FORUM
NORTH CAROLINA MEDICAL BOARD
PRIMUM NON NOCERE
FALL 2010

What physicians don't know about nutrition
(Pg. 6)

2009-2010: The NCMB's 'Year of Transparency'

It's hard to believe it's been a year since I was sworn in as the first osteopathic physician to serve as the NCMB's president. It's been an honor and a pleasure to serve and, I hope, to forge the way for others in osteopathic medicine.

When I was appointed in 2005, I had a preconceived notion of what the Board was like. To be blunt, I assumed I would be working with a bunch of arrogant, know-it-all physicians, each with a personal agenda. Instead, I've had the good fortune to work with a group of caring, thoughtful doctors who, to a person, are deeply committed to the people of North Carolina, as well as to their physician colleagues. My non-physician colleagues on the Board have been equally dedicated.

NCMB President Donald E. Jablonski, DO, says "I believe everyone. . .should be involved when the Board sets up rules, adopts position statements or sets policy of any kind."

At the same time, the Board is no monolith. Its members are often divided, at least initially, which I think brings credibility to the Board. Cases and policy issues are usually decided after vigorous debate, and decisions are never made lightly.

I often wish that more licensees could see the Board in action, so they could witness how diligent, thoughtful and compassionate this Board is in its treatment of sensitive matters that, we are all too aware, affect people's lives and livelihoods. But most licensees will never see Board proceedings firsthand, either as observers or as the subjects of disciplinary cases. I suspect many licensees have their own preconceived notions of the Board.

The Board was reminded of this last year when an effort mounted by licensees, professional groups and others resulted in a new law that requires the NCMB to provide additional rights to licensees under investigation.

To me, the most surprising thing about this effort was not the suggestion that the NCMB should improve its investigative and disciplinary policies and procedures (what organization can't do better?) It was the obvious perception among those advocating for change that the NCMB hid its way of doing things from the regulated, perhaps even deliberately. I, and my colleagues on the Board, knew this perception to be false.

Well, in my view, if you disagree with the way outsiders perceive your organization the best remedy is to shine a bright light on your proceedings and let your actions speak for themselves.

That's what I've tried to do as Board president during the past year, which I hope will be remembered as a year of transparency. I believe everyone—patients, the profession

IN THIS ISSUE

—should be involved when the Board sets up rules, adopts position statements or sets policy of any kind. (Incidentally, this belief is central to my personal management style. I often begin meetings by reminding participants to interrupt me if I leave anything out or fail to recognize someone who wants to speak.)

Of course, the NCMB has followed an open, multi-step process before making any significant change since long before I was on the Board. Many Board committee meetings where proposed policy changes are discussed (the Policy Committee, for example) are open to the public. Draft position statements are published, both on the Board's website and in this newsletter, for licensee review and comment. Similarly, changes to administrative rules are published for comment and, in most cases, subject to formal public hearings before they can take effect.

But, as I noted earlier in this article, few licensees, or members of the public for that matter, participate in the official, public process. So what we've done over the past year is create even more opportunities for stakeholders outside the Board to have input into its work.

The most visible way we've done this is by creating more special committees and task forces, whose memberships have included representation from interested parties outside the Board, to tackle specific issues. Over the past year, the work of these types of groups has helped to determine whether the Board should create a new license type for those practicing administrative medicine (decision: No); to develop clear standards for physicians who wish to advertise board certifications and, most recently; to explore the subject of "practice drift" (see related article Page 3).

Another way we have deepened the Board's commitment to transparency is through the administrative rulemaking process. Over the past 12 months, the Board has overhauled its licensing rules to clarify requirements and processes, and to create an expedited path to licensure for experienced physicians. In addition to the new statutory requirements that afford more protections to licensees under investigation by this Board, the NCMB thinks it can improve its investigative and disciplinary processes further still by setting down much of its internal processes as rule. Once these rules, which are still under development, are in effect, we believe licensees will have all the information they need to understand the disciplinary processes.

I think the Board has improved every year, and we are always looking for new opportunities to do better.

If you think the Board can do still more, by all means, think about getting involved. I'd encourage any physician who's willing and able to put in the hours to seek a seat on the Board. At least two seats will come open next year.

I think most licensees would be as impressed as I have been with the way the NCMB conducts itself.

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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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Primum Non Nocere

Revisiting "practice drift"

Reader response calls for clarification

In the Summer 2010 issue of the *Forum*, Dr. Jablonski's President's Message discussed the phenomenon of "practice drift" and stated the Board's intention to look further into this issue. The Board defines practice drift as the outflow of physicians from areas in which they were trained into new areas of practice. Areas into which both primary care and specialty physicians are "drifting" include cosmetic procedures, mental health and pain management.

The article generated an unprecedented response from *Forum* readers, who posted a record number of comments to the online version of Dr. Jablonski's article. The Board and, more specifically, the *Forum* staff are gratified to see licensees engaging in this way, even though many licensees disagreed strongly with Dr. Jablonski's words! It was also encouraging to see several comments that applauded the Board's interest in practice drift as prudent and appropriate to its regulatory mission and mandate.

If you have never visited the online version of this newsletter, please go to *www.ncmedboard.org* and click on "*Forum*" in the Professional Resources section. Readers may post comments at the end of each article. Comments are screened by the *Forum* editor. Personal attacks, profanity or other derogatory comments are not posted. Criticism or commentary of the Board and its policies is invited and encouraged, provided it is delivered in a collegial manner.

After reading the many comments posted to Dr. Jablonski's article on practice drift, it seemed necessary to clarify the Board's intentions.

Several licensees who commented on the article expressed concern that Board attention to practice drift would lead to a "witch hunt" to identify and sanction licensees practicing outside their areas of formal training. Some opined that a certain amount of "drift" is inevitable in primary care due to numerous factors, including the scarce availability of subspecialists in certain areas, namely psychiatry.

Dr. Jablonski wrote that, bottom line, the Board's primary concern about drift is about professional competence. He further stated that, if a licensee is practicing competently within an area that falls outside the area they trained in, the Board does not have a problem with their "drift." Second, the Board is a complaint-driven organization that investigates licensees based on patient complaints or information that comes to it through a variety of other sources. It does not knock down doors looking for misconduct and it does not use its Investigations and Complaints departments to search out cases of a particular type. Fears about witch hunts are simply unfounded.

The Board is pleased to report that Dr. Jablonski did indeed appoint a Special Task Force on Practice Drift, as he indicated he would at the end of his *Forum* article. The Special Task Force held what is expected to be its only face-to-face session on Oct. 13, with 21 participants, including representatives from primary care, the subspecialties and the liability insurance companies, among other constituencies. With Board Member Thomas H. Hill, MD, presiding, participants engaged in a thorough discussion of practice drift with a goal of reaching mutual agreement on the meat of a to-be-drafted Board position statement on practice drift.

What's next: The Special Task Force agreed that the Board should adopt a position statement that declares its expectation that licensees practicing outside of areas in which they have received extensive training (e.g. residency and/or fellowship training) must be competent in the new areas of practice. The Board aims to have a draft statement prepared by January 2011.

