FORUM
NORTH CAROLINA MEDICAL BOARD
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Celebrating 150 Years

FROM THE PRESIDENT

Protecting patients:
We're all in this together

Some think of the North Carolina Medical Board as an all-knowing organization with superhuman powers. For example, at a recent physician gathering, I was asked why the Board doesn't make health insurance companies pay doctors their full fees. If only the Board had such authority!

The truth is that the Medical Board has virtually no direct influence over the day-to-day workings of medical practice. Nor does the Board have direct influence over hospitals, insurance companies, medical liability insurers or most other health organizations.

The Board has direct authority over its licensees—no one else. The Board has the power to issue or deny a license and to discipline its licensees. Period.

NCMB President, George Saunders, MD, says "The Board needs its licensees to step up to the plate as partners if we are to be successful."

In discharging these duties, the Board, like any other regulatory agency, must make the best use of finite resources. We maintain a full-time staff of investigators and a complaint department, but we also rely on you, our licensees, as well as the public, pharmacists, nurses and other medical professionals to tell us when something is wrong. We have 10 investigators and four complaint representatives in a state with 100 counties. You do the math.

I want to discuss two cases to illustrate a point. These two examples both involve surgeons, but similar cases are found in all specialties.

Case No. 1: A respected surgeon leaves academia for private practice. A single report of substandard care by this surgeon arrives at the Medical Board. It is one of more than 250 patient complaints received that month. Over the next few months several more cases about the same surgeon come to light. The investigation of the surgeon is fast-tracked. But as complainants are interviewed and cases are sent out by the Board for expert medical review, the story breaks in a local newspaper, and that story is picked up by several media outlets across the region. A dozen malpractice claims are filed against the physician in the space of a few months. Meanwhile the Board's investigation continues, though neither the press nor the public is aware of it as investigations are confidential under North Carolina law. End result: the Board is roundly criticized for failing to protect the public.

Case No. 2: A surgeon develops a niche performing bariatric surgery (surgery for drastic weight reduction). The surgeon has poor outcomes, which eventually lead to the suspension of some of the surgeon's hospital privileges. Lawsuits number in the dozens. A number of patients get one surgery even though they gave informed consent for another. Again, the story is widely covered by regional media. Once again, the Medical Board is castigated for allowing the surgeon's conduct to go on for far too long.

These two cases led to intense self-examination by the Board, which turned a critical eye towards improving its internal practices. Your Board learned from the above experiences, among others. And it made significant changes to its policies that have helped reduce pro-

IN THIS ISSUE

cedural delays that slow down the final resolution of any of the literally hundreds of open disciplinary cases the Board is managing at one time.

However, in the cases cited above and in too many other cases, hospitals, individual medical practitioners or other medical professionals were aware of problems that put the public at risk long before those problems came to the Board's attention.

Sometimes, information fails to get to the Board because of a breakdown in systems intended to report possible misconduct. For example, in both of the examples cited earlier, hospitals failed to report changes in staff privileges (CISP) to the Board as required by North Carolina law. The Board suspects underreporting of these actions by hospitals is a chronic problem, judging by the very small number of reports made each year. Last year, for example, the Board received just 14. Hospital CISP reports are an important source of information to the Board, which reviews each one thoroughly. Often, the Board's review determines there is no cause of action, but sometimes a CISP report identifies poor care or other issues that warrant investigation and, in some cases, discipline.

More often, the Board finds that physicians and other medical professionals know about substandard care or other issues but say nothing until problems snowball and patients are harmed or even killed. Worse, sometimes physicians and others may say nothing even when a situation is out of control. I know this because the Board sometimes hears through the grapevine—often after the Board has taken public disciplinary action—that local doctors had been fixing mistakes or steering their patients away from a problem practitioner for years.

Most medical professionals are not comfortable in the role of whistleblower. None of us wants to be the cause of a colleague losing his or her medical license. It may surprise some of you to know that the Board believes its licensees have an obligation to report incompetence or misconduct to the appropriate authority, whether that authority is the Medical Board or not (the full position statement appears at the end of this article). While the Board prefers to receive tips and complaints from sources who reveal their identities, it is also willing to accept written anonymous complaints.

It is important for physicians and other practitioners to understand that just a small fraction of the disciplinary actions taken by the Board in a given year result in the loss of license (see the "Year in Review" feature on pages 10-11). Depending on the circumstances of the case, it's often possible to avoid even a public disciplinary record.

The Board can and frequently does use a range of non-public methods intended to evaluate and, where appropriate, remediate physicians who exhibit troubling behavior. These methods include calling licensees in for a private sit-down with members of the Board (this is known as an informal interview) during which issues of concern are discussed. Frequently, based on information gathered during such interviews, the Board may mandate education or training, refer licensees for physicals or skills assessments, or order a physician to the NC Physicians Health Program or other useful resources.

The earlier the Board becomes involved, the greater the chance is that the matter may be resolved with a relatively minor corrective action. Overlooking a colleague's obvious incompetence or detrimental behavior serves neither the colleague nor our patients.

COMPLAINTS & INFORMATION RECEIVED | 2008

Source	Total
From Patients/Public	1,194
From Other Health Care Professionals	45
Board Staff	123
Anonymous	60
From Malpractice Reports	339
From Privilege Reports by Hospitals, etc.	14
From Other Boards/FSMB	314
From Other Sources (media, etc.)	75
Total complaints received	2,164

North Carolina Medical Board Forum Credits

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

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Two things we must always keep in mind. Physicians serve their patients first. Second, if we are to maintain the privilege of self-regulation in North Carolina, we must regulate effectively, fairly and objectively. The Board needs its licensees to step up to the plate as partners if we are to be successful. •

Send feedback to *forum@ncmedboard.org*.

SUBMITTING AN ANONYMOUS COMPLAINT OR TIP

The NC Medical Board prefers to know the identity of people who submit complaints. Sometimes, however, complainants are more comfortable providing information to the Board anonymously. Here's what you need to know:

Q: Can I be known to the Board but remain anonymous to the licensee I am complaining about?
A: Possibly. Complainants may request that Board investigators not reveal their name to the subject of the investigation and others. However, in certain cases, such as those that result in a hearing, the Board may be required under the law to provide the complainant's name to the subject of the complaint/investigation and his or her attorney.

Q: I can't take the chance that someone will find out I reported a colleague to the Board. How do I submit an anonymous complaint?
A: The Board's investigative department requires that all anonymous complaints be submitted in writing. At minimum, a written complaint should include the full name of the licensee, his/her location (where they practice/live) and the conduct the Board should investigate. It is also helpful to provide the names of people the Board should talk to as part of an investigation, as well as some indication of the type of information these individuals might provide. In quality-of-care cases, it is imperative to have the names of specific patients whose care was poor.

Q: Where do I send an anonymous complaint?
A: You may send a written complaint to the Board's mailing address, which is P.O. Box 20007, Raleigh, NC 27619-0007. Direct your complaint to Curtis L. Ellis or Donald R. Pittman in the Board's Investigations Department.

Q: Will I know the final outcome of my complaint if I submit it anonymously?
A: Not unless the Board takes public disciplinary action, in which case the outcome will be publicly reported. North Carolina law allows only named complainants to be informed of the resolution to their complaint (i.e. what action, if any, the Board took, and the basis for such action).

