North Carolina Medical Board
FORUM
ISSUE NO. 2 | SUMMER 2017

FROM THE PRESIDENT

Caring for pain patients in the midst of mounting opioids regulation

Eleanor E. Greene, MD, MPH

This summer marked a milestone in North Carolina's efforts to stem the tide of opioid overdoses in the state with the passage of the Strengthen Opioid Misuse Prevention (STOP) Act. The STOP Act aims to reduce overdose deaths through strategic provisions designed to prevent inappropriate and/or excessive opioid prescribing. NCMB supports these goals.

As Board President, I understand that the STOP Act contains necessary changes which, over time, should reduce the supply of prescription opioids circulating in NC and prevent patient harm. As a practicing physician, I cannot help but worry about the negative impact these changes may have on patients depending on how clinicians respond to intensified government and regulatory scrutiny.

Since NCMB announced its opioids investigative program, the Safe Opioid Prescribing Initiative (SOPI), in Spring 2016, the staff has fielded countless calls and emails from patients who report their providers have cut opioid dosages precipitously, or have arbitrarily declined to prescribe opioids at all. Many of these patients tell NCMB that their prescribers specifically stated they will "lose their license" if they don't cut back on opioid prescribing and/or fail to strictly follow the *CDC Guideline for Prescribing Opioids for Chronic Pain*. Within hours of the signing of the STOP Act into law on June 29, the Board started getting calls from concerned patients and prescribers, who wondered how this new law might further impact or limit access to pain treatment.

There's no question that, with increased regulation and evolving standards of care, the difficult challenges faced by medical professionals who treat pain are becoming more arduous. Clinicians undoubtedly feel more pressure to reduce prescribing, even as patients

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SPOTLIGHT

2016 marked the first year in which physician practice ownership is no longer the majority arrangement, according to data gathered through the American Medical Association's Physician Practice Benchmark Surveys.

Find more at
www.wire.ama-assn.org

47.1%

Percentage of physicians who are practice owners

NORTH CAROLINA MEDICAL BOARD

Find a summary of the STOP Act and FAQs about NC's new law on p. 8 of this issue.

continue to request treatment.

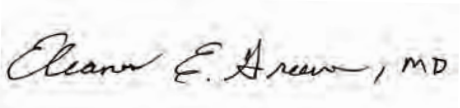
What is a prescriber to do?

There is no simple answer to this question. I can only say that treatment decisions must be guided by clinical judgment individualized for each patient, not by a desire to avoid Board scrutiny or regulatory action. Sometimes clinical judgment may lead to a course of treatment that diverges from specific recommendations contained in the CDC Guideline, but is the best option for the patient. As with anything else in medicine, when making difficult treatment decisions clinicians must ask themselves: "Is this treatment safe? Is it medically justifiable? Is it going to benefit the patient?"

The Board's goal with respect to opioids has always been safe and appropriate care. That means putting a stop to inappropriate or excessive opioid prescribing. It also includes supporting the professional obligation of medical practitioners to provide effective and responsible care to their pain patients. These aren't platitudes or empty promises. I know, because I've observed how the Board handles opioid prescribing investigations firsthand. For example, at the July Board Meeting, NCMB reviewed several cases that were opened through the Safe Opioid Prescribing Initiative. Three cases that were opened based on high dose, high volume opioid prescribing (NCMB investigated the top one percent of licensees prescribing 100 morphine milligram equivalents per patient, per day) were closed with no action against the licensee, even though each of these prescribers routinely managed patients at doses far exceeding 100 MMEs per day. Why? In each case, review of patient records by the Board and by independent medical expert reviewers found the care to be thoughtful, reasonable, medically justified and well documented. The prescribers confirmed pain generators, documented failed nonopioid therapies, supplied evidence of improved pain and function in response to opioids, demonstrated pharmacovigilance and showed reasonable efforts to minimize opioid doses. In short, the Board found the care to be appropriate.

It's clear that the practice of medicine is in the midst of a swift pendulum swing towards a much more cautious and conservative role for opioids in pain management. As NC prescribers decide how this should change what they do in clinic, we must remember who is at the heart of the opioid crisis: patients with pain. NCMB can't (and shouldn't) tell prescribers in advance exactly what they should do when faced with hard choices with their pain patients, but the Board is committed to providing support through the resources and information on its website at *www.ncmedboard.org/safeopioids*

Be well,



Eleanor E. Greene, MD, MPH
Board President

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Documenting compliance with the new CS CME requirement

Now that the new continuing medical education (CME) requirement for controlled substances prescribers is in effect, NCMB is receiving regular inquiries from licensees asking what they should do to notify the Board of their compliance.

The short answer is: nothing. NCMB is handling the new controlled substances CME (CS CME) requirement the same way it handles its general CME requirement. Licensees should complete the required CME and retain records of the courses they have completed. If selected for a compliance audit, the licensee will be asked to show documentation of courses completed at that time. The Board recommends retaining CME records for six years.

The annual license renewal questionnaire has been updated to include information about the new CS CME requirement. A licensee who prescribes controlled substances should check the box that they prescribe, and that they understand they are responsible for completing the required CME. A licensee who does not prescribe controlled substances will check a box to notify the Board.

CS CME: the Basics

What is required? Physicians must earn three hours of controlled substances CME every three years; PAs must earn two hours every two years.

