



North Carolina Medical Board FORUM

ISSUE NO. 4 | First Quarter 2018

FROM THE PRESIDENT

NCMB's mission: more than patient protection

Timothy E. Lietz, MD

In November, I had the honor of being sworn in as the North Carolina Medical Board's 119th President. A little over five years ago, when I was a new Board Member, it would have been hard to believe I'd find myself in the top leadership position. Like many physicians, aside from the direct experience renewing my license each year, I had very little understanding of NCMB's role in the practice of medicine. I became interested in learning more through my work as a partner in a large emergency medicine practice in Charlotte, where I am responsible for responding to the occasional complaints we receive from patients. We are usually able to resolve concerns without further escalation but, from time to time, I'd receive a letter from NCMB directing me to respond to a complaint from a patient seen by a provider in my group had submitted.

I'll admit to feeling somewhat

affronted by having to answer to the medical board. I happen to believe that my practice, and the larger community of physicians and other medical professionals, hospitals and others involved in the delivery of medical care in Charlotte, do an excellent job of holding one another accountable, when necessary. In an emergency department, we practice in a fishbowl and everyone knows what everyone else is doing. When someone is not practicing up to standard, everyone knows and that behavior won't be tolerated for long. What additional value, I wondered, could the medical board possibly provide?

Serving on the Board – and specifically, reviewing disciplinary cases – quickly taught me that the level of transparency and accountability I take for granted isn't necessarily in place in every practice environment. There are a lot of areas in NC where the licensee practices in his or her own bubble and no one is watching. Who holds that physician or PA responsible if patient care is substandard? Who intervenes if the licensee exploits patients sexually or financially? Who will ensure that he or she gets assistance with substance

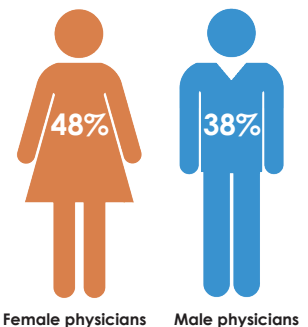
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SPOTLIGHT

The burnout burden

According to the 2018 Medscape National Physician Burnout & Depression Report, 42 percent of physicians in 29 specialties reported symptoms of professional burnout. Women report burnout more frequently than men.



Burnout rates reported, by sex

Source: Medscape 2018 National Physician Burnout & Depression Report

Continued on pg 2



Dr. Timothy E. Lietz was sworn in as NCMB's 119th President on November 16, 2017

holding medical providers accountable, and the only agency with the authority and imperative to act. I should also say that inadequate oversight is not limited to rural or less populous parts of North Carolina. No part of the state or practice environment is perfect at identifying and addressing problems with professional misconduct or medical care.

When NCMB acts to address serious problems with licensee conduct or care, we protect both the people

use or mental health problems, if needed? In many cases that come to the Board's attention, NCMB is the patient's only means of

of North Carolina and the integrity of the medical profession. Allowing misconduct or substandard care to continue unchecked impugns the reputations of all honorable and competent medical professionals. In situations where impairment has eroded a physician or PA's professional and personal life, the Board's involvement is often the start of a process that literally saves that licensee's practice, not to mention life.

NCMB's mission truly is to regulate medicine and surgery for "the benefit and protection of the people of North Carolina" – a group I have come to realize includes the medical professionals it regulates.



Be well,

Timothy E. Lietz, MD
Board President



FREE IN PERSON CONTROLLED SUBSTANCES CME NEAR YOU

- 3/31 Morehead City - Crystal Coast Civic Center
- 4/3 Concord - Carolinas Medical Center
- 4/19 Salisbury - Rowan Museum
- 5/8 Shelby - Carolinas Medical Center,
- 5/9 Clemmons - Village Inn Event Center

NCMB and Wake AHEC with support from Governor's Institute have collaborated on a new webinar and in person panel discussion series on controlled substances prescribing and we may be coming near you. See full details at www.ncmedboard.org/controlled-substances-cme-requirement

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The *Forum* of the North Carolina Medical Board is published four times a year. Articles appearing in the *Forum*, including letters and reviews, represent the opinions of the authors and do not necessarily reflect the views of the North Carolina Medical Board, its members or staff, or the institutions or organizations with which the authors are affiliated. Official statements, policies, positions, or reports of the Board are clearly identified.

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

TRENDING AT NCMB

NC's new opioid prescribing limits

The prescribing limits contained in NC's opioids law, the STOP Act of 2017, took effect Jan. 1, imposing new restrictions on initial prescriptions for acute pain. This change to state law has generated many questions from prescribers and patients.

The basics

The limits apply to initial prescriptions for acute pain, including post-operative pain, when a Schedule II or Schedule III opioid or narcotic is prescribed. For post-operative pain, initial prescriptions must be limited to no more than a 7-day supply. For non-postoperative pain, initial prescriptions must be limited to no more than a 5-day supply. The STOP Act's prescribing limits do not affect prescriptions for chronic pain patients.

Learn more

NCMB has created an extensive list of FAQs about the new prescribing limits to help licensees understand what has and has not changed about current acceptable clinical practices when treating acute pain. The Board first distributed this content to email readers of the *Forum* in January in the digital supplement NCMB is testing in between full issues of the newsletter.

The FAQs present basic information about the prescribing limits, as well as specific scenarios in which the limits do and do not apply.

What kinds of questions?

You'll find this and other questions in our prescribing limit FAQs:

Q: Are prescriptions for Tussionex subject to the new prescribing limits?

A: No. Although Tussionex (hydrocodone syrup) is a Schedule II drug, it is typically prescribed for cough, not acute pain. The STOP Act prescribing limits apply only when a Schedule II or Schedule III opioid is prescribed for acute pain. That said, Tussionex is frequently abused and prescribers should exercise caution when writing for this medication. Consider prescribing a short course sufficient to get the patient through the illness, rather than authorizing whatever insurance will cover (e.g. 30 days).

Find the STOP Act prescribing limits FAQs at www.ncmedboard.org/STOP

STOP Act notice now available in Spanish!



