



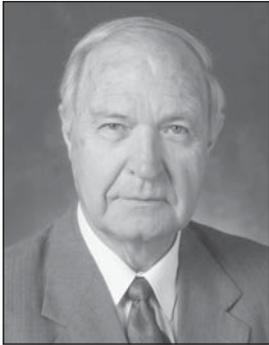
forum

N C M E D I C A L B O A R D

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President's Message

On Reentering the Practice of Medicine



Robert C. Moffatt, MD

On page three of this number of the *Forum* appears a new position statement proposed for the Board's consideration by its Policy Committee. The statement deals with the issue of reentry to clinical practice by those who have been out of such practice for two years or more. It is the result of extensive discussion among Board members, staff, and others arising from our experience with increasing numbers of physicians who have left clinical practice

and then find themselves wanting to return. It seems clear to the Board that the skills of those who have been away from clinical practice for several years may have been dulled a bit, even if they made a reasonable effort to keep up their CME. Generally, those wanting to return also recognize that fact.

The increase in those leaving active practice for various personal or professional reasons has become a significant issue for all state medical boards. A number of reasons are noted for this occurrence. Women often take this step to have children, and both men and women may do so because of other family responsibilities, to explore other opportunities, or to deal with personal issues.

An example would be the woman physician who stops her

practice of medicine for an extended period in order to start her family and, after a few years, wishes to resume her practice. During the ensuing years, her license has become inactive and she has not kept up with her continuing medical education requirements. There is also the very real possibility that she has lost some of her medical skills. Or consider the physician who decides to simply drop out for a time—possibly to see the world or pursue a dream, or the one who moves into purely administrative work, never seeing patients. The time may come when they wish to reenter practice, pick up where they left off. That's the issue the Board has been dealing with and the challenge it has been facing with greater frequency.

As a result, the Board established a Reentry Subcommittee to analyze the problem and propose a solution. Among its responsibilities was determining how long a physician could be out of active practice before some reentry requirement would be needed. It was also responsible for creating an acceptable and appropriate reentry program that would serve to best protect the public while meeting the needs of those physicians seeking to reactivate their licenses. After extended study, the position statement that appears on page three, "Competence and Reentry to the Active Practice of Medicine," was developed and, in turn, endorsed by the Board's Policy Committee. It will soon be considered for final adoption by the Board. I hope you will take time to read it, just as I hope you make an effort to read all the Board's position statements. You never know when one or another may affect you.

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Primum Non Nocere



forum

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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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NCMB Policy Committee Continues Review of Position Statements, Offers Results of Recent Review

The Policy Committee of the North Carolina Medical Board regularly reviews the Board's various position statements. The Board's licensees and others interested in the subjects dealt with by the statements are invited to offer comments on any statement in writing to the chair of the Policy Committee by e-mail (info@ncmedboard.org) or post (PO Box 20007, Raleigh, NC 27619). Comments will be collected over time and considered when the relevant statement is reviewed.

The Policy Committee discusses the position statements in public sessions during regularly scheduled meetings of the Board. The results of each review are published on the Board's Web site and in the *Forum* before consideration by the Board, allowing for further written comments to assist the Policy Committee in preparing the final version for Board action.

Action Taken on Five Position Statements

Over the past few months, recommendations of the Policy Committee resulting from the Committee's review of four position statements have moved forward and a new statement has been proposed.

1. The position statement titled "Prescribing Legend or Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties" will not be changed. It will be marked "Reviewed March 2006."
2. The following position statement was amended and formally approved by the Board. It now reads as follows.

SALE OF GOODS FROM PHYSICIAN OFFICES

Inherent in the in-office sale of products is a perceived conflict of interest. On this issue, it is the position of the North Carolina Medical Board that the following instructions should guide the conduct of physicians or licensees.

Sale of practice-related items such as ointments, creams and lotions by dermatologists, splints and appliances by orthopedists, spectacles by ophthalmologists, etc., may be acceptable only after the patient has been told those or similar items can be obtained locally from other sources. Any charge made should be reasonable.

Due to the potential for patient exploitation, the Medical Board opposes licensees participating in exclusive distributorships and/or personal branding, or persuading patients to become dealers or distributors of profitmaking goods or services.

Licensees should not sell any non-health-related goods from their offices or other treatment settings. (This does not preclude selling of such low-cost items on an occasional ba-

sis for the benefit of charitable or community organizations, provided the licensee receives no share of the proceeds and patients are not pressured to purchase.)

All decisions regarding sales of items by the physician or his/her staff from the physician's office or other place where health care services are provided must always be guided by what is in the patient's best interest.

(Adopted March 2001, Amended March 2006)

3. The following new position statement is being considered for final action by the Board.

COMPETENCE AND REENTRY TO THE ACTIVE PRACTICE OF MEDICINE

The ability to practice medicine results from a complex interaction of knowledge, physical skills, judgment, and character tempered by experience leading to competence. Maintenance of competence requires a commitment to lifelong learning and the continuous practice of medicine, in whatever field one has chosen. Absence from the active practice of medicine leads to the attenuation of the ability to practice competently.

It is the position of the North Carolina Medical Board, in accord with GS 90-6(a), that practitioners seeking licensure, or reactivation of a North Carolina medical license, who have had an interruption, for whatever reason, in the continuous practice of medicine greater than two (2) years must reestablish, to the Board's satisfaction, their competence to practice medicine safely.