Selection of comments excerpted from the Web version of Dr. Jablonski's article:

> *"This article is right on target and long overdue. It is not "anti-physician." It is pro-patient."*

> *"There used to be a phenomenon called physician integrity which, loosely, meant a doctor would do the right thing because it was the only way to practice.."*

> *"Perhaps if compensations were adequate the pressure to seek additional services to offer would be minimized. It is unfortunate that primary care is in such a current sad state of affairs with cuts to the SGR impending every 6 months."*

Board clarifies standards for publication of misdemeanors

The Board has approved changes to the rules governing publication of misdemeanor convictions by physicians and physician assistants on the Board's website.

The rule, 21 NCAC 32X .0106, currently requires the Board to publish misdemeanor convictions falling within four broad categories. These misdemeanors are public information and are posted on licensees' information pages at *www.ncmedboard.org* in accordance with state law.

The Board felt the rule should provide more explicit guidance regarding which misdemeanors would be published. The revised rule itemizes the specific misdemeanor crimes for publication and makes certain other refinements. The provision mandating publication of misdemeanor convictions for ten years would remain unchanged under the current proposal. The current rule will remain in effect until the revised rule is approved by the NC Rules Review Commission. The Board has not determined when it will begin the formal rule-making process.

Misdemeanor crimes that would be posted under the revised rule include:

Crimes against a person: manslaughter; assault; battery; sexual crimes; hazing; false imprisonment; stalking; abuse and neglect.

Crimes of moral turpitude : fraud; arson; blackmail; burglary; embezzlement; extortion; false pretenses; forgery; malicious destruction of property; receiving stolen goods with guilty knowledge; bribery; counterfeiting; mail fraud; perjury; harboring a fugitive from justice with guilty knowledge; failure to file taxes; tax evasion; tax fraud; abandonment of a minor child; bigamy; gross indecency; incest; solicitation; prostitution; attempting, aiding and abetting or serving as an accessory in the commission of a crime involving moral turpitude, and taking part in or attempting to take part in a conspiracy involving moral turpitude where the underlying crime would not involve moral turpitude.

Convictions related to drug/alcohol use: The Board currently posts all misdemeanors involving drugs and alcohol. The proposed change would eliminate posting drug- and alcohol-related convictions entered prior to a physician or PA's enrollment in medical and professional school.

PLEASE NOTE:
Changes are not in effect until the rule-making process is complete.

Violations of public health and safety codes: The Board would continue to publish all such violations.

The Board will no longer publish reckless driving convictions.

To comment on the proposed rule changes, email *rules@ncmedboard.org*

Guidelines for advertising board certifications advance

At its September meeting, the Board adopted the report of its Task Force on Physician Advertising Standards. The report proposes an approach to providing guidance to physicians who wish to advertise board certification to the public while also equipping patients with information to use when vetting a physician's credentials. The Board has not determined a timeline for completion of the report's recommendations.

In adopting the report, the Board emphasized that its recommendations apply exclusively to the issue of advertising board certifications to the public. Board statements and guidelines should not be construed as a referendum on the legitimacy of certain certifying organizations. Proposed guidelines for advertising to the public are not intended for use by organizations when making credentialing decisions nor should they be relied upon by health care payors when setting physician reimbursement rates.

The Board initially approved proposed rule 21 NCAC 32Y .0101 *Advertising of Specialty and Board Certification* in 2009. The proposed rule generated a number of responses during the public comment period, prompting the Board to convene a Task Force of physician experts on the issue, chaired by Board Member William A. Walker, MD. Task Force participants heard testimony and engaged in debate with representatives of various certifying organizations during an evening session, followed by a round table discussion.

The Task Force report proposes adopting a modified version of the original proposed rule. The current draft would clarify that physicians may advertise board certification by boards recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA) and the Royal College of Physicians and Surgeons of Canada (RCPSC). In addition, physicians could advertise certification by boards meeting criteria established in the rule, so long as the physician maintains documentation substantiating that the criteria have been met. Physicians who are board certified in an area other than the specialty or sub-specialty in which they completed residency or fellowship training would be required to make that explicit in their ads.

The report further recommends that the Board adopt a more comprehensive position statement on advertising to help physicians interpret the Board's proposed rule. Finally, the report recommends that the Board develop patient resource materials on its website to foster greater understanding of the significance of board certification.

Medical Board installs officers for 2010-2011

The NC Medical Board has seated its officers for the coming year. Janice A. Huff, MD, of Charlotte, will serve as president; Ralph C. Loomis, MD, of Asheville, will serve as president-elect; William A. Walker, MD, of Charlotte, will serve as secretary/treasurer.; and Pamela Blizzard, of Raleigh, will serve as member 'at large.' The position does not follow the standard procession towards presidency, yet can be renewed upon nomination by the Board in 2011. Their terms run until October 31, 2011.

JANICE E. HUFF, MD, PRESIDENT

Janice E. Huff, MD, of Charlotte, graduated with honors from Michigan State University, completing a BS degree in physiology. She earned her medical degree from Saint Louis University School of Medicine. She completed internship and residency in the Department of Family Medicine at Carolinas Healthcare System, formerly Charlotte Memorial Hospital and Medical Center.

Janice E. Huff, MD
President

Dr. Huff is a part-time faculty member of the Family Medicine Residency Program at Carolinas Medical Center in Charlotte and is a clinical instructor in the Department of Family Medicine at the University of North Carolina at Chapel Hill. She also practices part-time at Presbyterian Urgent Care and Mecklenburg Health Care Center in Charlotte.

Dr. Huff was appointed to the Board in 2007. She chairs the Executive Committee and serves on the Physicians Health Program Committee.

RALPH C. LOOMIS, MD, PRESIDENT-ELECT

Dr. Loomis took his undergraduate degree, cum laude, at Vanderbilt University, and his MD degree from Indiana University. He did his internship at Indiana and remained at the same institution for his residency in neurosurgery. He also took the Theodore Gildred Microsurgical Course and was coauthor of an article in the Annals of Surgery.

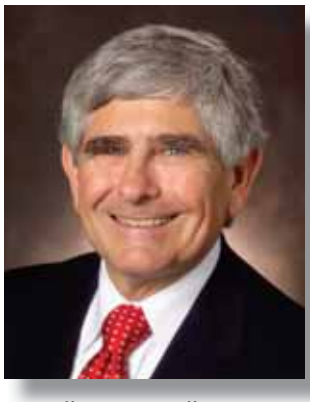
Ralph C. Loomis, MD
President Elect

Dr. Loomis practices at the Carolina Spine and Neurosurgery Center in Asheville, NC.

Appointed to the Board in 2005, Dr. Loomis completed a three-year term in 2008. He was reappointed to a second three-year term in 2009. Dr. Loomis chairs the Policy Committee and serves on the Executive and Physicians Health Program Committees.