AVISO A LOS PACIENTES: Nuevos límites para recetas para medicamentos para el dolor agudo y postoperatorio.

A partir del 1 de enero de 2018, la ley de Carolina del Norte (la Ley STOP del 2017) limita la cantidad de medicamento para el dolor que puede ser recetado para el tratamiento del dolor de la mayoría de las lesiones y cirugías.

P: ¿Cómo limita la Ley STOP las recetas de medicamentos para el dolor?

R: La ley restringe la cantidad de ciertos tipos de medicamentos que pueden ser recetados para el dolor agudo. La Ley STOP limita las recetas iniciales para el dolor postoperatorio a un suministro de no más de 7 días. La ley limita las recetas iniciales para todo otro tipo de dolor agudo a un suministro de no más de 5 días.

P: ¿Las recetas para dolores crónicos están sujetas a estos límites?

R: No.

P: ¿Qué tipos de medicamentos están sujetos a estos límites?

R: Los límites de la Ley STOP solo se aplican a los opiáceos o narcóticos Schedule II y Schedule III, específicamente cuando se recetan para el dolor agudo. Algunos opiáceos del Schedule II son el OxyContin y el Percocet (nombres de marca para la oxicodona). El Tylenol n.º 3 (acetaminofén y codeína) es un ejemplo de opiáceo Schedule III.

P: ¿Les pueden volver a reabastecer la receta a los pacientes que aún sientan dolor después de terminar una receta inicial?

R: Sí. Los pacientes que aún sufren dolor agudo después de terminar su suministro de 5 o 7 días tienen que comunicarse con el consultorio. La persona que recibió el medicamento puede emitir la orden de reabastecimiento, si determina que es necesario.

Para aprender más sobre la Ley STOP y otras iniciativas sobre opiáceos, visite:
www.ncmedboard.org/safeopioids

NORTH CAROLINA
MEDICAL BOARD
www.ncmedboard.org
info@ncmedboard.org

NCMB has created a Spanish language version of its printable patient notice on the acute pain prescribing limits that took effect Jan. 1. The Board first distributed the notice to email readers of the *Forum* in January,

along with information about the limits, which are imposed by the STOP Act of 2017.

Licensees are invited to download the notice, which can be used to inform patients about the limits. The idea for this resource originated with a request from a medical practice that contacted NCMB to ask if the Board had prepared anything to help licensees explain the new prescribing limits to patients.

Find English and Spanish versions of the notice at www.ncmedboard.org/safeopioids under "NC's new opioids law - the STOP Act". NOTE: Licensees who practice in settings that provide care on demand (such as emergency rooms) are urged to seek legal advice before posting the notice to ensure compliance with federal EMTALA laws.

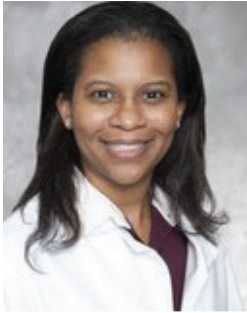
TAX
TIME IS
COMING

Need a copy of your 2017 license renewal receipt?

Print one on demand at
www.ncmedboard.org/PrintMyReceipt

High Point neurosurgeon named to Board

Governor Roy Cooper recently appointed High Point neurosurgeon Dr. Michaux R. Kilpatrick, MD, PhD, to a three-year term on the Board. Kilpatrick will serve through October 31, 2020.



**Michaux R. Kilpatrick,
MD, PhD**

Dr. Kilpatrick's practice focuses on diagnosing, evaluating, and treating disorders of the spine, brain, and peripheral nervous center in adults. She currently practices with UNC Health Care Regional Physicians Neurosurgery in High Point.

Michaux R. Kilpatrick, MD, PhD

Dr. Kilpatrick, a native of High Point, attended Hampton University in Virginia, where she earned a Bachelor's degree in Chemistry, magna

cum laude. She completed her medical degree at the UNC School of Medicine at the University of North Carolina, Chapel Hill, and a doctorate in neurobiology at the same institution. Dr. Kilpatrick completed postgraduate training in neurosurgery at UNC Hospitals and went on to complete a fellowship in stereotactic and functional neurosurgery at the Hospital of the University of Pennsylvania in Philadelphia. Dr. Kilpatrick is certified by the American Board of Neurological Surgery.

Dr. Kilpatrick is a member of the American Association of Neurological Surgeons, the Congress of Neurological Surgeons and the National Medical Association. She serves on the Surgery Governance and Professional Improvement committees of the UNC Health Care High Point Regional Health System, where she was named the 2016-2017 Specialist of the Year.

Beware of faxed "requests" for medicines and medical products

SCAM

ALERT

The NC Board of Pharmacy (NCBOP) took action in fall 2017 against several NC pharmacies involved in a national scam that resulted in unnecessary billing for diabetic pain creams and other products not prescribed by the patients' medical providers. Physicians and PAs are advised to be wary of faxed requests seeking authorization for any treatments they have not personally recommended for their patients.

The pharmacy scam targeted patients with diabetes, often with advertisements promoting free or low cost diabetic testing supplies. According to NCBOP, patients who responded to these ads spoke by telephone with unlicensed, non-medically trained sales representatives who pitched additional products, such as non-narcotic topical pain treatments including lidocaine ointment and diclofenac sodium gel.

After patients provide billing and insurance information, prescription orders are then faxed to the patients' medical providers for signatures, sometimes without the consent of the patient. Orders indicate that the patient has "requested" the items listed, prompting unsuspecting prescribers to authorize prescriptions and other items not prescribed by a licensed medical professional. This results in billing for items that may be unnecessary and unwanted by the patient. In some instances, patients never received items ordered on their behalf, according to NCBOP.

Bottom line: Be careful about automatically authorizing any order for medicine or medical supplies that you did not prescribe or recommend.

2017 position statement review

The Board reviews position statements at least once every four years, or more frequently if new information or issues come to light that may necessitate reconsideration, expansion or revision of an existing NCMB position. Here's what the Board worked on in 2017:

New position statements

The Board adopted one new position statement in 2017, entitled *Policy for the use of audio or visual recordings in patient care* (see the full text of the new position statement on page 6).

