FORUM
NORTH CAROLINA MEDICAL BOARD
FOR THE BENEFIT AND PROTECTION OF THE PEOPLE OF NORTH CAROLINA
FALL 2012

Pg. 6: Recognizing signs of child abuse

Accountability and equity for all

A patient undergoes surgery to have a brain tumor removed. Although the surgeon believes the tumor was successfully excised he did not, in fact, remove it. The surgeon does not review post-operative imaging studies that show that the tumor is intact. Months later the patient returns to her primary care doctor with worsening headaches, blurred vision and other symptoms. A scan reveals the tumor the patient thought had been removed. The patient files a complaint with the Medical Board, which investigates the case and takes public action against the surgeon.

Ralph C. Loomis, MD, says "I feel strongly that the federal government's process for holding its clinicians accountable is inferior to the process the NCMB guarantees to North Carolina patients."

Now imagine that the patient is the spouse of a soldier on active military duty and that the surgery and followup care took place in a military hospital. It might go something like this:

The patient files a complaint with the Medical Board. The Board contacts the surgeon and the military hospital where he is employed to request the patient's records, as well as an account of the surgeon's handling of the case. The surgeon provides his account of the patient encounter. The military hospital, however, declines to release the records to the Board, citing federal law. The Board is unable to proceed with an investigation.

North Carolina law authorizes the Medical Board to regulate medicine and surgery for the benefit and protection of North Carolinians. It seems to me that the protections afforded by the law ought to apply to everyone in our great state. But in point of fact, this isn't the case.

The Board is often unable to proceed with investigations related to physicians and physician assistants who are licensed in NC but employed by federal facilities or the US military. When the Board receives complaints about these professionals, its investigators and legal staff always try to obtain the records and other information needed to proceed with an investigation of the alleged misconduct. The Board has a skilled staff and is sometimes successful, with considerable effort, at obtaining medical records from federal institutions. More often than not, however, the records are out of reach.

Why does this matter? First and foremost, it means that NC licensed physicians and PAs who work in federal institutions are not subject to the same rigorous standards and processes that all non-federal physicians and PAs are held to by the NCMB. From the licensee perspective, it's a question of fairness: shouldn't all licensees be accountable for their actions, regardless of where they happen to work?

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Second, but certainly no less important, it shortchanges patients who are treated in federal institutions because they do not have access to the same protections as North Carolinians treated in non-federal settings.

Another situation the Board is sometimes faced with involves privileging actions taken against NC licensed physicians or PAs working in federal institutions. When a federal institution revokes or suspends a NC licensee's clinical privileges, the institution sometimes reports the action to the Medical Board. The Board has an obligation to investigate the actions, since the conduct that led to the privilege suspension or revocation may represent a threat to patient safety. In these situations, we face the same problems obtaining medical records and are usually unable to complete an investigation.

Situations in which a licensee of the Board has lost privileges at a federal institution are especially troubling. Where do these clinicians go when they can no longer practice in the federal system? They set up in private practice in North Carolina or get a job at the local urgent care. Meanwhile, the Board is limited in its ability to assess whether that licensee is competent and safe to practice.

This isn't just a North Carolina issue, by the way. You may or may not know that clinicians working in federal institutions are required to hold a state medical license to practice in a federal facility, but the license does not necessarily have to be issued from the state in which they are working. Many, if not most, clinicians working in federal facilities in NC do, in fact, hold NC medical licenses. Some hold licenses in other states, in which case those state boards would have an interest in investigating alleged misconduct.

The difficulties the Board has had getting medical records from federal institutions has always troubled me. In my six years on the Board, I've helped to review complaint cases that involved serious allegations of substandard practice or misconduct on the part of federal medical practitioners (military, Veterans Administration, federal prison). It is a hard pill to swallow when it becomes clear that, despite our best efforts, the Board will be unable to conduct an appropriate investigation to resolve what appears to be a legitimate allegation of misconduct or substandard care. The national Federation of State Medical Boards has intervened on state boards' behalf to persuade federal health care facilities to be more forthcoming, with little success.

I have worked in the VA system. I have friends and colleagues who still work in federal institutions and I know them to be competent and caring practitioners. I certainly don't wish to malign the professionals who choose to practice in federal facilities or suggest that their care is categorically inferior. Indeed, they perform an essential and often thankless service.

As a former fulltime member of a VA facility's medical staff, however, I feel strongly that the federal government's process for holding its clinicians accountable is inferior to the process the NCMB guarantees to North Carolina patients.

When patients file a complaint, the Medical Board investigates and comes to a decision, after a careful, multi-step review of the facts, on how to resolve it. Patients and family members who file complaints aren't always satisfied with their outcomes. I am confident, nonetheless, that their concerns get a fair and thorough review. I am proud of the Board's high standard for transparency.

The NCMB informs the complainant, in writing, of the outcome of his or her case, whether no formal action is taken, private action is taken or some type of public action is taken. Cases that are resolved with public actions are publicly available in a variety of formats. Public documents are posted in their entirety on the information page of the licensee receiving the action. In addition, public actions are listed chronologically on the Board's website and are published quarterly in the NCMB's newsletter.

I acknowledge that I'm not fully informed about the federal government's means of investigating and ad-

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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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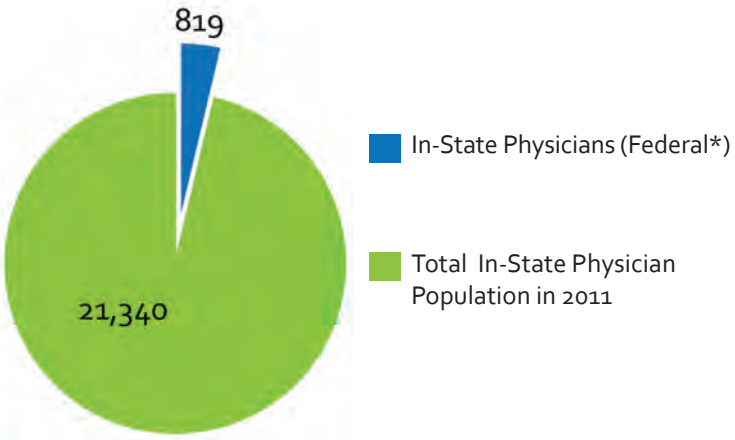
dressing patient complaints. I do know that some of the patients who have filed complaints with the Board indicate that they have not been advised whether their concerns were seriously considered by the federal institution or told what action, if any, was taken. I also know I'd feel a lot more comfortable if the Medical Board were able to do its job when it receives complaints about licensees working in federal settings.