WILLIAM A. WALKER, MD, SECRETARY/TREASURER

William A. Walker, MD, of Charlotte, earned his BA in chemistry and psychology and his MD from the University of North Carolina, Chapel Hill. He completed his internship and residency training in general surgery and a fellowship in gastrointestinal physiology at the University of Michigan in Ann Arbor. He also completed a fellowship in colon and rectal surgery at the University of Minnesota in Minneapolis.



William A. Walker, MD
Secretary/Treasurer

Dr. Walker currently practices at Charlotte Colon and Rectal Surgery Associates and is a community faculty member in the Department of Surgery at Carolinas Medical Center in Charlotte. He also served as chief of staff at Presbyterian Hospital.

Dr. Walker was appointed to the Board in 2007. He chairs the Disciplinary Committee and serves on the Policy, Executive and Allied Health Committees.

PAMELA BLIZZARD, MEMBER AT LARGE

Ms. Blizzard earned her bachelor's degree in urban studies from Brown University in Providence, RI, and her MBA in marketing and finance from the University of Santa Clara in Santa Clara, CA.

Pamela Blizzard
Member At Large

She currently serves as executive director and founder of the Contemporary Science Center in Research Triangle Park, NC, where she established and now directs its science education non-profit program.

From March 2005 to 2006 she was a member of the State Board of Education's E-Learning Commission and the Curriculum and Instruction subcommittee where she was charged with creating an online learning strategy for the State of North Carolina.

She was appointed to the Board in 2007 and serves on the Disciplinary, Allied Health and Executive Committees.

What physicians don't know about nutrition (but have every reason to learn)

A conversation with Nutrition in Medicine Program Director Dr. Martin Kohlmeier

A quick look at the leading causes of illness and death makes it clear that knowledge of nutrition is critical to the modern practice of medicine. Cardiovascular disease, type 2 diabetes, hypertension, innumerable cancers —all are linked at least in part to poor diet. What's more, the success of many of the treatments and interventions used to address these illnesses hinges on improving diet and nutrition.

Yet a recent study by the Nutrition in Medicine (NIM) program at UNC Chapel Hill's School of Public Health found nutrition education at U.S. Medical Schools to be woefully inadequate. Just one in four U.S. medical schools offer students the minimum recommended number of hours in nutrition education, according to the study, which was published in September in the journal *Academic Medicine* (See STUDY sidebar, pg 9). That suggests conspicuous nutrition-knowledge gaps exist among practicing physicians, according to the study authors. And, by extension, it means that many patients are likely receiving less than optimal care.

NIM combats this problem on two fronts. First, it has developed core nutrition curricula for use by U.S. medical schools for nearly 15 years. Currently, a majority of medical schools in this country use the NIM curriculum. However, even schools using the curriculum don't cover nutrition at the level needed to give physicians the practical knowledge they need to practice.

That's where NIM's latest endeavor comes in. The Nutrition Education for Practicing Physicians (NEPP), fully funded by a grant from the National Cancer Institute, offers brief, targeted modules that teach physicians specific topics in nutrition, such as encouraging behavior change in overweight patients. Modules are designed with busy practicing physicians in mind. Most are between just five and 15 minutes in length and lessons are designed to allow the physician to immediately use what he or she has learned in practice. For those seeking deeper knowledge of nutrition, the program also offers several longer foundational modules. The entire NEPP curriculum is posted online and is available to registered users free of charge. Visit *http://nutritionin-medicine.org/* for more information.

Credit Chad Mitchell

Dr. Kohlmeier

Forum Editor Jean Fisher Brinkley recently spoke with NIM program director Martin Kohlmeier, MD, about Nutrition Education for Practicing Physicians.

Q&A

How did the NEPP get started?

We have had our NIM for medical students curriculum for about 15 years. It had evolved into a full and robust curriculum that now is used by a majority of U.S. medical schools with, I believe, very good outcomes. But it is still not enough. We still do not reach the level of instruction that is necessary to really prepare a physician for practice. So that's how it got started. It was the logical next step. I must say, we are fortunate to be fully funded by the National Cancer Institute. Without them, this whole program would not exist.

Why is it important for a practicing physician to have an understanding of nutrition?

The simple truth is that we estimate that somewhere between 50 to 70 percent of disease burden and mortality is related in some way or another to nutrition. And, probably more important in a practical way, a lot of the therapies and the interventions that physicians do really don't work as well if they don't work on a foundation of nutrition intervention. Very often it's very simple things, but you have to know them.

Who comes up with the curriculum?

We have a very good team here [in the NIM program] and we do it. When we put together the grant application, we proposed a set of topics. We also solicit input from our national advisory board, which is made up of 20 or so nationally renowned nutrition educators. They provide us with input. We also ask users, what else would you like to see? So it's continuously evolving.

What types of physicians do you envision using these modules?

Our primary target right now is physicians in training, or residents. Because they are just not done with their training. We know that. They're also usually part of structured programs so we can approach residency directors, fellowship directors, etc., so it's an efficient way for us to get this out to people.

So you think you can have the most impact with residents?

I'm not sure I would say that. We have to start somewhere and it's an obvious place to start. We definitely see the importance also for all physicians. A lot of this science didn't even exist when many physicians completed their training. All physicians are welcome to use the curriculum.

How do you envision physicians who complete some of these modules using what they have learned in practice?

We want to provide skill-building education that empowers physicians to use that information directly. I like to say when they get up from the computer they go right to their patients and use it. Our vision is that physicians will continue using this information. And as they encounter particular issues, problems or interesting cases, they can return and use it as a resource. And that's part of the reason why we have it so focused.

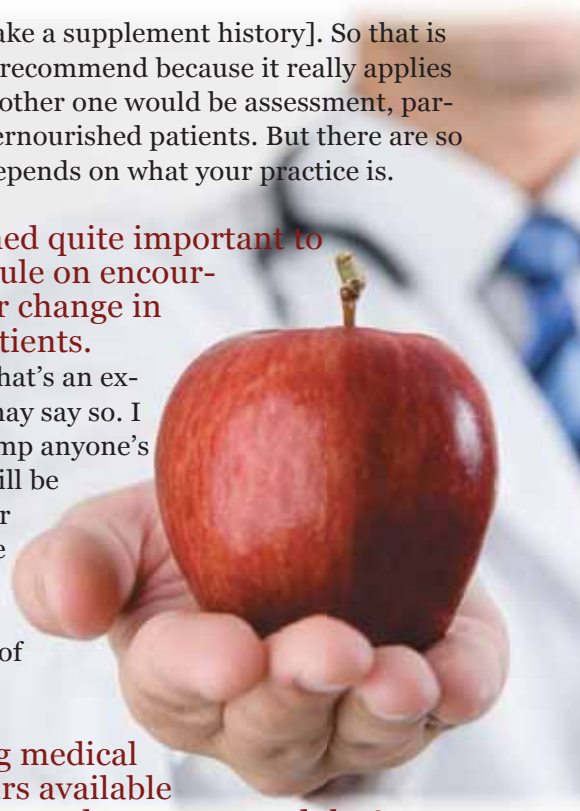
It's 5-10 minutes. You can always fit that in. We provide pocket notes, which are basically printable summaries of the key information learned in the module. They can print these out when they're done and literally put them in their pocket. The pocket notes are designed to help them remember. We are also working on tools that would allow these pocket notes to work on portable devices so you can keep the information on your iPad, your smart phone, etc. This is where we're going—to have resources that are used while they are studying and that they continue to use as they practice. As we go along, feedback will shape how these things are delivered. We see it as an iterative, interactive process with physicians.