NCMB POSITION STATEMENT

Professional obligation to report incompetence, impairment and unethical conduct

It is the position of the North Carolina Medical Board that physicians have a professional obligation to act when confronted with an impaired or incompetent colleague or one who has engaged in unethical conduct.

When appropriate, an offer of personal assistance to the colleague may be the most compassionate and effective intervention. When this would not be appropriate or sufficient to address the problem, physicians have a duty to report the matter to the institution best positioned to deal with the problem. For example, impaired physicians and physician assistants should be reported to the North Carolina Physicians Health Program. Incompetent physicians should be reported to the clinical authority empowered to take appropriate action. Physicians also may report to the North Carolina Medical Board, and when there is no other institution reasonably likely to be able to deal with the problem, this will be the only way of discharging the duty to report.

This duty is subordinate to the duty to maintain patient confidences. In other words, when the colleague is a patient or when matters concerning a colleague are brought to the physician's attention by a patient, the physician must give appropriate consideration to preserving the patient's confidences in deciding whether to report the colleague.

Adopted Nov. 1, 1998

A note from the editor...

We are proud to introduce a redesigned Forum with this issue. From now on, you'll see color photographs and a more visual, engaging layout throughout the newsletter. Another big change: The extended disciplinary report that typically fills the back pages of this publication has been replaced with an abbreviated listing. The full content of this report is available at *www.ncmedboard.org*

We hope you like the new look! Your feedback is welcome at *forum@ncmedboard.org*

Lyme Disease Update:

Focus on North Carolina and Recommendations for Clinicians

Jeffrey Engel, M.D.
State Health Director, Division of Public Health

The diagnosis and management of lyme disease is a controversial topic. With the recent revision of the Centers for Disease Control and Prevention (CDC) definition for Lyme disease in 2008, this article is intended to be a timely review of Lyme disease with particular emphasis on NC and the southeastern United States. This is an update for clinicians on the diagnosis and management, and is intended to elicit assistance in determining whether Lyme disease is an emerging infectious disease in the state.

Background

Lyme disease is a tickborne infection caused by the spirochete *Borrelia burgdorferi* (Bb) which was first discovered as a human pathogen in 1976. Named after the initial cluster that occurred in Lyme, Connecticut, the disease is now endemic in three major areas of the country and is the most common vectorborne disease reported in the U.S. with over 20,000 cases annually. Most cases are reported from the northeastern US, the northern Midwest and northern California. The vector of *Bb* in the eastern US is the black-legged tick *Ixodes scapularis*, and the preferred hosts and reservoir are the white-footed mouse and other small mammals, especially shrews. These mammals harbor *Bb* in their bloodstream, remain asymptomatic and are essential for the enzootic maintenance of *Bb* in the wild. Large mammals, especially deer, are also needed for maintenance as they are the preferred hosts for the adult tick. Incidental infections occur in humans and other mammals such as dogs.

In Lyme endemic areas such as the northeastern US, the two year lifecycle of *I. scapularis* ticks determines the transmission characteristics of *Bb*. After hatching from an egg in the early spring, an uninfected larval tick must feed on a *Bb* spirochetemic mammal to become infected. The fed larva, harboring *Bb* in its gut, drops off the host and morphs during the summer into the nymph stage carrying the spirochete with it (transstadial transmission). In the following late spring and early summer the nymph feeds again, commonly infecting a new reservoir host, sustaining the cycle. The nymph can also feed on an incidental host which explains why most human cases of Lyme disease are acquired between April and June. After feeding, the nymph morphs to the adult stage during the second summer. In the early fall it feeds one more time usually on deer. The adult tick feeding accounts for the second peak incidence in humans from September to November. The lifecycle ends with the adult ticks mating and the female laying eggs in the third spring. Thus for a human to become infected, the *Bb* lifecycle must be established and the human must be exposed to the habitats of this tick.

Ecology in the Southeast: Focus on North Carolina

While burgeoning human cases were reported from endemic areas such as the northeastern US in the past 25 years, surveillance reports from the southeastern US, including NC, remained sporadic. In NC, there are published studies that have demonstrated that both the vector (*I. scapularis ticks*) and *Bb*-infected reservoir host (small mammals) exist in the state. However, the studies have been small and there have been no systematic regional surveys done in NC. There have also been published reports that fail to identify the classic *Bb* transmission cycle in NC, or alternatively, show a transmission cycle involving small reptiles. Unlike small mammals, reptiles appear to be incompetent reservoir hosts for *Bb* resulting in low levels of enzootic transmission and less likely infection of humans. This natural phenomenon in the reptilian host seems to protect the incidental mammalian host from infection.

Further confounding the Lyme disease ecology in the southeast was the discovery of a clinical presentation of localized early infection (Stage 1, at right) in patients. Outbreaks (including NC) and sporadic cases were reported in people presenting with classic erythema migrans (EM) rash following tick bites from the common southern tick *Amblyomma americanum* (the "lone star" tick named for the identifying bright spot on the dorsum of adult females). However, in these southern cases, skin biopsies were negative for *Bb* and serology lacked *Bb*-specific antibody production. Because no microorganism has been conclusively identified in this syndrome, it currently is called the Southern Tick-Associated Rash Illness or STARI.

Jeff Engel, MD, North Carolina State Health Director says "Early Lyme disease . . . is difficult to differentiate from the other common tickborne infections seen in NC."

> “Antibiotics for a suspected clinical case should not be withheld pending test results because of the poor sensitivity of available serologic tests”

Pathogenesis and Clinical Manifestations of Human Disease

Lyme disease is best described as an infection with early and late manifestations categorized in three stages: early, early disseminated, and late (persistent) infection. Following the bite of an infected nymph or adult *Ixodes* tick, the tick must embed and feed for at least 24 hours for *Bb* inoculation to occur. This is why it is so important to perform tick inspections after exposure to tick habitats. Lyme disease can be completely avoided by prompt removal of ticks from the skin.

Stage 1: Early Infection (Localized)

After inoculation into the dermis, *Bb* begins to replicate and elicit an immune response. As many as 30 days following the bite, the classic early manifestation of Lyme disease, the target or bull's eye rash of EM, appears. Most people do not remember the tick bite because of the small size of *Ixodes* nymphs. The rash is at least 5 cm across and expands, with or without central clearing, from the point of inoculation. Primary EM lesions associated with tick bites are single or multiple, erythematous or violaceous, macular or papular, often pruritic and occasionally burning or painful. In about 20% of early Lyme cases, no EM rash is documented. This may mean that the rash did not occur or was not seen (e.g. as can happen on the scalp).

The early signs and symptoms of Lyme disease may spontaneously resolve within a week with clearance of *Bb* from the body by the immune response. Only 20% of persons will have positive serologic tests during the acute illness, but this increases to 50% to 80% in the convalescent phase after antibiotic therapy. Antibiotics for a suspected clinical case should not be withheld pending test results because of the poor sensitivity of available serologic tests in early Lyme disease. Detection by culture of *Bb* from a skin biopsy of an EM lesion has a sensitivity as high as 75%; however skin biopsy is not practical in most clinical settings.

Stage 2: Early Disseminated Infection

In untreated cases weeks to months following the acute phase, hematogenous dissemination occurs with the subsequent development of systemic manifestations of Lyme disease. There may be a period of well-being after resolution of the acute phase and some patients may not recall any acute symptoms. Disseminated disease may also overlap with the acute phase resulting in EM on physical exam along with systemic manifestations of fever, headache, malaise and fatigue, generalized achiness and regional lymphadenopathy. Early Lyme disease in this phase is difficult to differentiate from the other common tickborne infections seen in NC: Rocky Mountain spotted fever (RMSF) and Ehrlichiosis, particularly in patients without documented primary EM.