The Board could do this if federal law and policies were amended to require the federal government to release the relevant medical records to the relevant state medical boards. That's what I think needs to happen.

Send comments to *forum@ncmedboard.org*

Federally Employed Physicians in NC



Source: Cecil B. Sheps Center for Health Services Research, NC Health Professions Data System (2011 Annual Profile).

*Physician whose principal employer is the federal government. This includes physicians in the armed services, US Public Health Service, Indian Health Service and the Department of Veterans Affairs.

What do you think?

Should federal health care facilities be required to release relevant medical records to relevant Medical Boards to enable the Board to conduct investigations of physicians and PAs working in these facilities?

Visit *www.ncmedboard.org* to complete our brief survey or scan the QR code below with your smartphone.

Board reviews, revises five Position Statements

The Policy Committee of the NC Medical Board regularly reviews and, as needed, amends its position statements to ensure they remain current and relevant to the situations licensees face in day-to-day practice. During its meetings in July and September, the Policy Committee reviewed and the full Board approved changes to five position statements. The titles of the revised statements appear below, along with a brief summary of changes approved.

The complete position statements of the Board are available online at *www.ncmedboard.org/position_statements*

Care of the Patient Undergoing Surgical or Other Invasive Procedure: Changes simplify language in the second and third sentences of the statement.

Writing of prescriptions: Changes modify statement to address electronic prescribing of controlled substances and revise language so that it is consistent with the Board's position on Self-Treatment and Treatment of Family Members.

Medical Testimony: No substantive changes; the word "physician" is changed to "licensee" throughout.

The physician-patient relationship: Italicizes, for emphasis, the line that reads: The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. In addition, statement is amended to say that its fundamental principles apply to all licensees.

The retired physician/licensee: No substantive changes; the word "physician" is changed to "licensee" throughout.

Board elects officers to lead in 2013

The NC Medical Board officers for the coming year begin their terms November 1. William A. Walker, MD, of Charlotte, will serve as president; Paul S. Camnitz, MD, of Greenville, will serve as president-elect and Cheryl Walker-McGill, MD, of Charlotte, will act as secretary/treasurer. Two at-large members have also been named: Eleanor Greene, MD, of High Point, and Thelma C. Lennon, a public member, from Raleigh. Together, the officers serve on the NCMB's Executive Committee, which sets Board priorities and handles governance responsibilities. Officer terms expire October 31, 2013.

William A. Walker, MD, President

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 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.

Dr. Walker

Throughout his career, Dr. Walker has served in a number of administrative and professional positions, including as president of the Mecklenburg County Medical Society. He currently serves on the North Carolina Medical Society's Physician-Hospital Relations Committee, is Medical Director of the operating room at Presbyterian Hospital and is president of Charlotte Colon and Rectal Surgery Associates. Dr. Walker served on the Federation of State Medical Boards Editorial Committee from 2009-2011, and currently serves on the FSMB's Audit Committee.

Dr. Walker is a fellow of the American College of Surgeons and the American Society of Colon and Rectal Surgeons. He is an active member of the Mecklenburg County Medical Society and the North Carolina Medical Society. He is the recipient of the Mecklenburg County Medical Society's President's Award. He has coauthored numerous publications and given presentations across the United States.

Dr. Walker was appointed to the Medical Board in 2007. In 2011, he was named president elect of the NCMB. In the past, he has chaired the Board's Licensing, Allied Health, Policy and Disciplinary Committees in addition to serving on a number of other board committees.

Paul S. Camnitz, MD, President Elect

Dr. Camnitz attended the University of North Carolina, Chapel Hill, where he earned bachelor's degrees in both English and Chemistry. He earned his medical degree at the UNC School of Medicine in Chapel Hill and did his residency in Otolaryngology-Head and Neck Surgery at the same institution, finishing in 1979.

Dr. Camnitz is certified by the American Board of Otolaryngology and the American Academy of Facial Plastic and Reconstructive Surgery. He currently practices at Eastern Carolina Ear, Nose & Throat/Head and Neck Surgery in Greenville. He is also a Clinical Professor of Surgery and Head of the Division of Otolaryngology at the Brody School of Medicine at East Carolina University, where he has been selected by the graduating medical school class as "Outstanding Teacher" 12 times and in 2003 was named a "Master Educator" by the faculty. He received the Outstanding Professor Award from the Family Medicine Department in 2004 and the Bernie Vick Outstanding Professor Award from the Department of Surgery in 2003. Dr. Camnitz has received many other honors, including the Distinguished Service Award of the School of Medicine at the University of North Carolina, Chapel Hill, which was bestowed in 2006.

Dr. Camnitz is a fellow of the American College of Surgeons and of its North Carolina chapter and a fellow of the American Academy of Otolaryngology-Head and Neck Surgery. He is a member of numerous professional groups, including the Alpha Omega Alpha Honor Medical Society, the American Medical Association and the North Carolina Medical Society, among others. Dr. Camnitz has served as chief of staff at Pitt County Memorial Hospital and has served on the boards of numerous other health care and civic organizations in Pitt County.

Dr. Camnitz

Dr. Camnitz was appointed to the Board in 2008. In the past, he was chairman of the Board's Continued Competence Committee and Review Committees. He currently chairs the Policy Committee and serves on the Disciplinary and Continued Competence Committees.

Cheryl Walker-McGill, MD, Secretary/Treasurer

Cheryl Walker-McGill, MD, MBA earned her undergraduate and medical degrees from Duke University. She completed a residency in internal medicine and a fellowship in allergy-immunology at Northwestern University. In addition, she earned a master of business administration from the University of Chicago. Dr. Walker-McGill is certified by the American Board of Internal Medicine and by the American

Dr. Walker-McGill

Board of Allergy and Immunology and she is a Fellow of the American Academy of Allergy, Asthma and Immunology.

Dr. Walker-McGill is president of American Health Strategy and Quality Improvement Institute in Charlotte, an organization dedicated to developing strategies for improving health and healthcare outcomes in high-risk, high-cost patient populations. In addition, Dr. Walker-McGill is medical director for Daimler Trucks, NC, with oversight of the Gastonia and Mount Holly facilities. She has significant experience in clinical medicine, physician education, community health education and health economics.