As you know, practicing physicians are extremely busy. They don't have a lot of time and there are quite a lot of modules to choose from. Could you recommend a top five, or maybe suggest just one module that, if you're only going to do one, you wouldn't want to miss?

One of them, which would be fairly close to the top, is how to take a supplement history. Because more than 60 percent of adults are taking dietary supplements and their physicians don't know about it. And we know quite well about the impact. Very often, physicians are unsure how to do this [take a supplement history]. So that is one that I would recommend because it really applies to everybody. Another one would be assessment, particularly for undernourished patients. But there are so many. It really depends on what your practice is.

One that seemed quite important to me is the module on encouraging behavior change in overweight patients.

Oh, yes. I think that's an excellent one, if I may say so. I don't want to crimp anyone's style. I think it will be quite different for everybody. We've always been quite surprised which topics are of most interest.



Are continuing medical education hours available for those who complete NEPP modules?

Not at this time, but we are preparing to do this. I would expect that within a year or so, maybe less, we will do that. The project is so new. We are still filling in the content and running as fast as we can.

Is there any formal program in place to measure the response to the curriculum?

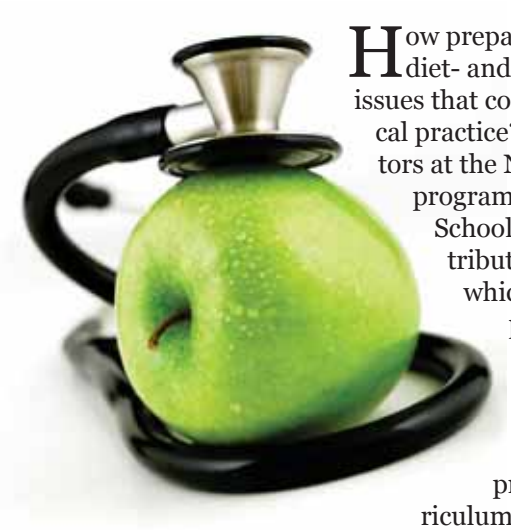
It's planned at two levels. The first level is a simple survey at the end that asks about use and practice. The second level is, as physicians continue to use this, we will ask returning users if they have implemented these particular skills [learned in a previous module] in practice. We are very interested in how effective this is.

Is there anything I haven't asked you about that you would like practicing physicians to know about this project?

It's most important that they understand that this is a work in progress and that we are developing and releasing new modules almost monthly. There's a whole slew in the pipeline. If they don't see it today, they should definitely come back. It might well be there a little bit later.

NUTRITION KNOWLEDGE:
How much do you know?
Take the quiz (pg 8-9)

Test your nutrition KNOW-HOW



How prepared are you to address diet- and nutrition-related issues that come up in your clinical practice? The program directors at the Nutrition in Medicine program at UNC Chapel Hill's School of Public Health contributed the following quiz, which highlights situations physicians frequently address in their practices. Questions are drawn from the Nutrition in Medicine program's online curriculum for practicing physicians. Subjects are taken from a range of medical specialties.

1 A 4th year medical student asks a patient, "Do you take any supplements?" How should the student follow this question in order to collect the most complete and accurate information about the patient's supplement use?

a. No further questions needed; this general question captures 90 percent of all typical supplements used

b. Ask why the patient takes the supplement mentioned

c. Ask specific questions by category (single or combination vitamins, herbals, etc.), giving examples

d. Go through all of the essential nutrients one by one, asking if the patient takes them

e. Ask the same question again later in the interview; sometimes you will get additional information

2 Evaluate the appropriateness of asking the following question in taking a dietary supplement history: "Do you use any plant sterols or stanols?"

a. The question is appropriate

b. The question uses jargon that a patient may not understand

c. The question does not ask whether the compound is in pill or food form

d. It is unnecessary to ask about supplements derived from plant sources

e. The question is inappropriate because there are no dietary recommendations for plant sterols/stanols

3 Joshua is a successful athlete. Lately he has been feeling more tired than usual. He mentions that he has been taking a new dietary supplement. He buys it at a local health food store. Because it is sold commercially, what statement can you make with regard to its quality, purity, composition, safety, or effectiveness?

a. It has been evaluated for efficacy and safety by independent studies before being marketed

b. It has been evaluated for safety only by the FDA

c. The USDA/FDA can assure its purity and composition only

d. The FDA and DEA monitor reports of adverse events and contamination

e. There is no assurance of quality, purity, composition, safety, or effectiveness

4 You are performing an exam on a patient who has a BMI of 28 and slightly elevated blood pressure. When you tell the patient you are concerned that her weight could put her at risk for heart disease and cancer, she replies "I can't lose weight, and I'm tired of trying. I've accepted that this is just the way I am." What is an appropriate response to this patient?

a. Move on with the appointment without making further mention of her weight

b. Give the patient several handouts detailing how she can lose 1-2 pounds per week

c. Refer the patient to a registered dietitian for counseling on how to lose weight

d. Reflect back her frustration empathetically, and provide information about risks of overweight

e. Point out the patient's negative attitude and tell her that she needs to try to lose weight

5 You are seeing a 46-year-old female patient with recently confirmed diabetes mellitus, type 2. She is currently following an energy-neutral diet and is doing 150 minutes of aerobic exercise per week. Her BMI is 29.2, and her HbA1c has fallen from 8.2 to 7.6%. She wants to know how she can improve her glycemic control further without the use of medication. Which area should she work on next?

a. Switching from her aerobic exercise to one hour of strength training twice a week

b. Avoiding any sugar or other added sweeteners

c. Skipping one meal and a snack most days

d. Reducing intake by 300-500 kcal/day across all meals

e. Increasing her daily fruit intake

6 You are seeing a patient with gestational diabetes mellitus in the 16th week of her pregnancy. She was normal weight before becoming pregnant with a BMI of 24. She is gaining weight slightly faster than is desired. Currently she exercises a

Nutrition quiz answer key on page 10

total of 90 minutes/week and eats three meals and two snacks per day. In order to get her back to her target weight range while still promoting glycemic control, you could suggest:

a. Lose at least one pound before her next visit

b. Tell her to increase total weekly exercise to 180 minutes/week and to eliminate her snacks

c. Find a few high-calorie foods in her diet to replace with healthier, low-calorie options

d. Eliminate all of her snacks and only eat three meals a day

e. Continue her current regimen because energy needs will increase as her pregnancy progresses

7 Describe the first step for measuring waist circumference properly.

a. Place the measuring tape in a horizontal plane, parallel to the floor, around the abdomen

b. Locate the mid-axillary line

c. Place the measuring tape in a horizontal plane across the navel

d. Have the patient bend forward from the waist, letting the arms fall towards the floor

e. Draw a horizontal mark at the uppermost lateral border of the right iliac crest