The target organs of early disseminated *Bb* include the skin, heart, nervous system, joints and eyes. Disseminated skin lesions differ from primary EM. They tend to be multiple evanescent salmon-colored macules of varying sizes and might be missed on physical exam because of their transience and subtle coloring, particularly on dark skinned people. They are not associated with tick bites. Both EM and secondary lesions usually fade within a month.

In about 15% of untreated patients, frank neurologic disease develops. In early disseminated infection, the hallmark neurological lesion is a motor or sensory radiculopathy, classically unilateral or bilateral 7th cranial nerve (Bell's) palsy. Meningoencephalitis presents with the typical features of aseptic meningitis: fever, headache, meningismus, and mental status changes. Cerebrospinal fluid analysis shows a lymphocytic pleocytosis with a total WBC count about 100 cells/mm3, elevated protein and a normal glucose. Gram stain and routine cultures are negative. Other manifestations include mononeuritis multiplex, cerebellar ataxia, and myelitis.

Five percent of untreated patients develop cardiac involvement with focal lesions in the conduction system resulting in varying degrees of atrioventricular (AV) heart block; sometimes requiring temporary pacing. Some patients have evidence of more diffuse disease compatible with acute myopericarditis (mild left ventricular dysfunction but rarely cardiomegaly). Heart murmurs do not occur. Heart involvement presents with palpitations, lightheadedness or syncope; chest pain and shortness of breath are uncommon. Cardiac disease is brief, lasting from three days to six weeks.

In this stage, migratory musculoskeletal pain is common in joints, tendons, bursae, muscle and bones. Conjunctivitis is the most common eye abnormality but there are case reports of iritis, panophthalmitis, choroiditis with retinal detachments, or interstitial keratitis.

Stage 3: Late (Persistent) Infection

Months after the primary infection in the context of robust cellular and humoral immune responses, about 60% of untreated patients experience attacks of joint swelling and pain. It was this presentation in Lyme, Connecticut in 1976 in a cluster of children mistakenly

diagnosed with juvenile rheumatoid arthritis that lead to the discovery of *Bb*. Large joints, especially the knees, are affected. Attacks last from weeks to months with periods of complete remission. Arthrocentesis fluid is typical of an acute inflammatory infectious arthritis with a neutrophilic leukocytosis, but with negative gram stain and routine cultures. In untreated cases, arthritis attacks last longer in the second and third year of illness; however, the total number of patients who continue to have attacks diminishes by 10% to 20% each year. Even in untreated cases, chronic or intermittent arthritis resolves within several years except in about 10% of patients who will have persistent arthritis that resists antibiotic treatment. Chronic, antibiotic-treatment resistant Lyme arthritis is associated with specific host factors including human leukocyte antigen (HLA) haplotypes DRB1*0401, DRB1*0101 and related alleles.

In about 5% of untreated patients, chronic neurologic disease develops months to years after initial infection, sometimes following long periods without symptoms (i.e. latency). Syndromes include axonal polyneuropathy (spinal radicular pain or distal paresthesias) and Lyme encephalopathy (subtle cognitive disturbances). In the former, electrophysiologic studies often demonstrate an axonal neuropathy affecting proximal and distal nerve segments. In the latter, the cerebrospinal fluid (CSF) is normal but intrathecal antibody production to *Bb* can be present. Neuropsychological tests and brain scans may be abnormal but are non-specific.

Laboratory Criteria for Diagnosis

Diagnosis is usually based on the clinical picture, exposure to a tick habitat in a Lyme-endemic area, and positive antibody production to *Bb*. In Stage 1, skin biopsy of EM for culture of *Bb* is the most sensitive and specific lab test but requires an invasive procedure and rapid transport into specialized medium making this test impractical. Because of poor sensitivity (20% to 30% IgM positive), serologic testing of serum in Stage 1 infection is not recommended in favor of treatment in the setting of EM. IgM antibody detection improves to 50% to 80% in the convalescent phase (two to four weeks) even in treated EM cases; however, serologic testing is much more valuable in Stage 2 and 3 infections. After a month, >95% of patients with active infection have positive IgG antibody responses, and a positive IgM alone likely represents a false positive and should not be relied upon.

For serologic testing, the CDC recommends a two-test approach with samples first tested using an enzyme-linked immunoabsorbant assay (ELISA) with equivocal or positive results followed by Western blotting. For IgM, two of three bands (23, 39, and 41 kDa) and for IgG, five of ten bands (18, 23, 28, 30, 39, 41, 45, 58, 66, and 93 kDa) must be present for a positive result.

In suspected cases of neuroborreliosis (Stage 2 meningitis or Stage 3 neuropathy or encephalopathy), intrathecal measurement of IgG antibody is recommended. Encephalomyelitis must be confirmed by demonstration of antibody production against *Bb* in the CSF, evidenced by a higher titer of antibody in CSF than in serum. Detection of *Bb* DNA using polymerase chain reaction is superior to culture in joint fluid but has been only positive in small numbers of CSF samples. The Lyme urine antigen test has been unreliable and is not recommended.

Prevention and Treatment

Primary prevention involves avoiding tick infested areas, and when not possible, preventing tick bites by wearing protective clothing pre-treated with permethrin or application of DEET-containing repellant to the skin and/or clothing. For people living in endemic areas or those who have daily tick exposure, secondary prevention involves performing frequent. careful tick checks, especially on the legs, groin and axillae. Lyme disease is prevented if ticks are removed within 24 hours and before engorgement, though it may not always be possible to find all embedded ticks due to their small size. For tertiary prevention, in endemic areas, a single 200 mg dose of doxycycline was shown to prevent Lyme disease if given within 72 hours of finding an engorged nymphal *I. scapularis tick*.

Evidence-based treatment regimens are derived from controlled clinical trials primarily performed in Lyme-endemic regions. For early infection (Stage 1 and 2) in adults, a 14-21 day course of oral doxycycline (100 mg bid) is preferred even in cases of meningitis. When an acute presentation is less clear (e.g. absence of EM), this regimen will also cover the other major tick borne infections common in NC, RMSF, STARI and Ehrlichiosis. Alternative regimens for early Lyme disease include amoxicillin (500 mg tid), cefuroxime axetil (500 mg bid), or erythromycin (250 mg qid). In children 8 or younger, choices include amoxicillin (250 mg tid or 20 mg/kg/day in divided doses), cefuroxime axetil (125 mg bid), or erythromycin (250 mg tid or 30 mg/kg/day in divided doses).

For Lyme arthritis, longer courses of 30 to 60 days are recommended using doxycycline (100 mg bid) or amoxicillin (500 mg qid); or 14-28 day parenteral regimens including ceftriaxone (2 g daily) or penicillin G (20 million units in four divided doses daily). Parenteral regimens are most commonly used in neuroborreliosis; or in high degree AV block until the patient is stabilized when the course can be completed with oral regimens. Oral regimens for early infection are recommended for first-degree AV block (P-R interval >0.3 seconds) and facial palsy alone. Approximately 15% of patients experience a Jarisch-Herxheimer-like reaction within the first 24 hours of treatment of a disseminated infection.