Why was this position statement needed?

This position statement originated from the Board's review of an enforcement case that involved a medical practice's use of video cameras for security, both in patient examination rooms and in public spaces such as the waiting and parking areas. A patient complained to the Board about this practice, stating specific concerns that the practice did not provide a private area for undressing and dressing. The Board's primary goals in drafting the position statement were to ensure that 1. Patients are provided a place to disrobe or redress in private and 2. Files are stored in a secure manner that is compliant with HIPAA privacy rules.

Amended position statements

The Board approved revisions to the following position statements.

Drug overdose prevention

What changed? The Board added language to encourage licensees to support the use of opioid antagonists (e.g. naloxone) as a means of preventing death from overdose; The Board also updated language that summarizes the Board's efforts to address patient deaths and harm from opioid over-

dose to include information about NCMB's opioids investigative program, the Safe Opioid Prescribing Initiative and implementation of a CME requirement for controlled substances prescribers.

Guidelines for avoiding misunderstandings during physical examinations

Revised to replace the word "sex" with "gender" in bullet point number two of the position statement.

Medical record documentation

Revised to include a substantial new section specific to Electronic Health Records. The new section is excerpted in the box on page 6.

Professional use of social media

Minor text change to second bulleted statement.

The treatment of obesity

Amended to add concerns about phentermine as an example.

Reviewed, no changes:

The Board reviewed the following position statements and determined that no changes are needed at this time.

Professional obligations pertaining to incompetence, impairment, and unethical conduct of healthcare providers

Unethical agreements in complaint settlements

What are the position statements of the Board and to whom do they apply?

What are position statements anyway?

Position statements provide guidance on a range of subjects, including direct clinical practice, professional ethics, legal and policy matters and other practice related topics. All position statements may be accessed at www.ncmedboard.org/PositionStatements.

A downloadable .pdf copy of the complete position statements is also available online.



Amended Position Statement

Electronic Health Records (excerpted from the position statement entitled, Medical record documentation)

The promise and potential of information technology in health care, particularly the use of electronic health records (EHR), presents providers with distinct challenges. While the Board encourages the adoption and appropriate use of various forms of EHR there are some unique aspects and problems that have been repeatedly encountered by the Board, some of which are discussed below. This subsection does not identify all of the issues and problems encountered by providers using EHR. Rather it is meant to identify issues which the Board has repeatedly found to be problematic in malpractice cases and complaints coming to the Board's attention. It is important to recognize that this, and other Board position statements, are not comprehensive and do not describe exhaustively every standard that might apply in every circumstance. Basic, well-established principles of medical record documentation, as outlined above, apply to all forms of medical record documentation, including EHR.

The following guidelines are offered to assist licensees in meeting their ethical and legal obligations:

EHR Deficiencies. Providers, on occasion, attribute errors or lack of follow-up, such as missed or lost abnormal laboratory results or x-ray reports, to deficiencies in their EHR. This is not acceptable. Providers must be aware of the idiosyncrasies and weaknesses of the EHR system they are using and adjust their practice accordingly. Providers are ultimately responsible for the adequate oversight and monitoring of the EHR.

Responsibility of Licensees. EHR are becoming increasingly sophisticated and may provide flags for follow-up care or other clinical decision-making support, such as health maintenance recommendations. While an EHR system may assist in the clinical decision-making process, it is not responsible for decision making. For example, it is not acceptable to blame an EHR because it failed to recommend particular testing. Increasingly elaborate documentation, clinical management, and productivity tools may also result in increased opportunities for errors or omissions. These errors are a failure of the provider to assume appropriate responsibility for the care of the patient. In the end, decision-making responsibility rests solely with the provider; regardless of the information or notices provided by the EHR.

Use of Templates. The Board cautions against overuse of template content or reliance on EHR software which pre-populates, carries forward, or clones information

from one encounter to the next, or from different providers, without the provider carefully reviewing and updating all information. Documentation of clinical findings for each patient encounter must accurately and contemporaneously reflect the actual care provided.

Availability of, or Access to, Medical Records. Physicians must be able to provide patient medical records in a timely manner for various situations, such as consultations, transfer of care to another provider, or practice closure. The Board has encountered situations where providers were unable to access their patients' medical records due to fee or other disputes with the EHR vendor. This is particularly true when the medical records are maintained off site (cloud storage). Providers must understand provisions of their contract with the EHR vendor in this regard. These principles of medical record access apply as well to telemedicine providers.

Breakdown of Patient-Provider Communication. Misunderstandings and miscommunications between patients, patient family members, practitioners, and office staff generate a substantial percentage of complaints received by the Board. Many EHR systems allow direct patient-provider communication (i.e. "patient portal"). While this form of communication can facilitate communication, such as follow-up of lab or x-ray results or medication refills, they also place a responsibility on the provider to provide timely responses to legitimate requests from patients for feedback or information.

New Position Statement

Policy for the use of audio or visual recordings in patient care

The Board recognizes that there may be valid reasons for licensees to make audio or visual recordings of patients during a healthcare encounter. However, such recordings must be made for appropriate professional reasons and should employ safeguards that protect a patient's autonomy, privacy, confidentiality, and dignity. **In instances where a patient may be asked to disrobe, the patient should be provided an opportunity to disrobe beyond the view of any camera.**

Prior to an audio or visual recording being made of a patient, licensees should ensure that they have obtained the patient's informed consent. The informed consent should be documented in the medical record and should allow the patient an opportunity to discuss any concerns before and after the recording.

Recordings that could lead to disclosure of the patient's identity constitute protected health information and must be managed and transmitted in a manner that complies with HIPAA requirements.

NC CSRS connects to multistate data sharing network



Physicians and other controlled substances prescribers registered with the state's prescription drug database now can see what medications their patients have received in other states.

Currently, NC prescribers who use the NC Controlled Substances Reporting System (NC CSRS) can get patient information from Virginia, South Carolina and over a dozen other states through the National Association of Boards of Pharmacy's PMP InterConnect, which NC recently joined. More states are coming online regularly, as the NC Department of Health and Human Services works to enable additional two-way prescription data sharing agreements with individual states. In all, 45 states are connected to PMP.

