLIGHT

E-prescribing deadline

A provision of the NC STOP Act of 2017 that requires e-prescribing for outpatient prescriptions for Schedule II and III opioids will be in effect January 1, 2020. NCMB is preparing resources to guide licensees. Find information on the STOP Act at: *www.ncmedboard.org/STOP*.

media no matter what your settings say. Derogatory content or comments have a way of finding their way into the light.

NCMB doesn't actively monitor medical professionals' social media activity, but Board Members and staff do review it when patients, colleagues or others complain about a licensee's online antics. Based on the still small but increasing volume of cases that involve social media of one kind or another, I have every reason to believe this will continue.

If you are not familiar, I highly recommend reviewing relevant guidance documents on maintaining professionalism on social media. In addition to NCMB's own position statement entitled *Professional use of social media*, NCMB recommends reviewing the Federation of State Medical Boards' policy on *Social Media and Electronic Communications*, which was recently revised by a committee chaired by a former NCMB President, Cheryl Walker-McGill, MD. Finally, the *AMA Code of Medical Ethics* Opinion 2.3.2 - Professionalism in the Use of Social Media is another useful resource on this topic.

In case you are wondering, neither of the cases mentioned above resulted in public action against a licensee. NCMB did vote to issue confidential letters to the licensees involved, expressing the Board's concerns and expectations for professional conduct.

The bottom line is that medical professionals are held to a higher standard of conduct because of the ethical and professional obligations inherent in the practice of medicine. Be mindful of this in all you do, online or otherwise.

Be well,

Barbara E. Walker, DO
Board President

Find Dr. Walker's first President's Message, *From ineligible for licensure to Madam President,* at *www.ncmedboard.org/PresidentsMessage.*

Don't miss out on NCMB news!

The print edition of the *Forum* newsletter is now published twice a year, in summer and winter. Each issue includes the most important news from the previous six-month period. For a timelier report of NCMB news and happenings, sign up to receive the digital *Forum*, which is sent every two months.

Up next in the digital *Forum*: Understanding medication-assisted treatment (MAT) for opioid use disorder. What is MAT and who can benefit from it? How does one become an authorized MAT prescriber? What MAT resources are available to help prescribers in NC?

We'll answer these questions and more in the July-August digital *Forum*. Check the back cover of this newsletter for information on how to subscribe.

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VOLUME XXIV | No. 1

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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.

CME pilot seeks to simplify tracking and reporting of hours

NCMB is one of just three state medical boards participating in a pilot project that allows numerous accredited CME providers to automatically report clinicians' earned credit hours to regulators and specialty boards.

The yearlong pilot overseen by the Accreditation Council for Continuing Medical Education (ACCME) seeks to reduce the administrative burden of complying with continuing medical education (CME) requirements and/or participating in specialty board Maintenance of Licensure programs. When a licensee completes an accredited CME activity from one of the participating CME providers, he or she may be asked to provide information such as state license number or national provider identifier (NPI), name, birth day and month. This information will enable ACCME's CME system to automatically share information about credits earned with participating boards.

So far, NCMB and the medical boards in Maine and Tennessee are the only state boards set up to receive e-reporting from CME providers through the ACCME pilot project. After one year, ACCME will assess the feasibility and value of continuing e-reporting, and may seek to expand the program to include an even broader range of CME providers.

Reporting CME providers include:	
American Medical Association	Quillen College of Medicine, East Tennessee State University
The Center for Research and Education	Saint Thomas Health
Cherry Hospital	The Society for Translational Oncology
Clinical Tools, Inc.	Southern Medical Association
Consortium for Southeastern Hypertension Control	Southern Regional AHEC
Duke University Health System Department of Clinical Education & Professional Development	Tennessee Medical Association
East Tennessee Children's Hospital	University of North Carolina School of Medicine
Federation of State Medical Boards	University of Tennessee College of Medicine
Curi, a Medical Mutual Insurance Company	Vanderbilt University Medical Center
Medscape, LLC	Wake Forest University Health Sciences
Meharry Medical College	

NCMB is pleased to offer licensees who use these CME providers the convenience of having credit hours automatically reported. Physicians and PAs should recall, however, that e-reporting has only been in place since January 1, 2019. NCMB will not receive electronic confirmation of CME credits completed before this date, so licensees are responsible for maintaining documentation. Licensees are advised to retain CME records for six years, so they may be prepared to provide documentation if randomly selected by NCMB for a CME compliance audit.

Questions? Contact Malinda Sink at *malinda.sink@ncmedboard.org* or 919-326-1109 x231.

CME basics

Physicians: Must report 60 hours of Category 1 CME during each three-year CME cycle; Controlled substances (CS) prescribers must ensure that three of the 60 hours cover CS prescribing topics.

Physician assistants: Must report 50 hours of Category 1 CME during each two-year CME cycle; Controlled substances prescribers must ensure that two of the 50 hours cover CS prescribing topics.

TRENDING AT NCMB

CBD Oil

In just a couple of years, products containing cannabidiol (CBD oil) have gone from virtually unknown to the hottest thing in non-prescription treatments for pain, anxiety and a host of other ailments. A recent survey conducted by BDS Analytics and Arcview Market Research projected that the market for CBD sales in the United States will exceed $20 billion (yes, billion) by 2024.