Public Health Surveillance in North Carolina

In 2008, in consultation with the Council of State and Territorial Epidemiologists, the CDC updated its surveillance case definition for Lyme disease. Case definitions are broadly based on clinical, epidemiological and laboratory criteria.

Prior to 2008, stage 1 (EM) Lyme disease was based on an exposure to an endemic area and the EM rash. In 2008, an endemic region or county was further defined as one with an established population of a tick vector (*I. scapularis*) infected with *Bb*, or two or more people with laboratory confirmed Lyme disease (Stage 1: EM with positive culture or IgM serology; Stage 2 or 3, clinically compatible syndrome with positive IgG serology).

However, the new CDC case definition may still lead to misclassification of cases in NC and the southeastern US. Established populations of *I. scapularis* infected with *Bb* have been found here, especially in the eastern part of the state, but because larvae and nymphs feed preferentially on reptiles, mammalian and human infections may not occur frequently. Since STARI is a common clinical presentation in NC, counting these cases as Lyme disease may result in over-estimation of Lyme disease incidence and prevalence.

Therefore, beginning with the 2009 tick season, the NC Division of Public Health (DPH) is seeking to better understand Lyme disease incidence in NC. The most accurate method to accomplish this surveillance is using Stage 1 disease; thus, for patients presenting with EM, the division's staff is requesting primary care providers to report EM cases to their local health departments, elicit a travel history within the past 30 days, and obtain a blood serological IgM test (ELISA and reflex Western blot if ELISA equivocal or positive).

EM patients should still be treated with standard regimens for Stage 1 Lyme disease. Treated patients who are IgM negative or in whom acute specimens were not obtained will be asked to give a convalescent specimen within two to four weeks. NC counties (the county where the person was most likely exposed) with two or more laboratory confirmed EM cases will be declared endemic for Lyme disease. Lyme disease testing is available at most clinical reference labs and at no cost if the specimen is routed to the CDC via the NC public health courier system. The CDC turn-around time is approximately six weeks; however, as stated above, awaiting an IgM lab result should not influence a treatment decision.

This enhanced surveillance will assist public health agencies in improving important tick bite prevention messages to the public and in informing clinicians on estimating the probability of Lyme disease in their patients presenting with EM or later manifestations. This surveillance will also help to determine incidence and trend of Lyme disease in NC and the southeastern US. •

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Send feedback to *forum@ncmedboard.org*.

Serve on the Medical Board

The independent panel that nominates candidates for certain seats on the North Carolina Medical Board is seeking applications for three positions that will come open this year.

Two physician seats on the Board will be vacated by Dr. George L. Saunders and Dr. Janelle A. Rhyne, who each complete their second consecutive terms on Oct. 31. Under state law, Saunders and Rhyne are ineligible for reappointment.

A third seat on the Board, to be filled by a physician assistant or nurse practitioner, will come open when Peggy Robinson, PA-C, completes her first three-year term on the Board, also on Oct. 31. Robinson is eligible for reappointment. However, state law allows other licensed PAs or NPs to apply.

The nominating panel must recommend at least two candidates for each open seat to Gov. Beverly Perdue, who will make the final selection. Applicants must have an active, nonlimited license to practice medicine in North Carolina, or in the case of a PA or NP, hold an active license or approval to perform medical acts in the state, among other qualifications. Applicants must have no public disciplinary history with the NCMB or any other licensing board over the past ten years. Applications are due July 1.

For more information, visit the Web site of the Review Panel for the North Carolina Medical Board at *www.ncmedboardreviewpanel.com* Applicants may complete an online application or download a copy of the application and detailed instructions.

Ticks in North Carolina:
Increasing Disease and Confusion

Marcia E. Herman-Giddens, PA, DrPH

In 2007 North Carolina reported almost 800 cases of tick-borne diseases (TBDs) and close to 1,000 the year before (see Table 1). This indicates that many thousands of citizens may get sick each year from ticks since studies have found that only a minority of reportable cases are usually reported.[1] There are also several non-reportable TBDs. On average, a few fatalities also occur.

Four species of NC ticks bite humans and all may carry one or more human pathogens. New "emerging infections" are also being identified. The most common tick is the lone star. Thirty years ago when this aggressive tick appeared in NC many people assumed they were the "deer" ticks that carry the Lyme disease spirochete since the larvae and nymphs are so small. Black-legged ticks, the Lyme disease vector, are also established in a number of counties in NC.[2] Ticks, most active from February through October, may also be active during warm spells in the winter, so TBDs need to be considered all year if symptoms are suggestive. The distribution and prevalence of human-biting ticks and TBDs in North Carolina are not well characterized although work is beginning on this for the black-legged tick.[2]

Ticks have three blood feeding stages: larval, nymph, and adult. They feed and molt between each stage over one to three years. Usually, the only larval ticks (commonly called "seed ticks") that bite humans are lone stars. In North Carolina, nymphs of lone stars (sesame seed size) frequently attack people. Bites by black-legged nymphs (poppy seed size) are much less common. Nymphal bites are highly associated with disease since their small size makes them harder to detect. Infections are transmitted by nymphal and adult ticks. The female lone star, known by the white spot on its back, is the only tick easily identified by the non-professional. Tick populations are growing in our state along with suburbanization and the deer population. Deer serve as hosts to the lone star and black-legged ticks.

Most tick infections may initially cause similar symptoms—often flu-like with fever, aches, and pains. Most tick-borne infections in North Carolina are not associated with a rash, especially early in the infection. Some rashes, when they occur, may be pathognomonic. Serologic tests are usually negative in the acute phase and sensitivity and specificity are far from ideal.[3,4] Co-infections may also occur. A history of tick bite is not necessary for diagnosis.

Lyme disease is emerging in North Carolina. Studies have identified cases, the vector tick *Ixodes scapularis*, and the bacteria, *Borrelia burgdorferi*, a spirochete related to *Treponema pallidum*, the spirochete which causes syphilis. The so-called "bulls-eye" rash, erythema migrans (EM), associated with Lyme disease and Southern Tick Associated Rash Illness (STARI) is a misnomer because many EM rashes may be solid red.[5] EM starts at the site of the tick bite, is usually oval, and expands to greater than two inches. (Most patients have a normal small red, itchy, local reaction to tick bites, especially the lone star.) People presenting with an EM rash should be treated for Lyme disease/STARI immediately. Only 60% to 80% of people with Lyme disease (the percentage is unknown for STARI) will get or find an EM rash so recognition of an infection may be difficult. Lyme disease diagnosis, testing, chronicity, and treatment is complex and controversial.[6]

STARI is associated with the lone star tick. The causative organism is not known in spite of on-going research by the CDC and others.[5,7] There are no diagnostic tests for STARI and, at this time, it is not a reportable disease. The lone star tick, widely distributed in the coastal plain and piedmont of North Carolina, is aggressive and all life stages readily bite humans. This suggests that there may be a high potential for transmission of the causal agent of STARI.