Any such applicant must meet all the requirements and complete an application for a regular license. In addition, full-scale assessments, engagement in formal training programs, supervised practice arrangements, formal testing, or other proofs of competence may be required.

The Board will cooperate with appropriate entities in the development of programs and resources that can be used to fulfill the above requirements, including the issuance, when necessary and appropriate, of a time or location limited and/or restricted license (eg, residency training license).

It shall be the responsibility of the applicant to develop a reentry program subject to the approval of the Board.

4. The following position statements are proposed re-

visions of existing statements and are being considered in their new form for final action by the Board.

AVAILABILITY OF PHYSICIANS TO THEIR PATIENTS

It is the position of the North Carolina Medical Board that once a physician-patient relationship is created, it is the duty of the physician to provide care whenever it is needed or to assure that proper physician backup is available to take care of the patient during or outside normal office hours.

The physician must clearly communicate to the patient orally and provide instructions in writing for securing after-hours care if the physician is not generally available after hours or if the physician discontinues after-hours coverage.

REFERRAL FEES AND FEE SPLITTING

Payment by or to a physician solely for the referral of a patient is unethical. A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

It is unethical for physicians to offer financial incentives or other valuable considerations to patients in exchange for recruitment of other patients. Such incentives can distort the information that patients provide to potential patients, thus distorting the expectations of potential patients and compromising the trust that is the foundation of the patient-physician relationship.

Furthermore, referral fees are prohibited by state law pursuant to N.C. Gen. Stat. Section 90-401. Violation of this law may result in disciplinary action by the Board.

Except in instances permitted by law (NC Gen Stat §55B-14(c)), it is the position of the Board that a physician cannot share revenue on a percentage basis with a non-physician. To do so is fee splitting and is grounds for disciplinary action.

Commentary

Physician Prescribing Habits and the Epidemic of Opioid Addiction

David A. Ames, MD

Across the country, there has developed an epidemic of opioid addiction fueled by misuse of easily available prescribed opioid medication. North Carolina is no exception. One patient said his county of residence was "awash in Oxycontin®." Addiction treatment programs can attest to the growing number of young adults seeking help whose addiction began as recreational use of hydrocodone and oxycodone, drugs that are widely available at entertainment frequented by young people. *The National Drug Control Strategy* (2004) states: "The abuse by

high-school seniors of brand name Vicodin. . .has become a deadly youth fad, with one out of every ten high-school seniors reporting nonmedical use."¹

The National Center on Addiction and Substance Abuse, in its report *The Diversion and Abuse of Controlled Prescription Drugs in the US*, observed:

. . . in 2003, 2.3 million teens aged 12 to 17 (9.3 percent) reported abusing a controlled prescription drug in the past year; 83 percent of them reported abusing opioids. . . . Between 1992 and 2003, the percent of teens aged 12 to 17 who admit abusing controlled

prescription drugs increased 212 percent.²

The Task Force to Prevent Death from Unintentional Drug Overdoses reported in 2004:

North Carolina is experiencing an epidemic of poisoning deaths from unintentional drug overdoses. Since 1997 the number of deaths in North Carolina from unintentional drug overdoses has increased over 100% and continues to increase annually. However the number of unintentional deaths from illicit drugs (cocaine and heroin) has decreased over time. In contrast unintentional deaths from licit drugs (i.e. legal, and mostly prescription drugs) are increasing and are now responsible for over half of the unintentional poisonings. Over half of the prescription drugs associated with unintentional deaths are narcotics. . . and, of these, . . . deaths from Methadone have increased seven-fold since 1997.³

There are many ways that these drugs become available and physicians traditionally think of the major mechanism as being "doctor shopping," i.e. addicted individuals who deliberately deceive a number of physicians. However, addicts coming into treatment report otherwise: more often than not, their major source is patients being treated for bona fide pain conditions who sell part of their prescrip-

tion. The revenue generated this way is so great that many succumb. Thus, the physician's challenge is not primarily to identify the addict in his or her practice but rather to manage the prescription of opioids in such a way as to minimize opportunities for diversion. Beyond the individual physician practice, there is a need for policy change in the type of practice arrangements suited for treatment of chronic pain with long-term maintenance opioids.



Dr Ames

1. *National Drug Control Strategy Report*. The White House, March 2004. Washington, DC.

2. *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the US*. July 2005. The National Center on Addiction and Substance Abuse at Columbia University, New York.

3. Injury and Violence Prevention Branch, Division of Public Health, (2004). Executive Summary: *Findings and Recommendations of the Task Force to Prevent Deaths from Unintentional Drug Overdoses in North Carolina*. Department of Health and Human Services. Raleigh, NC.

Dr Ames is a psychiatrist in Greenville, NC.

"The physician's challenge is . . . to manage the prescription of opioids in such a way as to minimize opportunities for diversion"

Drs Jablonski and Loomis Appointed to NCMB, Drs McCulloch and Fretwell Reappointed

R. David Henderson, executive director of the North Carolina Medical Board, has announced that Governor Easley has appointed Donald E. Jablonski, DO, of Etowah, and Ralph C. Loomis, MD, of Asheville, to the North Carolina Medical Board. He also announced that the Governor has reappointed H. Arthur McCulloch, MD, of Charlotte, and E. K. Fretwell, PhD, of Charlotte, to the Board. Mr Henderson said: "The members and staff of the Board are pleased by these appointments and reappointments of such outstanding individuals. We look forward to working with Drs Jablonski and Loomis, and to the continued service of Drs McCulloch and Fretwell."

