FORUM
NORTH CAROLINA MEDICAL BOARD
PRIMUM NON NOCERE
SUMMER 2009
Celebrating 150 Years

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FROM THE PRESIDENT

Helping licensees stay *out* of trouble:
Yes, we do that too

The North Carolina Medical Board has often been accused of lying in wait for licensees to do wrong, eager to jump out of hiding and say, "Gotcha!" While it is certainly not the Board's intention to ambush its licensees, there is at least a kernel of truth behind this perception.

The NCMB has about 50 employees to regulate medical practice in 100 counties and more than 35,000 licensees. The reality is that the Board barely has the resources to adequately respond to the more than 2,000 complaints it gets annually. While I and my fellow Board members see a need to be more proactive in helping licensees avoid problems, it often seems an unrealistic goal.

NCMB President, George Saunders, MD, says "when the physician-patient relationship breaks down, the result is often a patient complaint to the Medical Board."

The Board has been concerned that it is constantly dealing with variations on the same theme, the vast majority of times. We see different practitioners—and occasionally a licensee who does not learn his or her lesson the first time through the process—making the same missteps and errors.

During my term as president, I was determined to do something about this. I asked my fellow Board members and the Board staff to take a serious look at ways we might assist licensees in acquiring new skills and information aimed at avoiding some of the most common problems we see in the course of our regulatory work. In February, the Board dedicated part of a retreat to brainstorming ways it might achieve this, and came up with an action plan. Now one of those action items is nearing implementation.

While the Board does see examples of inappropriate and substandard care, most often the mistakes we see have to do with dysfunctional communication. For example, a patient may find his or her physician's tone insulting or dismissive. A practitioner may make personal comments the patient finds inappropriate. Or there may be incomplete communication about possible clinical outcomes and side effects of care, which can set up unrealistic expectations for the likely outcome of treatment.

Practicing the healing arts centers on the relationship between the physician and patient. In family medicine we often speak of the "therapeutic alliance." This relationship is not unique to any one specialty. Indeed, it is essential to practicing in any part of the healing arts. As I often explain to my patients (usually the ones who are giving me heartburn), the relationship between a physician and patient is akin to an alliance between two nations. Each has responsibilities and rights. The physician has the responsibility to make an appropriate evaluation, to give each patient the information he or she needs to make a reasonable choice and to help each patient form an actionable plan of treatment. The patient has the responsibility to give accurate information and to follow the treatment plan they have consented to. Both the physician and patient have the right to disagree, but in a respectful manner.

Where does the Board come into all this? Well, when the physician-patient relationship

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breaks down, the result is often a patient complaint to the Medical Board and, frequently, a medical malpractice claim. Too often, the breakdown deals with some aspect of poor communication. I believe that more than 80 percent of the complaints the Board sees begin with dissatisfaction sown with the seed of miscommunication.

As physicians, we spent more than a decade in post-secondary school training to help people. Yet many of our patients feel that they are not helped, but harmed, either physically or emotionally, by an encounter with a physician. The imposition of the clinical skills portion of the U.S. Medical Licensing Exam (USMLE) is just one concrete example of patient dissatisfaction. As some of you may recall, the clinical skills portion of the examination was imposed by non-physicians who felt that many doctors lacked the skills to perform an adequate clinical assessment, or were deficient at communicating clinical information coherently to patients. The growing number of public Internet sites that invite patients to "review" their physicians is another example, and there are countless others.

Medical schools have made changes in their curricula to incorporate communication skills into physician training. Everyone will benefit if those changes result in better clinician-communicators.

But what of the practicing physician who is "communication-challenged?" Many of these doctors end up before the Medical Board. Some are referred to comprehensive, multiple-day communications courses in states from California to Ohio. A few are required to get in-depth psychiatric evaluation and, if necessary, treatment. But these are extreme measures. They are typically not appropriate for doctors with relatively minor communication issues that nonetheless are causing major problems with patients.

So your Medical Board sought a solution to this problem. Board staff and a few Board members looked for reasonable alternatives to the costly and lengthy out-of-state courses that communications-challenged licensees are most often referred to. I thought, conservatively, it might take up to two years to identify courses we might recommend to licensees as alternatives. I am happy to say I was mistaken.

Through truly outstanding work by staff, this initiative has come to fruition less than ten months after the Board started its search. The Board expects to begin referring licensees to in-state communication courses (specialized to the needs of clinicians) offered by a Triangle-area vendor in September and hopes to begin making referrals to a second North Carolina-based vendor shortly thereafter. The Board will also provide information on the course offerings on its website and in this newsletter in hopes that licensees who might benefit from them will seek training before a communications gaffe brings them to the Board's attention.

Your Medical Board identified a problem and acted decisively to try and solve it. We hope that these locally-developed courses will become a widely-used resource for all physicians who wish to improve their interactions with patients, not simply physicians whose words have gotten them into trouble. If these courses are used and taken to heart by the large number of physicians who could benefit from them, we might just usher in a new era in medical communication.

Send feedback to *forum@ncmedboard.org*

Board chooses leadership team for 2009-2010

The North Carolina Medical Board selected a new slate of officers during its July meeting. Officers serve on the Board's Executive Committee. Terms begin Nov. 1, 2009.

President: Donald E. Jablonski, DO
Home: Etowah
First osteopathic physician selected as NCMB President

President-elect: Janice E. Huff, MD
Home: Charlotte

Secretary/Treasurer: William A. Walker, MD
Home: Charlotte

At-Large Member: Thomas R. Hill, MD
Home: Hickory

At-Large Member: John B. Lewis, JD (Public member)
Home: Raleigh

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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New CME audit program to ensure accuracy in annual reporting of hours

Starting in January, the North Carolina Medical Board will implement a new audit program to verify that physician licensees accurately report continuing medical education (CME) hours.

Physicians must earn 150 hours of CME over three years, with at least 60 of those hours being Category 1 hours. Licensees are currently asked to report CME hours earned during the previous 12 months annually, when they renew their licenses with the Board. There is no annual requirement for CME hours earned. A licensee must simply meet the 150-hour minimum by the end of his or her current three-year cycle.

Beginning in January, the Board will randomly select a percentage of the physician licensees who renew each month to complete an audit form. Licensees will be asked to provide documentation of CME hours reported during the renewal process. Documentation for Category 1 CME (provider-initiated) can be as simple as keeping a dated record of your attendance at or participation in accredited CME programs. Licensees should also keep a file of receipts or certificates verifying the information recorded. Documentation for Category 2 CME (physician-initiated) can include keeping a list of CME activities and noting the nature of the activity, the date and the hours earned. Board staff will review reported hours to verify that CME is practice-relevant

The new audit program is aimed at encouraging licensees to fully and accurately report CME activity to the Board. Accurate reporting also should help ensure that the CME total displayed during the annual renewal process is up-to-date, allowing licensees to plan for additional CME accordingly. During the renewal process, the Board's online system shows licensees how many hours have been earned during the current three-year cycle.