To obtain information from another state NC CSRS users must select "Multiple State Query" from the left-hand side of the page, after logging in. Available states are in the field labeled, "Disclosing States." It will be necessary to run a separate query for each state. In other words, to check a patient's prescription histories in NC, SC and Virginia, a prescriber or registered delegate would have to run three queries.

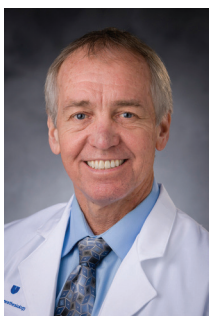
NC CSRS captures all controlled substances prescriptions that are dispensed by outpatient pharmacies in North Carolina. Other states' databases capture similar information. Prescribers can use prescription data to spot potentially harmful or contraindicated drug combinations and to better understand their patients' habits and behaviors.

So, is mandatory NC CSRS in effect now?

Not yet. NC CSRS's participation in PMP Interconnect is progress towards completion of NC CSRS improvements that are required before mandatory use can be in effect. However, NC DHHS must complete other technical improvements.

NCMB will continue to monitor progress and inform licensees when a specific effective date for mandatory NC CSRS use is established.

NC CSRS now provides multistate data. Now what?



Dr. Prakken

Prescribers registered with the NC Controlled Substances Reporting System (NC CSRS) can now obtain prescription drug histories from other states. The *Forum* asked the director of Duke Health's Medical Pain Service, Steven D. Prakken, MD, his thoughts on how this new capability fits in to clinical practice.

What factors would cause you to look at a patient's prescription history in another state?

If about 50 miles or less from the border then I would check it regularly. I would check at intake, then at least every 6-12 months. I would even suggest that anyone you give C2 meds to should have the neighboring states scanned once a year. If someone travels frequently to another state or if they have family in another state, I would check multi-state data regularly.

When would you not run out-of-state histories?

As I've indicated, there's no reason to run multi-state queries for every patient, every visit. I don't think there is anything that would make me "not" run out of state queries, if the situation fit the parameters stated above. Maybe if it was a script for someone in a nursing facility I could be convinced not to run one.

How do you see the availability of multistate prescription drug data fitting in to your practice and current NC CSRS use?

This is something I have looked forward to for a few years. There are situations every week where I wish I had easy access to surrounding state medication records. This is something I will check commonly for about 25% of my patients. This also is something that staff can be assigned to do.

Accepting role reversal: when the doctor becomes the patient

By Clark Gaither, MD



Collectively, too many healthcare professionals have a certain maladaptive mindset when it comes to their own health and healthcare. To varying degrees,

the internal script goes something like this:

- *I'm too busy to see to my own healthcare needs.*
- *My patients need me more than I need me.*
- *I will always know when I need help.*
- *My special knowledge will protect me.*
- *I will always be well.*
- *I am my own best doctor.*
- *Illness is a sign of weakness.*
- *Patient care always trumps self-care.*
- *Sure, I'm depressed but I'll just deal with it in my own way.*
- *I know I'm sick but I have to go in to work.*
- *All the good I do will protect me.*
- *Any health problems I may develop are too far off into the future to worry about now.*

These attitudes are inculcated into us throughout medical school and residency. They also come from the prevailing public notion of what a doctor is supposed to be, mostly driven by non-reality based Hollywood fiction.

So, dauntless, we put on our cloaks of invincibility, project the proper doctor persona, and carry on. Despite these attitudes, every provider currently training or in practice will one day take off the white coat and assume the role of patient.

This will happen, because all providers are human. Whether now or sometime in the future, we will experience the same medical maladies and infirmities as our patients. It can seem an especially cruel circumstance to a medical professional who has spent a lifetime seeing to the healthcare needs of others.

Doctors are great when it comes to caring for others, but they are not always so great at taking care of themselves. Far too many physicians and PAs get into trouble and end up before the Medical Board or at NCPHP because they chose to be their own providers and self-medicate rather than seek help from independent qualified professionals.

Burnout rates are extremely high and rising. When physicians burn out they will sometimes act out—with

drugs, alcohol or maladaptive behaviors. Depression can develop or deepen. Of course, the most serious way providers act out is with self-harm. Suicide rates among healthcare providers are alarmingly higher than the in the general population, especially among women.

We must become humble enough and love ourselves enough to accept our own humanity. Self-care must become a priority for every provider. The following changes to attitude and that “internal script” are all that is required:

- *Asking for help when I need it is a sign of strength.*
- *I need my own trusted healthcare provider and I will follow his or her advice.*
- *Sometimes I need to listen to what those around me are noticing because I may not always be able to see what others see in me.*
- *My own health comes first because I can't be the best doctor for my patients if I'm not healthy and at my best.*
- *I will never be so busy that I can't see to my own needs.*
- *I will never serve as my own healthcare provider.*
- *If I get sick I'll follow my provider's prudent advice.*

Everyone wants to achieve a state of wellness, and wellness begins with self-care. How can you determine where you are on the self-care scale? Ask yourself this one important question: Am I as great at taking care of myself as I am at caring for my patients? If the honest answer is no, it is time to turn away from the path of least resilience (pun intended) and make some changes. You, your patients, your family, and your community will be the better for it.



Clark Gaither, MD

Dr. Clark Gaither currently serves as Medical Director for the North Carolina Physicians Health Program. He is a board-certified family physician who has dedicated much of his professional career to helping physicians and other medical professionals overcome job-related burnout. He is an author and frequent presenter on the topic of professional burnout.

Supporting colleagues in a time of crisis

Physicians and physician assistants licensed by the Board contributed more than \$172,000 to the NC Physicians Health Program Treatment Scholarship Fund during the 12-months ended Dec. 31, 2017. The Scholarship Fund provides financial assistance to licensees who may not otherwise be able to afford treatment. Licensees can contribute to the fund during the annual license renewal process.