8 Which of the following patients is most likely at risk for refeeding syndrome upon starting oral or enteral feeding?

a. A 40-year-old woman undergoing a complete hysterectomy

b. A 90-year-old woman with dysphagia following a stroke two weeks ago

c. A 13-year-old boy with several long-bone fractures following a car accident

d. A 55-year-old man following a prostatectomy and radiation therapy five days ago

9 How much of which micronutrient(s) should a month-old breastfed infant get daily?

a. 50 µg vitamin K

b. 100 IU vitamin D3 and 50 µg vitamin K

c. 2 mg chelated iron

d. 400 IU vitamin D3

e. 2 mg chelated iron and 400 IU vitamin D3

10 Body fatness, frequent alcohol intake, and high red/processed meat consumption all increase risk of cancer at which of the following sites?

a. Endometrium

b. Colorectum

c. Breast

d. Lung

e. Stomach

UNC-CH study:

Nutrition education in med schools lacking

Kelly Adams, RD, MSPH
Study Author

Photo courtesy of Kelly Adams

A survey conducted by UNC Chapel Hill researchers found that, on average, students at U.S. medical schools receive 19.6 hours of nutrition instruction during their four years of professional education—significantly less than the minimum 25 hours recommended by the National Academy of Sciences. Only about one in four of the 105 medical schools surveyed met the NAS recommendation.

The findings, published in the September issue of the journal *Academic Medicine*, indicate that the amount of nutrition education provided to medical students in the U.S. continues to be inadequate and may even be eroding. A 2004 survey that used the same methodology and questions as the more recent one found that 38 percent of U.S. medical schools met the minimum recommended 25 hours of nutrition education. UNC-CH researchers have studied nutrition education at U.S. medical schools since 2000.

"It's definitely clear that things are not improving," said Kelly Adams, RD, MPH, and lead author of the recent study. She is a research associate in the Department of Nutrition at UNC Chapel Hill's School of Public Health and assistant project director of UNC's Nutrition in Medicine program. "We hope that our paper serves as a wake-up call to [medical school] administrators."

A total of 105 medical schools completed the portion of the survey regarding the number of nutrition contact hours completed by students. The number of hours taught ranged from zero to 70 hours. Just 28 schools, or 27 percent, surveyed indicated that they provide at least 25 hours of nutrition instruction. Thirty medical schools reported requiring 12 or fewer hours of nutrition instruction; Thirty-seven schools indicated that they provide between 13 and 24 hours of nutrition education.

Adams said the UNC Chapel Hill team also noted an apparent trend toward offering nutrition education as part of an integrated curriculum, as opposed to offering dedicated nutrition courses. That doesn't bode well for nutrition education, she said, because integrated courses appear to be less effective at teaching nutrition.

"I hear anecdotally that when nutrition is integrated, it tends to get pushed out," Adams said. "It's not seen as important enough when there are so many competing demands."

Jean Fisher Brinkley

Getting started with NEPP:
'Bite-sized' nutrition education for practicing physicians

The Nutrition Education for Practicing Physicians (NEPP) program at UNC Chapel Hill's School of Public Health teaches nutrition to physicians in active clinical practice. Training modules are completed online and, for now, are available to registered users free of charge. Read on for more information about NEPP and instructions for accessing the curriculum.

Q: What nutrition topics are covered?
A: NEPP currently offers 14 targeted modules on subjects such as behavior change counseling, primary prevention of cancer, glycemic control for patients newly diagnosed with Type 2 diabetes, taking a dietary supplement history and more. The program also offers 10 longer foundational reviews that provide more in-depth nutrition knowledge as it applies to aging, pregnancy and lactation, infancy and young children, dietary supplements, micronutrients, sports nutrition and cancer.

Q: How much time does it take to complete a training module?
A: Targeted modules take between five minutes and 15 minutes to complete—the program directors call them "bite-sized." Foundational modules take about 45 minutes to complete.

Q: How do I access the courses?
A: Courses are available at *www.nutritioninmedicine.org* Click on "Practicing Physicians" for a brief overview of the program.

Q: Do I need to register to access the courses?
A: Yes. Select "Webcourses Login" to register. You will be asked to provide your name and email address. Don't forget to select "Physicians" or "Residents" (whichever is appropriate) when asked to identify your institution.

Q: Who is NEPP trying to reach with its curriculum?
A: The program directors are currently reaching out to residency training programs to encourage them to use the NEPP curriculum. However, the content should be of value to most physicians or physician assistants.

Q: I don't practice primary care. Would the NEPP curriculum be of value to me?
A: Probably. NEPP's directors believe that, potentially, all physicians can benefit from the training modules due to the unique position physicians occupy in society. People frequently approach physicians outside of clinical settings (at cocktail parties, on the sideline of a soccer match, etc.) to ask medical advice, including advice about nutrition.

Q: Can physician assistants use the NEPP curriculum?
A: Yes, for the time being, the program is open to PAs as well as physicians.

Answer key—Nutrition quiz

1. The answer is **C.**
Ask specific questions by category (single or combination vitamins, herbals, etc.), giving examples. Do not just ask patients whether they use dietary supplements. You want to ask targeted questions to get the information you need without wasting time.

2. The answer is **B.**
The question uses jargon that a patient may not understand. It is appropriate to ask patients about their intake of various categories of dietary supplements, including plant sterols and stanols. However, it is important to use language that patients can understand and to give examples from each category in order to ensure that patients give the most accurate answers. In this case, give examples of popular products (brand names) that contain sterols or stanols, such as Benecol spreads.

3. The answer is **E.**
There is no assurance of quality, purity, composition, safety, or effectiveness. Dietary supplements are largely exempt from food and drug laws and regulations.

4. The answer is **D.**
Reflect back her frustration empathetically, and provide information about the risks of overweight. This patient is in the "precontemplation" stage of change. The goal is to move her toward the "contemplation" stage, during which she will begin to consider taking steps toward positive change. Your role is to empathetically validate her feelings about weight loss while providing information about the risks of not changing.

5. The answer is **D.**
Reduce intake by 300-500 kcal/day across all meals. This reduction should allow her to lose about half a kg (one pound) a week in the long run.

6. The answer is **C.**
Find a few high-calorie foods in her diet to replace with healthier, low-calorie options. Replacing a high-calorie food with something healthier/low-calorie is a strategy suggested for decreasing total calorie intake and will help slow the rate of weight gain.

7. The answer is **E.**
Draw a horizontal mark at the uppermost lateral border of the right iliac crest. The first step in measuring waist circumference is locating and marking the uppermost lateral border of the right iliac crest.

8. The answer is **B.**
A 90-year-old woman with dysphagia following a stroke two weeks ago. Refeeding syndrome can occur with repleting a previously malnourished patient. Dysphagia may have caused suboptimal energy intake for two weeks in this patient.