The Board currently monitors all physician licensees to ensure that they meet the three-year minimum requirement of 150 CME hours. Licensees who do not meet the requirement are notified that they are deficient and provided several options for getting into compliance with the Board's CME rules. This compliance program will continue.

NEW CME AUDIT

Who is affected? Physician licensees
What is it? Verification of CME hours reported for the previous 12 months
When? Starting January 2010
Why? To ensure accurate reporting of CME on an annual basis
How to prepare: Save documents verifying CME completed

Board establishes "Legislative Update" column

This summer the NC Medical Board established an online column on the Board's website to provide regular updates on legislation, administrative rules and new laws that affect the Board and its licensees. Content is posted, depending on legislative activity, when the General Assembly is in session. Posts that deal primarily with administrative rules or new laws will be made on an ongoing basis.

Below is a summary of recent legislative activity:

H703: Reporting threshold for malpractice

House Bill 703, which was signed by Gov. Beverly Perdue on June 30 and is now Session Law 2009-217, would require that settlements of $75,000 or more that occurred on or after May 1, 2008, be publicly reported. Malpractice data will be posted on the NCMB's website later this year. (See related article, page 11)

H878: NCPHP access for all NCMB licensees

House Bill 878, now Session Law 2009-363, would permit the NC Physicians Health Program to extend its assistance to all NCMB licensees with substance abuse/alcohol issues. Currently NCPHP's services are limited to physicians and physician assistants.

H951: Repeals outmoded licensing provisions

H951, now Session Law 2009-447, repeals the vestigial osteopathic licensing provisions that became obsolete after the Medical Board began licensing DOs in 1969. Prior to that time, DOs were licensed by a board separate from the Medical Board.

S628: Controlled Substances Reporting System

Senate Bill 628, now Session Law 2009-438, makes numerous changes to the Controlled Substances Reporting System. The Board believes these changes will make the system easier for prescribers to use. (See related article, page 7)

S958: Overhauls NCMB processes

Senate Bill 958 has passed both houses of the legislature and was sent to the Governor on August 6. The bill makes numerous changes to the Board's investigative and disciplinary processes. Once law, these changes would take effect October 1, 2009.

SPECIAL FEATURE

Using the NC Controlled Substances Reporting System

A conversation with CSRS administrator William D. Bronson

The NC Department of Health and Human Services implemented the Controlled Substances Reporting System (CSRS) two years ago to monitor outpatient dispensing of prescription controlled substances on a statewide basis. The system is authorized by a 2005 state law, which clearly states the CSRS's purpose: To "improve the State's ability to identify controlled substance abusers or misusers and refer them for treatment, and to identify and stop diversion of prescription drugs in an efficient and cost-effective manner that will not impede the appropriate medical utilization of licit controlled substances."

The law requires all outpatient dispensers of controlled substances in North Carolina to regularly report prescription data to the CSRS. Eligible prescribers (medical practitioners must hold either a valid DEA registration or a valid pharmacist's license to view data) may register for access to the system, for the purpose of viewing individual patients' prescription profiles.

Since the system went live in July 2007, more than 4,200 physicians, physician assistants, nurse practitioners and other prescribers have signed up to access CSRS data, and that number is growing every week. (See instructions on registering to access the system, page 7)

Recent changes authorized by the NC General Assembly would eliminate tight controls that make it unlawful for prescribers to discuss a patient's CSRS prescription profile with other clinicians (related article, page 7). This change, which the NC Medical Board requested after licensees brought their concerns about the system to its attention, should make it easier for prescribers to use CSRS data in planning and coordinating treatment for their patients. The Board appreciates the gracious cooperation of Sen. William R. Purcell, MD, who agreed to amend his bill to include the requested changes.

NCMB Public Affairs Director Jean Fisher Brinkley recently spoke with William D. Bronson, who oversees the NC Controlled Substances Reporting System. They discussed how clinicians can use the system to greatest effect.

Q&A

Under what circumstances might a physician check a patient's prescription profile with the CSRS?

They should be doing it to provide care to an established patient. It is not intended to be used as a means of deciding whether to take on a potential patient who's coming in.

What information would a query to the CSRS on a particular patient return?

It would indicate the date a prescription was dispensed, the amount dispensed, whether it was a refill or a new prescription, the number of refills, the pharmacy where it was dispensed and the practitioner who wrote the prescription. It will also indicate the patient's name and address.

CSRS DATA FOR NC: WHAT THEY CAN TELL US; WHAT THEY CAN'T

Catherine (Kay) Sanford, MSPH

So far, the North Carolina Controlled Substances Reporting System (CSRS) is a gold mine of information on how many and what kinds of prescriptions for controlled substances (CS) are dispensed statewide. In 2008, more than 16 million (16,167,781) CS prescriptions were written and dispensed in our state. More than 5 million (5,297,074) individual patients were recorded as having been dispensed a prescription. Schedule III drugs were most often prescribed to patients (37.0%), followed by prescriptions for Schedule IV drugs (29%), Schedule II drugs (27.4%) and Schedule V drugs (6.5%).

Data for 2008 also show that dispensing rates varied widely by month and by county. The lowest number of CS prescriptions was dispensed in June (1,126,903) and the highest numbers were dispensed in October (1,489,801) and December (1,477,139). The state CS prescription rate in 2008 was 17,878 scripts per 10,000 persons or 1.7 prescriptions per person in a state of more than nine million residents. Most of the counties with the highest prescription rates were in western NC (See Table 1). In descending order of rank, the top 10 prescribing counties were Columbus, Wilkes, Stokes, Richmond, Carteret, Martin, Gaston, Burke, Bladen and Cherokee. There was greater geographic (and socioeconomic) diversity among the counties with the lowest prescription rates (See Table 1). The top 10 lowest prescribing counties included two of the state's most urban counties (Durham and Mecklenburg) as well as some of the state's most rural eastern counties (Pasquotank, Hyde, and Currituck).

How should physicians and other prescribers be using this data?

To provide better care for their patient, not to exclude patients. If the data reveal that the patient may be seeking large quantities of controlled substances or seeking prescriptions from multiple providers, then the practitioner should discuss this with the patient and offer help.

Are you aware of situations where prescribers are using data obtained through the system to "fire" a patient?

Yes, not only to fire a patient, but to exclude. We've heard of a couple of situations where a pain management specialist decides that a patient is doctor-shopping and, based on what he sees in the CSRS, decides not to take on that patient. That is not an appropriate use of the system.