Who must comply? Licensees who prescribe controlled substances of any kind

When did this go into effect? July 1, 2017

When is the CME due? By the end of the current CME cycle (for cycles ending on or after July 1)

Where can I learn more?
www.ncmedboard.org/prescribingCME

2017 North Carolina Medical Board

NCMB finalizes leadership team for 2017-2018

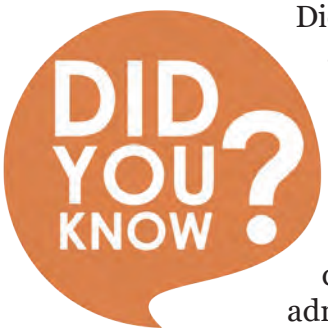
The Board approved its leadership team, known as the Executive Committee, for the 2017-2018 operating year during the July Board Meeting.

In accordance with NCMB's Bylaws, the current President-elect of the Board, Timothy E. Lietz, MD, will automatically become Board President effective Nov. 1. The Board voted to approve the following slate of other officers. Along with the Board President and Immediate Past President, these individuals make up the Executive Committee of the Board.

President-Elect: Barbara E. Walker, DO

Secretary/Treasurer: Bryant A. Murphy, MD

At-large member: A. Wayne Holloman



Did you know that NCMB licensees are required by law to keep current mailing and email addresses on file with the Board? NCMB strongly encourages licensees to provide the Board with email and mailing addresses that reaches them directly (as opposed to a practice administrator or other staff person) so they do not miss important information. Each month, NCMB receives dozens of "undeliverable" emails when sending out annual license renewal notices.

Make sure your licensee information is accurate by visiting *www.ncmedboard.org/LicenseeInformation* After logging in, select "Address" from the menu to check or update your contact information.

Revised opioids investigative criteria now in effect

New investigative criteria for NCMB's Safe Opioids Prescribing Initiative (SOPI) took effect July 1, expanding the Board's oversight of licensees who are managing large numbers of patients on high doses of opioids. Specifically, the revised criteria will enable the Board to investigate the top two percent of prescribers authorizing 100 morphine milligram equivalents (MMEs) per patient, per day, as well as any prescriber who meets this criterion and also prescribes in combination with a benzodiazepine.

Prior to July 1, the Board investigated the top one percent of such prescribers, which resulted in 12 licensees being investigated between April 2016, when SOPI was established, and May 2017. The Board determined that prescribing was below current accepted standards of care in about 90 percent of these cases, which led NCMB to conclude that reviewing more high dose, high volume prescribers might reveal more substandard prescribing. Assuming trends remain constant, the Board expects the revised criteria to double the number of investigations opened based on this criterion.

Investigative criteria focused on prescribers who have had two or more patient deaths due to opioid overdose within a 12-month period have also been revised. Effective July 1, the Board will open investigations only when the prescriber is confirmed to have authorized more than 30 tablets of an opioid to the decedent within 60 days of the death. NCMB believes adding these additional filters will result in fewer "false positive" cases – instances where, upon examination of the licensee's prescribing history, it is determined that the licensee did not prescribe opioids in close proximity to the patient death, or did not prescribe in sufficient quantity to cause an overdose. Between April 2016 and May 2017, the Board opened 50 cases based on the patient deaths criterion. In a majority of cases opened based on the initial "patient deaths" report, the Board found no evidence of prescribing that could reasonably be concluded to have been a cause of the death.

Revised SOPI investigative criteria:

- Top two percent prescribing 100 morphine milligram equivalents (MME) per patient per day.
- Top two percent prescribing 100 MMEs per patient per day in combination with any benzodiazepine and within the top one percent of all controlled substance prescribers by volume.
- Prescribers with two or more patient deaths within a 12–month period due to opioid poisoning AND authorized more than 30 tablets of an opioid to the decedent AND scripts were written within 60 days of the patient's death.

New structure, name for PA advisory body

The Board voted in March to restructure the group that advises NCMB on matters related to physician assistants to allow greater input from PAs practicing in North Carolina. The body formerly known as the Physician Assistant Advisory Council (PAAC) will now be known as the Physician Assistant Advisory Meeting (PAAM). The PAAM will report its business to the Board through the Advanced Practice Providers and Allied Health Committee. The PAAM will meet twice a year, in March and September. Meetings are open to any PA who is interested in attending. The Board will continue its practice of engaging with PA stakeholders and organizations before each meeting to solicit agenda items and topics for discussion. Any PA is welcome to bring issues forward for consideration, however. Email suggestions to: *forum@ncmedboard.org*

Physician Burnout: A Coach's Perspective

By Ryan P. Bayley, MD

"I don't know how much longer I can keep doing this."

"I used to care so deeply but now I barely care at all."

"By the end of work, I'm so depleted I can't even enjoy my time off."

Study after study tells us there is an epidemic of burnout in our profession. As an emergency physician I have experienced it personally, and as a coach who works with physicians I see it every day in my clients.

The reasons for burnout are increasingly well understood. Rapid changes in healthcare have brought a loss of physician autonomy, increased administrative minutiae, and unreasonable performance expectations. These compound the more traditional challenges of constantly dealing with death and suffering, high-stakes decision making, and long, irregular work hours.

As a physician, these hurdles can seem insurmountable. However, as a coach I know that physicians with burnout can recover and even thrive. When I begin to coach a physician, I often start with thought exercises to pinpoint the areas of their life that need immediate attention and have real potential for improvement. The exercises below are two of my favorites:

What is your ideal day?