Donald E. Jablonski, DO, Etowah

A native of Michigan, Dr Jablonski took his undergraduate degree at the University of Windsor, Windsor, Ontario, Canada, with graduate study at Oakland University, Rochester, Michigan. He received his DO degree from the Chicago College of Osteopathic Medicine. He did his internship at Lakeview General Hospital in Battle Creek, Michigan, where he served as chief intern. He is certified by the American Osteopathic Board of Family Practice. In 1996-1997, he participated in the Academic Leadership Fellowship Program of the Ohio University College of Osteopathic Medicine.

Dr Jablonski is a member of numerous professional organizations, including the American Osteopathic Association, the American College of Osteopathic Family Physicians, the Association of Osteopathic Directors and Medical Educators, and the North Carolina Osteopathic Medical Association. He is a fellow of several professional groups.

He is licensed and has practiced in Florida and Ohio as well as North Carolina. Before coming to North



Dr Jablonski

Carolina, he was an associate professor of family medicine at the Ohio University College of Osteopathic Medicine. The list of his professional activities over the years contains over 50 citations. He is currently a member of the Mountain Area Health Education Center and a preceptor for Duke and North Carolina medical students. He is president of the

North Carolina Society of the American College of Osteopathic Family Physicians and has served as president of the North Carolina Osteopathic Medical Association. At the same time, he is very active in community affairs.

Among other awards, he has been given the Outstand-

ing Achievement Award of the Chicago College of Osteopathic Medicine and the Physician of the Year Award of the American College of Osteopathic Physicians.

He has published several articles on the management of diabetes.

Ralph C. Loomis, MD, Asheville



Dr Loomis

A native of Kentucky, Dr Ralph C. Loomis took his undergraduate degree, cum laude, at Vanderbilt University, and his MD degree from Indiana University, where he received the Senior Honors Program Award. He did his internship at Indiana and his residency in neurosurgery at the same institution, during which he received the Willis

Gatch General Surgery Award. He also took the Theodore Gildred Microsurgical Course and was co-author of an article in the *Annals of Surgery*.

Dr Loomis is certified by the American Board of Neurological Surgery and is a fellow of the American College of Surgeons. He is a member of the Congress of Neurological Surgery and the American Association of Neurological Surgery, an officer in the North Carolina Neurosurgical Society, and the North Carolina delegate to the national Council of State Neurosurgical Societies.

He practices at the Mountain Neurological Center in Asheville.

H. Arthur McCulloch, MD, Charlotte



Dr McCulloch

A native of Ohio, Dr H. Arthur McCulloch received a BA degree from Ohio State University and took his MD degree from the Medical College of Ohio. He did his internship at St Thomas Hospital Medical Center in Akron, Ohio, and his residency in anesthesiology at North Carolina Memorial Hospital.

Following his residency, he was a staff anesthesiologist at Wilford Hall USAF Medical Center. He is a diplomate of the American Board of Anesthesiology and is a clinical assistant professor of anesthesiology at the University of North Carolina. He practices with Southeast Anesthesiology Consultants, in Charlotte, and is vice chief of the Department of Anesthesiology at Carolinas Medical Center.

Dr McCulloch is an active member of the North Carolina Medical Society and, among other things, has served on its MedPAC Board and its Task Force on Office-Based Surgery. He is also a member of the North Carolina Society of Anesthesiologists, serving on that organization's Executive Committee and as its presi-

dent. He is a member of the House of Delegates of the American Society of Anesthesiologists. He was first appointed to the Board in 2002 and has served as the Board's treasurer, secretary, and president elect. He has served on several Board committees and is chair of its Policy Committee.

Dr McCulloch is co-author of three journal articles.

E. K. Fretwell, PhD, Charlotte



Dr Fretwell

Dr Fretwell is the chancellor emeritus of the University of North Carolina at Charlotte. Born in New York City, he took his BA at Wesleyan University (CT), his Master's at Harvard University, and his PhD at Columbia University. His long and distinguished career in higher education has included serving as an associate professor and assistant to