We've also heard of numerous cases where, based on the data, physicians have dismissed an established patient. I don't mean to suggest that they can't or shouldn't do that. But there's a right and a wrong way to do it. It's complicated. First, we've had several instances where the data has been wrong and the patient has been right and the physician hasn't believed the patient. And potential harm may come to the patient when a physician decides to exclude them. The fact that they've been labeled or branded as a doctor-shopper follows them and then other physicians decide not to take them on.

What would be a preferable response?

If a patient is starting to see different doctors, the physician can establish an agreement or contract with the patient that he only sees one physician or that he notify and get approval from his physician to see another physician. If that contract is violated, you don't need to throw the patient out. It may be an opportunity to expand the care. Maybe refer that patient to more specialized care or to a substance abuse program, that kind of thing. Would you dismiss a cardiac patient for not following his or her diet?

Ultimately you're going to have some patients who are ripping off the system and playing games, and then, after you've tried to intervene and refer them for care and all of those things you've attempted, and documented and sat down with the patient and talked about have failed, then it's OK to dismiss them.

But it shouldn't be the first action you take.

Correct. You may be able to use the data to take a different approach. For example, an emergency room doctor who checked on a patient may say, 'I don't want to give this person an opiate. I'm going to give them something else because they've gotten a lot of opiates.' It can be useful in deciding what kind of treatment you're going to provide.

What if a patient claims that the information the CSRS has on them is not accurate?

Believe them. Sit down and discuss it with the patient. Either the doctor or the patient can contact us and we can help sift through what is accurate and what is inaccurate in the system. Don't just assume that it's a doctor-shopper and because he's an addict, he's lying. He might be, but he might not be.

We've had too many occasions where either there's been a mistaken identity or the dispensing pharmacy has loaded up the wrong DEA number so the wrong prescriber is on there, or other things like that. Give the patient the benefit of the doubt, at least the first time. Then inform the patient you are going to follow them very closely.

Could you go over the protocols for accessing the CSRS? Who is authorized, within a medical practice, to access the system?

The prescriber or dispenser. Period. Only the person with that log on, not their nurse, not their office manager, not another prescriber. Each practitioner in the office has

Three-quarters (74.5 percent) of the CS prescriptions dispensed in North Carolina were for narcotic analgesics (45.4%), tranquilizers (17.8%) and sedatives (11.3%). The remaining quarter (25.5%) were for anticonvulsants, amphetamines, central nervous system stimulants, colds and coughs and other miscellaneous controlled substances.

What these data cannot tell us is whether these variations reflect 'good' or 'appropriate' prescribing profiles to treat the illnesses of the people of North Carolina or whether or not medical practitioners are using these data as a tool to help determine when or what controlled substances should be prescribed to their patients. The reporting system is young. More medical care providers need to use it, and more need to interpret its findings.

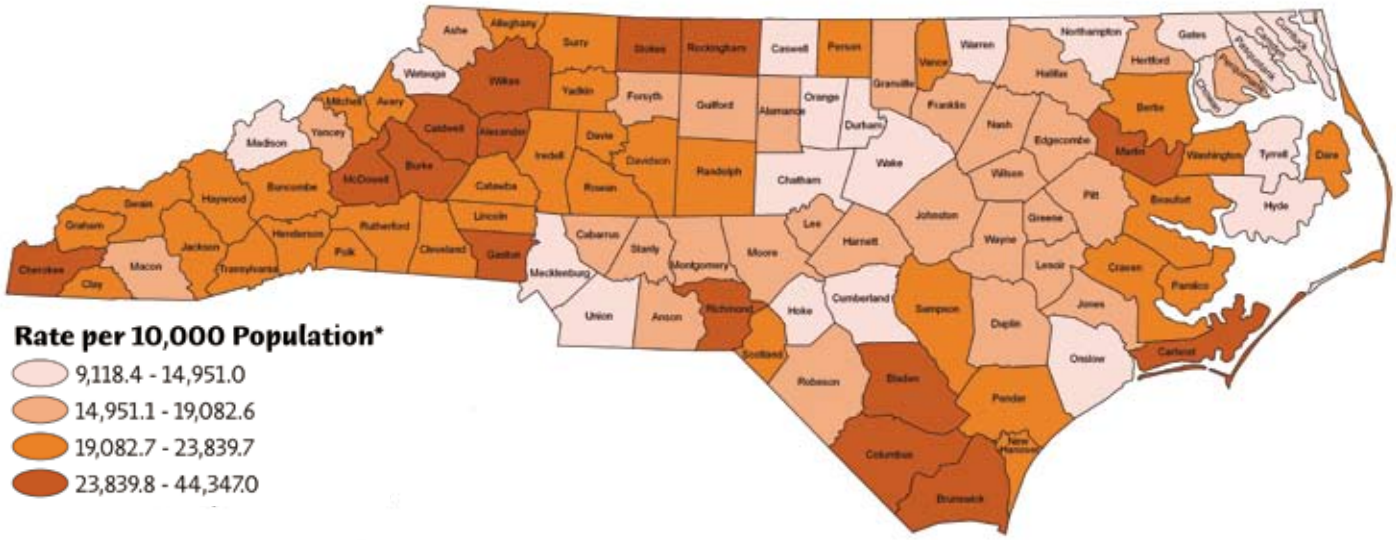
TABLE 1: Highest and Lowest Outpatient Controlled Substances Prescription Rates/ 10,000 population by County: North Carolina, 2008

County	Rate	County	Rate
1. Columbus	29,705	91. Pasquotank	13,067
2. Wilkes	27,436	92. Hyde	12,871
3. Stokes	27,376	93. Currituck	12,817
4. Richmond	26,835	94. Onslow	12,742
5. Carteret	26,697	95. Warren	12,570
6. Martin	26,478	96. Mecklenburg	12,536
7. Gaston	26,344	97. Durham	12,505
8. Burke	26,227	98. Northhampton	12,267
9. Bladen	25,932	99. Madison	12,161
10. Cherokee	25,650	100. Gates	9,118

NC rate: 17,787 scripts/10,000 residents

Source: NC Controlled Susbstances Reporting System, March 2009

2008 Outpatient Prescription Rates for Controlled Substances Dispensed in NC



*Note: Data is based on the total number of prescriptions and may include multiple prescriptions per person.
Source: NC Controlled Substances Reporting System | State Center for Health Statistics and North Carolina Public Health

to have their own login. Currently, that's all that's permitted under the law.