Of all the TBDs found in NC, Rocky Mountain Spotted Fever (RMSF) is associated with the highest rate of mortality. The overall case fatality rate is 5%-10% and may approach 20% in those untreated.[4] In the last 25 years, NC has had an average of 3.5 deaths per year from RMSF. Deaths are usually

TICKS, AGENTS AND PRESENTLY KNOWN TICKBORNE DISEASES IN NC*

The Lonestar Tick - *Amblyomma americanum*

Adult Female

Agent
Ehrlichia chaffeensis
Ehrlichia ewingii
Unknown
Franciscella tularensis
Toxin
Rickettsia amblyommii (may be a human pathogen)

Illness
Human Monocytotrophic Ehrlichiosis (HME)
E.e. infection
Southern Tick Associated Rash Illness (STARI)
Tularemia
Tick Paralysis
Not characterized

Black-legged Tick - *Ixodes scapularis*

Agent
Borrelia burgdorferi
Babesia microti
Anaplasma phagocytophilum
Bartonella spp

Illness
Lyme disease
Babesiosis
Human Granulocytotrophic Anaplasmosis (HGA)
Bartonellosis

Adult Female

due to delayed recognition and treatment. Ehrlichiosis may be quite prevalent in the Piedmont. Studies have suggested that reports underestimate the true burden of disease.[4] Less than 2-3% of untreated Ehrlichiosis and Anaplasmosis may be fatal.[4]

Prevention and removal

Prevention and control methods may be found at *www.cdc.gov/Features/StopTicks/*. Complete protection is not possible. Environmental tick control methods are not practical or affordable for everyone and no personal prevention method offers infallible protection.[8]

Physicians should teach patients to save biting ticks because if an illness follows, identification can help sort out which infection(s) may be causing illness. The easiest method is to scotch tape the tick to an index card recording the date and place on the body. Most studies show that ticks need to feed for several hours or even days before infective agents can be transmitted, though the amount of time is controversial and varies with the tick and the pathogen.

North Carolina Public Health Pest Management has initiated tick education, awareness, collection and testing programs thanks to recent funding from the General Assembly, although this funding may be in jeopardy due to economic conditions. Work is also underway to ascertain which counties may become endemic for Lyme disease.[2, 9] Ongoing research from the Entomology Department at NC State University and the NC School of Veterinary Medicine is contributing to knowledge about known and emerging TBIs. Prevention of tick-borne diseases requires a comprehensive multi-disciplinary approach. •

TABLE 1:
Reported* Tickborne Diseases, North Carolina 2006- 2007

DISEASE	NUMBER OF CASES	
	2006	2007
Anaplasmosis, human granulocytic**	1	4
Ehrlichiosis, human monocytic	54	53
Ehrlichiosis, Other	3	3
Lyme disease	31	53
Q Fever	4	4
Rocky Mtn Spotted Fever	852	664
Total	945	781

*Reported cases include confirmed and probable TBDs in NC residents acquired in NC and elsewhere. Confirmed cases must meet strict surveillance criteria. Reporting criteria are not meant to be used for diagnosis. Public health officials agree that an unknown number of cases are not reported
** This disease was previously known as Human granulocytic ehrlichiosis.

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Marcia E. Herman-Giddens, PA, DrPH is adjunct professor at the UNC School of Public Health and president of the Tick-borne Infections Council of North Carolina, Inc.

Members of the state Vector-borne Disease Task Force have provided valuable comments to the content of this article.

Send feedback to *forum@ncmedboard.org*

American Dog Tick - *Dermacentor variabilis*

Agent
Rickettsia rickettsii
Franciscella tularensis
Toxin
Possibly Rickettsia amblyommii (may be human pathogen).

Illness
Rocky Mountain Spotted Fever
Tularemia
Tick paralysis


Adult Female

Not characterized

Brown Dog Tick - *Rhipicephalus sanguineus*

Agent
Possibly Rickettsia rickettsii

Illness
Rocky Mountain Spotted Fever


Adult Male

*As of 2008, emerging diseases continue to be discovered. Includes TBD cases in NC residents acquired in NC and those acquired elsewhere.

Tick images are not actual size and have been enlarged to show detail.

Year in Review

A look back at data from 2008

In this issue, the *Forum* introduces a new annual feature, the "Year in Review". This collection of tables and charts provides a snapshot of certain aspects of the Board's work during 2008, particularly licensing, complaints and disciplinary activities. You'll find general demographic information about the Board's physician licensees, facts about the volume of complaints and malpractice payment reports received and details on how some of those cases were resolved. The total number of complaints and malpractice reports does not correspond exactly with the total number of case resolutions because not every case is resolved the same year it is reported. Finally, we have included a summary of public actions (including all public disciplinary actions) taken in 2008. All data is as of December 31, 2008.

An expanded version of the "Year in Review" will soon be available on the Board's redesigned Web site, which is launching publicly in late May. The content published below, as well as additional charts and tables not included in this report, will be available to licensees and to the public in the new Web site's "Data Center" section. •

PUBLIC BOARD ACTIONS | 2008

Comparative Data for 2007 in *italics*

Prejudicial Actions*

License Denied:
14 Actions (11 Physicians, 2 PAS, 1 CCP)
[2007: 6 Actions (4 Physicians)]

Annulments:
1 Action (1 Physician)
[2007: NONE]

Revocations:
7 Actions (7 physicians)
[2007: 9 Actions (7 physicians, 1 PA, 1 NPs]

Suspensions:
44 Actions (29 physicians, 14 PAs, 1 NP)
[2007: 55 Actions (41 Physicians, 10 PAs, 2NPs)]

Summary Suspensions:
3 Actions (3 Physicians)
[2007: 4 Actions (2 physicians, 2 PAs]

Miscellaneous Actions:
5 Actions (4 Physicians)
[2007: 2 Actions (2 Physicians)]

Denials of Reconsiderations/Modification:
NONE
[2007: NONE]

Surrenders:
19 Actions (14 Physicians, 5 PAs)
[2007: 34 Actions (28 Physicians, 6 PAs)]

Public Letters of Concern:
41 Actions (34 Physicians, 4 PAs, 3 NPs)
[2007: 46 Actions (43 Physicians, 2 PAs, 1 NP)]

TOTAL NUMBER OF PHYSICIANS BY COUNTY | 2008

County	Total	County	Total	County	Total	County	Total	County	Total
Alamance	222	Clay	7	Harnett	62	Nash	171	Stokes	19
Alexander	14	Cleveland	171	Haywood	99	New Hanover	666	Surry	113
Alleghany	12	Columbus	58	Henderson	232	Northampton	4	Swain	24
Anson	14	Craven	206	Hertford	39	Onslow	185	Transylvania	63
Ashe	26	Cumberland	644	Hoke	14	Orange	1402	Tyrrell	1
Avery	19	Currituck	8	Hyde	1	Pamlico	7	Union	149
Beaufort	68	Dare	53	Iredell	296	Pasquotank	90	Vance	54
Bertie	10	Davidson	136	Jackson	90	Pender	26	Wake	2108
Bladen	20	Davie	30	Johnston	125	Perquimans	3	Warren	6
Brunswick	110	Duplin	24	Jones	22	Person	33	Washington	17
Buncombe	956	Durham	1936	Lee	84	Pitt	713	Watauga	125
Burke	181	Edgecombe	46	Lenoir	102	Polk	31	Wayne	195
Cabarrus	398	Forsyth	1649	Lincoln	62	Randolph	135	Wilkes	72
Caldwell	77	Franklin	25	Macon	68	Richmond	59	Wilson	103
Camden	1	Gaston	363	Madison	17	Robeson	125	Yadkin	21
Carteret	100	Gates	1	Martin	16	Rockingham	99	Yancey	19
Caswell	11	Graham	6	McDowell	30	Rowan	239	**In State**	**21,008**
Catawba	371	Granville	85	Mecklenburg	2491	Rutherford	84		
Chatham	84	Greene	7	Mitchell	32	Sampson	52	**Out State**	**9,370**
Cherokee	38	Guilford	1165	Montgomery	27	Scotland	60	**Grand Total**	**30,378**
Chowan	30	Halifax	77	Moore	291	Stanly	76		