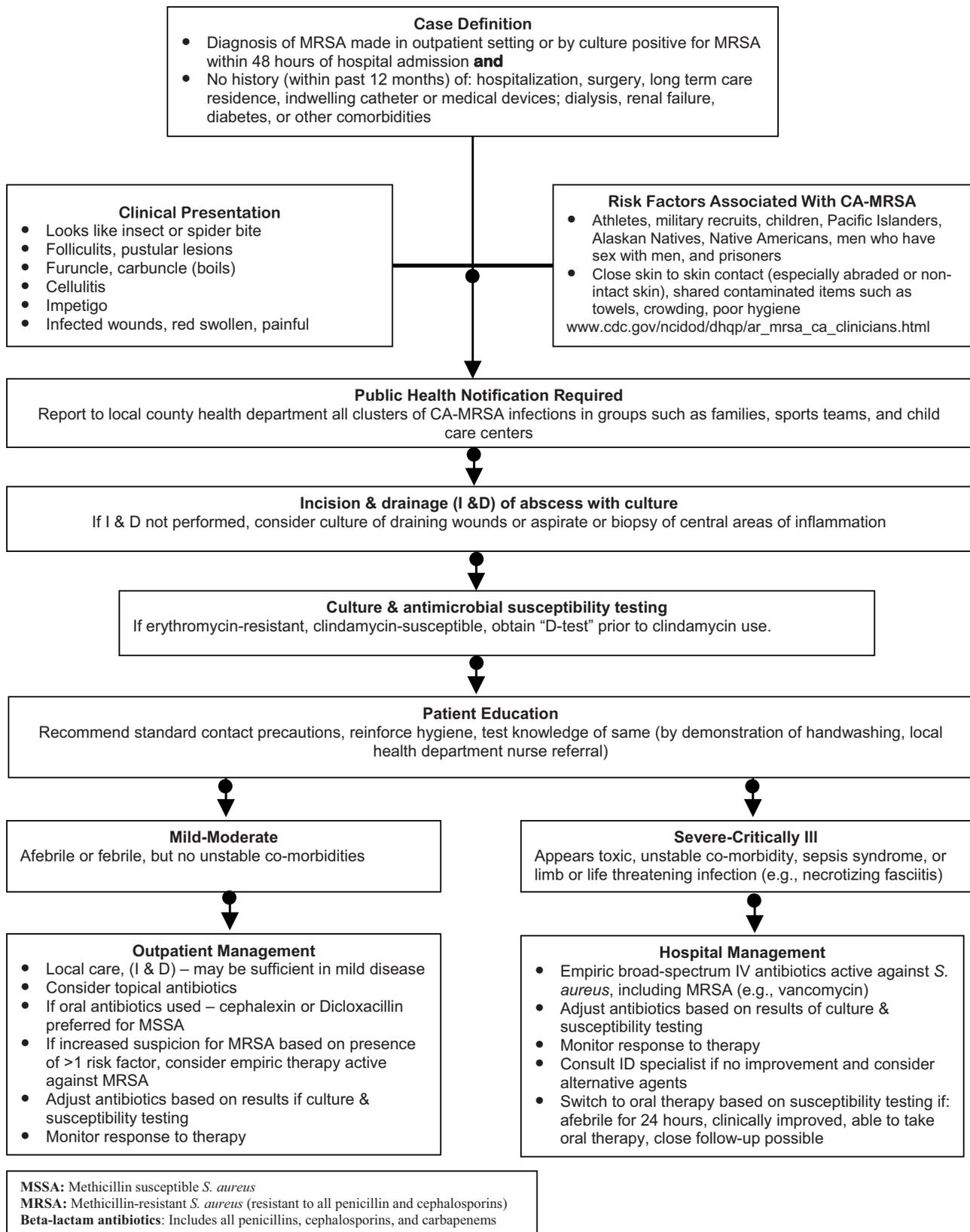
the Dean of Columbia's Teachers College; assistant commissioner for higher education in New York; university dean for academic development at the City University of New York; president of the State University of New York College at Buffalo; chancellor of the University of North Carolina at Charlotte; senior associate of MDC, Inc, of Chapel Hill; interim president of the University of Massachusetts five-campus system; and interim president of the University of North Florida.

Among Dr Fretwell's many honors have been honorary doctorates from the Technical University of Wroclaw, Poland, Wesleyan University, and UNC at Charlotte. In 1998, he was presented the Hugh McEniry Award for outstanding service to North Carolina Higher Education. Over the years, he has served on or chaired a wide range of special committees and boards at the local, state, and national level. He was chair of the North Carolina Education Standards and Accountability Commission from 1993 to 1997 and a member of the North Carolina Medical Society's Bioethics Subcommittee on Managed Care in 1999. He is a member of the Charlotte Symphony Orchestra Board of Directors and has been a trustee of Peace College, Raleigh, and the North Carolina Transportation Museum Foundation. He was president of the Charlotte Rotary Club in 1994-1995. In 1990-1992, he worked with the Federation of State Medical Boards of the United States on that group's special task force on assessing the work of state medical boards. In his first term on the Board, Dr Fretwell served on its Licensing, Investigative, Research, and Allied Health Committees.

He has written several books and articles on higher education, including *Wise Moves in Hard Times: Creating and Managing Resilient Colleges and Universities* (David Leslie, senior author), in 1996; and *System Heads, Boards, and State Officials: More Than Management*, in 2000.

[Guideline provided by Eva P. Clontz, MEd, Program Coordinator, Statewide Program for Infection Control and Epidemiology, UNC School of Medicine.]

NC Consensus Guideline for Management of Suspected Community-Acquired Staphylococcus aureus (CA-MRSA) Skin and Soft Tissue Infections (SSTIs)



North Carolina Guideline for Empiric Oral Antimicrobial Treatment of Outpatients with Suspected CA-MRSA Skin and Soft Tissue Infections (SSTI)