NCMB's Policy Committee recommended at the May 2019 Board meeting that NCMB not develop a formal position statement on CBD at this time. The Policy Committee did direct staff to study and develop FAQs to address questions raised by licensees.

At its July 2019 meeting, the Board approved a single FAQ, which discusses the sale of CBD products by medical practices. The FAQ references the Board's existing position statement on the sale of goods by medical practices while citing recent guidance from the NC Dept. of Agriculture and the U.S. Food and Drug Administration. Licensees are advised to carefully consider the statements of these agencies.

Find the FAQ online at *www.ncmedboard.org/FAQs* under the heading CBD Oil.

2019 FSMB Annual Meeting highlights

NCMB has a long tradition of serving the public and the medical profession at the national level through participation in the Federation of State Medical Boards. 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. FSMB's annual meeting always provides numerous opportunities for NCMB to participate in national conversations relevant in medical regulation, patient safety and excellence in medical practice. This year's meeting, held in Forth Worth, was no exception. Here are some highlights:

Current, former NCMB members selected for leadership roles

Cheryl Walker-McGill, MD, who served as a Board Member with NCMB from 2011-2018, was selected as Chair-elect of the FSMB Board during the FSMB Annual Meeting. Dr. Walker-McGill, of Charlotte, will assume the role of Chair in April 2020. Congratulations Dr. Walker-McGill!

Cheryl Walker-McGill, MD

In addition, current NCMB Public Member Shawn P. Parker, JD, MPA, won election to his first full term on the FSMB Board of Directors. Mr. Parker, who lives in Raleigh, was elected to a partial term on the FSMB Board in April 2018 and was obliged to run again this year.

Shawn P. Parker, JD, MPA

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.

NCMB policy contributions: medical board handling of sexual assault

One of the most compelling reasons for NCMB to participate in the FSMB's annual meeting is the opportunity to participate in education sessions and panel discussions on important topics affecting medical regulation or the practice of medicine. This year, NCMB contributed to the national discussion regarding medical board handling of sexual assault cases by participating on a panel discussion, Sexual Boundary Violations: What State Medical Boards Need to Know. Many state medical boards are actively questioning how well they are positioned to address sexual assault by licensees in the wake of the case of Dr. Larry Nassar. NCMB Deputy General Counsel Brian Blankenship represented the Board on the FSMB panel, sharing information about steps NCMB has made to improve its processes. For example, since 2017, Board Members, Board investigators and members of NCMB's Legal Department have completed training on the effects of trauma on the brain.

NCMB Victim Services Coordinator, Wanda Long discusses details of the Victim Services Program at the 2019 FSMB Meeting

In addition, NCMB supports victims of sexual assault through its Victim Services Program, which connects individuals who report professional sexual misconduct by a licensed physician or PA with available assistance and resources in their part of the state. NCMB's program was inspired by similar services offered to sexual assault victims by law enforcement, district attorney's offices and the U.S. military. NCMB's Victim Services Coordinator – a Board paralegal who took on the role as an additional responsibility – assists victims of trauma across the state, regardless of the outcome of the case against the licensed physician or PA, or whether an enforcement case is active. The Board shared information about this innovative program with other medical regulators at the 2019 FSMB annual meeting through a poster presentation displayed during the conference.

Learn more about the Victim Services Program at *www.ncmedboard.org/VictimServices*.

NCMB's new and improved expert review process


Lynne DeVenny, NCCP

The Board created a new staff position in fall 2018 to enhance its outside expert medical review process, with a goal of increasing the number of expert reviewers available to consult on quality of care cases. Paralegal Lynne DeVenny, who accepted the role of Quality of Care Paralegal in November 2018, spoke with *Forum* Editor Jean Brinkley to answer clinicians' most frequently asked questions about providing outside medical reviews.

Q: Why does the Medical Board need outside medical reviewers?
A: Outside expert reviewers are truly critical to the Board's case review process. NCMB's success depends on its ability to draw on the knowledge and experience of medical experts regarding standards of care in their areas of practice.

Q: What is the specific service outside expert medical reviewers provide to the Board?
A: The reviewer's role is to determine whether standards of care were met at the time of treatment. Reviewers are provided with bookmarked electronic copies of medical records, which they evaluate. They also receive a worksheet for the case review and provide their opinions to the Board in the form of a written report.

Q: Are outside expert medical reviewers compensated?
A: Yes. Reviewers are compensated at a rate of $175 per hour for the time spent reviewing records and writing their reports. It is also a wonderful way for clinicians to serve patients and the medical profession, by ensuring that standards of care are upheld in North Carolina.

Q: May outside expert medical reviewers remain anonymous or will the clinician under investigation know who reviewed his or her care?
A: Generally, yes, reviewers can remain anonymous. On rare occasions, when a case proceeds to a public hearing, reviewers may be asked to provide testimony. This is not needed in a significant majority of cases where outside reviews are sought.

Q: Am I at risk of being sued for serving as an expert reviewer or testifying at a hearing for the Board?
A: No, reviewers for the Board are provided statutory immunity from civil liability and will not be held liable in any civil proceeding for testifying before the Board in good faith and without fraud or malice.