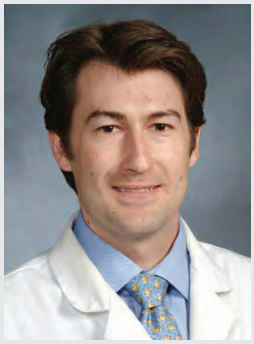
When someone is burned out, it is natural for them to ruminate over external causes, vent frustrations, and assign blame. It is far more difficult to shift into a positive mindset and visualize an ideal work day, from wake to sleep, in minute detail. Making a deliberate effort to do this forces them to see the large and small areas of joy and difficulty both at work and at home. I ask clients to log their actual workdays for a week. After completing this exercise, physicians are often shocked at just how much of their day is unintentional. There are almost always several clear areas ripe for relatively easy improvements. This question, "What is your ideal day?" is also powerful simply because most physicians I work with have never thought about this before. Once individuals identify the things that are important to them, it is much easier to address barriers and begin taking specific steps to achieve their ideals.

If you could wake up tomorrow and find that miraculously one part of your job could be permanently changed, what would it be?

This question forces physicians to zero in on where they are struggling the most. The Pareto Principle tells us that 80% of our job dissatisfaction is caused by only 20% of our work activities. Therefore, making even small improvements in the most frustrating activities can drive enormous increases in our work satisfaction. This exercise is about identifying concrete stressors so that the individual has the opportunity to take specific actions to improve his or her situation.

The real power of these coaching questions is that they begin the process of reclaiming an internal locus of control. They help physicians shift from a state of passive frustration and victimization to a mindset of engagement and change. Physicians who recover from burnout do so not because they discover a single silver bullet for the problem, but because they ask themselves what they truly want in each area of their lives, and then act to bring about change to that effect. Being burned out is a lonely and even desperate place to be. I find it reassures physicians to understand that even a small positive first step can lead to meaningful and lasting change for the better.

ABOUT THE AUTHOR



Dr. Ryan Bayley is a board certified emergency physician and a professional development coach. Through his coaching practice he works with physicians on a wide range of career and leadership issues, with a particular interest in burnout and work-life balance. He can be reached at rb@ryanbayleymd.com.

Your "quick start" guide to the STOPAct of 2017

This June, Gov. Roy Cooper signed the Strengthen Opioid Misuse Prevention (STOP) Act of 2017 into law. The Act is intended to stem the opioid epidemic that has had such a severe impact in North Carolina, primarily by establishing practices aimed at reducing inappropriate and excessive opioid prescribing. The Board has prepared a short summary of the Act that highlights provisions that will have the most direct impact on licensees. STOP Act provisions are listed in order of their effective dates. An expanded summary that includes information on additional provisions of the law that affect NCMB licensees is available at *www.ncmedboard.org/safeopioids*. Be sure to read the related STOP Act FAQs on p 8.

Effective July 1, 2017

Opioid Prescribing Consultations with Supervising Physician

Physician Assistants and Nurse Practitioners prescribing targeted controlled substances are required to personally consult with the supervising physician if (1) the patient is being treated at a facility that primarily engages in the treatment of pain by prescribing narcotic medications or advertises for any type of pain management services, and (2) the therapeutic use of the prescription will, or is expected to, exceed 30 days.

Furthermore, when prescribing to the same patient continuously, Physician Assistants and Nurse Practitioners are required to consult with a supervising physician at least once every 90 days to verify that the prescription remains medically appropriate.

The Board has directed NCMB staff to develop a formal definition of "consultation," with the intention of eventually adopting rules to guide PAs, NPs and their supervisors. Draft language is expected to be presented to the Board for review at the September 2017 Board meeting.

Streamlined Set Up of Delegate Accounts

This provision streamlines the process of creating delegate accounts for prescribers in emergency departments in the North Carolina Controlled Substances Reporting System (NC CSRS). To register delegates visit *www.ncmedboard.org/NCCSRS*. Delegate accounts must be linked or associated with the prescriber(s) for whom the delegate will complete queries.

Effective September 1, 2017

Timely and Accurate Prescription Reporting by Pharmacies

Pharmacies are required to report prescriptions to NC CSRS by the close of business the day after a prescription is delivered (previously the law required pharmacies to report the prescription within three days of the date it was delivered).

In addition, the STOP Act authorizes NC CSRS to assess monetary penalties against pharmacies that do not supply correct data to NC CSRS after being informed that information is missing or incomplete.

Provisions effective January 1, 2018

Limitations on Prescriptions for Acute Pain

Acute pain is defined as pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. It does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.

Practitioners cannot prescribe more than a five-day supply of any Schedule II or Schedule III opioid or

What are targeted controlled substances? Most of the provisions in the STOP Act apply to licensees who prescribe "targeted" controlled substances. These are select medications listed in N.C. Gen. Stat. § 90-90(1), (2) or 90-91(d).

What's on the list? All Schedule II and Schedule III opioids and narcotics; medical professionals who prescribe must comply with STOP Act provisions.

What's not? Stimulants and hormones; any other medication that is NOT listed in N.C. Gen. Stat. § 90-90(1), (2) or 90-91(d)

narcotic upon the initial consultation and treatment of a patient for acute pain unless the prescription is for post-operative acute pain relief for immediate use following a surgical procedure, in which case the prescription cannot exceed a seven-day supply.

Upon subsequent consultation for the same pain, practitioners may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance.

This provision does not apply to prescriptions issued by practitioners ordering targeted controlled substances to be wholly administered in a hospital, nursing home, hospice facility, or residential care facility.

Practitioners acting in accordance with these limitations are immune from civil liability and disciplinary action from this Board.