PHYSICIAN LICENSES ISSUED | 2008

10 MOST POPULAR SPECIALTIES | 2008

Among new MD/DO licensees* Among all MD/DO licensees*

Temporary/Date Licenses Issued:
(4 Via a Consent Order): 8 Actions (5 Physicians, 2 PAs)
[2007: 14 Actions (11 Physicians, 3 PAs)]

Temporary/Dated Licenses expire:
NONE
[2007: None]

Consent Orders:
106 Actions [6 Mod., 9 Non Disciplinary]
(84 Physicians, 17 PAs and 1 NP)
[2007: 122 Actions [6 mod, 7 N-D]
(97 Physicians, 18 PAs, 4 NPs)]

TOTALS: 247 prejudicial actions in 2008
184 persons (152 Physicians; 27 PAs; 4 NPs; 1 CCP)
292 prejudicial actions in 2007
208 persons (174 Physicians; 27 PAs; 7 NPs)

Non-Prejudicial Actions

Dismissals:
5 Actions (5 Physicians)
[2007: 4 Actions (4 Physicians]

Temporary/Dated Licenses Extended:
21 Actions (10 Physicians, 4 PA)
[2007: 19 Actions (16 Physicians)]

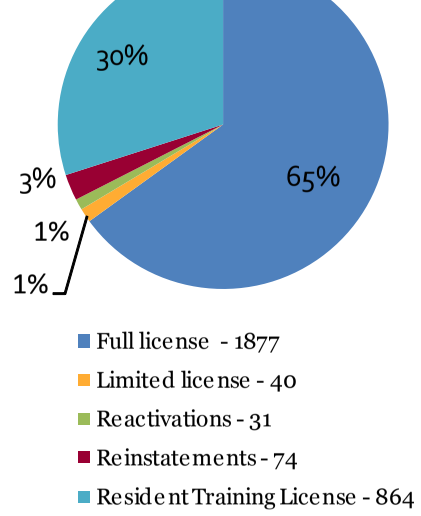
Temporary Licenses to Full and Unrestricted:
9 Actions (9 Physicians)
[2007: 10 Actions (6 Physicians, 4 PAs)]

Consent Orders Lifted:
23 Actions (18 Physicians, 3 PAs, 2 NPs)
[2007: 24 Actions (18 Physicians, 6 PAs)]

Reentry Agreements:
15 Actions (9 Physicians, 5 PAs, 1 CCP)
[2007: 25 Actions (15 Physicians,10 PAs)

TOTALS: 73 non-prejudicial actions in 2008
60 persons (45 Physicians; 12 PAs; 2 NP; 1 CCP)
82 non-prejudicial actions in 2007
67 persons (51Physicians; 16 PAs; 0 NP)]

*Prejudicial Action: A "prejudicial action" is disciplinary in nature and reflects a violation of the Medical Practice Act by the practitioner.
**Non-Prejudicial Action: A "non-prejudicial action" reflects either the Board's determination of satisfactory performance by the practitioner following a previous disciplinary action or the dropping of charges.

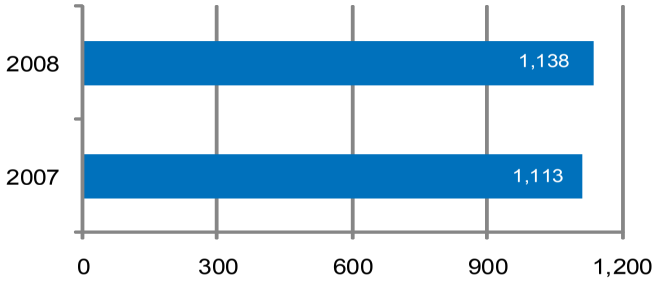


Primary Specialty	Total
Internal Medicine	428
Pediatrics	160
Family Practice	124
Emergency Medicine	119
Anesthesiology	97
Obstetrics and Gynecology	96
Diagnostic Radiology	95
Radiology	88
Family Medicine	86
General Surgery	74
Grand Total	1367

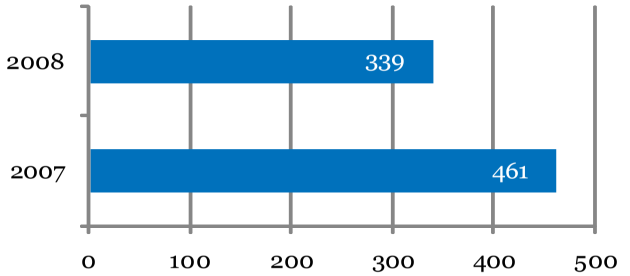
Primary Specialty	Total
Internal Medicine	4,108
Family Practice	2,825
Pediatrics	2,042
Emergency Medicine	1,588
Psychiatry	1,569
Anesthesiology	1,563
Obstetrics and Gynecology	1,363
Diagnostic Radiology	1,132
General Surgery	995
Radiology	986
Grand Total	18171

*Licensees are not required to report a specialty

COMPLAINTS RECEIVED | 2007-2008



MALPRACTICE PAYMENT REPORTED | 2007-2008

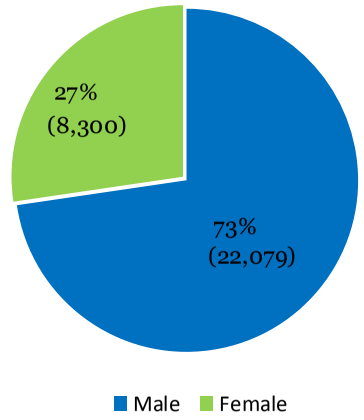


CASES RESOLVED WITH NON-PUBLIC DISCIPLINARY ACTION | 2008

Case Resolution	Total
Accept as Information (No formal action taken)	644
Private Letter of Concern	354
Interim Letter of Concern/Follow-up Private Letter of Concern	33
Informal Interview	32
Issue a Notice of Charges and Allegations	30
Miscellaneous (i.e. order CME, Communications training, etc)	21
Cease and Desist Letter	18

Cases resolved with public disciplinary action are reported in the table to the left (Summary of the 2008 Board Action Report). A more detailed report can be found at *www.ncmedboard.org*.

LICENSEES BY GENDER | 2008



The NC Medical Board:

150 years of service to patients and medical professionals

The North Carolina Medical Board marked its 150th anniversary with a reception at the North Carolina Museum of History in Raleigh in March. The celebration brought together about 200 guests, including current and past Board members, legislators, medical society and regulatory board members, public advocacy groups and others. Established on April 15, 1859, the Board is one of the oldest medical regulatory boards in the country.

Several exhibits gave guests a look at medicine as it was 150 years ago. Artifacts on display included medical equipment and supplies from the late 1800s to mid-1900s. Costumed history enthusiasts representing a North Carolina Confederate surgeon and a 19th century apothecary were on hand. The Museum of History also provided the Board's guests access to a permanent exhibit that recreates a 1920s-era drugstore.

The Board displayed original minute books from its first meetings dating back to 1859 and presented a short video highlighting the first Board, first female licensee, first African American licensee and major advancements in medicine from 1859 to the present. Finally, the Board showed off a historical highway marker it commissioned in honor of the anniversary. In April, the marker was installed two blocks from the Board's original meeting place, the Old State Capitol in Raleigh.