9. The answer is **D.**
400 IU vitamin D3. All newborn infants need 400 IU vitamin D3 daily, and breastfed newborns should be given this dosage via oral drops.

10. The answer is **B.**
Colorectum. Body fatness, alcohol intake and red/processed meat intake all increase the risk of colorectal cancer.

Compliance program monitors Licensee Information

The NCMB has established a new program to ensure complete and accurate reporting and publication of certain licensee information, including details about convictions, certain malpractice payments and disciplinary actions by health care regulatory authorities.

A state law that took effect October 1, 2007, directs the Board to collect from licensees and publish information in 13 required categories. Last fall, the Board built an online portal at its website, *www.ncmedboard.org*, and mailed letters requesting that its physician and physician assistant licensees use the system to provide their information. The response rate to the Board's notices about the Licensee Information (LI) project was about 90 percent.

To ensure full compliance with the law, Board staff systematically review certain required data reported via the LI portal, identify errors or omissions and make changes to the published reports where needed. Licensees are notified and invited to review changes when their information is revised. Categories of information that are reviewed include: healthcare agency actions, hospital suspensions/revocations, malpractice payments, misdemeanor convictions and felony convictions.

The new compliance program's priorities include: reviewing existing reports of required information to verify accuracy and completeness; proactively identifying licensees with new, unreported required information to ensure that the Board is appropriately notified and a public report completed; and reaching out to licensees who by law are subject to inclusion in the Board's LI pages but have not yet responded to Board requests to update their information. In future, the Board intends to begin general compliance audits to verify the accuracy of certain reported information, including current practice address, postgraduate training and board certifications, if any.

While the Board is authorized to discipline licensees who fail to report required information, or who provide false information, the Board's primary concern is with compliance. To date, the Board has not disciplined a licensee due to problems with his or her LI page.

Board member perspective:

On improving physician-patient communication

Thomas R. Hill, MD

Effective interpersonal communication with patients is not a subject I have occasion to reflect on regularly. Nonetheless, like most physicians, communicating successfully with patients is something I must do on a daily basis. I recently chose to spend a Saturday completing a one-day course designed to improve physician-patient communication. My instructor was Joe Kertesz, who offers this communications course to doctors across North Carolina. His course is one of two identified by the Board last year as part of an effort to locate cost-effective, in-state programs that might be used by licensees, either because they have an identified need to improve communication skills, or because they want to. Interestingly, three of the participants in the session I completed were physicians who enrolled in the course at the Board's request. The course materials and section topics prepared by Mr. Kertesz are designed to prepare participants to communicate with any patient, in any health care venue.

Dr. Hill

We role-played, taking turns playing "patient" and "physician" for insight into being the patient, and for the opportunity to practice approaching patients with specific needs and attitudes. Some of the more sensitive scenarios we acted out included end-of-life situations and injuries that occur as a result of medical care.

We discussed the need to recognize that patients may present with anger, fear, intimidation and reliance for/on physicians. Mr. Kertesz emphasized the importance of clearly identifying each patient's complaint so that you may address their issues. Perhaps even more important, we discussed finding ways to form an alliance with the patient and his or her family for either the short, episodic care, (which, as an anesthesiologist, is what I most often provide), or long term relationships. Making that connection is an important step that can help prevent future miscommunication and/or misunderstanding.

Effective physician communicators acquire these skills early in clinical training, but Mr. Kertesz believes that it is never too late for a physician to cultivate them. In addition, practitioners who value good communication always have the opportunity to sit back and say, "How am I doing?" I approached the course in this spirit.

I found Mr. Kertesz's course to be a refreshing seven hours of constant feedback and open discussion of the many possible settings and scenarios that we as physicians walk into, both prepared and unprepared.

North Carolina Medical Board

Quarterly Disciplinary Report | May-July 2010

Board actions are now published in an 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 website at *www.ncmedboard.org* Readers who prefer the more comprehensive version may sign up on the website to be notified when a new report is posted. Go to "Professional Resources" and select "Subscriptions" to sign up for an RSS Feed to be notified. Be sure to select the feed for "Bimonthly Disciplinary Report."

Name/license#/location	Date of action	Cause of action	Board action
REVOCATIONS			
BERKOWITZ, Howard Martin, MD (000023174) Atlanta, GA	05/14/2010	MD entered a guilty plea to felony health care fraud in NY	MD's NC medical license is revoked
SUSPENSIONS			
APOSTOLOU, Michael Phillip, MD (009701222) Roanoke, VA	06/24/2010	MD had a relationship with a patient and did not document treatment of the patient. Complaints indicated MD delayed providing patients with medical records and exhibited bizarre behavior; Voluntarily surrendered license	MD's NC medical license is indefinitely suspended
BUMBALO, Thomas Samuel, MD (009800203) Wilmington, NC	05/14/2010	MD periodically smoked marijuana; MD has no disciplinary/complaint history and nothing suggests patient care is compromised; MD agreed to self-refer to NC Physicians Health Program (NCPHP)	MD's NC medical license is suspended for six months; immediately stayed
CARLSON, James Lennart, MD (200200010) Cerro Gordo, NC	05/17/2010	MD admitted to abusing prescription opiate medications; voluntarily surrendered license	MD's NC medical license is indefinitely suspended
CATLIN, Roger William, MD (000021633) Hixson, TN	07/07/2010	MD surrendered license in TN and PA based on misuse of prescription medication, health and substance abuse problems	MD's NC medical license is indefinitely suspended
DEVIRGILIIS, Juan Carlos, MD (000028719) Boone, NC	06/24/2010	MD lost DEA authorization to prescribe Schedule II, III and IV controlled substances yet continued to prescribe controlled substances using another MD's presigned prescription blanks and through supervision of an NP with a valid DEA registration	MD's NC medical license is indefinitely suspended
DUNN, Lawrence Anthony, MD (000030018) Durham, NC	05/20/2010	Three experts testified MD's care of patients A-G fell below standard in several respects	MD's NC medical license is indefinitely suspended
FANN, Benjamin Bradley, MD (000033034) Boone, NC	07/19/2010	MD assisted another MD in circumventing DEA laws by presigning prescription blanks when the other MD had restrictions on prescribing	MD's NC medical license is suspended for six months
GARRITY, Alyce Loretta, MD (009900047) Cordova, AK	07/08/2010	MD became intoxicated while on call; MD was summarily suspended of her duties at community medical center; surrendered Alaska medical license	MD's NC medical license is indefinitely suspended
GRAY, Robert Bourdeaux, MD (000028198) Morehead City, NC	07/02/2010	KY action based on MD admitting that he abused alcohol, including multiple alcohol related arrests	MD's NC medical license is indefinitely suspended
HALL, Charles Daniel, MD (009401205) Supply, NC	07/20/2010	MD has history of substance abuse and was arrested for DWI; surrendered license in May 2009	MD's NC medical license is indefinitely suspended
MBADINUJU, Adanma Ijeoma, MD (200501741) Monroe, NC	06/17/2010	MD prescribed to a family member and diverted the prescription for self use. MD called in and forged prescriptions for self use in the name of two other physicians without their authorization	MD's medical license is indefinitely suspended; stayed all but three mos./ probation for 12 mos.
OGILVIE, James William, PA (000101326) Raeford, NC	05/24/2010	PA prescribed controlled substances using blank prescription pad of MD no longer at PA's office. PA admitted problem with opioid pain medications; voluntarily surrendered license	PA's license is indefinitely suspended
SANCHEZ, Clare Jeanne, MD (000028335) Raleigh, NC	06/14/2010	MD allegedly appeared to be impaired as a result of her alcohol use. MD inactivated medical license and agreed to NCPHP evaluation and treatment	MD's NC medical license is indefinitely suspended
SMITH, Bryan Dorsey, MD (200201531) Durham, NC	05/21/2010	MD determined he was an abuser of alcohol, obtained assessment and entered into a residential treatment program; voluntarily surrendered license	MD's NC medical license is indefinitely suspended