Provisions effective January 1, 2020

Electronic Prescribing

Practitioners must prescribe electronically for all targeted controlled substances. This provision does not apply to:

- Practitioners, other than a pharmacist, dispensing directly to an ultimate user.
- Practitioners ordering for administration in a hospital, nursing home, hospice facility, outpatient dialysis facility or residential care facility.
- Practitioners experiencing temporary technological or electrical failure or other extenuating circumstances that prevent the prescription from being transmitted electronically. Practitioners must document the reason for this exception within a patient's medical record.
- Practitioners writing a prescription to be dispensed by a pharmacy located on federal property. Practitioners must document the reason for this exception in the patient's medical record.
- Persons licensed to practice veterinary medicine.

Provision effective upon completion of NC CSRS technical upgrades* (date TBD)

Mandatory Review of NC CSRS

*DHHS will work on various technical upgrades to NC CSRS in order to make the system more user-friendly, improve reporting capabilities, provide inter-state connectivity with other Prescription Drug Monitoring Systems, and connect to the statewide health information exchange. Mandatory NC CSRS registration and use provisions become effective once the State Chief Information Officer confirms the required upgrades to

NC CSRS are fully operational within the Department of Information Technology and the system is connected to the statewide health information exchange.

Prior to prescribing a Schedule II and Schedule III opioid or narcotic, practitioners are required to review a patient's 12-month prescription history in NC CSRS.

For every subsequent three-month period that the Schedule II or Schedule III opioid or narcotic remains part of the patient's medical care, practitioners are required to review the patient's 12-month history in the NC CSRS.

Reviews should be documented within the patient's medical record, along with any electrical or technological failure that prevents such review. Practitioners are required to review the history and document the review once the electrical or technological failure has resolved.

Certain practitioners may, **but are not required to**, review NC CSRS when prescribing a targeted controlled substance to a patient in any of the following circumstances:

- Medication is administered in a health care setting, hospital, nursing home, outpatient dialysis facility or residential care facility.
- Medications are prescribed for the treatment of cancer or another condition associated with cancer.
- Medications are prescribed to patients in hospice care or palliative care.

The STOP Act authorizes NC CSRS to conduct periodic audits to determine prescriber compliance with review requirements. NC CSRS shall report to the Board any licensee found to be in violation of the requirement to check the system; violations may result in regulatory action by the Board.

FAQs: The STOP Act of 2017

NCMB has received numerous calls and emails from licensees seeking guidance about various provisions of the state's new opioids law, the Strengthen Opioids Misuse Prevention or STOP Act.

Q: The STOP Act requires that, effective July 1, 2017, PAs and NPs practicing in pain clinics "consult" with their supervisors before prescribing any Schedule II or Schedule III opioid or narcotic. This provision took effect July 1, 2017. How does NCMB define a "consultation" between a physician assistant or nurse practitioner and his or her supervising physician?

A: The Board has directed staff to make a recommendation on what is considered a consultation. This will be presented for Board review at the September Board meeting. The Board's intention is to adopt a rule that formally defines what type of interaction between supervisee and supervisor is required to constitute a consultation. An important consideration is whether a meaningful consultation about the patient and the recommended treatment occurs and is documented in the patient record. The Board might ultimately leave it to the discretion of PAs, NPs and their supervising physicians to determine how consultations occur (e.g. in person, via telephone or other electronic means).

Q: How is "pain clinic" defined in the STOP Act so PAs or NPs know whether they practice in one?

A: The STOP Act defines a pain clinic as "a facility that primarily engages in the treatment of pain by prescribing narcotic medications or advertises in any medium for any type of pain management services." This definition would not normally include recognized hospice or palliative care practices which may, as a part of their usual practice, provide palliative care for pain.

Q: Effective Jan. 1, 2018, the STOP Act establishes limits on initial prescriptions for acute pain and post-surgical pain to a five day supply and a seven day supply, respectively. Is it permissible for the prescriber to authorize additional pain medication if the patient's pain persists after the initial prescription is exhausted?

A: Yes, a prescriber may authorize additional pain medications if he or she determines more medication is clinically indicated after the initial supply has been exhausted.

Q: Does the STOP Act place any limits on how much pain medication may be initially prescribed to a patient for the treatment of chronic pain?

A: No. The STOP Act limits only initial prescriptions for acute pain and post-surgical pain. There are no limits on the amount of medication that can be prescribed to treat chronic pain in a new or established patient, although any treatment recommended should be consistent with current accepted standards of care. The prescriber would be obligated to comply with the STOP Act provision that calls for a mandatory review of the patient's 12-month prescription history with NC CSRS before authorizing any prescription for chronic pain. Periodic CSRS reviews should be conducted every three months after the initial prescription for a Schedule II or Schedule III opioid or narcotic is written, for as long as the patient continues on the medication.

Q: How should the prescriber determine three month intervals for the purpose of periodically reviewing the 12-month NC CSRS prescription history of a patient who is continuing on Schedule II or Schedule

III opioids or narcotics? (Mandatory use of NC CSRS will not be in effect until system upgrades are completed – date TBD)

A: NC DHHS will determine this through the NC Controlled Substances Reporting System (NC CSRS), as the STOP Act identifies NC DHHS as the agency that will audit prescribers for compliance with this provision. The most obvious option is to review the 12-month prescription history three months after the initial prescription is written (review of the 12-month history prior to the initial prescription is also required). However the prescriber chooses to calculate the three month period, it seems important that the required review be performed before issuing another prescription for the targeted controlled substance. It might also be beneficial to be consistent and use the same method each time.

Q: How are prescribers going to manage the additional work involved with conducting NC CSRS queries and reviewing results in order to comply with the STOP Act provisions related to mandatory use of the prescription monitoring system?