Licensee donations support two types of scholarships. Gifts from the Treatment Scholarship Fund help cover the cost of alcohol and substance use treatment. In some cases, funds also may be used to pay for inpatient and outpatient assessments. A second fund, the Michael Wilkerson Family Fund, assists families of practitioners who are in treatment. Awards from this fund can be used to assist with family expenses that arise during the time when a licensee is unable to practice.

The Treatment Scholarship Fund awarded 60 scholarships in 2017, totaling about \$170,000.

NCPHP is a not-for-profit organization that provides assessment, referral, monitoring, educational and support services for medical professionals with behavioral and substance use issues. Referrals to NCPHP are confidential. Licensees may remain anonymous, including to the Medical Board, if NCPHP can establish safety to practice or the licensee withdraws from practice while receiving treatment.

Want to donate?

- Visit: www2.ncmedsoc.org/Donate
- Complete the donation form
- Be sure to select NC PHP Treatment Fund or NC PHP Wilkerson Family Fund to direct your gift
- Donations may also be made through NCMB's annual renewal process

GETTING TO KNOW THE PEOPLE OF THE NC MEDICAL BOARD

Five Questions: Shawn P. Parker, JD, MPA

APPOINTED 2016 | ATTORNEY WITH SMITH ANDERSON | PUBLIC BOARD MEMBER | RALEIGH, NC

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

A: The Medical Board functions both as a quasi-judicial and quasi-executive body and it is truly fascinating to be involved in policy and process development in this capacity. I am quite proud to be part of such a prestigious institution.

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

A: The people. There is a very human element to matters that come before the board. I have found my fellow Board Members to be extremely thoughtful and compassionate, and the staff of NCMB regularly demonstrate these same qualities. It is a real honor and very rewarding to serve and work among such dedicated and skilled individuals.

Q: What is the last book you read?

A: I recently read *Humanity at Work*, by Sandy Costa. It is a compilation of letters, learnings, and other musings connected with humor and historic context. I was first drawn in by a reference to [Italian psychologist Roberto] Assagioli's quote, "There is no certainty, only adventure" and found myself wanting to apply the included wisdoms in my everyday life. Specifically, I like to repeat the following passage to my daughter as part of our tuck-in ritual: "You are a person on unimaginable worth and a treasure unique in all the universe." I highly recommend saying this to someone you love or even to yourself and see how well it resonates.

Q: What do you like to do in your leisure time?

A: I enjoy spending time with my family. I am a huge Carolina Panthers fan and I enjoy most, if not all, sports. I am also a bit of a foodie and enjoy watching cooking demonstrations and attempting new recipes.

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

A: "Be kind and try hard" is a mantra offered to me by a colleague and good friend, which has now become the expectation and unspoken rule within our family. I find it to be equally applicable professionally as well, and while I cannot quantify the number of successful outcomes from this approach, I fully believe it has improved the quality of the process.



North Carolina Medical Board

Quarterly Board Actions Report | August 2017 - October 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 | | | |
| GILLESPIE , Dorothy Lee, MD (201500423) Hattiesburg, MS | 10/02/2017 | In her January 2015 application MD failed to disclose a pending disciplinary investigation by the Mississippi Board of Medical Licensure for improper prescribing practices. MD was issued a license in NC in March 2015; The same month, the Board discovered that MD had surrendered her Mississippi medical license. MD's failure to disclose these circumstances on her application for a NC license violated the provisions of N.C. General Statute § 90-14(a)(3). | Annulment of NC medical license |
| SUMMARY SUSPENSIONS | | | |
| SMITH , Michael Alson, MD (000033467) Mount Holly, NC | 10/24/2017 | Board possesses information that indicates that MD engaged in forced or coerced sexual acts, sexual contact, and/or vaginal intercourse with patients in an examination room at his practice. | Summary suspension of NC medical license; hearing set for December 2017 |
| REVOCATIONS | | | |
| NONE | | | |
| SUSPENSIONS | | | |
| BYRD , Elizabeth McNeill, MD (009901257) Winterville, NC | 08/08/2017 | Alleged boundary violation; MD denies that she engaged in an inappropriate relationship with her patient. MD also denies patient's allegation that MD requested the he share a portion of his narcotic medications, which MD prescribed, for her own inappropriate personal use. | Indefinite Suspension |
| FLOM , Jonathan Andrew, MD (200400331) Fayetteville, NC | 08/21/2017 | Relapse of substance abuse disorder. MD voluntarily surrendered his license effective June 2017. | Indefinite Suspension |
| GYARTENG-DAKWA , Kwadwo, MD (200500050) Durham, NC | 10/12/2017 | In 2014, the Board received a complaint from a relative of one of MD's patients concerning quality of care. After a records review by an independent physician expert who opined that MD's overall treatment failed to conform to the standards of care, MD was assessed for medical competency by the Center for Personalized Education for Physicians. Their report found that MD was not practicing in a dangerous manner and his knowledge of pain management was mostly adequate, but that there were areas where MD would benefit from additional education and remediation. CPEP recommended a structured, individualized remedial medical education plan for MD. | Suspension for one-hundred eighty (180) days immediately stayed in its entirety. MD to begin his Center for Personalized Education for Physicians (CPEP) Educational Intervention Plan within 30 days from the date of consent order. This includes, and is not limited to, oversight, supervision and direction provided by an approved pain management educational preceptor physician. |
| LONG , James Randall, MD (000033456) Lexington, NC | 08/29/2017 | MD entered into a plea agreement in October 2016 to one felony count of unlawful distribution of Fentanyl. While MD was under federal indictment and was anticipating accepting the plea agreement where he would plead guilty to the charge, MD opened two additional medical practices. MD operated one of them by placing a physician in the practice after MD had surrendered his license on December 2016. Although MD made a good faith effort to transfer ownership after surrendering, by continuing to own and operate the medical practice MD engaged in the corporate practice of medicine. | Indefinite suspension of NC medical license; MD may not apply for reinstatement for a period of two years from the date of the surrender of his license, which shall be December 1, 2018. |
| MCGRATH , Timothy John, MD (200200571) Greensboro, NC | 08/04/2017 | Relapse of substance abuse disorder. MD voluntarily surrendered his license in May 2017. | Indefinite Suspension of NC Medical License |