Dr. Walker-McGill is currently an assistant professor of clinical medicine at the University of North Carolina School of Medicine, and an adjunct professor at the Wingate Graduate School of Business.. Previously, she served on the faculty at the Northwestern University School of Medicine. She was honored as a pioneer by the Duke University Baldwin Scholars Program. Dr. Walker-McGill is a recipient of the Chicago Public School System Distinguished Achievement in Asthma Education Award and of the National Medical Association Floyd J. Malveaux Award in Allergy, Asthma and Immunology.

Dr. Walker-McGill is chair of the Allergy, Asthma and Immunology Section of the National Medical Association. She is immediate past president of the Charlotte Medical, Dental and Pharmaceutical Society and chair-elect of the Committee for the Underserved of the American Academy of Allergy, Asthma and Immunology.

Dr. Walker-McGill was appointed to the Board in 2011. She currently serves on the Continued Competence, Allied Health and Review Committees.

Eleanor E. Greene, MD, MPH, At-large member

Eleanor E. Greene, MD, of High Point, earned a BS degree in medical technology from the former Bowman Gray School of Medicine (now Wake Forest University School of Medicine) in Winston-Salem, NC. She received her MD and a Master of Public Health in Maternal and Child Health from the University of North Carolina, Chapel Hill, and completed residency in obstetrics and gynecology at the Ohio State University in Columbus, OH. She currently practices with Cone Health Medical Group at Triad Women's Center in High Point.

Dr. Greene is a member of the North Carolina Medical Society, Doctors for America, North Carolina Obstetrics and Gynecology Society, and the National Medical Association, where she served on the Board of Directors, Finance and Health Policy Committees. She serves on the Piedmont Health Services and Sickle Cell Agency. She served on the North Carolina Advisory Committee on Cancer Coordination and Control on the Board of Directors of the Healthy Start Foundation, completing two terms on each. Dr. Greene is past president of the Old North State Medical Society, and continues to serve on its current Executive Committee. She is a fellow of the American College of Obstetrics and Gynecology.

Dr. Greene

Dr. Greene is the first physician from High Point, NC, and the first African American female physician to serve on the NC Medical Board. She speaks on the topic of Women's Health and Women in Medicine at numerous church and community forums. Dr. Greene recently served as moderator for a conversation on Women's Health and the Affordable Care Act featuring the Department of Health and Human Services Director, Secretary Kathleen Sebelius.

Dr. Greene was appointed to the Board in 2010. She currently serves on the Disciplinary, Licensing and Policy Committees.

Thelma C. Lennon, At-large member

Ms. Lennon earned her undergraduate degree from North Carolina Central University. She earned her master's degree from Boston University in guidance and counseling and did further study of the subject at Harvard University. She also completed graduate study in adult education at North Carolina State University. During her professional career, Ms. Lennon served in education as an instructor and dean of students at a number of academic institutions. Before retiring, she worked as director of guidance and counseling for the North Carolina Department of Education.

Ms. Lennon

Since her retirement, Ms. Lennon has devoted much of her time to volunteer activities focusing on health and education. She has served as a counselor at the North Carolina Department of Insurance's Senior Health Insurance Information Program (SHIIP), a member of the Board of Directors of the Carolinas Center for Medical Excellence, and as chairman for the Alliance for Medical Excellence. She is also a member of the Wake County Community Advisory Council for Nursing Homes and the Governor's Advisory Council on Aging. From 1996 to 2012, Ms Lennon was the first North Carolina state president for AARP and was selected as an alternate delegate to the White House Conference on Aging.

Recognizing and responding to suspected child abuse and neglect

Sarah Currier, chief program officer, Prevent Child Abuse NC

If our society is to prosper in the future, we must make sure our children have safe, supportive environments where they can grow socially, emotionally and physically. When children are abused or neglected their opportunity for healthy development is undermined by toxic stress that damages the developing architecture of their brains. This damage weakens the foundation that future development is built on and is traumatic and long term, resulting in physical, mental and behavioral problems later in life. Understanding of child maltreatment and its impact has resulted in heightened awareness about the responsibility of adults to respond. When we take the time to respond to suspicions of abuse and neglect, we ensure families get the support they need and children's basic foundation for future success is solid. A solid foundation will reap many rewards later on as children grow into successful, contributing members of our community.

Physicians and physician assistants have relatively limited access to children. They may see their pediatric patients annually or just a few times a year, usually for no more than 15 minutes. Nonetheless, clinicians can be an important means of identifying potential abuse and neglect . It is important to remember that sometimes a physician is the only professional involved in the life of a young child and may have the opportunity to perform comprehensive evaluations of a child's health and well-being. Non-pediatric physicians also treat other family members—parents or guardians—who may disclose information about a child's environment and experiences.

The Impact of Child Maltreatment

In 2005, the Centers for Disease Control and Prevention and insurer Kaiser Permanente released the most comprehensive research to date on the impact of child abuse and neglect. The Adverse Childhood Experiences (ACE) Study, surveyed 17,000 adults about their childhood experiences and compared them with their health histories. The research found that children who suffered severe adversity in childhood—violence, abject poverty, substance abuse in the home, child abuse and neglect—were far more likely to suffer long-term intellectual, behavioral and physical and mental health problems.

Problems now concretely linked to child abuse and neglect include behavioral and achievement problems in school; heart, lung and liver disease; obesity and diabetes; depression, anxiety disorders and increased suicide attempts; increased criminal behaviors, illicit drug use and alcohol abuse; increased risky sexual behavior and unintended pregnancies; and other problems.

What is Child Maltreatment?

North Carolina General Statutes define child abuse as any non-accidental or substantial risk of injury or pattern of injuries to a child inflicted or allowed to be inflicted by a parent, guardian, caretaker or custodian. Child maltreatment includes:

- **Physical Abuse -** Any non-accidental physical injury to the child; Can include striking, kicking, burning or biting the child, or any action that results in a physical impairment of the child. Signs of possible physical abuse can include physical injuries that are not likely to have occurred as described; nervousness, hyperactivity, aggressiveness; disruptive and destructive behaviors; unusual wariness of physical contact or fear of a parent or caretaker.
- **Sexual Abuse -** Any sexual behavior imposed on a juvenile. Sexual abuse can include fondling the genital area, masturbation, oral sex or vaginal or anal penetration by a finger, penis or other object. It also includes exhibitionism, child pornography and suggestive behaviors or comments. Signs of possible sexual abuse can include reversion to behaviors such as bed-wetting, speech loss and thumb-sucking; sleep disturbances or nightmares; pain, itching, bruising or bleeding in the genital area; frequent urinary tract infections; or venereal disease

- **Emotional Abuse -** Includes attitudes or behaviors toward a child that create serious emotional or psychological damage. Signs of possible emotional abuse include very low self-esteem; antisocial and destructive behaviors; depressed or suicidal tendencies; or, in some cases, delayed development.
- **Neglect -** The failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care or supervision such that the child's health, safety and well-being are at risk. Signs of possible neglect include consistent hunger, inappropriate dress and poor hygiene; self-destructive behaviors; or unattended medical needs.