To indicate your interest in providing expert reviews, contact lynne.devenny@ncmedboard.org or 919-277-1874. The Board is always interested in establishing contact with qualified expert reviewers.

Board sets leadership team for 2019-2020

NCMB elected officers for the coming year at the July meeting of the Board.


Bryant A. Murphy, MD

In accordance with the NCMB bylaws, current President-elect Bryant A. Murphy, MD, of Durham, will automatically assume the role of Board President on Nov. 1. The Board voted to elect the following slate of officers. Together, the Board President and elected officers make up NCMB's Executive Committee, which sets Board priorities and handles governance responsibilities. Terms run from Nov. 1, 2019 until Oct. 31, 2020.

- **President-elect**: Venkata R. Jonnalagadda, MD
- **Secretary-Treasurer**: John W. Rusher, MD
- **Executive Committee At-Large Member**: Jerri L. Patterson, NP
- **Executive Committee At-Large Member**: Shawn P. Parker, JD

Death comes for all of us — signing death certificates is a public service

By Scott G. Kirby, MD
Associate Medical Director


Scott G. Kirby, MD

To discourage situations where no one will accept responsibility to certify a death, in March NCMB adopted a position statement entitled, *Clinician obligation to complete certificates of death*. The position urges licensees to complete death certificates for patients (whether current, recent or remote) "as a professional, ethical, civic, and public health responsibility."

Most refusals to complete a death certificate that come to the Board's attention involve an unattended death at home. It's not difficult to imagine the reservations some licensees have about signing the death certificate under such circumstances:

"How should I know why a patient died at home? Am I just supposed to guess the cause of death?!"

"What if I haven't seen the patient in months or even years?"

"Why can't the medical examiner just certify the death?"

At the Board's request, I am writing to offer some clarifications and additional guidance to minimize licensee confusion about NCMB's expectations.

First and foremost, it's important for clinicians to understand what their role is in certifying a death. Signing a death certificate does not require the clinician to definitively determine the precise anatomic or physiologic cause of death. Rather, the certifying physician, PA or NP should specify a reasonable or probable cause of death based on the best evidence available at the time. Is this a scientific means of determining the precise cause of death? Unfortunately not. The death certificate is primarily a legal document not a scientific document – entering a presumed or probable cause of death is sufficient. When specifying a cause of death you may include the term "probable" if it makes you more comfortable when faced with uncertainty. I have confirmed with staff at NC Vital Records that this is an acceptable practice.

Licensees who have shared feedback on signing death certificates with the Board frequently question the appropriateness of certifying the death of a patient the licensee may not have seen for several months, or even years. It is currently accepted practice for the medical professional who most recently treated the patient or who would be familiar with the patient's medical history to sign the death certificate. If a patient dies unexpectedly at home, the request will almost always go to the decedent's primary care provider of record. In such situations, licensees should use the best information available, including the patient's history and known underlying or pre-existing medical conditions, to identify a probable cause of death. This is true whether the patient was seen a month ago, or whether they were last seen three years ago. Just do your best with what information you have.

At times there may be additional circumstances surrounding a death that reasonably cause a clinician to feel especially reluctant to certify the death. Medical examiners accept cases when there are "suspicious, unusual or unnatural circumstances". In virtually all cases, the death will have already been evaluated to determine if it is within the medical examiner's jurisdiction before a licensee is asked to certify the death. However, it is simply not possible for the medical examiner system in North Carolina to accept every case. In such difficult situations, the Board urges licensees to sign the death certificate as a last service to their patient.

Finally, I want to share the news that NCMB is actively pursuing changes to state law that will provide civil immunity to medical professionals who complete a death certificate in good faith and to the best of their ability. This is included in House Bill 228, if you care to track its progress. The Board itself has no interest in pursuing action against licensees who make reasonable judgments about causes of death.

I hope I've helped to ease some concerns on this subject. If you have questions or concerns I haven't addressed here, look at my earlier writings on completing death certificates or feel free to reach out to me at *scott.kirby@ncmedboard.org*.

New Position Statement

Clinician obligation to complete certificates of death

North Carolina law requires that when a death does not meet criteria for jurisdiction by the Medical Examiner (N.C. Gen. Stat. § 130A-383) the death certificate shall be completed and signed by the physician, physician assistant, or nurse practitioner ("clinician") in charge of the patient's care for the illness or condition which resulted in death. Delaying the completion of a death certificate or refusing to sign a death certificate makes an already difficult time for surviving family members and other loved ones even more so and may result in unnecessary complications with funeral arrangements, estate proceedings, and other legal and personal matters.

The Board recognizes that clinicians may not be comfortable with uncertainty, however, a clinician should not decline to sign a death certificate simply because the exact anatomic or physiologic cause of death is uncertain. Less than 10% of deaths result in an autopsy. Clinicians are not expected or required to establish beyond a doubt the specific cause of death but should exercise their best judgment under the circumstances using available information.

Review of the patient's medical history should provide adequate information to state a reasonable or likely cause of death. Examples of acceptable causes of death may include arteriosclerotic cardiovascular disease, hypertension, Alzheimer's disease, or complications of diabetes mellitus. Furthermore, it is acceptable to use "probable" or "possible" to identify a suspected cause of death. In the end, a clinician's determination of the cause of death is a medical opinion and is based on the best available medical evidence, which may include the cumulative effects of multiple risk factors or a previously known disease process. Use of standard nomenclature without abbreviations and legible writing is encouraged.