A: There is no question that complying with mandatory NC CSRS use provisions will create additional work for prescribers and their staff. However, here are some points to keep in mind:

- Provisions related to mandatory registration for and use of NC CSRS do not have a firm effective date, so prescribers will have time to plan and prepare. The provisions will not go into effect until NC DHHS makes technical upgrades to NC CSRS in order to make the system more user-friendly, improve reporting capabilities, provide interstate connectivity with other Prescription Drug Monitoring Systems, and connect to the statewide health information exchange. Mandatory CSRS registration and use provisions become effective once the State Chief Information Officer confirms the required upgrades to NC CSRS are fully operational within the Department of Information Technology and the system is connected to the statewide health information exchange.
- The STOP Act also includes provisions to streamline the process of registering delegates (nurses, medical office staff) with NC CSRS. Delegates can conduct NC CSRS queries for the prescriber, who can then review the information before the patient visit. This allows the prescribers to share the workload with other members of the health care team.

Q: Are Ritalin and other medications used to treat Attention Deficit Hyperactivity Disorder (ADHD) considered "targeted controlled substances" and, thus included in the electronic prescribing and mandatory CSRS use provisions of the STOP Act?

A: No. Targeted controlled substances are Schedule II and III opioids and narcotics per the North Carolina Controlled Substances Act, specifically those listed in N.C. Gen. Stat. § 90-90(1), (2) or 90-91(d). Ritalin and other stimulants are listed in N.C. Gen. Stat. § 90-90 (3) and, thus, are not considered targeted controlled substances under the STOP Act.

Suggest additional FAQs

Question not on our list? Suggest additional FAQs by emailing *forum@ncmedboard.org*

STOP Act effective dates

July 1, 2017: PA/NP consultation with supervising physicians prior to prescribing; Hospice providers to notify families of safe disposal options for unused drugs; Streamlined process for registering delegate NC CSRS accounts; Community distribution of naloxone by organizations with standing orders

Sept. 1, 2017: Pharmacies required to report prescriptions to NC CSRS by close of business the day after a medication is delivered

Jan. 1, 2018: Limits on initial prescriptions for acute pain (no more than a five day supply) and post-operative pain (no more than a seven day supply)

Jan. 1, 2020: Electronic prescriptions required for all targeted controlled substances

Date not yet determined: Mandatory use of NC CSRS prior to prescribing Schedule II or Schedule III opioids or narcotics; Subsequent reviews required every three months thereafter

Workshop aims to reenergize physicians

Anne Micheaux Akwari, MD

Anne Micheaux Akwari is a Durham physician and attorney who develops personalized solutions for physicians seeking to enhance their professionalism, communication skills, teamwork, and leadership abilities. Akwari will present a day long workshop entitled, *"Why did I choose to practice medicine? A Communications Approach to Constructing Professional Identity and Satisfaction"* on Sept. 23 at the Andrews Center at WakeMed Health & Hospitals in Raleigh (visit *www.wakeahec.org* for more information). Dr. Akwari agreed to share some insight into the workshop with *Forum* readers:

Q: Why is this sort of workshop needed?

A: To be only a little bit provocative, our profession is under siege. We should be proactive and be protective of our patients and our profession. Communication is our most frequently used clinical tool - it's how we get our work done. Skilled communication is more efficient in the clinic and it is imperative in cycles of communication we should be having within our systems and in civil discourse in order to preserve the profession's ability to serve patients.

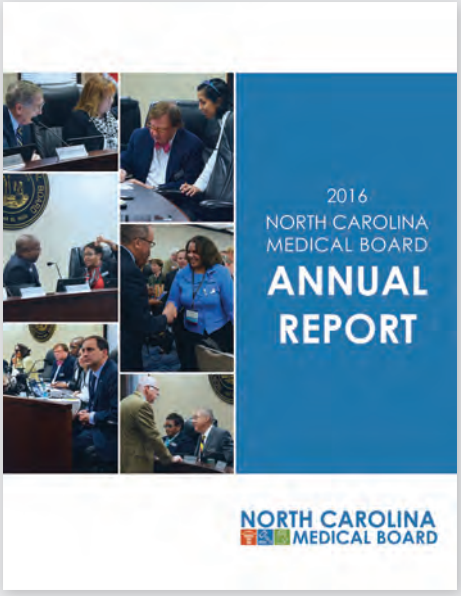
Q: Who would benefit from participating?

A: Everyone. Until the 2003 requirement for communication education in all US medical schools, how we related to others was thought to be innate; either you had it or you didn't. Fortunately, scholarship has shown that we can develop skills to be as purposeful and precise with our words as we are with palpation or the scalpel. Every physician needs to communicate well with patients and know how to partner and lead to enhance personal, patient, and organizational capacity.

Q: Why is it important for clinicians to retain their purpose and passion for medicine in today's challenging practice environment?

A: We need a personal and professional identity rooted in the constructive ideals that drew us to medicine. Our patients cannot afford for us to lose heart. They need to know that we can answer their needs at whatever place of life they find themselves and that we can preserve American medicine toward that end.

Request a copy of our 2016 Annual Report



NCMB presents highlights of the Board's work during each calendar year in its agency annual report. The Board has published a limited number of paper copies, which are available upon request. To request a hard copy, email your name and mailing address to *forum@ncmedboard.org*. The report can be accessed online at *www.ncmedboard.org/about-the-board/annual-reports*.