Abuse is rarely one isolated incident. Often, there is a pattern of behavior that emerges over a period of time. Children often have difficulty talking about the abuse. This leads to many children "acting out" as a way of expressing their hurt or anger. It is important to remember that even if you see signs, they do not necessarily mean that a child has been abused. The signs will vary according to the type of abuse, its intensity and the developmental age of the child. Some children who are abused display no signs. For this reason, it is important to listen carefully to any child who tells you about an act of maltreatment.

Child maltreatment is not the result of a single cause but of complex interactions between individuals and their environment that influence both development and behavior. Child maltreatment can be examined through a social-ecological model that presents a continuum of risk and protective factors that can either increase resilience or vulnerability to specific behaviors or conditions. Society, community, families and individuals all contribute to the health and well-being of families and children.

Referring a Family to the Department of Social Services

If you suspect child abuse or neglect, you are required by law to refer the family by calling, writing or visiting your county Department of Social Services—Child Protective Services Unit. County contact information can be found at *www.dhhs.state.nc.us/dss/local/*. You can also call the CARE LINE at 1-800-662-7030 to speak with a counselor who can refer you to the appropriate contact. An intake social worker at the local Child Protective Services Unit will listen to you, ask questions and record all the information provided.

Remember that you do not need to prove that abuse has taken place; you only need reasonable grounds for suspicion. While you may choose to include the parent or caregiver in the referral process, you do not need their permission. You also do not need permission from your workplace; ultimately, you are responsible for making sure the referral has been made. If you make a referral in good faith, you will receive immunity from civil or criminal liability.

North Carolinians also bear an ethical responsibility to make referrals in cases of suspected maltreatment. Child abuse rarely stops without intervention and help. By making a referral, you are helping the family get the services and support that they need to end the cycle of abuse.

Abused children carry the trauma associated with abuse throughout their lives. These childhood experiences result in higher risk of poor health outcomes—a risk that is compounded by each additional negative experience.

What Happens After a Referral Has Been Made?

After you have discussed your concerns with a social worker at Child Protective Services, a determination is made as to whether or not the Department of Social Services will complete an assessment.

If intervention is warranted, Child Protective Services may use either an investigative assessment or a family assessment to determine future actions and supports needed for the child and family. The Department of Social Services is required to initiate an assessment within 24 hours for abuse and within 72 hours for neglect.

The assessment may include a visit to the child's home and school along with interviews of those who are in regular contact with the child. The safety of the child is the top priority at all times.

North Carolina's Multiple Response System (MRS) is the state's on-going effort to reform the entire continuum of child welfare services in order to make child welfare more family centered and to keep children safe. MRS begins with the first referral of concerns about a child and his/her family and continues all the way through finding a permanent home for those children who enter foster care. As a reform effort, MRS is not one single program. Rather, MRS is comprised of seven separate strategies delivered to families through a practice model grounded in the use of family-centered practice and system of care principles.

Referred families may have access to counseling, referrals to other agencies and supports, intensive in-home services, as well as help with housing, finances, medical needs and child care. A Child and Family Team will be developed to build a support network for the family. If necessary, emergency foster care services can be established.

See Children page 9

Statewide Summit Focuses on Effective Prevention

What: Learning and Leadership Summit on Advancing Child Well-Being through Effective Prevention (AMA PRA Category 1 Credits available)

When: March 4-6, 2013; Registration opens December 2012

Where: Raleigh Convention Center, 500 South Salisbury Street, Raleigh, NC

More Information: *www.preventchildabusenc.org/summit*

Avoiding common pitfalls in PA practice

Physician assistants and their supervising physicians often face a variety of challenging issues when obtaining and maintaining a license to practice medicine in North Carolina. The appropriate course of action is not always apparent, and unintentional missteps can sometimes land PAs, and/or their supervising physicians, in trouble with the Medical Board.

This article will review a selection of scenarios that involve common issues related to PA practice in NC and provide guidance on how to proceed in an appropriate manner. Becoming educated about these issues and their remedies may help both new and seasoned PAs avoid some of the common pitfalls of successful practice in North Carolina.

Scenario 1: No license, no practice – period

A new PA graduate is offered a job before successfully passing the PA National Certifying Examination (PANCE), a requirement for licensure in North Carolina. As the PA is preparing to begin practice, he is notified that he did not pass the PANCE. The PA's well-intentioned employer extends an offer to the PA to shadow in the office while preparing for a second attempt on the exam. The practice offers a small stipend to the PA to offset living expenses, which the PA accepts. Meanwhile, the NC Medical Board receives information that an unlicensed, uncertified PA is "practicing" with the medical group. A Board investigation determines that the PA did, in fact, perform medical tasks. The Board issues the PA a nondisciplinary Public Letter of Concern, which is a public document posted on his information page on the NCMB website. The letter will remain on the PA's record for the rest of his career and will likely need to be disclosed on all future license applications, hospital privilege applications, health insurance credential applications, etc.

Determining what a PA graduate can and cannot lawfully do before obtaining licensure in North Carolina is a frequent area of confusion for PAs and supervisors.

To obtain a license in North Carolina, PAs must complete an accredited PA program, and if applying for initial licensure, must successfully complete the PANCE and meet all other requirements. Once licensed, a PA cannot perform medical acts until he or she completes the Intent to Practice form on the Board's website and confirms that the Board has received and processed the PA's submission (an easy way to do this is to look up the supervising physician using the "Look Up a Licensee" tool on the Board's website. If the PA's name appears under that physician's name as a supervisee, the ITP has been processed).

If any medical tasks are performed by the PA before he or she is licensed and listed as a supervisee, it constitutes practicing without a license and may result in discipline by the Board. Peggy Robinson, PA-C, a member of the faculty at Duke University's PA Program who completes her second term on the Medical Board in October, has said that it's best for new PA graduates to "keep their hands in their pockets" until they are fully licensed. In other words, the PA should refrain from performing any duties that can lead to practicing without a license or even giving the appearance of doing so. Remember, an unlicensed new graduate actually has less privilege than a current PA student to perform medical acts, because PA regulations do not apply to students. The Board recommends that PAs wait until they are "official" to avoid problems.