There's another practice I see doctors doing that is unlawful, and that is calling up the police. You can't do that. You cannot release this data to the police. If you have evidence, other than what you see in the system, that you have a doctor-shopper, then doctor-shopping is against the law and you can report it to the police if you otherwise would. But the information you obtained from the system cannot be the sole basis for it. If the only basis for the doctor coming to that conclusion is what he sees in the system, he shouldn't be calling the police. There have to be other reasons that stand on their own merit.

Is there anything else you'd like to mention that you feel is important for physicians and other prescribers to understand about the CSRS?

We would eventually like to see this become a standard of care in prescribing controlled substances. Our hope is that checking the system becomes an accepted part of practice. A physician would not be doing his or her best if they didn't check the system.

The other message is that this needs to be seen as a tool and not as the gospel truth. It's one piece of the puzzle just like an X-ray or a lab test or anything else. And it should be used in combination with all the other stuff. Physicians should not be relying on it as a standalone item when making patient care decisions. We hope this tool can assist a physician in providing appropriate care for the patient, including a referral for treatment if indicated.

Anything else?

If you're using the system, tell your patients you're doing it. Don't do it behind the patient's back. Practices can post a sign in their waiting rooms that says, 'We use the Controlled Substances Reporting System when prescribing controlled substances.' That will chase the riff-raff out of their offices. Also, to help prescribers become more comfortable with confronting patients —I prefer to call it 'carefrontation'—I would suggest learning more about SBIRT, which stands for Screening, Brief Intervention and Referral for Treatment. This is now a billable service. You can learn more about SBIRT by visiting *www.samhsa.gov*, which is the Internet site for the U.S. Substance Abuse & Mental Health Services Administration.

William D. Bronson is Drug Control Unit Manager for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, NC Department of Health and Human Services. He oversees the Controlled Substances Reporting System.

Send feedback to *forum@ncmedboard.org*

SIGN UP TO USE THE SYSTEM

Clinicians who want to check a patient's controlled substances prescription profile must register for access with the NC Controlled Substances Reporting System. To qualify, you must be authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for patients.

How do I sign up for access?

Download and complete a short enrollment application from the CSRS website, *www.ncdhhs.gov/MHDDSAS/controlled-substance/* Please note that the form must be notarized and mailed with a copy of a photo ID and signed copy of a privacy statement to the CSRS. Approved applicants will be notified via e-mail, typically within two weeks.

Once I get access, who in my practice may use my login to query the CSRS database?

Because of strict confidentiality provisions in the law, only the registered practitioner may access the system. The law prohibits other members of the practice from using it.

How often is the database updated?

State law requires outpatient dispensers of controlled substances to report prescription data to the CSRS at least twice a month, on the 15th and the 30th, so it may take up to three weeks for a prescription to show up in the system. A bill recently passed by the General Assembly would require dispensers to report no later than seven days after the prescription is dispensed, starting January 2, 2010.

What if I have concerns about accuracy of the data, or a patient questions its validity?

Contact John Womble or William D. Bronson at the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Drug Control Unit at 919-733-1765, Monday through Friday between 9 a.m. and 5 p.m.).

Lawmakers eliminate CSRS "gag rule"

The NC General Assembly took action July 30 to fix what has been clinicians' main gripe about the Controlled Substances Reporting System: a strict prohibition on discussing a patient's prescription profile with other medical professionals.

Senate Bill 628 rewrites state law to allow physicians and others to discuss patient information obtained from the CSRS with authorized colleagues. The bill, sponsored by Sen. William R. Purcell, MD, passed both houses of the legislature July 30 and was sent to the Governor for signature. It is effective when it becomes law.

Under current law, practitioners may not disclose a patient's prescription profile or discuss it with anyone, other than the patient. This has been frustrating to many physicians, who feel the restrictions hamper their ability to effectively consult with colleagues who may be treating and prescribing for the same patient.

William D. Bronson, who oversees the CSRS for the NC Department of Health and Human Services, predicts that prescribers will embrace the changes authorized by S628.

"Everyone will be happier," Bronson said. "I believe [the gag rule] was an unintentional side effect of the law when it first passed because of very strong concerns about privacy. I don't believe the legislature intended it to be that tight."

S628 would expressly permit authorized prescribers to disclose and discuss data obtained by checking a patient's controlled substances profile with another prescriber authorized to access the reporting system. The bill further rewrites the law to clarify that CSRS data may be retained in a patient's confidential medical record. Finally, S628 authorizes county medical examiners who are investigating the death of an individual to access the CSRS.

Strong response to call for Board members

The independent panel that reviews and nominates candidates to sit on the North Carolina Medical Board received about 30 applicants for the three seats that come open this fall. The application period is now closed.

The Review Panel for the North Carolina Medical Board is scheduled to meet in late August for two days. Interviews of the candidates for the NCMB seats will be conducted during this meeting. The panel must select at least two candidates for each open seat. Candidates' names will be forwarded to Gov. Beverly Perdue, who will make the final selection.

Two seats will be filled by physicians and the third seat will be occupied by a nurse practitioner or physician assistant. The NP/PA seat is currently occupied by Peggy Robinson, PA-C, who is seeking reappointment. Newly-seated or reappointed Board Members will begin their terms Nov. 1.

The Review Panel will solicit applications for physician Board Members again in 2010. Check the Review Panel's website early in 2010 for information on available seats and instructions for applying. Previous applicants who are not selected for a Board seat are welcome to reapply. For more information visit: *www.ncmedboardreviewpanel.com/?page=about*

Understanding the NC Medical Board's disciplinary work

As Medical Director for the North Carolina Medical Board I review the complaint, malpractice, medical examiner and investigative case information that comes to the Board from a variety of sources. Watching the Board evaluate this information has given me a good understanding of the actions that follow the analysis of each case.

Michael Sheppa, MD

From the O ce of the Medical Director

Most readers of the *Forum* are no doubt aware of the Board's public actions, which are printed in the back pages of this newsletter. However, readers may not be aware of the far greater number of Board actions that are not public. Both public and non-public actions are important in helping the Board fulfill its mission to regulate medicine and surgery for the benefit and protection of the people of North Carolina.

This is the first part of a two part commentary that will provide insight into the Board's disciplinary processes. This article will discuss the number of cases reviewed and actions taken in the most recent year, and review the range of public and private actions used to resolve disciplinary cases. Part 2, which will be published in a subsequent issue of the *Forum*, will discuss the multi-step review process used to determine whether discipline is warranted in a particular case and, if so, what type of discipline the Board feels is appropriate.

Overview

In 2008, the Board opened more than 2000 cases based on information received from patients and other private citizens, health care institutions, health care workers, out-of-state medical boards and other regulatory bodies, insurance companies, the National Practitioner Data Bank, the North Carolina Medical Examiner's Office and other sources. The overwhelming majority of cases centered on an individual licensee. A handful of cases involved multiple practitioners or an entire practice. Most cases involved quality of care issues, and others involved licensees who came to attention because of alcohol or substance abuse issues, criminal convictions, changes in hospital privileges, disruptive behavior, ethical and boundary concerns or other aspects of professionalism.