BOARD ACTIONS

| Name/license #/location | Date of action | Cause of action | Board action |
|--|----------------|---|---|
| SPERRAZZA , Robert Bruce, MD (009401053) Panama City Beach, FL | 09/26/2017 | In April 2014, MD was convicted of a felony for Tax Evasion and Structuring Financial Transactions in United States of America v. Robert B. Sperrazza, 1:12-CR-00006-01. MD was sentenced to a period of imprisonment and released in February 2017. MD's NC medical license became inactive in November 2014. | MD's NC medical license suspended retroactively from April 2014 to February 2017. MD's NC medical license shall remain inactive. |
| PROBATION/CONDITIONS | | | |
| BAILEY , Scott Allen, MD (200500604) Mebane, NC | 10/03/2017 | MD has a history of alcohol abuse and had previously had his NC medical license indefinitely suspended. MD is an ongoing participant in NCPHP; NCPHP reports that MD is fully compliant with all its recommendations, and advocates for his return to practice. | MD shall maintain his NCPHP contract and complete 36 hours of Category 1 CME in pediatrics, including a pediatric advanced life support CME course approved in advance by the Board's Office of Medical Director. |
| BECERRA , Gonzalo Daniel, MD (201101599) Winterville, NC | 10/13/2017 | MD has a history of alcohol abuse and had previously entered into a consent order in November 2016 with the Board, in which his license to practice medicine was indefinitely suspended. NCPHP reports that MD has fully complied with his monitoring contract and advocates for MD licensure reinstatement. | License reinstated; MD to maintain his current contract with North Carolina Physicians Health Program and abide by its terms. |
| REPRIMANDS | | | |
| HINES , Marcono Raymond, MD (000022578) New Bern, NC | 08/03/2017 | In September 2016, the Board received information from the NC Department of Health and Human Services ("DHHS") related to MD's controlled substance prescribing. Four patients' records were reviewed by an expert pain management physician and each record showed that MD significantly departed from standards of acceptable and prevailing medical practice. Areas of concern included inadequate record keeping, inadequate drug screening and failure to appropriately respond to aberrant drug test results, poor evaluation of patient risk factors and potential drug interactions, opioid prescribing in the absence of a documented and justifiable diagnosis, and inadequate pharmacovigilance. | Reprimand; MD agrees to refrain from prescribing Schedule II and III controlled substance within 60 days following date of this order. MD's records shall be monitored by a Board approved physician monitor for six months, with regular face-to-face meetings. MD is ordered to complete 10 hours of Category 1 CME in medical record keeping and controlled substance prescribing. MD shall query the NC Controlled Substances Reporting System for every prescription for Schedule IV and V controlled substances he issues. MD shall read the Board's Position Statement entitled Policy for the use of opiates for the treatment of pain and submit a written attestation that he has. After completing all requirements, MD may petition the Board to modify this order to allow him to prescribe Schedule II and III controlled substances; the Board is under no obligation to approve such a request. |
| KWIATKOWSKI , Timothy Carl, MD (009701443) Charlotte, NC | 09/19/2017 | The Board received a complaint in March 2016 from a patient's family regarding MD's care and treatment of their family member in January 2015. MD had failed to attend to patient's low oxygen saturation levels, and the patient suffered a cardiac arrest and died. In February 2016, the Board received a report of a Change in Staff Privileges ("CISP") from Carolinas Healthcare System and the Board opened an investigation addressing MD's care of three additional patients. The reviewing medical expert found several quality of care issues with MD's diagnoses and treatments. | Reprimand; MD shall maintain his current two-year contract with NCPHP. |
| DENIALS OF LICENSE/APPROVAL | | | |
| SHANTON , Gregory Damon, PA (000101943) Newport, NC | 08/31/2017 | The Board denied PA's application for reinstatement of his license based on PA's prior history of substance abuse, diversion of controlled substances for personal use and history of failing to comply with the terms of his September 2007 consent order, which ordered that PA refrain from the use of alcohol. In addition, PA did not actively practice medicine during the two-year period immediately preceding the submission of his application to reactivate his suspended license. | Denial of request to reinstate PA license |