Scenario 2: Suddenly supervisor-less

A licensed PA with several years of clinical practice places an urgent call to the Board. She explains that her primary supervising physician has developed a sudden illness that will make it impossible for the physician to continue as her supervisor. The PA does not have a suitable backup physician who can take over as her primary supervising physician. The PA works in a busy primary care practice, where she carries an active caseload of more than 2,000 patients. She is concerned about a possible interruption in her ability to continue to care for her patients due to the loss of her primary supervising physician.

More information

- PAs are expected to be familiar with applicable laws, rules and position statements, all of which are available on the Board's website. Review this information at least annually, perhaps when renewing your license.
- Answers to the questions raised in this article, and many others, are provided in the PA "Frequently Asked Questions" or FAQs on the Board's website.
- If you, your supervising physician or employer are confused about any aspect of PA licensure and acceptable conduct or practice, call 919-326-1000 or 1-800-253-9653 and ask to speak to the PA liaison or PA license coordinator.

NC law authorizes PAs to practice medicine only under the oversight of a primary supervising physician. Situations arise, however, when a PA loses a primary supervising physician due to circumstances out of his or her control. The Board has a policy to address these situations. When a primary supervisor is unable to continue supervision, the PA shall notify the Board within two (2) business days of the emergency situation by first calling the Board and then following up with a letter describing the emergency situation. The PA then has 30 days to submit an Intent to Practice for a new primary supervising physician.

Scenario 3: Shadowing before resuming practice

A PA who had been out of clinical practice for eight years asks a physician colleague if he can shadow the physician as the PA prepares to reenter the workforce.

Under some circumstances it is permissible for a non-licensee to shadow a physician. However, it is recommended that a PA whose ultimate goal is to regain licensure wait until the license is issued before shadowing or observing in a clinical setting. While lay and unlicensed people may perform delegated tasks in a physician's office, PAs are not allowed to perform medical acts under any circumstances without an active PA license. In the Board's view, it is too easy for an unlicensed PA who begins shadowing with the best of intentions to slip into performing medical acts (practicing without a license).

Any applicant who has been out of active clinical practice for two or more years (eight years in this example) would be required to complete a program of reentry to clinical practice, which consists of a period of mentoring under the supervision of a Board-approved physician mentor. Typically, the first phase of a reentry program involves having the reentering applicant shadow his or her physician mentor. The reentry process is designed to ensure that the reentering licensee has ample time to reacclimate to clinical practice before they are cleared for a full and unrestricted license.

Katharine D. Kovacs PA-C is the staff physician assistant in the NCMB's Office of the Medical Director. Jane Paige is a physician assistant licensing coordinator at the Board.

Children continued:

Get More Information

Prevent Child Abuse North Carolina has developed a free online self-guided training module that educates viewers in recognizing and responding to suspected child abuse and maltreatment. Refer to the box below for information on accessing this training.

In addition, Prevent Child Abuse North Carolina will host a statewide summit on advancing child well-being through prevention of abuse and maltreatment March 4-6, 2013. The meeting will be held at the Raleigh Convention Center. Dr. Vincent Felitti, co-principal investigator for the Adverse Childhood Experiences Study, will open the summit with an inside look into the study and discuss its relevance to the everyday practice of medicine and mental health, as well as its impact on healthcare costs. Additional information on the summit is provided in the box on page 7.

Thank you for your commitment to child safety and well-being. Your efforts make a difference in lives of countless children.

Clinicians spend a limited amount of time with their pediatric patients, but nonetheless, can play a valuable role in identifying and addressing abuse and neglect.

Free Online Training sharpens ability to respond when abuse is suspected

What: Prevent Child Abuse North Carolina offers a free Web-based self-guided training module,Recognizing and Responding to Suspicions of Child Maltreatment. The training provides a comprehensive overview of the signs and symptoms of maltreatment, related North Carolina law and the child protection system.

How to access: Go to *www.preventchildabusenc.org/rrcourse* You will be asked to register to complete the training

Medical-Legal Partnerships: When medicine and self-care aren't enough

By Madlyn Morreale, JD, MPH

Medical professionals have long understood that patients' wellbeing is influenced by many factors that are outside of the traditional purview of medical and self-care. "We know that psychosocial stress has a significant impact on our patients' health," notes Meggan Goodpasture, MD, Assistant Professor of Pediatrics at Wake Forest Baptist Medical Center. "Too often our efforts to help our patients are limited because we can't address the underlying problems that they're experiencing outside of the medical office."

A growing network of Medical-Legal Partnerships (MLPs), which team hospitals and clinics, clinicians, patients and families with lawyers, is helping to change that. These partnerships represent a valuable resource that clinicians may call on to help address some of the social and environmental determinants of health. These include substandard housing conditions; domestic violence; food, income and housing insecurity; improper denials of Medicaid and other public benefits; failure to provide children special education services to which they are entitled; and end-of-life issues.

When a clinician becomes aware of social and environmental factors that threaten a patient's health, he or she makes a referral to a medical-legal partnership. A legal team is assigned to the case and intervenes on the patient's behalf to resolve problems. For example, an MLP might be contacted to help a cancer patient overcome bureaucratic hurdles with a Food Stamps application (see case studies). Services are made available to patients at no charge.

The Medical-Legal Partnership model has been endorsed by the American Bar Association, the American Medical Association, the American Academy of Pediatrics and numerous other national organizations. During 2010, more than 80 MLPs nationwide partnered in 235 hospitals and health centers to provide legal assistance to more than 34,000 individuals and families. MLPs fostered cooperation among 23 medical schools and 29 law schools as well as legal services organizations and hundreds of private law firms and other pro bono partners who provided more than $13 million in in-kind services to medical-legal partnerships.

In North Carolina, Medical-Legal Partnerships have been established in seven locations, including Durham, Chapel Hill, Winston-Salem, Greensboro, Charlotte, Asheville and Prospect Hill (see chart pg. 11). Each MLP is designed to address the particular needs and capacity of the local partners. However, they all share common components, including:

- Basic legal training for health care providers to help them screen and refer patients who may benefit from legal assistance;
- Regular presence of legal staff in clinic settings to conduct outreach to staff and to allow for patients to be screened for eligibility for legal assistance;
- Formal referral mechanisms between medical providers and legal partners; and,
- Direct legal assistance to patients-clients.