The Annual Report includes:

- Licensee demographic information
- Overview of significant policy and Board initiatives in 2016
- Summary of NCMB budget
- Licensing program highlights
- Complaint and investigative information
- Summary data about case resolutions, including public actions
- Preview of NCMB strategic goals for 2016
- Roster of current Board Members

Faculty needed for upcoming controlled substances CME panel sessions

NCMB and Wake AHEC have obtained grant funding to develop a statewide series of panel discussions on responsible opioid prescribing practices. Panel discussions will cover the educational topics required by NCMB's new CME requirement for controlled substances prescribers and will offer two hours of AMA PRA Category 1 CME credit at no cost to attendees.

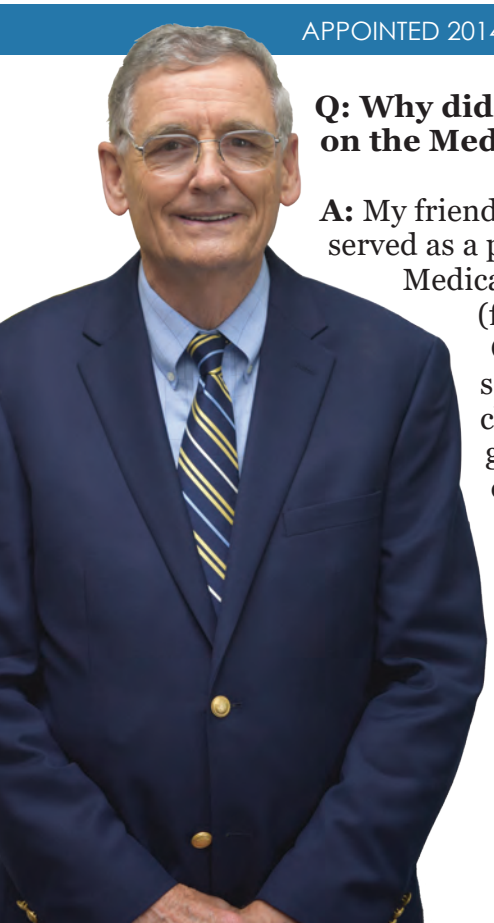
An initial series of four panel sessions reached about 400 prescribers in the greater Triangle area. The next phase of this project will include up to 20 additional panel sessions, to be held statewide beginning in September.

The Board is seeking clinicians with relevant experience in primary care, psychiatry, addiction medicine and pain management to serve as faculty. If you are interested in serving as a panelist for sessions held in your region, please email the Board at *PrescribingCME@ncmedboard.org*.

GETTING TO KNOW THE PEOPLE OF THE NC MEDICAL BOARD

Five Questions: Ralph W. Walker, JD

APPOINTED 2014 | RETIRED JUDGE | PUBLIC MEMBER | GREENSBORO, NC



Q: Why did you want to serve on the Medical Board?

A: My friend Judge Jack Lewis served as a public member on the Medical Board for six years (from Nov. 2007 until Oct. 2013). I likewise saw this to be a new challenge and a way to give back to the people of our state.

Q: What do you find most rewarding about your service on the Board?

A: As Board Members we engage in the pursuit of common goals after debate and discussion. I see medical professionals who have erred but who are then able to turn their lives around.

Q: What is the best lesson you have learned from your personal or professional life experiences?

A: As a lawyer and, later, as a judge, I learned to treat people with respect, to be a good listener and to treat everyone on a level playing field.

Q: What has surprised you about serving on the Board?

A: The number and types of issues and cases that come before us and upon which we must make decisions. Also, the amount of preparation required before and during meetings and hearings. It takes many, many hours to do all the reading necessary to participate.

North Carolina Medical Board

Quarterly Board Actions Report | February 2017 - April 2017

The Board actions listed below are published in an abbreviated format. The report does not include non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. A complete listing of recent Board actions is available at *www.ncmedboard.org/BoardActions*.

Name/license #/location	Date of action	Cause of action	Board action
ANNULMENTS			
NONE			
SUMMARY SUSPENSIONS			
NONE			
REVOCATIONS			
MITCHELL, James Alistair, MD (200400921) Oklahoma	02/17/2017	Boundary issue, inappropriate prescribing of narcotics; While practicing in Fayetteville, MD developed a close personal relationship with a patient who was later diagnosed with chronic pain. MD prescribed pain medication to an acquaintance of the patient, with the understanding that this person would give the medication to the patient. This was done on more than one occasion. MD was charged in September 2016 with multiple felony counts of prescribing controlled substances with no legitimate medical purpose and multiple felony counts of conspiring to traffic opium.	Revocation of NC medical license
SUSPENSIONS			
NONE			
PROBATION/LIMITATIONS/CONDITIONS			
ELLISON, Carrol Wendell, MD (000019994) Morganton, NC	02/15/2017	Inappropriate and excessive prescribing of controlled substances for the treatment of pain.	Beginning on Feb. 28, MD shall not prescribe any controlled substance other than Suboxone; Beginning March 6, MD shall not prescribe controlled substances of any kind. MD shall give up his DEA registration prior to March 10, 2017.
GETTINGS, Justin Luke, MD (201700229) Chapel Hill, NC	02/13/2017	MD's May 2015 consent order is amended; MD is issued a full medical license effective the date of this order. MD is restricted to practicing only within his residency program and to locations approved by his residency program. This restriction shall be lifted upon MD's successful completion of the residency program.	History of substance use; MD has completed inpatient treatment and NCPHP has advocated for his return to active medical practice.
MCCLELLAND, Scott Richard, DO (000029064) Wilmington, NC	04/25/2017	Quality of care; Substandard treatment of chronic pain; inappropriate prescribing of controlled substances.	DO shall surrender DEA registration; Within 60 days of the date of this order DO must submit himself to the Center for Personalized Education for Physicians (CPEP) for a comprehensive assessment.
REPRIMANDS			
LOCKLEAR, Leverne, PA (000101065) Raeford, NC	02/22/2017	PA began practicing medicine without appropriately submitting and receiving confirmation of receipt of a mandatory Intent to Practice form. PA practiced for 22 months without a valid Intent to Practice in place.	Reprimand
MCKEOWN, John Michael, MD (201700808) Oak Brook, IL	04/18/2017	In Jan. 2015, MD entered into a consent order with the Illinois medical regulatory board based on his admission of having ordered non-FDA approved chemotherapy products for use in his practice. MD then failed to disclose this order to the Kentucky medical board, for which he was reprimanded. The Kentucky action led the Illinois board to suspend MD's action in May 2016. MD appealed the suspension and the Illinois board vacated the May 2016 order and issued a reprimand in Jan. 2017.	Reprimand
MILLER, Jeffrey Scott, MD (000028781) Torrington, CT	02/13/2017	Action taken by another state medical board; MD entered into a consent order with the Connecticut board wherein he accepted a reprimand and a $5,000 fine based on findings that MD prescribed controlled substances to family members with whom he did not have a legitimate physician-patient relationship.	Reprimand