The Board does not resolve every case opened in a given year. In cases where the Board acted in 2008, public actions were issued approximately 10 percent of the time. Private action was taken 30 percent of the time and no action was taken in 60 percent of cases. "No action" is technically an incorrect term, since the actual Board action in these cases is to "Accept as Information" (more on this later).

A fundamental and important aspect of the Board's disciplinary work is to remediate, whenever possible, the behavior or practice that led the Board to take a private or public action. The remediation activity may be implicitly or explicitly stated as part of the action, and depending on the circumstances, broad or narrow in scope. For example, if a practitioner is not prescribing controlled substances safely, the Board might first direct the licensee to obtain additional training and/or supervision that would result in better prescribing. If this approach is not appropriate for the circumstances, the Board might instead restrict the practitioner's ability to prescribe specific controlled substances or prohibit the licensee's use of controlled substances altogether.

Public actions

As noted above, just one in 10 cases reviewed by the Board resulted in a public action last year. However, there is no doubt that these actions have the greatest impact on licensees. Public actions arise from licensee behavior or practice that deviates significantly from accepted standards and that has the potential to extend beyond the circumstances of a single case. Public actions include Public Letters of Concern, Consent Orders, Orders of Discipline, Notice and Entry of Revocation, and Order of Summary Suspension. All public actions are reported on the Board's website via the licensee's public information page, and to the Federation of State Medical Boards. All of the actions listed above, except for the Public Letter of Concern, are disciplinary in nature and are also reported to the National Practitioner or Healthcare Integrity and Protection Data Banks.

Public Letters of Concern and Consent Orders accounted for about two-thirds of public actions in 2008.

A Public Letter of Concern is just what it sounds like—a formal letter from the Board to a licensee that expresses concern about a behavior that may pose a risk to public safety. When a public letter is issued, the behavior examined was determined to be below accepted standards. In quality of care cases, the conduct of concern usually involves a failure to follow a fundamental component of good medical practice. When the Board issues a Public Letter of Concern to a licensee, the licensee must either agree to accept it or proceed to a public hearing before the Board, which is a process much like a trial. A public letter may also be issued following a hearing or agreed to as part of a Consent Order.

A disciplinary Consent Order is a negotiated agreement between the Board and a licensee that involves behavior of greater concern to the Board than that associated with a public letter. The Board and the licensee must agree on the content of the Consent Order, which typically contains one or more disciplinary actions and may also subject the licensee to terms and conditions. Depending on the extent of the Board's concern, disciplinary actions may range in severity from a reprimand or period of probation to a suspension, revocation, or annulment of a practitioner's license. In addition, Consent Orders may impose conditions that direct the licensee to complete continuing medical education. A Consent Order may also limit the licensee's practice or prescribing, require mentoring, physical or neuro-psychiatric evaluation, substance abuse evaluation and treatment, or other terms meant to restrict and remediate behavior that poses a risk to patient safety.

An Order of Discipline, which follows a hearing, is similar to a Consent Order in terms of the range of Board concerns about a licensee's practice or behavior and the severity of associated disciplinary actions. An Order of Discipline does not require the licensee's consent, but it does require due process.

Notice and Entry of Revocation is a relatively infrequent Board action taken specifically in response to a licensee's criminal felony conviction. It rescinds the licensee's ability to practice. A practitioner's license may also be revoked for reasons other than a felony conviction by a Consent Order or Order of Discipline. Under state law, when a license is revoked, the licensee is prohibited from seeking reinstatement for a period of at least two years.

A summary suspension temporarily removes a licensee from practice due to what the Board perceives as an immediate threat to public safety. When a license is summarily suspended, the licensee is entitled to a prompt hearing.

Private actions

A private action occurs when the Board determines that a practitioner's behavior does not pose a risk to public well-being, but nonetheless is a cause for concern. The concern is expressed in a Private Letter of Concern or "PLOC", and is not a disciplinary action. The letter directs a licensee to

GUIDE TO PUBLIC DISCIPLINARY ACTIONS

INCREASING ORDER OF DISCIPLINE

PUBLIC ACTIONS	COMMENTS
Public Letter of Concern	• Requires licensee's agreement or proceeds to hearing • Reported on NCMB website and to FSMB • Although public, is not disciplinary
Consent Order or Order of Discipline with: • reprimand • stayed or limited suspension	• Consent Order arises from Board allegations or charges, requires licensee's agreement or proceeds to Board hearing; • Order of Discipline results from Board hearing, does not require licensee agreement • Reported on NCMB website, to FSMB, possibly NPDB or HIPDB • Contains disciplinary action: reprimand, stayed or limited suspension • Typically contains other conditions
Consent Order or Order of Discipline with: • revocation • annulment • indefinite suspension	• Consent Order arises from Board allegations or charges, requires licensee's agreement or proceeds to Board hearing; • Order of Discipline results from Board hearing, does not require licensee agreement • Reported on NCMB website, to FSMB and NPDB/HIPDB • Contains disciplinary action: revocation, annulment or indefinite suspension • Typically contains other conditions
Notice and Entry of Revocation	• Disciplinary action specifically in response to licensee felony criminal conviction • License revocation has same implications as Consent Order or Order of Discipline with revocation
Order of Summary Suspension	• Temporary emergent Board action in response to immediate and significant threat to public safety. • Licensee may request and is entitled to prompt hearing

improve practice or behavior before it leads to more serious problems and, potentially, a public action by the Board. The private letter is meant to focus a licensee's attention on conduct of concern to the Board, and is meant to be persuasive in getting the practitioner to take steps to improve. Private letters may contain a request for the licensee to complete remedial activity to help achieve that improvement.

A Private Letter of Concern usually arises from an isolated, self-limited, non-recurring event. Examples include failing to communicate with a patient effectively, writing a prescription for a medication to which the patient has a known allergy, or terminating a physician-patient relationship inappropriately. In quality of care cases, the Board typically considers the outcome of care and whether the practitioner deviated from accepted standards in determining the tone and content of the private letter.

When a private letter is issued, it becomes part of the practitioner's permanent Board file. An individual who complains to the Board about a practitioner may be told that the Board has issued a private letter of concern as a resolution to their case. However, the content of the letter is not public. It is not posted on the Board's website, nor is it described in the *Forum*.