Medical-Legal Partnerships make sense. Health care providers are more likely to screen patients about problems when they know that they can refer patients for services to address those concerns. Lawyers can often get better results for a client when a medical professional is on the team. And, by collaborating with lawyers, medical professionals are gratified to see that they can often improve the health of their shared patients/clients.

Madlyn Morreale, JD, MPH, Staff Attorney, Medical Legal Partnership Legal Aid of North Carolina, Inc.

How MLPs work: Case Studies

Substandard housing

Kelvin*, age 9, was treated in the ER for acute respiratory distress. ER doctors learned that Kelvin had a history of asthma-related symptoms, despite compliance with standard medications. They talked with Kelvin's mother about possible environmental triggers. After she told them that the family's home had a severe cockroach infestation and that the landlord had refused to exterminate, the doctors referred her to the Medical-Legal Partnership. The legal team worked with the landlord to ensure that the entire building was exterminated, using safe and effective methods, and to establish procedures to have all of the buildings inspected and treated on a regular basis, at no charge to the tenants.

Delay in Food Stamps benefits

Margaret* applied for Food Stamps benefits before she went into the hospital for breast cancer surgery. Margaret's application was approved, but she never received her benefits card. She worked with her cancer center case manager to try to resolve the situation, with no success. Margaret's primary care provider, concerned that Margaret's lack of nutrition could compromise her recovery, referred her to the Medical-Legal Partnership. Margaret's legal team worked to get her nutrition benefits expedited, allowing Margaret and her medical team to focus on her recovery.

**Not the real names of MLP participants*

Michael Steiner, MD, Chief of the Division of Pediatrics and Adolescent Medicine at UNC Health Care's North Carolina Children's Hospital said being part of an MLP has been positive for staff and patients.

"We see children for about 20 minutes, three or four times a year, at the most," Steiner said. "But outside of that time is where their lives are truly happening. Since forming the MLP, our staff feels more empowered to help families with issues that we cannot reach. Through partnerships like MLPs, medical providers can broaden our impact and go much further to improve the health and well-being of the patients and families that we care for."

Get in touch with medical-legal partnerships in NC by contacting Madlyn Morreale at (919) 226.5912 or *madlynm@legalaidnc.org*

Medical-Legal Partnership Programs in North Carolina*

Location	Medical Partner(s)	Legal Partner(s)
Asheville, NC	• Mission Hospital • Mountain Area Health Education Center	Pisgah Legal Services
Chapel Hill, NC	North Carolina Children's Hospital	• Legal Aid of NC, Inc. (statewide) • Pro Bono Program, UNC School of Law
Charlotte, NC	Carolinas HealthCare System	• Legal Aid of NC, Inc. (Charlotte office) • Legal Services of Southern Piedmont, Inc.
Durham, NC	• Duke Primary Care for Children • Pediatrics Department, Lincoln Community Health Center • Pediatric clinics at Duke University Medical Center	• Legal Aid of NC, Inc. (Durham office) • Children's Law Clinic, Duke University School of Law

Greensboro, NC	• Triad Adult and Pediatric Medicine
	  • HealthServe Community Health Clinic
	  • Guilford Child Health
		Legal Aid of NC, Inc. (Greensboro office)

Prospect Hill, NC	Piedmont Health Services: Prospect Hill Community Health Center	Legal Aid of NC, Inc. (Durham office)
Winston-Salem, NC	Pediatrics Department, Downtown Health Plaza, NC Baptist Hospital	Legal Aid of NC, Inc. (Winston-Salem office)
Winston-Salem, NC	Wake Forest University Baptist Medical Center and School of Medicine	Elder Law Clinic, Wake Forest University School of Law

**What is a Medical-Legal Partnership?*

A Medical-Legal Partnership ("MLP") is an innovative service delivery model that brings together physicians, nurses, social workers, attorneys and paralegals to address social and environmental determinants of health, including but not limited to substandard housing conditions; domestic violence; food, income, and housing insecurity.

Professional corps and LLCs: It's time to renew

Medical professional corporations and limited liabilities companies are required to renew their corporate registration annually with the Board no later than Dec. 31. The Board emails or mails a renewal notification to the email or business address on file with the NCMB during the fourth quarter. Failure to renew may result in suspension of the corporate registration pursuant to NCGS 55B-13. If suspended by the NCMB, a business may no longer provide professional services to the public under the protections afforded by PC or LLC status.

All medical professional businesses must renew online. Paper renewals are not accepted. Be prepared to update and verify for accuracy the following:

- Mailing address, phone numbers and email address for PC or PLLC
- Current Registered Agent listed with NCMB and the Secretary of State
- Current approved shareholders or members of the PC/PLLC (You will have the opportunity to request approval of a newly added shareholder/member during the renewal process)

North Carolina Medical Board

Quarterly Board Actions Report | May - July 2012

The Board actions listed below are published in an abbreviated format. The report does not include non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. Recent Board actions are also available at *www.ncmedboard.org*. Go to "Professional Resources" to view current disciplinary data or to sign up to receive notification when new actions are posted via the RSS Feed subscription service.