The Board will not pursue disciplinary action against clinicians who complete death certificates in good faith and to the best of their ability in accord with the information available — even if that information is limited. The clinician completing the death certificate is only asked to provide a cause of death "to the best of [his or her] knowledge," not to a medical certainty (which is not possible in many instances). The Board also recognizes that clinicians may believe, for a variety of reasons, they were not "in charge of the patient's care for the illness or condition which resulted in death." This is often because death has occurred weeks or months after the last contact with the patient. The Board encourages clinicians to undertake completion of death certificates for patient's (current, recent, or remote) under these circumstances as a professional, ethical, civic, and public health responsibility. Failure or refusal to complete a death certificate, when the licensee clearly has a responsibility to do so, could lead the Board to consider disciplinary action.

Licensees should perform this final aspect of patient care promptly and with consideration for the decedent and his or her loved ones. Questions or concerns by clinicians regarding medical examiner responsibilities in a particular case or for advice on the completion of a death certificate may be discussed in a collegial and professional manner with the county medical examiner or Chief Medical Examiner's office. Legal requirements regarding completion of a death certificate may be found at N.C. Gen. Stat. § 130A 115. Additional guidance on the proper completion of death certificates is available at *www.cdc.gov/nchs/data/misc/hb_cod.pdf (Physicians' Handbook on Medical Certification of Death).*

NCMB Position Statements: Changes in 2018

NCMB regularly reviews and revises, as needed, its existing position statements. Here are the position statements the Board's Policy Committee touched during calendar year 2018.

Reviewed, no changes
- *Advertising and Publicity*
- *The Medical Supervisor-Trainee Relationship*

Retired
- *Retention of Medical Records*
- *Access to Physician Records*
- *Medical Record Documentation*

Content incorporated into new composite medical records position.

Revised
- *Departures from or Closings of Medical Practices*

New
- *MEDICAL RECORDS – Documentation, Electronic Health Records, Access, and Retention* – combines three previous position statements on medical records access, documentation and retention.

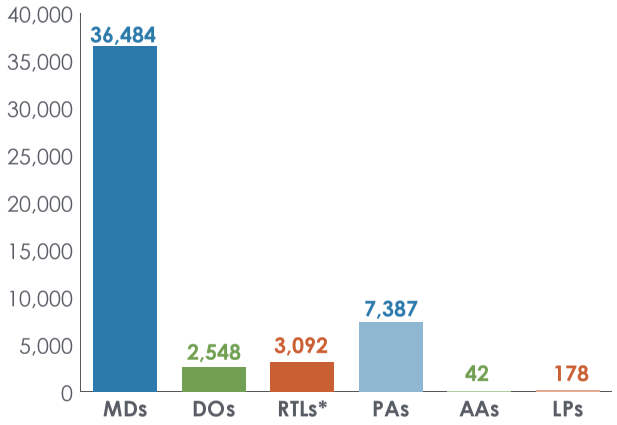
View position statements online at *www.ncmedboard.org/positionstatements*

Year in Review: A look back at data from 2018

Data reflect information for the calendar year beginning Jan. 1, 2018 and ending Dec. 31, 2018

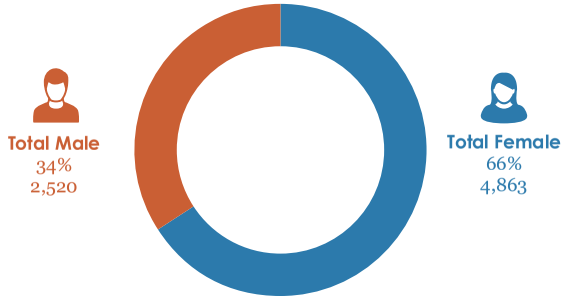
ABBREVIATIONS: MD: Allopathic Physician, DO: Osteopathic Physician, RTL: Resident Training License, PA: Physician Assistants, CPP: Clinical Pharmacist Practitioner, LP: Licensed Perfusionist, AA: Anesthesiology Assistant

TOTAL LICENSEE POPULATION



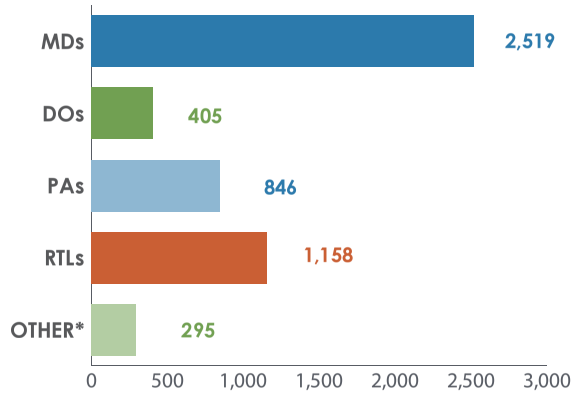
PHYSICIANS BY SEX*

PAs BY SEX*



* Total does not equal total population because a small number of licensees decline to state their sex

LICENSES ISSUED IN 2018



* Includes Volunteer, Limited emergency, Special permit/faculty, Perfusionists, and Anesthesiology Assistant

DATA SPOTLIGHT

DOs experienced the highest rate of year-over-year growth, with an increase of 12 percent from 2017. The total DO population has increased 57 percent since Dec. 31, 2013.