Selection of empiric therapy should be guided by local <i>S. aureus</i> susceptibility and modified based on results of culture and susceptibility testing. The duration of therapy for most SSTI is 7-10 days, but may vary depending on severity of infection and clinical response. NOTE: Before treating, clinicians should consult complete drug prescribing information in the manufacturer's package insert or the PDR.		
Antimicrobial	Adult Dose	Pediatric Dose
Trimethoprim-sulfamethoxazole (TMP-SMX) DS	2 DS tablets (160 mg TMP/800 mg SMX) PO bid	Base dose on TMP: 8-12 mg TMP (& 40-60 mg SMX) per kg/day in 2 doses; not to exceed adult dose
Minocycline or doxycycline	100 mg PO bid	Not recommended for pediatric use - suggest consultation with infectious disease specialist before use.
Clindamycin	300-450 mg PO qid	10-20 mg/kg/day in 3-4 doses; not to exceed adult dose
<p>If considering clindamycin, isolates resistant to erythromycin and sensitive to clindamycin should be evaluated for inducible clindamycin resistance (MLS_B phenotype) using the "D test." Consult with your reference laboratory to determine if "D testing" is routine or must be specifically requested. If inducible resistance is present, an alternative agent to clindamycin should be chosen.</p> <ul style="list-style-type: none"> If Group A streptococcal infection is suspected, oral therapy should include an agent active against this organism (β-lactam, macrolide, clindamycin). Tetracyclines and trimethoprim-sulfamethoxazole, although active against many MRSA, are NOT RECOMMENDED treatments for suspected GAS infections. Outpatient use of quinolones or macrolides: Fluoroquinolones, (e.g., ciprofloxacin, levofloxacin, moxifloxacin, gatifloxacin) and macrolides (e.g., erythromycin, clarithromycin, azithromycin, and telithromycin) are NOT RECOMMENDED for treatment of MRSA because of high resistance rates). If fluoroquinolones are being considered, consult with infectious disease specialist before use. Outpatient use of linezolid in SSTI Linezolid is costly and has great potential for inappropriate use, inducing antimicrobial resistance, and toxicity. Although it is 100% bioavailable and effective in SSTI, it is not recommended for empiric treatment or routine use because of these concerns. It is strongly recommended that linezolid only be used after consultation with an infectious disease specialist to determine if alternative antimicrobials would be more appropriate. Topical mupirocin may be used tid for 7-10 days with or without systemic antimicrobial therapy. 		
Rifampin*	300 mg PO bid x 5 days*	10-12 mg/kg/day in 2 doses not to exceed 600 mg/d x 5 days*
<p>*Rifampin may be used in combination with TMP-SMX, OR rifampin with doxycycline, OR rifampin with minocycline, for recurrent MRSA infection despite appropriate therapy. Never use rifampin monotherapy, due to the rapid emergence of resistance. Rifampin interacts with methadone, oral hypoglycemics, hormonal contraceptives, anticoagulants, protease inhibitors, phenytoin, theophylline, cardiac glycosides and other drugs.</p>		

Skin antiseptics with chlorhexidine or other agents may be used in addition any of the above regimens.

Eradication of CA-MRSA Colonization

Efficacy of decolonization in preventing re-infection or transmission in the outpatient setting is not documented, and is NOT routinely recommended. Consultation with an infectious disease specialist is recommended before eradication of colonization is initiated.

This algorithm is available online at <http://www.unc.edu/depts/spice/CA-MRSA.html>

More information is available online at http://www.epi.state.nc.us/epi/gcdc/ca_mrsa/ca_mrsa.html

Modified from "Interim Guidelines for Management of Suspected *Staphylococcus aureus* Skin and Soft Tissue Infections" from Infectious Diseases Society of Washington, Tacoma/Pierce County Health Department, Public Health-Seattle and King County, and Washington State Department of Health, September 2004.

Developed by NC Statewide Program for Infection Control and Epidemiology (SPICE) in conjunction with the Public Health and Institutional Task Force for Best Practices, North Carolina, December 2005.



What Are You Doing About Health Care Quality in Your Practice?

Part I

Marjorie A. Satinsky, MA, MBA
President, Satinsky Consulting, LLC



Ms Satinsky

“Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge”

In May 2005, Paul Miles, MD, vice president and director of Quality Improvement of the American Board of Pediatrics, addressed the annual meeting of the Alice Aycock Poe Center for Health Education (Miles, 2005). Dr Miles talked about six core competencies for physicians in the 21st century: provision of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and system-based practice. He contrasted these core competencies with the traditional idea of: “I’m a physician; trust me.” Dr Miles suggested that every practicing physician ask him or herself two important questions: (1) How do I know that what I’m doing works? and (2) How can I improve what I do? He was talking about the quality of health care and the imperative of each and every physician to improve it. Physicians in the future must be able to respond to their patients and society saying: “Yes, we trust you, but show us the data” (Brennan, 2002).

Focusing on Improving the Quality of Care

From my perspective as a practice management consultant, physicians frequently express concerns to me about inadequate reimbursement, problems with cash flow and human resources, compliance issues, marketing, and making good investments in new information technology to support their practices. However, they rarely mention how they are measuring the quality of health care they are providing or how they are planning to improve it.

My personal observations about physician concern for the quality of health care and quality improvement were confirmed by the recently reported findings of a 2003 Commonwealth Fund Survey of Quality of Care covering more than 1,800 physicians (Audet, et al, 2005). The study’s authors found that physicians’ adoption of measures, tools, and quality is moving slowly and is not where it should be to achieve a high performance. One of the major obstacles to making quality improvement routine was lack of information about their own practices. The study also noted that physicians are not comfortable sharing physician-specific performance data with the general public, with their own patients, or with medical leadership. Finally, the study noted that practice size affects the likelihood that physicians receive

and use data on quality of care. Those in practices with 50 or more physicians were more likely to be involved in quality improvement activities than those in smaller practices.

Physicians need to become more proactive in measuring and improving the quality of care they are providing. Not only will they improve patient care, but they will be more capable of responding to payer/purchaser incentive programs. Quality and quality improvement (QI) in health care are complex subjects. My goal in this article is to raise your awareness. I hope that my comments will be informative and provocative so that when you finish reading you will want to learn more and do more in the setting where you provide care. I’ll begin with definitions of quality and quality improvement. I’ll describe some of the quality and quality improvement initiatives that already exist and with which you may already be familiar. I’ll talk about the importance of measurement for comparing the current status with post-improvement status. Most important, I’ll offer guidance to those of you who want to make quality of care and quality improvement a priority for your practices.