Name/license#/location	Date of action	Cause of action	Board action
ANNULMENTS			
None			
SUMMARY SUSPENSIONS			
None			
REVOCATIONS			
YORK, David Allen, MD (200401357) August, ME	05/29/2012	Felony convictions. Ten counts of possession of sexually explicit material involving a minor under age 12.	Entry of Revocation
SUSPENSIONS			
EVANS, Michael Allen, MD (200001370) Smithfield, NC	06/18/2012	Following surgery to repair a fractured hand, MD was prescribed pain medicine. In an effort to obtain additional pain medication, MD began writing and filling prescriptions in fictitious patients' names. MD was arrested and charged with felony attempt to obtain controlled substance by forgery/fraud on or about 10/5/11.	MD's medical license is indefinitely suspended; MD shall not be eligible for reinstatement before November 8, 2012.
FANTAUZZI, Mark Rudolph, DO (200000212) Portland, ME	05/4/2012	Action by Ohio Board regarding DEA issued Order based on allegations of prescribing controlled substances for other than legitimate medical purposes outside the usual course of professional practice.	NC medical license is indefinitely suspended
MAYNOR, Michael Lee, MD (000030677) Folly Beach, SC	06/26/2012	The KY Board of Medical Licensure summarily suspended MD's license on 10/20/11, based on a finding of probable cause that MD was under the influence of alcohol while at work (in KY). The SC Board of Medical Examiners summarily suspended MD's SC license based on the KY action.	NC medical license is indefinitely suspended.
NEAL, Gabrielle Logan, PA (001001444) Lumberton, NC	07/19/2012	PA prescribed a controlled substance to a coworker and diverted the medication for her own use.	PA's license is indefinitely suspended.
SUNDERHAUS, Earl E., MD (000015809) Asheville, NC	07/03/2012	History of inappropriate, unprofessional communication and physical contact (pushing, poking in thigh) with a patient and members of the general public.	Indefinite suspension of medical license; may not apply for reinstatement for one year and until MD attends the CPEP ProBE course and has neurologic and neuropsychiatric assessments as specified by the Board.
Thompson, David Stuart, MD (009801531) Nags Head, NC	05/31/2012	Inappropriate relationship with a patient and an inappropriate relationship with the parent of two pediatric patients.	Consent order executed. MD's NC medical license is indefinitely suspended.
URBAN, Edward John, DO (000027410) Asheville, NC	06/22/2012	Inappropriate prescribing of controlled substances; quality of care.	Indefinite suspension of medical license. DO agrees to never apply, request or petition the Board for reinstatement in NC or in any other state, territory or district in the U.S. He further agrees not to practice medicine in any other state, territory or district outside of NC.
WRENN, Cynthia Helen, PA (000102752) Jacksonville, NC	05/29/12	PA provided false statements to the Board regarding prescriptions for controlled substances when the PA did not have the ability to prescribe controlled substances. The prescriptions were written by clinicians in the same practice without them independently examining the PAs patients.	Consent order executed. PAs license is suspended for two years, immediately stayed except for four months on conditions.

Name/license#/location	Date of action	Cause of action	Board action
PROBATIONS			
None			
REPRIMANDS			
DOEBLER, William Clayton, MD (200701700) Bonita Springs, FL	07/09/2012	While practicing in the state of NY, MD was censured, reprimanded and placed on a 5-year-probation related to his April 2010 guilty plea to DWI (in Minnesota). MD failed to report the DWI and the NY Board action on his 2011 NC license renewal.	Via consent order, MD is reprimanded; MD must pay a $1,000 fine.
HUNTINGTON, William Parshall, MD (RTL) Charlotte, NC	07/26/2012	On April 26, 2012, MD was arrested for DWI and reckless driving after allegedly being involved in a traffic accident causing significant property damage and multiple injuries. MD is now under a two-year monitoring contract with NCPHP.	Via consent order, MD is reprimanded. In addition, MD is placed on probation for the term of his resident training license.
MAUTERER, David John, MD (000039195) Poplar Bluff, MO	05/10/2012	MD did not respond to the Board's repeated requests regarding information about a malpractice payment.	Via findings of fact conclusion of law and order of discipline. MD is reprimanded.
SHUTAK, Michael, PA (000101798) Jacksonville, NC	06/22/2012	PA failed to comply with a February 2011 Board Order to obtain additional assessment. PA contends he was unable to comply with this requirement. He has entered into a monitoring contract with NCPHP in lieu of additional assessment.	Via consent order, PA is reprimanded; PA shall maintain NCPHP contact and comply with all its terms.
DENIALS OF LICENSE/APPROVAL			
None			
SURRENDERS			
JUSTIS, Christopher Morrow, MD (000038991) Edenton, NC	06/15/2012		Voluntary surrender of NC medical license
MATHEWS, Robert Simon, MD (000014253) Susquehanna, PA	05/17/2012		Voluntary surrender of NC medical license
MCGRATH, Timothy John, MD (200200571) Mebane, NC	05/23/2012		Voluntary surrender of NC medical license
MCKNIGHT, Kevin Michael, MD (000038137) New Bern, NC	06/19/2012		Voluntary surrender of NC medical license
ORLI, Tom, MD (200201510) Winston-Salem, NC	07/09/2012		Voluntary surrender of NC medical license
URBAN, Edward John, DO (000027410) Asheville, NC	05/24/2012		Voluntary surrender of NC medical license
VANSTORY, Ashley Nowlan, PA-C (001001770) High Point, NC	07/26/2012		Voluntary surrender of NC physician assistant license
WARD, David Townsend, MD (009500473) Greensboro, NC	05/01/2012		Voluntary surrender of NC medical license
ZIMMERMAN, Mark, MD (009401104) 200801889	07/25/2012		Voluntary surrender of NC medical license
PUBLIC LETTERS OF CONCERN			
DUNN, Jack, III, MD (201200916) Natchez, MS	05/17/2012	History of chemical dependence and other state Board actions.	Non-disciplinary consent order. Public letter of concern.
FOSTER, James William, MD (201200891) Charlotte, NC	05/10/2012	TN Board action. MD closed his medical practice without proper notice to patients or instructions regarding retrieval of patient records. MD did not respond to patient record requests within TN ten day requirement.	Public letter of concern
HEIDER, Timothy Ryan, MD (200001489) Mooresville, NC	06/11/2012	MD's care of a patient admitted with acute appendicitis, on whom MD performed laparascopic appendectomy, may have been below standard. The patient died at home approximately 11 days post-op; An autopsy revealed a necrotic appendiceal stump and an abdominal abscess.	Public letter of concern
SCHMOKE, Raymond Edward Frank, MD (201200987) Manistee, MI	05/24/2012	MD omitted material information on his license application.	Public letter of concern