BOARD ACTIONS

| Name/license #/location | Date of action | Cause of action | Board action |
|---|----------------|---|--------------------------------|
| SURRENDERS | | | |
| MCCUTCHEN , William, DO (200501619) Aiken, SC | 10/23/2017 | | Voluntary Surrender of License |
| TESFAYE , Daniel, MD (009901623) Lithonia, GA | 08/23/2017 | | Voluntary Surrender of License |
| WADDELL , Roger Dale, MD (000030105) Aberdeen, NC | 08/18/2017 | | Voluntary Surrender of License |
| PUBLIC LETTERS OF CONCERN | | | |
| BERNDTSON , Keith Robert, MD (201701889) Park Ridge, IL | 08/02/2017 | Upon review of MD's application for a license to practice medicine in North Carolina, the Board was concerned about a Consent Order with the Illinois Board issued in June 2012, in which the Illinois Board found that MD inappropriately prescribed controlled substances to family members and prescribed excessive quantities of controlled substances to a patient. MD's Illinois medical license was placed on probation for one year and MD agreed to several conditions, including obtaining continuing medical education related to pain management and controlled substance prescribing. | Public Letter of Concern |
| BRILL , (II), Louis Beverly, MD (201200499) Fairfax, VA | 09/14/2017 | The Board is concerned about a Consent Order that MD entered into with the Virginia Board in February 2017, in which MD was reprimanded for failing to identify Patient A's tumor, resulting in a fourteen (14) month delay in the diagnosis and treatment of Patient A's cancer. | Public Letter of Concern |
| CONKWRIGHT , Caroline Elizabeth, PA-C (001005703) Elizabeth City, NC | 09/20/2017 | The Board is concerned that PA failed to file the required Intent to Practice form with the Board prior to commencing practice and this failure persisted for ~two years until PA was notified by the Board. Additionally, PA failed to conduct and document the required quality improvement meetings with her supervising MD for her first six months of practice. | Public Letter of Concern |
| DANIEL , Myriam Marie-Jude, MD (009401167) Greenville, NC | 09/13/2017 | The Board is concerned that MD co-signed approximately 15 controlled substance prescriptions in 2016 for patients she had not seen or treated. The prescriptions were then issued by a PA under MD's supervision that MD knew had an expired Drug Enforcement Administration registration. MD did this in an attempt to assist PA while he was in the process of renewing his registration. This is an unacceptable practice. | Public Letter of Concern |
| FULBRIGHT , Renee Annette, MD (200300619) Gastonia, NC | 09/19/2017 | The Board is concerned MD may have failed to conform to current accepted standards of care when MD discharged a patient who came to the Emergency Department (ED) complaining of chest pain and shortness of breath. MD ordered and reviewed tests, with the exception of the troponin test results, and discharged the patient before recognizing that her troponin levels were elevated and abnormal. An elevated troponin level is a marker for acute cardiac disease. Patient returned to the ED 10 hours later experiencing acute myocardial infarction and underwent an angiography and stent placement. | Public Letter of Concern |
| HOLM , Richard Philip, MD (200401073) Roanoke Rapids, NC | 10/20/2017 | MD was scheduled to perform trigger finger release surgery on a patient's right thumb. Prior to surgery and after consent documents had been reviewed, a nurse mistakenly combined the patient's signed consent form with the documents of another patient who was scheduled for carpal tunnel release surgery. MD subsequently performed carpal tunnel release surgery on the incorrect patient. Board acknowledges that while the nurse mistakenly indicated to MD that Patient A was to receive carpal tunnel release surgery, the MD has the ultimate responsibility to do all he can to ensure that the correct operation is performed even in the presence of mistakes by others. | Public Letter of Concern |

BOARD ACTIONS

| Name/license #/location | Date of action | Cause of action | Board action |
|---|----------------|--|---|
| JENSEN , Larry Jay, PA-C (000102963) Tarboro, NC | 09/21/2017 | Board is concerned that PA's examination of patient neglected to include areas relevant to the patient's presenting complaints. Consequently, PA's patient was released only to return two days later, to be referred to the hospital with ultimately fatal sepsis, thought due to a large necrotic sacral decubitus ulcer which PA failed to diagnose. | Public Letter of Concern, PA to complete Category I CME pre-approved by Board's Office of the Medical Director on the evaluation and management of decubitus ulcers and sepsis six months from the effective date of this public letter of concern. |
| MENON , Padman Achutha, MD (200301017) Virginia Beach, VA | 09/12/2017 | Board is concerned that MD allowed a PA to begin practicing under his supervision without first submitting the required Intent to Practice form with the Board. As the PA's primary supervising physician, MD is required to ensure her compliance with the Board's rules. Additionally, MD and PA failed to conduct and document quality improvement meetings for PA's first six months of practice, as required by rule. | Public Letter of Concern |
| PATTERSON , David Read, MD (000018696) Greensboro, NC | 10/23/2017 | Board is concerned that MD inappropriately obtained and prescribed controlled substances for himself and wrote controlled substance prescriptions for an immediate family member. Prescribing controlled substances to oneself or to close family members is prohibited by Rule 21 NCAC 32B .1001. | Public Letter of Concern; MD inactivated his license in February 2017 with no plans to return to practice. Board has provided MD a copy of Rule 21 NCAC 32B .1001 and the Position Statement titled "Self-Treatment and Treatment of Family Members". |
| SCALES , John Socrates, MD (201502423) Ocala, FL | 08/28/2017 | Action taken by Florida Department of Health (FL Board); The Board is concerned that MD performed a kyphoplasty on patient's T11 vertebrae, which was the wrong site. MD resolved this matter with the FL Board via a June 2017 Final Order and Settlement Agreement. Board urges MD to take steps to ensure the conduct does not happen again. | Public Letter of Concern |
| SIROIS , Cindy Nguyen, MD (200601680) Hudson, OH | 09/18/2017 | The Board is concerned that, when reviewing a patient's MRI, MD failed to recognize or report the presence of an intraspinal fluid collection that progressed to an epidural abscess compressing the cervical spinal cord. Patient underwent surgical drainage of the epidural abscess but was left with significant long term neurologic injury that might have been less had MD reported condition sooner. | Public Letter of Concern |
| SMITH , Tracey, PA-C (000102582) Greenville, NC | 09/20/2017 | Board received a quality of care complaint from a patient under PA's care and requested a review be conducted by an external expert specializing in pain management. Upon completion of review, the expert found four significant problems with care: (1) PA failed to use the NC Controlled Substance Reporting System query to determine patient suitability for initiating controlled substances; (2) PA failed to adequately monitor the signs of abuse, misuse, diversion or tampering; (3) PA failed to act on aberrant monitoring findings; and (4) PA's prescribed Suboxone® (buprenorphine) for opioid use disorder prior to receiving a DATA Waiver to lawfully do so. | Public Letter of Concern; Board requests PA take targeted CME to address quality of care issues outlined in investigation. Specifically, PA is directed to take four hours of CME in controlled substance management and two hours in urine drug screen interpretation and use. |
| YAKES , Wayne Francis, MD (200401355) Englewood, CO | 08/01/2017 | MD was arrested and charged with Driving While Impaired (DWI) in August 2010, but the charges were dropped. MD was arrested and charged with DWI in June 2015 and MD pled guilty to that charge. The Board is concerned that the MD did not report the August 2010 charge and arrest on his annual renewal applications until March 5, 2016. The 2015 DWI led MD to enter into a July 2016 Stipulation and Final Agency Order with the Colorado Medical Board, which placed MD's Colorado medical license on probation for five years and required MD to be monitored by the Colorado Physicians Health Program. | Public Letter of Concern; MD entered a contract with the North Carolina Physicians Health Program ("NCPHP") on February 20, 2017. The Board advises MD to comply with all recommendations. |