There are seven appendices at the end of Part II of this article: glossary of terms related to quality (Appendix 1); national and state public and private agencies, organizations, and associations that are focusing on health care quality and improvement (Appendices 2 and 3 respectively); recommended books and articles (Appendix 4); continuing education on quality and quality improvement (Appendix 5); on-line information related to the promotion of quality in health care (Appendix 6); and Programs in the Centers for Medicare & Medicaid Services (CMS) Physician Focused Quality Initiative (Appendix 7). Part II will appear in the next number of the *Forum*.

What Are Quality and Quality Improvement in Health Care?

The Institute of Medicine (IOM) defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Lohr, 1990). The IOM’s important 1991 report, *Crossing the Quality Chasm. A New Health System for the 21st Century* (Institute of Medicine, 2001), extends this concept a step further and comments: “Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge.” Quality is the difference between the care that is given now and the care that could be delivered, given what we already know. As the IOM report docu-

ments thoroughly, Americans don't have that guarantee, and the difference between what exists now and the ideal is a chasm, not merely a gap.

The quality chasm in health care isn't large because health care professionals don't know enough or try hard enough. We all know the problem with health care financing mechanisms in the United States – they pay for services, not quality of care. But misaligned financial incentives aren't the primary problem. Outmoded systems of work are the major barrier that prevents all Americans from receiving state-of-the-art health care. In laying out an agenda to address this system malfunction, the IOM calls for health care that is safe, effective, patient-centered, timely, efficient, and equitable.

The evaluation of quality of care should focus on structure, process, and outcomes (Donabedian, 1980). Structural quality refers to the health system capabilities of both large integrated and small systems. Process quality looks at clinician/patient interactions. Outcomes evaluation refers to changes in health status. Although it is possible to measure quality of structure, process, and outcome, most quality of care information is about appropriateness and professional standards (Institute of Medicine, 2001).

Just where does quality improvement fit in? Quality improvement is the method by which we close the gap between the current state(s) and the desirable state(s), using measurement before, during, and after to track changes and results. Improvement science is a formal body of knowledge that applies the scientific method to improving complex systems. The principles of improvement science involve: (1) understanding healthcare as a system, (2) using a balanced set of process and outcome measures tracked over time to determine if change results in improvement, (3) using an explicit evidence base to determine which changes should be implemented and tested, (4) focusing on multidisciplinary teams to make change, and (5) avoiding a focus only on poor performers (Speroff and O'Connor, 2004).

The IOM recommends six steps for bringing both the American health care system as a whole and its many components toward a place that will give every individual the care that he or she now lacks. Here is the list of recommendations and my related questions that can help you relate their application to your own practice setting.

1. **Redesign processes of care to more effectively meet the needs of the chronically ill.** Whatever your specialty, you take care of both individuals and groups of patients with chronic conditions. These patients consume more time and resources than your other patients, so you want to be sure that you, your care team, and your patients themselves are managing their care as efficiently as possible. Can you identify patients with chronic conditions? Does your practice have special protocols for providing care and for educating these patients and their families?
2. **Make efficient use of information technology to automate clinical information and make access to that information easier for both patients and the care team.** If you routinely collect demographic information about your patients and document the care that you provide, you have a head start in addressing quality of care. The important question is, how well can you access the information that you have and use it along with information that is available from other sources to help you provide quality care? Do you spend a lot of time looking for medical records that are piled on someone's desk? Do you have a Web site, and if the answer is yes, do you use it interactively to allow patients to communicate with your practice? If you have already purchased electronic health records (EHR) or are thinking about introducing this application into your practice, are you focusing on ways in which the technology can help you better meet the needs of your patients and your care team or are you fretting about the price? Do interfaces between your practice management system, your Web site, and your EHR allow you to access information from all three sources when you need it? Are you aware of the National Voluntary Consensus Standards for Ambulatory Care that have been endorsed by the National Quality Forum? Can you readily measure the quality of the care that you and your practice deliver for both individual patients and for your practice as a whole?
3. **Manage your own and your workforce's knowledge base and skills.** Your medical school and subsequent training gave you a good knowledge base, but it didn't teach you enough to sustain you for the rest of your medical career. The base of knowledge continuously expands, so even the smartest physician can benefit from the availability of new information on diagnoses and treatment. In the future, maintaining board certification and state licensure will require a commitment to lifelong learning and periodic self-assessment. The same high level of competency holds true for your clinical and administrative staff. Can each one of you access information on new findings, new treatments, new medications, new administrative requirements, new administrative solutions, and, most importantly, on your patients themselves?
4. **Coordination of care across patient conditions, services, settings, and time?** If you are a primary care physician or medical specialist, the office visit is the way in which you interact most frequently with patients. If you are a surgeon, your main interaction with your patients may be in a hospital or ambulatory surgery center setting, with briefer interactions in your office. Are you able to coordinate care for your patients across settings, regardless of the time of day or night that the patients or your medical colleagues contact you? Problems with handoffs and the management of transitions from one provider to another are major sources of medical error.
5. **Enhancing the effectiveness of teams.** Although the physician/patient interaction is of the utmost importance, your patients interact with other people in your office and/or at the hospital. Do all those who interact with patients work as a team, or do they work as individuals with little coordination of efforts? Communication skills are critical, and there is a growing awareness of the need to understand cultural, language, and literacy issues in relating to patients.
6. **Improving performance by incorporating care pro-**

“Quality improvement is the method by which we close the gap between the current state(s) and the desirable state(s)”

cesses and outcomes measurement into your daily work. You need to work smarter, not harder and longer. If you are part of a large health care system or belong to an IPA or physician association, process redesign may already be part of a larger organizational agenda into which your practice fits. Do you understand, analyze, and improve the processes that affect patient care? Do you measure the impact of what you do, set goals, and take steps to improve? Does your practice have an ongoing plan to systematically improve care?