Name/license#/location	Date of action	Cause of action	Board action
NUTTING, William Gardiner, MD (000028068) Dearborn, MI	07/17/2012	MD repeatedly failed to respond in a timely manner to inquiries from the Board regarding a professional liability payment made on his behalf.	Public letter of concern; $2,000 administrative fine
PATEL, Latika Dushyant, MD (000033730) Monroe, NC	06/22/2012	MD entered into a $750,000 settlement agreement with the U.S. Dept. of Justice related to allegations that MD billed Medicaid for certain services when the patients and the services did not support that billing.	Public letter of concern
RANA, Ahmad Sultan, MD (009701852) Dunn, NC	07/16/2012	MD's care of a patient who presented with burning pain in his upper abdomen that radiated to his back may have been below accepted standards. The results of the patient's electrocardiogram were consistent with myocardial infarction. The patient was released home with a diagnosis of reflux; later the same day he was found dead.	Public letter of concern; MD must complete 10 hours of CME in interpretation of electrocardiograms.
SKOTNICKI, Robert Alan, DO (201200807) Harrisburg, PA	05/2/2012	DO incorrectly completed the section of the NC medical license application related to Malpractice Data.	Public letter of concern
THERIAULT, Josepth Herman, LP (100000066) Raleigh, Nc	5/10/2012	LP had a positive drug screen for cannabis.	Public letter of concern
VANHAASTEREN, Loretta, MD (009800409) Goldsboro, NC	07/09/2012	MD prescribed various medications, including controlled substances, to a patient who was also MD's landlord, close friend and business partner.	Public letter of concern
VOGELSANG, Glenn David, MD (200001324) McAlester, OK	06/19/2012	MD answered two questions incorrectly on his reinstatement application. MD failed to state that he had been the subject of a complaint to NCMB in 2007. MD failed to report that he was dismissed from the University of Cincinnati School of Medicine in 1993.	MD's NC license is reinstated, with a public letter of concern.
WELSH, Mark Allen, MD (000026406) Oxford, NC	05/29/2012	MD's staff, under MD's supervision failed to employ alternative methods for securing a patients airway when the airway was lost. Failure resulted in patient's death.	Public letter of concern
MISCELLANEOUS ACTIONS			
LOWERY, Kerry Layne, MD (200500514) Grover, NC	07/12/2012	MD had a romantic relationship with a former patient, who she later married, in conflict with the ethics of the medical profession and the professional ethics of psychiatry. MD has been assessed and treated by Acumen Assessments, which believes she is at low risk for committed additional boundary violations.	Reinstatement of NC license via consent order; MD shall not practice psychiatry; must obtain approval from the NCMB's Office of the Medical Director prior to entering practice; and complete a program of reentry.
SHANNON, William Bartholomew, MD (000025080) Gastonia, NC	06/11/2012	Hospital privilege actions related to MD's conduct at Gaston Memorial Hospital; MD left an operating room while preparing to perform cataract surgery on a patient without providing instructions to the nursing staff as to what to do with the patient. In two other cases, MD had paperwork indicating the wrong eye on which to be operated (MD noted the discrepancies in each case and performed the surgeries on the correct eye). MD implanted an incorrect powered lens in a patient after a hospital nurse mistakenly gave him the wrong lens.	Non-disciplinary consent order: MD agrees to keep license on inactive status. Must apply for re-activation if he wishes to resume practice.
SMITH, Bryan Dorsey, MD (200201531) Apex, NC	06/20/2012	History of alcohol dependence; MD is under contract with NCPHP. MD has not practiced clinical medicine since January 2010.	Reentry and remediation agreement; MD shall complete a period of reentry and remediation under mentorship.
CONSENT ORDERS AMENDED			
ACOSTA, Daniel, MD (200100499) Greenville, NC	07/18/2012	MD has completed certain stated requirements in the consent order dated 3/13/12.	Amendment to consent order dated 3/13/12; MD has completed medical recordkeeping and prescribing courses as required by the March order.

Name/license#/location	Date of action	Cause of action	Board action
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
CALDWELL, Chad Cameron, PA (000103163) Winston-Salem, NC	05/17/2012		PA issued full and unrestricted license
GUARINO, Clinton Toms, MD (009900062) Hickory, NC	06/19/2012	History of substance abuse and dependency; CPEP assessment identified opportunities for education and remediation.	MD is issued a temporary medical license; MD shall extend his NCPHP contract for two additional years; he shall maintain a treating physician relationship with a psychiatrist and have that psychiatrist report on MD's status to the Board twice yearly. Must comply with other conditions.
MCANALLEN, Terry Joseph, DO (200301013) Henderson, NV	05/17/2012		DO temporary medical license is extended to expire 5/31/2013
PARIKH, Himanshu Pravinchandra, MD (009600971) Cary, NC	05/1/2012	MD was issued a license with conditions following a denial hearing through an "order of licensure" dated September 13, 2011. MD met with members of the Board for an investigative interview. The Board agreed to eliminate a 40 hour work week restriction and endorses the return of MD's DEA registration with conditions.	MD is issued a temporary medical license to expire.Conditions on license
SCHEUTZOW, Mark Howard, MD (009700166) Asheboro, NC	05/8/2012	MD has not practiced as a physician since 2003. MD has a prior history of substance abuse of which he sought treatment for from December 17, 2008 to March 28, 2009.	Temporary medical license issued to expire 11/30/2012; MD shall complete a program of reentry
SMITH, Bryan Dorsey, MD (200201531) Apex, NC	06/20/2012	History of alcohol dependence; MD is under contract with NCPHP	MD is issued a temporary medical license to expire 1/31/13
YOUNG, Sarah Wistran, MD (200801889) West End, NC	07/20/2012	History of substance abuse; MD has successfully completed treatment and is under contract with NCPHP.	Temporary medical license extended; expires 1/31/13.
ZELLER, Kathleen Elizabeth, MD (200700068) Greensboro, NC	05/17/2012		MD issued full and unrestricted license
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			

FINES

The NCMB issues non-disciplinary administrative fines in certain cases where incorrect and/or incomplete information on a medical licensing application causes Board staff to spend an inordinate amount of time resolving the issue(s),

Date	Reason	Amount
05/22/2012	Omitted material information on license application in regards to malpractice lawsuits	$500
05/30/2012	Failed to provide accurate information on NC medical license application	$1,000
05/31/2012	Failed to provide accurate information on NC medical license application	$500
06/06/2012	Failed to timely renew NC medical license	$350
07/02/2012	Provided an incorrect response when completing NC medical license application	$500
07/17/2012	Provided an incorrect response when completing NC medical license application	$500
07/17/2012	Failed to timely responsd to NCMB inquiry	$2,000
07/18/2012	Provided an incorrect response when completing NC medical license application	$1,000

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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 14-16, 2012 (Full Board)
December 13-14, 2012 (Hearings)
January 16-18, 2013 (Full Board)
February 21-22, 2013 (Hearings)

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.

NCMB guide aims to assist with mandatory reporting requirements

Communicable diseases. Deaths. Deaths from communicable diseases. Blindness. Child abuse. Pesticide-related illness or injury.

It can be overwhelming, if not impossible, for physicians and other clinicians to keep track of the myriad events and circumstances that must be reported to certain state agencies or other groups when they arise in the course of practice. To help licensees comply, the NC Medical Board has compiled a comprehensive guide to mandatory reporting requirements. Thanks to Medical Mutual Insurance Co. for its assistance with research.

The guide lists all mandatory reporting requirements that apply to health care workers, including a description of the requirement and the corresponding statutory reference.

Access the guide online at *www.ncmedboard.org* Look for a notice highlighting the guide in the rotating "Featured Content" section on the Home Page.