The most common resolution: no formal action

As I noted earlier in this article, most cases reviewed by the Board end with no formal action being taken against the licensee. In these cases the Board may conclude, after a review of the facts, that the practitioner met or exceeded accepted standards and has practiced professionally. When this happens, the Board moves to "Accept as Information" and the case is closed. This was the result in close to two out of every three cases where the Board took action in 2008. An "Accept as Information" case does become part of a licensee's permanent history with the Board, but is referred to as what it is: an item of information.

The Board recognizes that the overwhelming majority of its approximately 35,000 licensees practice medicine safely and behave professionally. Their good work is reflected in the benefits their patients receive and in the relatively small number of cases that come to Board attention.

Each of the actions I have described in this commentary arises from a lengthy process of information evaluation that is carried out by the Board and its staff. In a subsequent issue of the *Forum*, I will review that process and discuss how it results in various Board actions.

Seminar educates on safer opioid prescribing

Fred Wells Brason, II
Program Manager, Project Lazarus

The organization behind Project Lazarus, a novel Wilkes County program aimed at reducing deaths from accidental opioid overdose, has established a new CME-eligible physician seminar that encourages safer prescribing of these drugs.

The seminar, developed by the Northwest Community Care Network (NCCN), presents clinical segments on taking a comprehensive approach to pain management and safer opioid prescribing and background on deaths from drug overdose in North Carolina. The program also highlights the NC Controlled Substances Reporting System (CSRS) and describes how prescribers may use this resource to better manage their pain patients. Participants who are not registered to access the CSRS are assisted with completing an application. Finally, participants learn about the NCCN's Project Lazarus, which aims to distribute rescue doses of prescription naloxone to reverse respiratory depression from opioid overdose.

Seminar participants may earn AMA PRA Category I continuing medical education credit by completing an online test.

The NCCN is grateful for the North Carolina Medical Board's partnership on the new seminar, which was presented for the first time in May at a meeting of the Mitchell/Yancey County Medical Society. More than 50 physicians attended.

The Board's contribution includes sending a representative to attend seminars whenever possible, and donating copies of "Responsible Opioid Prescribing, A Physician's Guide." The book was developed in collaboration with author Scott Fishman, MD, by the Federation of State Medical Boards' Research and Education Foundation.

NCCN and Project Lazarus have applied for a grant to support eight additional opioid prescribing seminars for physicians, with a planned emphasis on the western region of the state, which has the highest opioid dispensing and accidental overdose rates in North Carolina.

Courtesy of Fred Brason, II

Fred Brason, II, and NCMB Past President Janelle A. Rhyne, MD, discuss the Board's collaboration with Project Lazarus and NCCN at the FSMB's annual meeting in Washington, DC.

It's time to complete your expanded NCMB information page

Jean Fisher Brinkley
Director, Public Affairs
Editor, *Forum*

The North Carolina Medical Board is moving ahead with plans to greatly expand the licensee information pages on the Board's public website.

This initiative received wide coverage by the mainstream media across North Carolina last year, as details of the project became known. The response from the press and the public has been overwhelmingly positive.

The reaction from some in the medical profession has been considerably less enthusiastic. This isn't surprising. After all, most discussion and media coverage has centered on the new types of prejudicial information— including malpractice payment data—that will appear in the expanded pages. It's understandable that few medical professionals would consider this something to cheer about, whether or not they are personally affected.

The emphasis on the "negative" piece of this expansion has resulted in most physicians and physician assistants remaining in the dark about the very real upside for the vast majority of the Board's licensees.

Few licensees will have negative information on their pages. The Board expects less than one percent of its 35,000 licensed physicians and PAs to have a reportable malpractice payment when the new pages go live. The data are less clear for other types of prejudicial information, such as a hospital privilege suspension or out-of-state disciplinary action, but the Board expects only a small fraction of licensees will have negative information of any kind.

For everyone else, the Board's expanded information pages represent an opportunity for high-visibility, free marketing.

The expanded pages will allow, but not require, licensees to provide detailed information about their education and training, honors and awards, faculty appointments, medical service work and publications, among other things. Licensees also will be able to include helpful details such as whether non-English languages are spoken at their practice and whether Medicare and Medicaid are accepted (and whether new patients in these insurance plans are welcome).

I tested my "sales pitch" for the expanded pages out on a group of physician and physician assistant leaders who recently visited the Board's administrative offices. Some were clearly skeptical. But I saw the proverbial light bulb go off over several other heads, especially after I told them the following:

- The Board's existing licensee information pages are the most popular destination on the Board's website. More than half of visitors access "Look up a Licensee"—the tool used to call up an individual's information page.
- The pages are viewed daily by an audience of thousands. The existing licensee information pages get up to 3,600 "hits" every day.
- Patients use the pages to make decisions about where to get care. Visitors often view the Board's licensee information pages when looking for a new doctor or when checking a practitioner's credentials after receiving a referral.

Starting in September, the Board will mail notices to all physician and PA licensees, directing them to the Board's website to provide information for their expanded pages.

When your notice arrives in the mail this fall, I hope that you will take full advantage.

Turn the page for a detailed summary of the optional information you will have the opportunity to include in your licensee information page. This page is aimed at helping licensees identify appropriate details for each category and prepare to complete a comprehensive page.

FINAL CRITERIA FOR MALPRACTICE REPORTING

A bill passed by the General Assembly in June and signed into law by Gov. Beverly Perdue establishes new criteria for the public reporting of malpractice payments.

House Bill 703, now Session Law 2009-217, requires that settlements of $75,000 or greater that occurred on or after May 1, 2008, be made public.

Under the law, payments are to be publicly reported regardless of whether payment is made in a lump sum or a series of payments (related to a single incident of alleged malpractice) totalling $75,000 or more. The Board expects less than one percent of its 35,000 physician and physician assistant licensees to have a payment reported on the Board's public website when the new pages go live, based on a preliminary analysis of malpractice data collected to date.

The reporting criteria established by the new law apply only to settled cases. All malpractice judgments or awards affecting or involving the physician or physician assistant will be made public, regardless of amount.

The law requires the Board to report:

- The date of the judgment, award, payment or settlement
- The specialty in which the physician or physician assistant was practicing at the time the incident that resulted in payment occurred
- The city, state and country in which the incident occurred
- The date the incident occurred

Your clip-and-save guide to creating a detail-packed NCMB information page

This page summarizes the new, optional information that physicians and physician assistants may include in their expanded licensee information pages. Please note that this is not a complete listing. Most details that currently appear in the Board's existing information pages—practice address, licensure history and hospital privileges, for example—will be carried over to the expanded pages and are not covered here.

GENERAL INFORMATION	YOUR PROFESSIONAL CONNECTIONS	YOUR SCHOLARLY ACHIEVEMENTS	WHAT SETS YOU APART
Practice web address Link current and prospective patients to your practice's Internet site for in-depth information.	List memberships in local, statewide and national professional societies and organizations.	Faculty appointments Publications	**Honors and awards** (professional) **Medical-related service** This is where you will indicate whether you volunteer in an indigent clinic or participate in programs such as Doctors Without Borders.