Appendix 1 contains a glossary of terms that are commonly used in talking about quality and quality improvement.

Examples of Health Care Quality and Quality Improvement Programs

Quality of health care and quality improvement are not new subjects. You may be familiar with and/or participate in some of the programs that already exist. Many of the current initiatives are external to medical practices and feature financial incentives for quality improvement. Although each initiative that I describe here has contributed in some way toward better understanding of quality problems and ways to address them, many of the externally-driven programs don't affect your structure and processes for delivering care. Only you can do that.

My list of quality and quality improvement initiatives is by no means exhaustive. It includes: disease management, centers of excellence, evidence-based medicine, practice guidelines, National Committee for Quality Assurance (NCQA) HEDIS standards, Bridges to Excellence, the Leapfrog Group, and Pay-for-Performance.

Disease management: a systematic and comprehensive approach to improving the management of a condition (Institute of Medicine 2001). The goal is to coordinate care and control costs by integrating components across the entire delivery system and by applying tools that are appropriate for the target population. One limitation of most disease management programs is that they focus on cost reduction and target the most severely ill patients. Patients do not always have a say in whether or not they can participate. Another shortcoming with disease management is that the primary care physician is sometimes excluded from the process unless his/her involvement is deliberately made part of the program. Although most disease management programs are not usually categorized as quality or quality improvement programs, there have been some successful efforts to improve the quality of care for chronic diseases using the Wagner Chronic Care Model and quality improvement (<http://www.aamc.org/newsroom/pressrel/2005/050428.htm>).

Centers of excellence: the underlying premise is that there is a high correlation between volume and positive outcomes. Both the Centers for Medicare and Medicaid Services and many of the managed care plans have established standards for centers of excellence. These centers receive a single bundled fee for all services related to specific complex procedures. As with disease management, the major focus is on cost reduction, and patients do not always have input on whether or not they will seek care from a center of excellence. Again, these programs are not usually labeled as quality or QI programs,

although some of them have achieved good results.

Evidence-based medicine (EBM): the concept of using research evidence to make decisions about the care of individual patients has existed since the 1950s and 1960s. Since that time, the standards for evidence have become more rigorous, and the tools for assembling evidence have become more powerful and widely available (Davidoff, 1999). Historically, one concern in using evidence-based medicine to improve the quality of care has been practicality. When information is widely scattered, busy independent physicians who are not researchers are unlikely to take the time to frame a research question, review available evidence, and select the best evidence as a guide in patient care. In order to address this issue, both the United Kingdom and the United States have made progress in synthesizing available evidence. The Cochrane Collaboration in England and the Agency for Healthcare Research and Quality's Evidence-Based Practice Centers (including Duke Medical Center in North Carolina) have facilitated the organization of evidence-based medicine so that the results are easier to use. Another concern with EBM is that for a large part of medical care, there is not yet solid evidence.

Practice guidelines: the IOM defines clinical practice guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances (Institute of Medicine, 1992). The guidelines take the evidence and move a step ahead; they build conclusions or recommendations about appropriate and necessary care for specific types of patients (Lohr et al, 1998). A problem with guidelines is that they are based on evidence. When there is variability in the reliability of evidence, there is variability in the guidelines. A partnership of the Agency for Healthcare Research and Quality, the American Medical Association, and the American Association of Health Plans has created a National Guideline Clearinghouse that offers on-line access to a large and growing resource. But guidelines alone don't produce quality, particularly if there is no opportunity for physician judgment and patient feedback in their application. The real issue is that physicians do not know how to improve in a systematic and measurable way. Dissemination of evidence-based guidelines alone has not significantly changed practice performance.

National Committee for Quality Assurance (NCQA): this organization sets standards for health plans and makes available comparative quality data. Its Health Plan Employer Data and Information Set (HEDIS) indicators focus primarily on the occurrence of desired or undesired events in specific population groups. Some HEDIS measures, such as rates of childhood immunization and mammography, deal with illness prevention. Other measures, such as the percentage of diabetics who have had an annual eye exam, focus on caring for people who have been diagnosed with a chronic illness. Similar to practice guidelines, quality measures or indicators alone do not have a major impact unless physicians know how to improve in a systematic and measurable way.

The Leapfrog Group (www.leapfroggroup.org/): this purchasing group was established in 2000 in order to drive "leaps" in quality and safety in hospitals by leveraging performance transparency at the provider level, consumer incentives, and provider rewards (Galvin, 2004). The Group includes 150 public and private purchasers and represents more than 34 million lives. Hospital participation is voluntary, and almost half of the 3,000 eligible institutions have chosen to be included. Leapfrog sponsors 15 initiatives throughout the country, and its Web site contains the results. In a recent editorial,

"Historically, one concern in using evidence-based medicine to improve the quality of care has been practicality"

Dr Robert S. Galvin, director of Global Health for General Electric and one of the founders of the Leapfrog Group, acknowledged that the initiative has not had the desired effect of significantly improving hospital safety (Galvin, Delbanco, Milstein, and Belden, 2005).