Why does the anniversary matter?

The Board's founders—who as you may know included the early leaders of the NC Medical Society—understood that establishing and enforcing high standards for medical education, training and practice not only protected patients from unqualified practitioners but raised the status and credibility of the profession. The modern Medical Board is very different from the one founded 150 years ago. But the essential mission—and value to the profession—remains the same.

Below, we offer a few thoughts on some important ways the Board enhances the quality of medicine in North Carolina and the dignity of the medical profession.

Screening out unqualified practitioners

A medical license is privilege not lightly granted by the Board. The Board's founders considered licensing to be a critical public service that would help patients tell qualified physicians from "ignorant pretenders". However, by modern standards the original criteria for licensure were spare. Under the 1859 Medical Practice Act, a candidate for licensure had only to be 21 years old, of good moral character and able to pass the exam. It wasn't until 1921 that the law was amended to require that all applicants prove they are graduates of a four-year medical school. Over the years additional requirements have been added so that, today, North Carolina is widely recognized to have one of the nation's most rigorous licensing processes. Keeping standards for physician licensure high enhances the value of the license hanging on every licensee's office wall.

Punishing misconduct and remediating deficient providers

The Board's founders implicitly understood that both medical professionals and their patients are best served when the Board is effective at identifying and suppressing unqualified or immoral practitioners. Initially, however, the Board did not have the authority to discipline its licensees. That power did not come until 1915, when the General Assembly granted the Board the authority to prosecute violations of the Medical Practice Act. Lawmakers strengthened the Board's disciplinary authority again in 1921, when it clearly defined the practice of medicine for the first time and created a list of specific acts of wrongdoing for which the Board could take action against a physician's license. That list included drug abuse, abortion, grossly immoral conduct, false advertising and unprofessional or dishonorable conduct. That list still forms the basis for most disciplinary cases brought by the Board today.

Acting as a resource for professionals, as well as the public

The Board believes that the vast majority of licensees are caring, competent professionals who want to act in the best interests of their patients. As such, the Board sees educating its licensees about its policies and applicable laws and rules as an important strategy for preventing misconduct, intentional or not. This is a relatively modern notion, however. The original Board consisted of seven physician members who met no more than once or twice a year. Their time was consumed with reviewing applications, conducting examinations and interviews and granting licenses. There was little or no outreach to licensees. In fact, the Board operated without support staff until the early 1950s. It wasn't until the 1990s that the Board substantially boosted its outreach to the profession and public. Since that time, the Board has drafted position statements to articulate its views on applicable rules and laws. These statements provide guidance to licensees who wish to avoid disciplinary action. In 1995 the Board hired a full time senior level staff person to establish a department of Public Affairs. The following year it began publishing the *Forum* with the objective of informing licensees about Board policy, applicable laws and rules, clinical guidelines and other matters. Shortly after introducing the Forum, the Board also launched a public Web site with information and news for professionals and patients. The current Web site includes all of the position statements of the Board and a complete archive of the *Forum*, as well as information about laws, rules and Board policy.

Preserving confidence in the Board and its licensees

An effective regulatory authority is essential to preserving patients' faith and trust in the medical profession. The North Carolina Medical Board strives each day to honor its mandate and mission—a commitment that benefits both the public and the profession. •

Send feedback to *forum@ncmedboard.org*.

EVENT PHOTOS

Guests mingle at the NCMB's 150th anniversary celebration, held Thursday, March 19, at the North Carolina Museum of History in Raleigh.

Guests admire a highway historical marker commissioned by the Board. The marker is now installed on the corner of Hillsborough and Dawson streets in Raleigh, two blocks from the Board's original meeting place, the Old State Capitol.

Lt. Governor Walter Dalton addresses the Board's guests, commenting on how far both medicine and medical regulation has come since the Board was established.

James Thompson, MD, former president of the Federation of State Medical Boards congratulated the NCMB on its anniversary and praised its contributions on the state and national level.

HISTORICAL TIMELINE

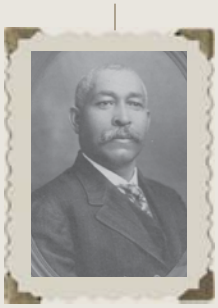
April 15, 1859 - A NC law establishing a medical licensing board takes effect.

May 12, 1859 - Members of the NC Medical Society elect the first Board.

June 6, 1859 - Board issues its first license to Dr. Lucius C. Coke.

1884 - Board adopts its official seal.

May 1885 -Board licenses its first woman, Dr. Annie Lowrie Alexander.



1886 - Board licenses first African American, Dr. Manassa T. Pope.

Photo courtesy of Dr. MT Pope House Museum Foundation

1915 - Board gains authority to prosecute violations of the Medical Practice Act.

North Carolina Medical Board

Quarterly Disciplinary Report | November 2008 – January 2009

Beginning with this issue of the *Forum*, Board actions will be published in a new, abbreviated format. The report no longer includes non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. If you prefer the previous method of reporting Board actions, you may access an expanded disciplinary report by visiting the Board's Web site at *www.ncmedboard.org* Readers who prefer the more comprehensive version may request that they be notified via e-mail when the report is posted on the Board's Web site. Look for the new "Subscriptions" section on the Board's redesigned Web site in coming weeks.

Name/license#/location	Date of action	Cause of action	Board action
ANNULMENTS			
BROWN, Douglas Allen, MD (009800794) Newport News, VA	12/29/2008	Prescribing issues; Providing false information	Annulment of NC license
REVOCATIONS			
BARRO, Lee Dennis (000025220) Bessemer City, NC	11/20/2008	Felony conviction	Notice of Revocation
SUSPENSIONS (see consent orders)			
CONSENT ORDERS			
AUGUSTINE, Santhosh, MD (009600445) Lumberton, NC	01/02/2009	Unprofessional behavior while conducting a procedure	Issued temporary license to expire 07/01/2009
BLISS, Laura Katherine, MD (009500018) Efland, NC	12/03/2008	History of substance abuse; Diversion of prescriptions for own use	Issued Temporary license to expire 06/02/2009
BLOCK, Matthew, MD (200100308) Laurinburg, NC	11/21/2008	Prescribing issues, prescribing to family	Two-year suspension stayed; Indefinite probation
CRUMMIE, Robert Gwinn, MD (000014636) Rutherfordton, NC	01/29/2009	Failure to comply with NCPHP contract	One-year suspension, stayed, except for a four-month period (completed)
FISHER, Anthony Lee, MD (009701350) Arden, NC	01/30/2009	Walked off the job while working in hospital ER	Six-month suspension, stayed, except for 30 days to begin 02/15/2009
KAUFMAN, Andrew Russell, MD (RTL) Durham, NC	11/26/2008	Suspended from residency; subsequently reinstated	Issue RTL; Simultaneously suspended for 30 days
KHOT, Prakash Nilkanth, MD (000019016) Wilkesboro, NC	12/12/2008	Prescribing, documentation problems	One-month suspension; limits on prescribing
LOWRY, Roswell Tempest, MD (000017882) Cornelius, NC	12/22/2008	Disciplined in state of VA	30-day suspension, stayed
LOWRY, Roswell Tempest, MD (000017882) Cornelius, NC	01/16/2009	Disciplined in state of VA	Reprimand
PATEL, Kirpesh Raojibhai, MD (200101261) Fayetteville, NC	01/23/2009	Suffers from medical condition that affects ability to practice	License made inactive
SHAH-KHAN, Sardar Mahmood, MD (000016726) Morganton, NC	12/04/2008	Prescribing issues; Poor documentation	Four-month probation; must comply with conditions
SMALL, Fairleigh David, MD (000024710) Abingdon, VA	11/21/2008	Disciplined in another state	Reprimand; Dr. Small may not treat children under six
STROTHER, Eric Furhman, MD (009901620) Durham, NC	01/12/2009	History of chemical dependency	Issue temporary license to expire 05/31/2009; must comply w/conditions
WERTHEIMER, Thomas Albert, MD (009900386) Wilmington, NC	12/17/2008	History of substance abuse; Diversion of prescriptions for own use	Issued temporary license
DENIALS OF LICENSE/APPROVAL			
BALENTINE, Kerry Layne, MD (200500514) Grover, NC	11/03/2008		Denial of application for reinstatement of license
MORRIS, John Christopher Lee, Jr., MD (NA) Winston-Salem, NC	01/16/2009	Failure to comply with Board inquiry	Application for NC medical license denied
MUNCIE, Herbert Lee, MD (NA) New Orleans, LA	01/27/2009	Disciplined in MD for boundary violation; Inappropriate prescribing	Application for NC medical license denied; Dr. Muncie has appealed
SURYADEVARA, Rao Radhakrishna, MD (NA) Floral Park, NY	01/15/2009	New York license revoked; permanently surrender in Pennsylvania	Application for NC medical license denied
UWAGERIKPE, Louis Almiro, MD (NA) Valdosta, GA	01/27/2009	Provided false info on application; failed to meet NC licensure requirements	Application for NC medical license denied