ENFORCEMENT ACTIVITY IN 2018

2,680 cases opened

2,502 cases closed

99 average # days to close a case

ENFORCEMENT ACTIVITIES BY TYPE

364 private actions

207 public actions, adverse

15 public non-adverse actions

TOP CAUSES OF PUBLIC ACTION in 2018

65 Quality of care

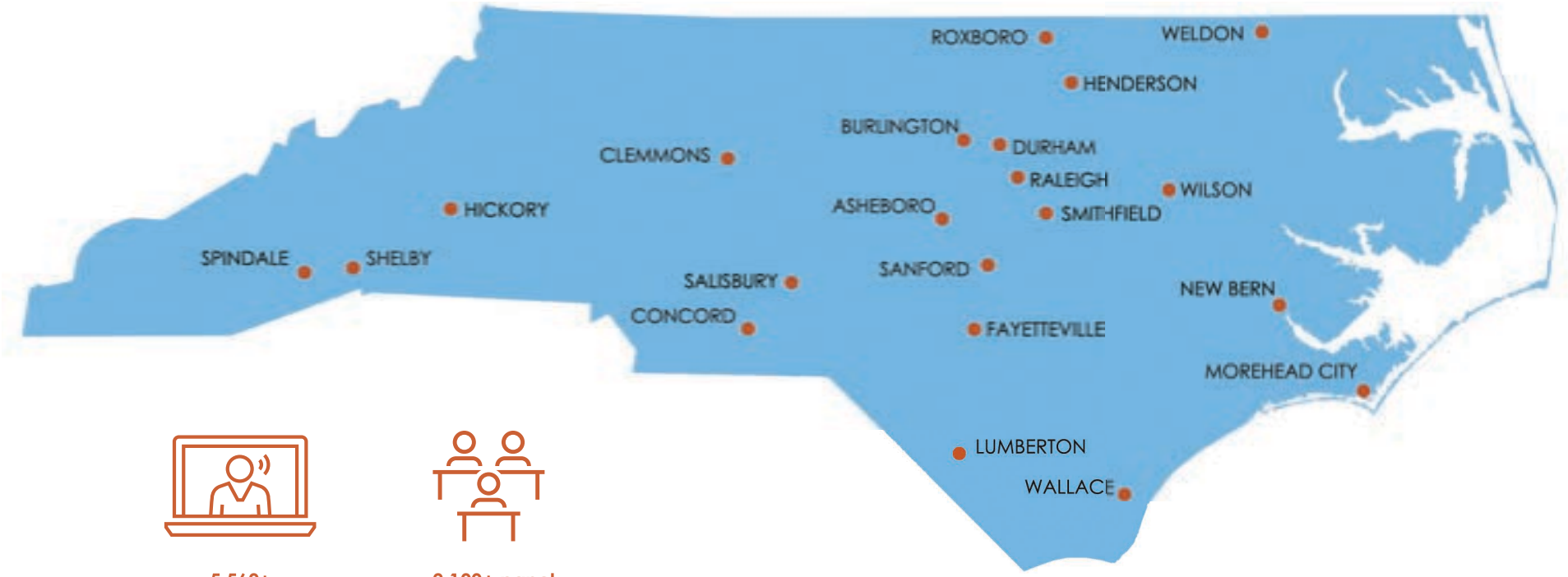
35 Alcohol/ substance use

32 Action by out of state medical authority

28 Issues with prescribing

15 Sexual misconduct/ boundary

INVESTING IN OUR LICENSEES: TRAINING INITIATIVE REACHES THOUSANDS



5,560+ webinar views

2,100+ panel attendees reached

NCMB wrapped up its controlled substances CME collaboration with Wake AHEC in 2018, organizing 22 live two-hour panel discussions during 2018 that reached more than 2,100 medical professionals in the state. A one-hour controlled substances prescribing webinar created as a companion piece to the live sessions has been viewed by more than 5,500 practitioners in 48 states and territories since it was first posted in 2017.

Viewing the webinar and attending a panel session, both offered at no charge, provided three hours of CME credit – enough to satisfy the physician or PA CME requirement for controlled substances prescribers.

NCMB and Wake AHEC are finalizing a videotaped version of the two-hour panel session, which will be available online in 2019. In addition, the one-hour webinar has been rerecorded and recertified for CME credit. Upon completion, these activities will be available at *www.ncmedboard.org/prescribingCME*.

Controlled Substance CME basics

Who is subject? Physicians and PAs who prescribe controlled substances

How many hours? Physicians must earn three hours during each three-year CME cycle; PAs must earn two hours during each two-year cycle.

How do I report my hours? There is no specific requirement to report controlled substances CME hours. Licensees should keep records of completed hours and be prepared to show documentation if selected for a CME compliance audit.