BOARD ACTIONS

| Name/license #/location | Date of action | Cause of action | Board action |
|--|----------------|---|--|
| MISCELLANEOUS ACTIONS | | | |
| FERGUSON , (Jr.), Robert Lee, MD (000034310) Hope Mills, NC | 09/14/2017 | Alleged inappropriate prescribing of narcotics; The Board has evidence from which it could conclude that MD's care failed to conform to current accepted standards of care. | MD's license is made inactive, in lieu of any further action by the Board. |
| JAYARAMAN , Arun Laxminarayan, MD (201200668) Phoenix, AZ | 09/26/2017 | In April 2017, MD submitted a license inactivation request to the North Carolina Medical Board. Additionally, in May 2017, MD entered into an Order for Probation; and Consent to the Same with the medical board in Arizona. In the Arizona Consent Order, MD admitted that he had presented for a scheduled shift while impaired by alcohol. The Arizona Consent Order indicated that while MD did not see any patients on that shift, MD's actions constituted unprofessional conduct; the order placed MD's Arizona license on probation. MD is required to participate in the Arizona Physician Health Program for one year. | NC medical license made inactive. |
| CONSENT ORDERS AMENDED | | | |
| LEWIS , Marvin, MD (000033542) Spring Lake, NC | 10/04/2017 | MD requested to be relieved of two conditions contained in his October 2014 Consent Order that 1) Restricted him from prescribing all controlled substances classified as Schedule II, III, and Schedule IV and 2) Restricted MD from supervising any advanced practice practitioners, including physician assistants and nurse practitioners. After meeting with MD, the Board decided to grant MD's request to lift these restrictions, subject to MD's completion of certain CME. | Amended Consent Order; MD is relieved of the obligations stated in paragraphs three and four of his October 2014 order; Within four months of the date of this amended order, MD shall complete continuing medical education ("CME") related to medical record keeping and controlled substance prescribing that has been approved in advance by the Board's Office of the Medical Director. |
| NAVARRO-MCGUINNESS , Cheryl Tan, DO (200601750) Mooresville, NC | 09/14/2017 | Amendment stems from August 2014 Consent Order wherein DO was reprimanded and fined \$1,000 for inappropriate and excessive prescribing of controlled substances. DO signed a Memorandum of Understanding (MOU) with DEA in May 2017. | Amendment to August 2014 Consent Order; DO must comply fully with the Memorandum of Understanding (MOU) with DEA signed May 2017 prohibiting DO from handling schedule II, IIN, III and IIIN controlled substances for two years and agreeing to prescribe only schedule IV and V controlled substances within the scope of DO's practice for patients with an established doctor-patient relationship. DO must also continue to adhere to all terms and conditions contained in her 2014 Consent Order with the Board. |
| WARONSKY , Roy George, PA-C (000102512) Charlotte, NC | 10/18/2017 | In June 2017, the Board and PA entered a consent order wherein PA agreed not to prescribe controlled substances. After accepting the consent order, PA completed 34 category I CME hours on the subject of prescribing controlled substances. Furthermore, PA is now practicing under different supervising physicians than those during the relevant times giving rise to the consent order. PA requested that he be allowed to prescribe Schedule IV and V controlled substances under a plan of increased supervision. | Amended Consent Order, PA may prescribe Schedule IV and V controlled substances under the following conditions: A) Whenever PA prescribes a controlled substance, a supervising physician must be onsite and available for consultation. B) PA's supervising physician(s) must review 25% of PA's patient charts in which PA prescribed a controlled substance, and document the review in the patient chart. C) PA and his primary supervising physician shall conduct and document monthly quality assurance meetings. D) PA shall, upon request, provide the Board patient charts so that the Board may review his care. All other terms and conditions of the June 9, 2017 Consent Order remain in effect. |

| Name/license #/location | Date of action | Cause of action | Board action |
|---|----------------|-----------------|--------------|
| 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.

Wait a minute, I don't supervise that NP or PA anymore...



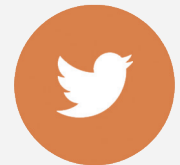
One of the most frequent inquiries NCMB gets is how a physician can remove a nurse practitioner or PA the physician no longer supervises from his or her licensee information page on the Board's website. Former PA supervisees can be removed by emailing a request to pa@ncmedboard.org.

NPs are licensed by the NC Board of Nursing and can only be removed by that agency. If you see a former NP still listed on your online NCMB licensee information page, teresaw@ncbon.org to let them know you no longer supervise the NP and would like them removed as an active supervisee. NCBON will notify the Board, which can then delete the NP from the physician's NCMB page.

TIP: It is the responsibility of the PA or NP to remove former supervisors by notifying the appropriate licensing board when they change supervisors. When ending a supervisory relationship, remind the PA or NP of this. PAs can remove old supervisors by going to www.ncmedboard.org/ITP and submitting an Intent to Practice form.

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Attention: Register with HealthConnex by June 1

NC DHHS recently announced that all providers who treat patients insured through Medicaid, NC Health Choice or the State Health Plan must register for the state's Health Information Exchange, HealthConnex, by June 1, 2018.

A health information exchange (HIE) is a secure electronic network that enables authorized health care providers to access and share health-related information. Its purpose is to improve health care quality, enhance patient safety, improve health outcomes, and reduce overall health care costs by enabling health information to be available securely whenever doctors, nurses and patients need it.

State law (NCGS 90-414.4) requires NC providers who participate with the state insurance programs listed above to register with HealthConnex no later than June 1 to continue receiving payments.

Visit www.hiea.nc.gov/ for more information. NC DHHS holds free monthly "How to Connect" conference calls that providers are welcome to join – check the website for upcoming dates.

Read FAQs about NC HealthConnex at:
www.hiea.nc.gov/frequently-asked-questions



BOARD MEETING DATES

March 14-15, 2018 (Full Board)
May 16-18, 2018 (Full Board)
June 21-22, 2018 (Hearing)
July 18-19, 2018 (Full Board)
Sept. 19-21, 2018 (Full Board)

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

www.ncmedboard.org