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TIDBALL, John Scott, MD (009600015) California, MD	03/02/2017	Action taken by another state medical board; MD entered into a consent order with the Maryland State Board of Physicians related to findings that MD's treatment of patients with chronic pain was below accepted standards.	Reprimand; MD is restricted from treating chronic pain. MD may treat acute pain in emergency cases, with opioid prescriptions not to exceed a seven day supply.
DENIALS OF LICENSE/APPROVAL			
SURRENDERS			
PUBLIC LETTERS OF CONCERN			
BEITZEL, Melissa Blakely, PA (001001440) Fayetteville, NC	02/13/2017	The Board is concerned that PA's care of a patient with schizoaffective disorder may not have been consistent with current accepted standards. Specifically, the Board is concerned that the patient's medication doses may have been too high. PA has agreed to take targeted CME to address the issues raised.	Public Letter of Concern
BOSS, Donald Jeffrey, MD (200500163) Rolling Hills Estates, CA	02/27/2017	Action taken by another medical board; In Sept. 2016, MD accepted a public reprimand from the Medical Board of California based on MD's plea of nolo contendere to driving with a blood alcohol content of 0.08 percent or higher in Los Angeles, California, on December 17, 2013.	Public Letter of Concern
BROWN, Howard Richard, MD (200101180) Henderson, NC	02/02/2017	MD's request to supervise mid-level practitioners is granted; MD is advised that failure to follow rules related to physician assistant supervision may result in the Board commencing formal disciplinary action.	Public Letter of Concern
DRIGGS, Shane Cash, MD (201300148) Corpus Christi, TX	02/03/2017	Action taken by the Texas medical board; MD entered into a Consent order dated December 4, 2015, with the Texas Board relating to MD's prescribing and medical record documentation. MD was required to complete CME, pass the Texas jurisprudence exam and pay a $2,000 fine.	Public Letter of Concern
HALL, Wesley Wilkinson, MD (000022575) Reno, NV	04/19/2017	Action based on action taken by the Nevada Board of Medical Examiners; The Board is concerned that MD entered into a settlement agreement with the Nevada board based on findings that MD provided substandard care to a patient upon whom MD performed laparoscopic cholecystectomy, as well as MD's postoperative management of complications from that surgery.	Public Letter of Concern
HEDRICK, William Weston, MD (000010830) Raleigh, NC	03/28/2017	Inappropriate prescribing of controlled substances.	Public Letter of Concern
KAPLAN, Robert David, (00 9400086) Greenville, NC	04/12/2017	The Board is concerned that MD wrote several prescriptions for controlled substances to a physician colleague with whom MD did not have a formal physician patient relationship. These prescriptions were provided intermittently over a period of several years. The Board recognizes that MD stopped prescribing to the colleague after MD had his nurse check NCCSRS and discovered the colleague was receiving prescriptions from another physician.	Public Letter of Concern
KORTESIS, Bill Gus, MD (200800206) Huntersville, NC	02/23/2017	The Board is concerned that, while MD was serving as medical director for a Charlotte medical spa, certain procedures involving the assessment of patients prior to treatments, including injections of Botox® and dermal fillers, were carried out by a registered nurse. It is beyond the lawful scope of practice for a registered nurse to assess patients prior to performing cosmetic medical procedures. Such assessments should only be performed by a physician, physician assistant or nurse practitioner.	Public Letter of Concern
MCANALLEN, Terry Joseph, DO (200301013) Henderson, NV	02/21/2017	Action taken by another state medical board: DO entered into a settlement agreement and order with the Nevada Osteopathic board related to findings that DO pre-signed prescription blanks and twice wrote prescriptions for controlled substances to a staff member without maintaining a medical record that documented a legitimate medical purpose. DO paid $175 in fees and costs and a $2,500 fine.	Public Letter of Concern