To see the entire 2018 Annual Report visit: *www.ncmedboard.org/about-the-board/annual-reports*

Celebrating the continued development of the PA profession in North Carolina

By Katharine D. Kovacs, PA-C
Assistant Medical Director


Katharine D. Kovacs, PA-C

I recently had the opportunity to reunite with six PAs I trained with, a group of women I have now known for more than 40 years. As we caught up and reminisced, it struck me that our group's experiences as physician assistants tell a compelling story about the growth and development of what is still a relatively new profession.

Looking around the table, I noted the sheer variety of PA practice represented. One colleague provides long-term care to ventilator-dependent patients with multiple chronic health conditions. Another is in a busy family medicine practice. One started a mobile program that provides specialty care for pulmonary disorders to patients in primary care offices. One works in orthopedics providing care from the office to the operating room, and another is on the cutting edge of Alzheimer's research. Still another has spent the last 39 years at one of the country's top institutions in cardiology and cardiothoracic surgery. Despite many changes over the years, PAs remain team members who strive to provide the best care in collaboration with physicians and other professionals across all disciplines.

My own 39-year career has afforded the opportunities to work in surgery, medicine, PA education, physical rehabilitation, neurology and, for the past nine years, as a staff member in NCMB's Office of the Medical Director reviewing quality of care cases for the Board. What a humbling journey it has been.

It would have been hard to imagine such a varied professional experience when I was just starting out as a PA, at a time when I had to explain at every turn just what in the world that was. Today, PAs can be found in virtually every area of practice and our presence in the health care delivery system is growing steadily, as more educational institutions bring accredited PA programs on board. In North Carolina, the licensed PA population has sustained annual growth of about 7 percent in each of the past several years, and the Board currently licenses more than 7,300 PAs. I am happy to note that patients seem to embrace PAs' contributions: a 2014 Harris Poll study found 93 percent of respondents agreed that PAs are "trusted healthcare providers" and improve access to care.

Many people know the PA profession began in North Carolina. The first training program, established in 1965 at Duke University by Dr. Eugene Stead, graduated a class of three PAs in 1967. By 1980 there were more than 50 PA programs; Today there are more than 250. North Carolina currently boasts eleven programs and more universities in the state are pursuing accreditation.

PA programs have grown in depth as well as number. When I trained, my alma mater in Pennsylvania offered a four-year bachelor's program, a unique opportunity for those of us needing more than the standard two-year programs offered at the time. It now offers a five-year master's level program. In accordance with standards set by Accreditation Review Commission, all PA programs must offer a graduate degree by 2020.

One of my personal goals in my work for NCMB has been to offer to address each graduating PA class in North Carolina, to provide information on PA licensure and practice. Last year I visited ten of the state's 11 programs. The hope is to help PAs avoid early missteps in practice, thus preventing regulatory difficulties that can follow a PA throughout his or her career. It is truly an honor to be a part of this profession and a pleasure to see PAs continue to develop and flourish in this great state. To learn more about PAs, consider visiting the websites of the American Academy of Physician Assistants, the NC Academy of Physician Assistants or the accrediting body, Accreditation Review Commission on Education for the Physician Assistant.

NC is home to 11 PA programs, 10 of which are represented above.

North Carolina Medical Board

Adverse Actions Report | April 2019 - June 2019

The print edition of the *Forum* presents a three-month report of recent adverse actions. This report does not include non-adverse action such as reentry agreements. To view all public actions, visit *www.ncmedboard.org/BoardActions*. To view previous installments of the *Forum* Adverse Actions Report, go to *www.ncmedboard.org/AdverseActions*.

Name/license #/location	Date of action	Cause of action	Board action
ANNULMENTS			
NONE			
SUMMARY SUSPENSIONS			
NONE			
REVOCATIONS			
SETZER, Howard Orson, DO (201401083) Charlotte, NC	06/11/2019	Felony conviction in State of Missouri v. Howard Orson Setzer, 1711-CR00424-01 of four counts of Sodomy, 2nd Degree, one count of Commission of a Fraudulent Insurance Act, one count of Making False Statement or Misrepresentation to Receive Health Care Payment, and one count of Attempted Sodomy, 2nd Degree.	Revocation of NC medical license
SUSPENSIONS			
BAILEY, Scott Allen, MD (200500604) Mebane, NC	04/24/2019	In November 2018, MD reported to North Carolina Physician's Health Program (NCPHP) that he had ingested alcohol and an illicit substance, in violation of his NCPHP contract. On November 7, 2018, MD made his North Carolina medical license inactive.	Indefinite suspension of NC medical license
BURKHEAD, Margaret K. MD (200700808) Raleigh, NC	05/31/2019	MD consumed alcohol in violation of her June 2016 Consent Order and NCPHP contract. In September 2018, MD signed a Non-Practice Agreement with the Board and in December 2018, requested that her license be made inactive.	Indefinite suspension of NC medical license
GAST, Timothy Michael, PA-C (000102365) Aberdeen, NC	04/02/2019	During PA's 2018 license renewal, PA self-reported to the Board that he had been terminated by his employer for: (1) prescribing controlled substances to a person with whom PA has a significant personal and emotional relationship; and (2) signing his supervising physician's name on the prescriptions to that person. PA also admitted that on at least one other occasion, he may have prescribed a controlled substance to this person using his own prescription pad and signature, which violates rule 21 NCAC 32S .0212(8).	Indefinite suspension of NC medical license immediately stayed, except for a period of 30 days. PA shall not prescribe any Schedule II or Schedule III controlled substances.
JAROSZ, Todd Stephen, MD (200601748) Hazard, KY	05/16/2019	Action based on the action of another state medical board. MD admitted to the South Carolina Board of Medical Examiners to having engaged in sexual misconduct with a patient. The SC Board recommended MD seek residential treatment for professional boundary/ sexual misconduct, which he has successfully completed.	Suspension of NC medical license, immediately stayed with conditions; MD to have informed female chaperone present when MD is in an examination room with a female patient.