EDUCATION, TRAINING AND CERTIFICATION	HOW YOU PRACTICE	DETAILS THAT HELP PATIENTS
More on residency training Residency is already posted on the Board's existing information pages, but the new pages will be more detailed. For example, the Board currently lists the institution where residency training was done and the year it was completed. In future, licensees will state their area of training. **New criteria for Board certifications** Licensees will now list only those certifications obtained from boards approved by the American Board of Medical Specialties or American Osteopathic Association.	**State a "practice philosophy"** In this area, licensees may provide a brief statement that describes their approach to patient care. This category was suggested by licensees. **Do you use electronic medical records in the office setting?** **Area of practice** This may or may not be different from your Board certification or area of residency training. In this category, licensees should provide specifics about their actual clinical activities—what they do on a daily basis. An orthopedic surgeon who specializes in elbow surgeries, for example, would state that here.	Percentage of time spent at primary practice address and days patients are seen at this location Non-English languages spoken in office and/or by you, the licensee Participation in Medicare and Medicaid and whether you are currently accepting new patients in these insurance plans Number of years in active clinical practice

IMPLEMENTATION SCHEDULE

September

Board begins mailing notices to 35,000 licensees, directing them to *www.ncmedboard.org* to provide details for expanded information pages.

October-November

Licensees update and expand their individual information pages. Licensees with prejudicial information will review and provide comment, if appropriate.

December

Expanded licensee information pages go live on the Board's website.

REQUIRED INFORMATION

There are five categories of required prejudicial information. Each category will appear in a licensee's information page. If there is no information to report, as is the case for the vast majority of the Board's licensees, the page will indicate "None" or "None reported."

- **Public actions** (NCMB, out-of-state medical boards, other state or federal regulatory authorities)
- **Final suspensions and revocations of hospital privileges**
- **Felony convictions**
- **Certain misdemeanors** Offenses against a person, offenses of moral turpitude, offenses involving the use of drugs or alcohol and violations of public health and safety codes will be posted.
- **Malpractice payments** (subject to reporting criteria established by law)

North Carolina Medical Board

Quarterly Disciplinary Report | February – April 2009

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			
BARRO, Lee Dennis, MD (000025220) Bessemer City, NC	02/04/2009	Felony conviction; improper prescribing	Entry of revocation
CAGGIANO, Christopher John, PA (000102355) Concord, NC	02/03/2009, 04/09/2009	Felony conviction	Notice of revocation, Entry of revocation
Suspensions			
FRIEDES, Larry Matthew, MD (200101041) St. Augustine, FL	03/04/2009	MD plead guilty to trafficking hydrocodone	Indefinite suspension of NC license
(See also Consent Orders)			
Summary Suspensions			
DRAGO, Paul Carl, MD (009700531) Charlotte, NC	03/06/2009	Quality of care issues; failure to disclose personal medical issues to Board	Summary suspension of NC medical license
NIEMEYER, Meindert Albert, MD (000030440) Elon, NC	03/24/2009	Issues with prescribing controlled substances	Summary suspension of NC medical license
Consent Orders			
ADELMAN, Richard D., MD (000029996) Raleigh, NC	03/23/2009	Failure to properly monitor patient, who died of complications from sedation	30-day suspension of license to begin at close of business on July 17, 2009; probation for 11 months thereafter.
BLOCK, Matthew, MD (200100308) Laurinburg, NC	02/02/2009	MD has demonstrated he can do in-office tests safely	Consent order amended to allow MD to do in-office stress tests
CLARK, Richard Stroebe, MD (000032670) West Memphis, AR	02/09/2009	Via consent order, AR medical board limited MD's practice to patients within state prison system	NC license suspended, suspension stayed; MD must comply with AR order
FERNZ, Miriam Minu, MD (009600530) Whiteville, NC	04/09/2009	Coding/billing issues	Reprimand
HANLY, Andrew Joseph, MD (200600988) Miami Lakes, FL	02/03/2009	MD provided false information on an application for licensure in AK	Reprimand
HARSHANY, Mark Lawrence, MD (200900331) Columbia, SC	03/17/2009	Failed to disclose 1992 DUI on NC license application	Reprimand
HEADEN, Kenneth Jay, MD (009400266) Burlington, NC	03/20/2009	Issues with prescribing controlled substances	Two-year suspension, stayed but for a period of 45 days to begin May 16, 2009; Limitations on license, probation
HEIM, Alan Lee, LP (100000098) Greensboro, NC	02/25/2009	LP tested positive for alcohol after reporting to work	Reprimand, must comply with conditions
JAMIESON, Brian David, MD (200600975) Raleigh, NC	03/18/2009	MD suffers from opioid addiction	Indefinite suspension of NC license
LEVINE, Melvin David, MD (000029321) Durham, NC	03/20/2009	Patients alleged MD performed inappropriate, non-medically indicated genital exams	MD agrees to permanently place license on inactive status; will never reapply in NC or practice elsewhere
LEWIS, James Howard, MD (200900469) Macon, GA	03/31/2009	MD failed to state he had been disciplined by another medical board.	Reprimand
LOCKLEAR, Leverne, PA (000101065) Raeford, NC	03/27/2009	Began work as a PA before Board confirmed receipt of Intent to Practice	Reprimand