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NEWMAN, Rosemarie Christine, MD (009800649) Raleigh, NC	02/14/2017	The Board is concerned that MD failed to appropriately stage a hysteroscopic resection procedure to avoid prolonged operative time and fluid overload. The patient suffered oxygen desaturation as a result of significant pulmonary and laryngeal edema.	Public letter of concern
NGUYEN, Tony Chieuvan Bui, MD (201101705) Oakton, VA	02/02/2017	Action taken by another state medical board; In April 2015, MD was convicted of misdemeanor sexual battery against two patients (Patients A-B) and misdemeanor assault and battery against five patients (Patients C-G). MD was sentenced to a total of seven months incarceration. MD entered into a Consent Order on October 1, 2015, in which the Virginia Board accepted the voluntary surrender and revocation of MD's Virginia medical license.	Public letter of concern
PO, Christopher Lucio, MD (201200260) Loris, SC	02/09/2017	The Board is concerned that MD may have provided substandard care to a thirty-one year old male with end-stage renal disease who presented to an Emergency Department ("ED") with a cough, fever, and acute pain. The initial presumptive diagnosis was sepsis and he was given cefazolin and gentamicin. Patient A's allergy history was noted to include penicillin and vancomycin. Patient A subsequently underwent two transfers of care. It was indicated during these transfers, by various physicians, that Patient A would require intravenous vancomycin to treat sepsis. As MD had served as Patient A's nephrologist in the past, MD was aware he had received vancomycin in the past (both intravenously and intraperitoneally) and had previously developed tachycardia and dyspnea after receiving vancomycin. MD stated he had concluded Patient A's reaction to the most recent exposure to vancomycin was not a true allergic reaction, but rather "red man syndrome" and that Patient A now required vancomycin to successfully treat the sepsis. Within minutes of the start of the vancomycin infusion Patient A developed tachycardia, dyspnea, and ultimately cardiac arrest, from which he could not be revived.	Public letter of concern
SHILKITUS, William Francis, PA (001000815) Whispering Pines, NC	04/12/2017	PA treated a ten-year-old who presented with a chief complaint of cough, headache, sore throat, and fever. The patient's blood pressure was elevated, 140/90, and she had a fever of 103.2 F°. According to the history taken by PA, Patient A denied nausea, vomiting, or diarrhea. The physical examination documented a normal respiratory assessment. PA diagnosed strep throat, prescribed amoxicillin, and discharged the patient home. PA did not consider influenza in his differential diagnosis or run any diagnostic testing to determine whether the patient had the flu. The patient died two days later from pneumonia secondary to influenza infection.	Public letter of concern
SALINAS, Ruben Rolando, MD (200201161) New Bern, NC	03/30/2017	The Board is concerned that MD's treatment of a patient for drug addiction may have failed to conform to accepted standards of care. In addition, MD has a working relationship with the patient, which created the potential for boundary issues. The Board is also concerned that MD prescribed Suboxone to the patient without first obtaining DEA authorization to prescribe this drug.	Public letter of concern
WALLER, Brenda Sue, MD (000030755) Lynchburg, VA	02/03/2017	Action taken by another medical board; On January 21, 2016, MD and the Virginia Board entered into an Order relating to MD's care of 11 patients that MD treated from 2005 to 2014. The Virginia Board found that MD engaged in inappropriate controlled substance prescribing, inappropriate pain management care and failed to maintain adequate medical records for these 11 patients.	Public letter of concern
MISCELLANEOUS ACTIONS			
KHAN, Farouk Yusaf, MD (200000488) Dothan, AL	04/13/2017	Action based on August 2016 action by the Alabama Board of Medical Examiners to suspend MD's Alabama pain management registration based on inappropriate prescribing of controlled substances.	Interim Non-Practice Agreement; MD agrees not to practice medicine until a disciplinary hearing is held in Alabama and a final order is entered by the Alabama board.

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CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			

Glossary of Terms

Annulment: Retrospective and prospective cancellation of the practitioner's authorization to practice.

Conditions: Actions or requirements a licensee must complete and/or comply with as a condition of licensure.

Consent Order: An order of the Board that states the terms of a negotiated settlement to an enforcement case; A method for resolving a dispute without a formal hearing.

Denial: Decision denying an application for licensure, reinstatement, or reconsideration of a Board action.

Dismissal: Board action dismissing a contested case.

Inactive Medical License: Licenses must be renewed annually in NC. The Board may negotiate a provider's agreement to go inactive as part of the resolution of a disciplinary case.

Public Letter of Concern (PubLOC): A public record expressing the Board's concern about a practitioner's behavior or performance. A public letter of concern is not considered disciplinary in nature; similar to a warning.

Revocation: Cancellation of authorization to practice. Authorization may not be reissued for at least two years.

Stay: Full or partial stopping or halting of a legal action, such as suspension, on certain stipulated grounds.

Summary Suspension: Immediate cancellation of authorization to practice; Ordered when the Board finds the public health, safety, or welfare requires emergency action.

Suspension: Withdrawal of authorization to practice, either indefinitely or for a stipulated period of time.

Temporary/Dated License: A License to practice for a specific period of time. Often accompanied by conditions contained in a Consent Order.

Voluntary Surrender: The practitioner's relinquishing of authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.

Limitation: A restriction placed on a licensee's practice. When practicing under a restriction, it is not lawful for the licensee to engage in the prohibited activity. Example: Dr. Smith is restricted from prescribing Schedule II and III medications.

NEED A SPEAKER?

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

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

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Call for physician applicants: serve on the NC Medical Board

As of November 1, NCMB will have one seat available for physician who is
1) an osteopathic physician

2) a member of the Old North State Medical Society OR

3) a full-time faculty member of an NC medical school who uses integrative medicine in practice.

Applicants are still needed for this Board seat, which is appointed directly by the Governor. Interested physicians may apply at:

https://governor.nc.gov/application-boards-and-commissions

BOARD MEETING DATES

September 20-22, 2017 (Full Board)
October 19-20, 2017 (Hearing)
November 15-16, 2017 (Full Board)
December 14-15, 2017 (Hearing)
January 17-19, 2018 (Full Board)

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

www.ncmedboard.org