Name/license#/location	Date of action	Cause of action	Board action
SURRENDERS			
BROADHEAD, Daniel David, MD (000016325) Virginia Beach, VA	11/06/2008		Voluntary surrender
DOBYNS, Perrin Thomas, MD (200701865) Fayetteville, NC	12/08/2008		Voluntary surrender
GREGORY, Ginger Dobbins, PA (000101410) Fuquay-Varina, NC	01/14/2009		Voluntary surrender
JAMES, James Franklin, MD (000015359) Greenville, NC	12/01/2008		Voluntary surrender
PUBLIC LETTERS OF CONCERN			
DANIEL, Selwyn George, PA (009001584) Raleigh, NC	01/05/2009	Did not meet Board expectations for care delivered by PA	Public letter of concern
HENDERSON, David James, MD (000026011) Greensboro, NC	12/22/2008	Failure to provide patient access to records	Public letter of concern
HOROWITZ, Alexander Ross, MD (200802040) Kannapolis, NC	12/11/2008	Failure to disclose malpractice info to the Board	Public letter of concern
MILLARD, Devon Delaney, MD (009700923) Huntersville, NC	12/23/2008	Concerns about quality of care	Public letter of concern
MYERS, Steven Alexander, MD (200101478) Raleigh, NC	01/02/2009	Inadequate supervision of mid-level practitioners	Public letter of concern
ROGERS, Bruce William, MD (000032563) Greensboro, NC	01/06/2009	Inadequate supervision of mid-level practitioners	Public letter of concern
SHARMA, Kshitij, MD (200900089) Portsmouth, VA	01/26/2009	Did not provide accurate info on license application	Public letter of concern
SLOAND, Timothy Peter, MD (200301292) Gastonia, NC	11/07/2008	Concerns about quality of care	Public letter of concern
SPENCER, David McCaughey, MD (009400362) Winston-Salem, NC	01/03/2009	Aesthetician under MD's supervision may have exceeded scope of practice	Public letter of concern
VINCENT, Mark Anthony, MD (009501448) Charlotte, NC	01/15/2009	Inadequate supervision of mid-level practitioners	Public letter of concern
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
BASILI, Richard Louis, MD (009700464) Kinston, NC	11/20/2008		Full license issue
BOYD, William Scott, PA-C (000102927) Siler City, NC	11/20/2008		Temporary license issued to expire on 11/30/2009
HARRIS, John Joel, MD (000032114) Cerro Gordo, NC	11/20/2008		Full license issued
KELLER, Philip Arthur, PA (000102305) Currituck, NC	01/22/2009		Temporary license issued to expire on 07/31/2009
ROBINSON, Lindwood Allen, MD (200101126) Raleigh, NC	01/22/2009		Full license issued
ROGERS, Bruce William, MD (000032563) Greensboro, NC	11/20/2008		Temporary license issued to expire on 05/31/2009
RUSSELL, Anthony Otis, MD (000035491) High Point, NC	11/20/2008		Temporary license issued to expire on 11/30/2009
VAUGHAN, Howell Anderson, MD (000101513) Knightdale, NC	01/22/2009		Full physician assistant license issued
WARD, Amy Elizabeth, MD (009600833) Pfafftown, NC	11/20/2008		Temporary license issued to expire on 05/31/2009
DISMISSALS			
DONALDSON. Brian Robert, MD (000023692) Healdsburg, CA	12/22/2008		Dismissal without prejudice; Charges issued 09/05/2008
GRANT, Gregory, MD (000027461) Asheville, NC	12/22/2008		Dismissal without prejudice; Charges issued 08/01/2008
LOWE, James Edward, Jr., MD (000037887) Fayetteville, NC	12/22/2008		Dismissal without prejudice; Charges issued 08/01/2008

Stay Up-to-Date on H1N1 Flu

The U.S. Centers for disease control and prevention has established an extensive collection of resources and information on novel H1N1 influenza— formally known as the "swine flu"—activity in the United States. The site includes a running tally of novel H1N1 cases and deaths in the U.S., as well as clinical guidelines for managing novel H1N1 infection in specific populations. As of this printing, there were 12 confirmed cases in North Carolina.

In addition, the CDC novel H1N1 influenza page includes a number of resources that may be distributed to patients or other lay people, such as guidelines on caring for a sick person in your home. This particular set of guidelines provides detailed information on preventing the transmission of the virus to other family members, as well as background information on novel H1N1 influenza and the medications used to treat it.

CDC is updating its Web site regularly. To make sure you have the latest information, sign up for an RSS feed from CDC or enroll in the agency's e-mail notifications at *www.cdc.gov/h1n1flu/whatsnew.htm*

Visit the CDC's novel H1N1 influenza site at *www.cdc.gov/h1n1flu/*

INFECTION CONTROL TIPS

Influenza is thought to spread mainly person-to-person through coughing or sneezing of infected people.

- Take everyday actions to stay healthy. Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
- Wash your hands often with soap and water, especially after you cough or sneeze. Alcohol-based hands cleaners are also effective.
- Avoid touching your eyes, nose or mouth. Germs spread that way.
- Stay home if you get sick.

Source: CDC Web site

EXAMINATIONS

Residents Please Note USMLE Information

United States Medical Licensing Examination
Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at *www.fsmb.org*.

Special Purpose Examination (SPEX)
The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

BOARD MEETING DATES

May 20-22, 2009 (Full Board)
June 17-18, 2009 (Hearing Panel)
July 15-17, 2009 (Full Board)
August 19-20, 2008 (Hearing Panel)

Meeting agendas, minutes and a full list of meeting dates can be found on the Board's Web site
ncmedboard.org

Visit the Board's Web site at *www.ncmedboard.org* to change your address online. The Board requests all licensees maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 30 days of a move.

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