Name/license #/location	Date of action	Cause of action	Board action
POWLOVICH, Lauren G. MD (201800718) Charlottesville, VA	05/21/2019	In November 2018, MD self-reported to the Board that her privileges had been suspended at the University Hospital at the University of Virginia due to her substance use disorder and to her felony charge with Possession of Schedule I/II Drugs. After successful completion of inpatient treatment, MD became a participant with the Virginia Health Practitioners' Monitoring Program and signed a five-year monitoring contract. MD was also assessed by the North Carolina Physicians Health Program and is currently under an out-of-state monitoring contract. She is in compliance with her contracts and both programs advocate for MD's safe return to practice.	Indefinite suspension of NC medical license, immediately stayed with conditions.
SEITZ, Kent, MD (200900067) Charlotte, NC	05/16/2019	MD's failed to comply with his March 2016 consent order. MD wrote prescriptions to a patient written in another patient's name after the first patient became ineligible for Medicaid. Additionally, MD engaged in substandard treatment of opioid use disorder, failed to document details in the records to support the diagnosis, treatment plan, or prescribing, and failed to address aberrant drug screening results and diversion behavior in his patients.	Indefinite suspension of NC medical license beginning thirty days from the date of Consent Order.
LIMITATIONS/CONDITIONS			
COLLINS, Paul Dwayne, MD Lumberton, NC	05/10/2019	MD has a history of alcohol abuse and of relapses in his recovery. After a relapse in July 2007, the Board decided to revoke his license. MD has not practiced medicine since then. He signed a one-year monitoring contract with the NCPHP in November 2017 which was extended an additional year in 2018. NCPHP advocates for MD's return to the practice of medicine.	MD issued a RTL license with conditions.
GILDERSLEEVE, Elizabeth Owens, PA-C (000102667) Conover, NC	05/29/2019	PA consumed alcohol in violation of her 2010 NCPHP contract. PA entered into a new agreement with NCPHP in September 2018 and has maintained continuous compliance. NCPHP advocates for her return to practice.	License reinstated; PA to maintain current contract with NCPHP and abide by its terms.
REPRIMANDS			
GOOSSEN, Maria Mathilda, LP (100000649) Fayetteville, NC	05/16/2019	In October 2018, LP was on call and asked to report to work where upon arrival, LP was observed to be inebriated. She admitted to consuming wine and her privileges were suspended on Oct. 15, 2018. On Oct. 24, 2018, LP signed a NPA with the Board. A comprehensive assessment found that LP has alcohol use disorder. She successfully completed treatment and signed a five-year monitoring agreement with the NCPHP. NCPHP and the residential program advocate for LP's return to practice. The Board has dissolved LP's NPA.	Reprimand

Name/license #/location	Date of action	Cause of action	Board action
QUINN, Christopher Michael, DO (201301779) Clarkston, MI	05/15/2019	Action based on the action of another state medical board related to DO improperly dispensing Vitamin D to patients at his Michigan medical practice and improperly allowing his staff to dispense Vitamin D to patients when he was not present. Additionally, DO failed to properly secure prescription medications in his office. In December 2018, DO entered into a Consent Order with the Michigan Board of Medicine in which he received a Reprimand and was required to complete continuing medical education among other terms and conditions.	Reprimand
URBAN, Derek Kurt, MD (201302312) Spring Hill, TN	06/19/2019	Action taken by another state medical board; In October 2015 the Board of Healing Arts of the State of Kansas, denied MD's Kansas medical license application due to several misrepresentations on MD's application, as well as MD's history prior acts of inappropriate prescribing and inappropriate personal use of a controlled substance medication. After an appeal process initiated by MD, the District Court of Shawnee County, Kansas Division Seven entered a Memorandum Opinion and Entry of Judgment in March 2019 that affirmed the Kansas Board's denial.	Reprimand
WILLIAMS, Lisa V. PA-C (001007609) Lake Havasu City, AZ	06/04/2019	Action taken by the Arizona Medical Board related to PA's substance abuse and inappropriate prescribing of controlled substances to her significant other without maintaining records or performing a physical examination.	Reprimand; PA placed on 12-month probation and required to complete CME on medical record keeping and on professional boundaries.
DENIALS OF LICENSE/APPROVAL			
LONG, James Randall, MD (000033456) Lexington, NC	04/16/2019	Board denied MD's application for reinstatement of his NC medical license based on MD's previous history of misconduct, suspension, convictions on federal misdemeanor and felony charges, fraudulent prescribing practices and poor pharmacovigilance and general moral turpitude, among other considerations.	Denial of request to reinstate MD license.
SURRENDERS			
SAPPINGTON, John S. MD (009400628) Rutherdfordton, NC	05/07/2019	Action related to action by another state medical board. In October 2018, MD entered into an Interim Non-Practice Agreement with NCMB based on two actions taken by the Rhode Island Board of Medical Licensure & Discipline in October 2018. On February 13, 2019, MD agreed to a Surrender of License with the Rhode Island Board in lieu of further contesting alleged violations.	Voluntary Surrender of License
WESSEL, (Jr.), Richard Fredrick, MD (009600772) Potsdam, NY	05/07/2019		Voluntary Surrender of License