Name/license#/location	Date of action	Cause of action	Board action
WARD, Amy Elizabeth, MD (009600833) Pfafftown, NC	05/07/2010	MD was not forthcoming in responses to NCMB members' questions during an informal interview; MD's temporary license was allowed to expire	MD's NC medical license is indefinitely suspended
SUMMARY SUSPENSIONS			
DYER, David G. (0000225621) Wilmington, NC	05/11/2010	MD prescribed controlled substances to patients exhibiting drug-seeking behavior without performing an exam/keeping records; MD issued early refills for patients for unacceptable reasons; created fraudulent records in response to a Board Order to Produce	MD's NC medical license is summarily suspended; concurrent with the issuance of the order of summary suspension.
REPRIMAND			
ALEXANDER, Eben III, MD (000030888) Charlottesville, VA	06/21/2010	VA action; MD performed wrong site surgery on two separate occasions. On one occasions he did not inform the patient in a timely manner; On the other, he did not follow-up in a timely manner on a postop x-ray report	MD is reprimanded
CASTILLO, Alissandro Roque, MD (009900793) Mooresville, NC	05/28/2010	MD treated patients without proper training and outside contravention of Board guidelines; medical record reviewing expert opined care was below standard	MD is reprimanded
CLAY, Henry Tucker, MD (000038748) Lansing, NC	07/28/2010	TN action; MD allowed an RN in his office to perform x-rays without being licensed to do so	MD is reprimanded
COLETTA, Harry Mario, II, MD (000024054) Walnut Cove, NC	05/11/2010	MD wrote prescriptions for himself/close family members without documentation and in violation of Board position statement	MD is reprimanded; Required to take a course on record keeping and prescribing
COOK, David Martin, MD (000036092) Cornelius, NC	07/23/2010	MD engaged in an intimate and inappropriate relationship with a patient	MD is reprimanded; required to take a course on boundaries
FINCH, Sudhir Eugene, MD (200101336) Fayetteville, NC	06/29/2010	MD wrote prescriptions for himself, family, friends and staff without documentation and in violation of Board position statement	MD is reprimanded
GUFFREY, Gregg J., MD (000036355) Ft. Myers, FL	07/20/2010	MD failed to provide accurate information on NC license application	MD is reprimanded
JAMES, James Franklin, MD (000015359) Winterville, NC	06/11/2010	MD retained/used medication prescribed for patients and family members throughout his years of practicing; voluntarily surrender license; entered NCPHP contract	MD is reprimanded
KELLER, Irvin Basil, MD (009401430) Vero Beach, FL	07/20/2010	FL board action—MD preformed disc surgery at the wrong level	MD is reprimanded
MAIER, Rudolph Joseph, MD (000028775) Fort Bragg, NC	07/19/2010	Record review shows MD's patient care/record-keeping were below standards	MD is reprimanded
SCOTT, Daniel Joyner, III, MD (000030722) Millington, TN	07/21/2010	TN board action; MD failed to report unlicensed practice of medicine; failed to keep adequate records and monitor patients who were prescribed opiates; prescribing issues	MD is reprimanded
SWARNER, David Reynolds, MD (009400655) Washington, NC	06/17/2010	MD wrote substantial prescriptions for controlled substances. Expert review of records show care of patients fell below standards; entered interim consent order 10/15/2009	Interim consent order is dissolved; MD is reprimanded; agrees not to prescribe controlled substances
UWENSUYI-EDOWOMWAN, Fidelis I., MD (009600362) Charlotte, NC	06/17/2010	MD handwriting in medical records is illegible; Board requests improvement over two years; MD is implementing EMR system	MD is reprimanded
WATFORD, Douglas Elry, MD (000035546) Kinston, NC	06/25/2010	MD arrested on felony charges and failed to disclose on his annual license renewal; charges reduced to misdemeanor	MD is reprimanded

Name/license#/location	Date of action	Cause of action	Board action
PROBATION			
MBADINUJU, Adanma Ijeoma, MD (200501741) Monroe, NC	06/17/2010	MD prescribed to a family member and diverted the prescription for self use. MD called in and forged prescriptions for self use in the name of two other physicians without their authorization	MD's medical license is indefinitely suspended; stayed all but three mos./probation for 12 mos.
SURRENDERS			
PARIKH, HIMANSHU P., MD (009600671) Cary, NC	07/23/2010		Voluntary surrender of NC medical license
PUBLIC LETTERS OF CONCERN			
BLACKMON, Edward Barton, MD (000029532) Jourdanton, TX	05/04/2010	TX Medical Board action; MD failed to provide a patient with timely access to medical records	Public letter of concern issued
CLINTON, Robert Allen, MD (200500848) Fayetteville, NC	07/29/2010	After closing his practice, MD failed to make restitution to patients who paid for services/procedures not rendered	Public letter of concern issued
DAUITO, Ralph, MD (200701012) Greensboro, NC	06/01/2010	MD misinterpretation of MRI led to unnecessary surgery; professional liability payment made	Public letter of concern issued
GRAVES, Benjamin Harrison, III, MD (000024768) Livingston, TX	07/16/2010	CA board action; MD prescribed medical marijuana to an undercover detective without proper exam/documentation	Public letter of concern issued
KAZDA, John Joseph, PA (000103575) Dunn, NC	07/19/2010	PA prescribed to self and family without proper exam/documentation and in violation of Board position statement	Public letter of concern issued
KRITZER, Randy Owen, MD (000039005) Greensboro, NC	05/17/2010	Confusion over MD's role in the care of a patient/diagnosis of an epidural hematoma; patient later required surgery to remove the hematoma	Public letter of concern issued
LARSEN, David Malcolm, MD (000020558) Jackson, TN	05/10/2010	Action by TN Board regarding MD's prescribing of controlled substances without proper patient history, exam or testing to justify prescriptions	Public letter of concern issued
MCINTOSH, Margaret Gloria, MD (000036117) Charlotte, NC	07/30/2010	MD's participation with laser tattoo removal entity constitutes aiding/abetting the unlicensed practice of medicine (entity was not owned by a licensee of the Board)	Public letter of concern issued
PRESTI-BONOMO, Juliea Ann, DO (200801420) Waynesville, NC	07/07/2010	DO failed to review a patient's medical record or obtain a thorough history resulting in inadequate treatment	Public letter of concern issued
SINN, Leslye Marie, MD (009701598) Hillsborough, NC	06/18/2010	Based on information/expert review it appears MD's care of five patients fell below standard; MD voluntarily made license inactive	Public letter of concern issued
SMITH, Bryan Dorsey, MD (200201531) Durham, NC	05/19/2010	Action by Maine board; MD provided inaccurate responses on license application	Public letter of concern issued
STURM, Susan Elizabeth, MD (009600423) Fort Myers, FL	06/02/2010	Action by FL board related to the care of a patient's hypotension and shock	Public letter of concern issued
TRAYLOR, Henry William, MD (000024304) Whiteville, NC	07/07/2010	MD assisted the unlicensed corporate practice of medicine and engaged in fee-splitting	Public letter of concern issued
WHINNA, James David, MD (000026481) Monroe, NC	07/09/2010	MD failed to properly address a portion of sheared off tube that remained in the patient after surgery	Public letter of concern issued
WHITE, Ava Balko, NP (000200319) Wadesboro, NC	07/12/2010	NP violated medical ethics regarding confidentiality of patient information when she released patient records without direct communication with the patient	Public letter of concern issued