Name/license#/location	Date of action	Cause of action	Board action
MATTHEWS, Karen R. Bissell , MD (000026314) Mooresville, NC	03/20/2009	Multiple charges of failure to file/ pay income taxes	Six-month suspension, stayed. Must comply with conditions
MCKINNON, Stuart James, MD (200501372) Durham, NC	03/24/2009	Wrote script for methadone to a family member	Reprimand; must comply with conditions
MONTAG, Thomas William, MD (009501706) Chesapeake, VA	03/11/2009	Prescribed to friend; also diverted meds for personal use	Reprimand
ODDONO, Ernest John, MD (009400116) **Greensboro, NC**	03/20/2009	MD wrote prescriptions to coworker, knowing that the drugs were intended for the coworker's spouse	License suspended for four months, stayed. MD placed on probation for one year.
PRICE, Amy Denise Vann, MD (000030455) Fremont, NC	03/23/2009	Prescribing issues; Failure to disclose personal medical disability to Board	Indefinite suspension of NC medical license
PUCILOWSKI, Olgierd Antoni, MD (200000116) Raleigh, NC	03/20/2009	Failure to appropriately supervise offsite PA	Reprimand
SARMIENTO, Pete Matibag, MD (009700136) High Point, NC	04/07/2009	Improper relations with multiple female patients	Indefinite suspension of NC medical license
SCHUPANSKY, Christine Ida, PA-C (001001724) Troutman, NC	02/09/2009	Provided false info on PA license application	Issued PA license, with a reprimand
SESSOMS, Rodney Kevin, MD (000033927) Clinton, NC	04/16/2009	02/21/2009 consent order indefinitely suspended license; MD ready to resume practice	MD issued temporary license to expire 11/30/2009
SLOAND, Timothy Peter, MD (200301292) Gastonia, NC	02/11/2009	History of alcohol abuse	Indefinite suspension of NC license, effective July 30, 2008.
SMITH, Gregory Eugene, PA-C (000103971) Fayetteville, NC	03/20/2009	PA submitted false info on an application for employment	Reprimand
SQUIRE, Edward Noonan, Jr., MD (009801509) West End, NC	03/17/2009	MD surrendered license in January 2007 due to improper prescribing	MD issued a license; must comply with conditions
TROMBLEY, Richard Walter, PA (000101702) Winston-Salem, NC	04/13/2009	PA was arrested for driving while impaired in March 2008	Reprimand; must comply with conditions
Findings of Fact, Conclusions of Law, Order of Discipline			
MIRANDA, Conrado J.R., IV, MD (000019516) Glendale, CA	03/11/2009	Improper prescribing	Indefinite suspension of NC medical license
ROSNER, Michael John, MD (000026865) Hendersonville, NC	02/06/2009	Following a hearing, Board decided care of cervical spine patients departed from accepted medical standards	Three-month suspension of license. Temp license to be issued May 1, 2009; must comply with conditions
Denial of License/Approval			
BORZUTZSKY, Carlos A., MD (NA) Pittsburgh, PA	03/31/2009	Made false statements, withheld information	Denial of NC license application
COLE, Jeffrey Randall, MD (NA) Winston-Salem, NC	02/18/2009	Gave false answers on license application	Denial of NC license application
MORETZ, Timmy Louis, LP (NA) Baltimore, MD	04/07/2009	Multiple concerns with prior work history	Denial of application for NC perfusionist license
NETTLES, Tamischer Baldwin, MD (NA) Asheboro, NC	02/09/2009	Gave false answers on license application	Denial of NC license application
SHUMWAY, David Lucius, MD (000021310) Newport, TN	04/21/2009	MD surrendered NC license in Sept 2000 after reporting to work intoxicated; DUI in 2008	Denial of NC license application
STEINER, Drew John, MD (009901479) Asheboro, NC	04/03/2009	History of alcohol/substance abuse	Application for reinstatement of NC license denied
Surrenders			
CHRISTIANSEN, Sara Lynn, MD (200201352) Carolina Beach, NC	04/21/2009		Voluntary surrender of NC license
EARLA, Janaki Ram Prasad, MD (200701202) Fayetteville, NC	02/20/2009		Voluntary surrender of NC license

Name/license#/location	Date of action	Cause of action	Board action
MCINTOSH, John Clarke, MD (000036570) Asheville, NC	02/12/2009		Voluntary surrender of NC license
ROLLINS, Curtis Edward, MD (200501895) Winston-Salem, NC	02/16/2009		Voluntary surrender of NC license
SCHOEN, Martin William, MD (200801382) Jacksonville, NC	04/24/2009		Voluntary surrender of NC license
AFRIDI, Saifullah Khan, MD (009500798) Cary, NC	04/24/2009	Care of an infant may have fallen below accepted standards	Public letter of concern
ANDERSON, Joseph Robert, MD (009500807) Asheville, NC	03/13/2009	Board concerned about care of patient with anorexia and anxiety	Public letter of concern
BHATTI, Naeem Ahmad, MD (200900519) Winston-Salem, NC	04/07/2009	Initially withheld information from NC license application	NC license issued, with a public letter of concern
CHATTERJEE, Madhumita, MD (200900238) Hickory, NC	02/24/2009	Gave a false answer on NC license application	NC license issued, with a public letter of concern
GISH, David Lawrence, MD (009800872) Mooresville, NC	04/03/2009	Failed to provide appropriate follow-up care to a patient	Public letter of concern
LEE, Barry Russell, MD (000036758) Gastonia, NC	04/03/2009	Boundary violation	Public letter of concern
MARSH, Stephen Saunders, MD (000031578) Raleigh, NC	04/24/2009	Inadequate supervision of mid-level practitioners	Public letter of concern
MILES, Christopher Alan, PA (000103309) Hickory, NC	03/06/2009	Concerns about quality of care	Public letter of concern
PITRE, Christopher Paul, PA (001000094) Raleigh, NC	02/10/2009	Concerns about quality of care	Public letter of concern
SHELTON, Timothy Lee, MD (200900589) Augusta, GA	04/14/2009	Withheld information on license application	Public letter of concern
YAGER, Howard Sanford, MD (009901493) Atlanta, GA	03/30/2009	Delay in diagnosis; quality of care issues	Public letter of concern
Temporary/Dated Licenses: Issued, Extended, Expired or Replaced by Full Licenses			
MCMANUS, Shea Eamonn, MD (009701056) Oxford, NC	03/19/2009		Full license issued
WHITLOCK, Gary Thomas III, MD (000024331) New Bern, NC	03/19/2009		Dated medical license issued to expire 03/31/2010
WERTHEIMER, Thomas Albert, MD (009900386) Whiteville, NC	03/19/2009		Full license issued
Dismissals			
BREWBAKER, Stephen Lewis, MD (000026202) Wilmington, NC	04/16/2009		Dismissal without prejudice of charges dated November 28, 2007

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This publication is printed on 70# Opus Dull Text. It is a Forest Stewardship Council paper.
Environmental savings realized by using this paper are summarized below:
5,165 lbs of paper used | 709 lbs of wood saved | 2,659 gallons of water saved | Landfill waste reduced by 709 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 website 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

September 16-18, 2009 (Full Board)
October 21-22, 2009 (Hearing Panel)
November 18-20, 2009 (Full Board)

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

Attention DEA registration holders

It has come to the Board's attention that some licensees who hold U.S. Drug Enforcement Administration registrations currently list their home addresses at their primary contact address with the Board. This may create a conflict with DEA rules, which require that the registered address be the same address as the location where the practitioner is seeing patients and writing prescriptions for controlled substances.

To ensure compliance with DEA rules, update your address with the NCMB so that your practice address is listed as your primary or "public" address.

You may change your address online by visiting the Board's Website at *www.ncmedboard.org*

Select "Change My Address" from the green Quick Links box that appears to the right of the screen. Addresses may be updated at any time. The Board asks that licensees promptly update their addresses in the event of a change.