Name/license #/location	Date of action	Cause of action	Board action
PUBLIC LETTERS OF CONCERN			
CHAN, Michael David, MD (200800435) Winston-Salem, NC	06/20/2019	The Board is concerned about the administration of radiation treatment to the incorrect site for a patient under MD's care. The radiation treatment was planned for the right trigeminal nerve root; however, the radiation was delivered to the left trigeminal nerve root.	Public Letter of Concern
COURT, Charles Joseph, MD (200501923) Charlotte, NC	04/03/2019	The Board is concerned that MD allowed a CRNA under his supervision to consume an alcoholic beverage in MD's presence while on call. Although the consumption occurred during meal time breaks and MD believed the CRNA was not impaired, it shows poor judgment for a physician supervisor to allow a member of the surgical team under his supervision to consume alcohol while on call.	Public Letter of Concern
KUNDRA, Arun, MD (201201060) Rock Hill, SC	05/06/2019	The Board is concerned that MD failed to give his patient an appropriate evaluation, not recognizing the potential seriousness of the patient's infection, which may have decreased the morbidity associated with her ICD device infection and subsequent episode of sepsis. Additionally, the Board is concerned that MD's medical record documentation was deficient to the point of hampering proper assessment of his actual patient care.	Public Letter of Concern
LEE, David Wayne, MD (000027384) Tarboro, NC	05/30/2019	The Board is concerned MD treated a patient who had end stage renal disease and was on chronic peritoneal dialysis with a single dose of parenteral methotrexate (25 mg) for a presumed ectopic pregnancy, without properly considering the potential toxicity of the methotrexate or consulting a nephrologist. MD believed this medication would be cleared during patient's next dialysis session, which was erroneous, did not clear, and resulted in life threatening toxicity.	Public Letter of Concern
LI, Zhicheng, MD (201001547) Wilmington, NC	04/02/2019	Board action based on a self-reported situation and a complaint received from a patient alleging an inappropriate examination by MD. Patient had complained of long-term back pain and MD explained he would conduct a comprehensive physical examination. During the exam, MD lifted his patient's right breast to gauge its weight because he suspected her low back pain was caused by psoas muscle dysfunction. Prior to lifting her right breast, MD did not explain the medical necessity and did not ask for her consent. MD acknowledges that by not effectively communicating the medical necessity for this part of his examination, his patient could have perceived the examination as inappropriate.	Public Letter of Concern

Name/license #/location	Date of action	Cause of action	Board action
WILLIS, Brenda Sue, MD (201002109) Gastonia, NC	04/05/2019	The Board is concerned that in March 2017, MD wrote herself a prescription for a controlled substance which is a violation of Rule 21 NCAC 32B .1001. On a separate occasion in April 2018, MD phoned in a controlled substance cough medicine prescription (with a refill) for a family member who did not have access to their established physician or pharmacy at the time. This also violated rule 21 NCAC 32B .1001.	Public Letter of Concern
MISCELLANEOUS ACTIONS			
HALLIDAY, Sharon Raynes, MD (201501072) Durham, NC	04/11/2019	In May 2018, the Board received information that MD's faculty appointment at Duke Medical School had been terminated. Upon investigation the Board found that MD had contested the termination and was temporarily reinstated by a Durham County Superior Court Justice in June 2018. However, MD's termination from Duke was eventually upheld by a Durham County Superior Court Justice. As of late June 2018, MD could not practice medicine with her MSFL because she did not have a full-time appointment as specified in N.C. Gen. Stat. § 90-12.3. In light of this, MD and the Board entered into an Interim Non-Practice Agreement in July 2018. MD's MSFL became inactive in December 2018, because she did not renew it.	MD's license made inactive; NPA dissolved.

Glossary of Terms

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.

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.

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As a reminder, NCMB now publishes a paper edition of the *Forum* just twice a year, with issues mailing in summer and winter. To provide licensees with important information faster, we now offer an email edition of the *Forum* every two months. Licensees have two options for receiving the email edition:

Option 1:

- Visit *www.ncmedboard.org/LicenseeInformation* and launch the Update my Info online form to login to your Licensee Information page.
- Select Preferences/CME from the menu. Under *Forum*, select either your home or practice email. All future issues of the *Forum* will be delivered via email. You will NOT continue to receive a paper copy.

Option 2:

- Visit *www.ncmedboard.org/Forum* and complete the online form. You will receive BOTH the email edition of the *Forum* and the print edition.

BOARD MEETING DATES

September 18-20, 2019 (Full Board)
October 17-18, 2019 (Hearing)
November 20-22, 2019 (Full Board)
December 12-13, 2019 (Hearing)
January 22-24, 2020 (Full Board)
March 18-20, 2020 (Full Board)

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

www.ncmedboard.org