Name/license#/location	Date of action	Cause of action	Board action
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED OR REPLACED BY FULL LICENSES			
JAMES, Franklin James, MD (000015359) Greenville, NC	07/22/2010		MD is issued a temporary license to expire 01/31/2011
LAND, Phillip Barton, PA (000102750) Clinton, NC	05/20/2010		PA is issued a temporary license to expire 05/31/2011
PIXTON, Jan Marie, PA (009001642) Charlotte, NC	06/23/2010	History of mental health issues/problems with substance abuse; PA surrendered license 02/2008, subsequently had license suspended by consent order 09/2008; provided inaccurate answers on reinstatement application	PA is issued six-month temporary license; must maintain a contract with NCPHP
SESSOMS, Rodney Kevin, MD (000033927) Clinton, NC	05/20/2010		MD issued a temporary license to expire 11/30/2010
STROTHER, Eric Furman, MD (009901620) Raleigh, NC	05/20/2010		MD issued a temporary license to expire 05/31/2011
MISCELLANEOUS ACTIONS			
BEASLEY, Lawrence Burton, MD (000039236) Forest City, NC	06/29/2010	Expert review found MD's treatment and prescribing to certain patients was below standard of care; MD neither admits nor denies that care/treatment was below standard	MD shall not practice pain management nor prescribe Schedule 2, 2N, 3 and 3N controlled substances for pain. Must obtain assessment
HOPE, Shelly-Ann, MD (200300157) Lanham, MD	05/13/2010	MD's license previously placed on probation; MD has satisfied terms/conditions and requested relief of probationary terms from 06/07/2007 consent order	MD's consent order is amended to remove probationary terms
HUSSEY, Felicia Duff, MD (009701412) Goldsboro, NC	06/14/2010	MD met with the Board on several occasions regarding prescribing practices; agreed to no longer prescribe Schedule II and III controlled substances	Non-disciplinary order; MD must surrender DEA privileges and complete CME
JONES, Jason Matthews, MD (201001103) Charlotte, NC	06/27/2010	MD was placed on probation during residency for behavior issues and poor interpersonal communications; resigned from residency program and referred to NCPHP	Non-disciplinary order; MD is issued a license and shall maintain a contract with NCPHP
SESSOMS, Rodney Kevin, MD (000033927) Clinton, NC	06/11/2010	MD's license suspended by consent order (02/2008); license reinstated by consent order (4/16/2009); order amended 12/2010; Board and MD agree to amend Dec. order	Consent order amended; MD issued temporary license with conditions; MD to take five hours CME on a monthly basis
SLOAND, Timothy Peter, MD (200301292) Gastonia, NC	07/07/2010		Consent order amended to permit MD to work up to, but no more than, 50 hours
STROTHER, Eric Furman, MD (009901620) Raleigh, NC	06/07/2010	MD has history of chemical dependency; received treatment in 2004 and relapsed in 2007; voluntarily surrendered license; NCPHP participant; Signed consent order in 1/2009 and amended in 6/2009	Consent order amended; MD may practice unsupervised and prescribe controlled substances for certain areas of practice; Other amendments
WEBER, Jeffrey Alan, PA (000101750) Fayetteville, NC	05/10/2010	PA ordered to obtain assessment; findings were embodied in a report that made recommendations for improvement of PA practice	Consent order; PA shall abide by recommendations; practice with continuous on site supervision
WEBER, Jeffrey Alan, PA (000101750) Fayetteville, NC	06/15/2010	PA ordered to obtain assessment; findings were embodied in a report that made certain recommendations for improvement of PA practice; PA requests amendment to Board order to allow him to work two to 2.5 days a week	Consent order amended; PA to abide by recommendations and NCPHP; must obtain CME and is granted request to work two to 2.5 days a week
REENTRY AGREEMENTS (History of discipline/impairment)			
SEAL, James Hargett, PA (000102454) Greenville, NC	06/02/2010	PA surrendered license 12/2002 due to substance abuse; PA has been compliant with NCPHP recommendations since 10/2007	Consent order and reentry program executed

North Carolina Medical Board
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This publication is printed on 70# Flo Dull Text. It is a Forest Stewardship Council paper.
Environmental savings realized by using this paper are summarized below:
3,602 lbs of paper used | 837 lbs of wood saved | 2,472 gallons of water saved | Landfill waste reduced by 837 lbs

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

November 17-19, 2010 (Full Board)
January 19-21, 2011 (Full Board)
February 17-18, 2011 (Hearings)
March 16-18, 2011 (Full Board)

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

NC DHHS calls on physicians, others, to display anti-fraud poster

The NC Department of Health and Human Services has created a poster asking citizens to report Medicaid fraud and abuse. In a memo dated June 4, 2010, DHHS Secretary Lanier Cansler asked all health care agencies and private health care providers to print and prominently display the poster in their offices.

"Whether you're a Medicaid provider, recipient or simply a taxpayer, fraud and abuse costs YOU," the NC DHHS poster asserts. The poster advises Medicaid recipients to help reduce fraud and abuse by keeping their paperwork in good order, keeping alert to unnecessary tests, repeat billing or statements that don't match their actual medical conditions.

DHHS also wants Medicaid recipients to monitor other Medicaid participants. The poster urges recipients to never loan their Medicaid card to anyone and to report any recipient who lies about eligibility or medical conditions, forges prescriptions or sells drugs, or loans his or her Medicaid card to others. "Don't feel guilty about reporting someone who steals health care from those who need and deserve it."

To download a copy of the poster, visit *www.ncdhhs.gov/dma/fraud/Fraud-Poster.pdf*

To read a copy of Secretary Cansler's memo, visit *www.ncdhhs.gov/dma/fraud/FraudMemo.pdf*