Pay-for-Performance (P4P): pay-for-performance programs offer financial incentives to physicians for achieving specific, measurable patient safety, quality, satisfaction, or efficiency objectives. These programs generally base a portion of physician payment on quantitative measures that may include patient care process measures, outcomes measures, or patient satisfaction scores (MGMA, 2005). Although pay-for-performance programs are relatively new, the programs in California and in Boston have already paid out financial rewards to physicians. Both the Medical Group Management Association (MGMA) and the American Medical Association (AMA) have developed specific standards to be met by any such programs (MGMA 2005 and AMA 2005). In July 2005, Senator Chuck Grassley (R-Iowa) introduced the Medicare Value Purchasing Act of 2005 (S. 1356) into the U.S. Senate. The bill would give the Secretary of DHHS broad statutory authority to develop and implement Medicare P4P programs.

Bridges to Excellence (BTE) (www.bridgestoexcellence.org/): spearheaded by General Electric and six other large employers, and physician leaders, Bridges to Excellence (BTE) is a pay-for-performance program that rewards physicians for delivering high quality care to patients with diabetes (Diabetes Care Link), and coronary disease (Cardiac Care Link). There is also a financial reward for the use of office-based EMR (Physician Office Link). In the diabetes and cardiac care programs, both of which are administered by the National Committee on Quality Assurance (NCQA), physicians can receive certification by meeting process and outcome goals developed by the American Diabetes Association and the American Heart Association. Because BTE uses process and outcome measures, it avoids the problem of small sample size that can penalize practices. The number of patients required for certification in each of these three programs is 35. Right now, a major shortcoming of BTE is that it is available only to physicians who provide care to the patients of participating employers. BTE is considering licensing the product so that large health plans can use it (Galvin, et al, 2005).

Importance of Measurement in the Quality of Medicine

If measurement is the key to understanding your current status and the improvements that you make, what do you measure? The Centers for Medicare & Medicaid Services (CMS) has been working with the American Medical Association's Physician Consortium for Performance Improvement and the National Committee for Quality Assurance to measure the improvement of care for such clinical conditions as coronary artery disease and heart failure, diabetes, high blood pressure, osteoarthritis, asthma, behavioral health, prenatal care, and preventive care. In January 2005, the Performance Measurement Workgroup proposed a starter set of measures based on their ability to meet five criteria: (1) clinical importance and scientific validity, (2) feasibility, (3) relevance to physician performance, (4) consumer relevance, and (5) purchaser relevance.

After an expedited review process, the National

Quality Forum endorsed National Voluntary Consensus Standards for Ambulatory Care. These standards represent the consensus of more than 260 health care providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality improvement organizations. They are a standardized set of measures for gauging and publicly reporting the quality of ambulatory care. Go to the Web site www.qualityforum.org for the approved measures.

Public and Private Initiatives in Quality of Care and Quality Improvement

The quality of health care as a national concern and priority is fairly recent. Following the occurrence and publicity around numerous errors and devastating consequences, the IOM published its 1999 report, *To Err is Human: Building a Safer Health System* (Institute of Medicine, 2000). That report was a wake-up call to the entire health care industry, and quality of care and quality improvement are now both high priorities at the national and state levels. Appendices 2 and 3 list many national and state public and private agencies, organizations, and associations that are concerned with both quality and quality improvement in health care.

Suggestions for Moving Ahead

Quality is a huge topic, and it is tempting to set it aside for another day. My advice is to learn more about national and state quality improvement initiatives. Use your research to gain a broad perspective so you can designate someone within your practice to organize your efforts, but remember that quality is everyone's responsibility. Then objectively assess your current situation, organize your findings, and decide what actions to take. Last but not least, document your quality efforts.

In my opinion, it is essential to distinguish quality improvement efforts that originate within your practice from activities that you undertake in order to satisfy external standards. Both are important. Standards that are imposed by outside agencies and organizations are likely to impact your bottom line more than the way in which you deliver patient care. But if you only strive to meet standards set outside your practice without critically examining the way in which you deliver care, you won't change the structures and processes that affect your clinical results.

Learn More About Quality and Quality Improvement

So much information on quality and quality improvement is available that the challenge is in knowing where to start. I recommend reading the IOM's *Crossing the Quality Chasm* (Institute of Medicine, 2001). Although the book is long and detailed, it will give you an excellent framework, providing insights into what is wrong and how to fix it. The observations and recommendations are well documented, and you'll have the confidence of knowing that the material comes from a

"It is essential to distinguish quality improvement efforts that originate within your practice from activities that you undertake in order to satisfy external standards"

reliable source.

Other good places to begin your quality journey are the Dartmouth Microsystems Web site (www.clinical-microsystem.org) and *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, by Langley, et al (Langley, et al, 1996). I also recommend the American Health Quality Association Web site (www.ahqa.org) for both information and links to other organizations and projects. AHQA's bimonthly Quality Update summarizes the many quality activities and events going on throughout the country, and its Web site has good information on patient safety. The Institute for Healthcare Improvement Web site (www.ihp.org) also has excellent information.

Quality and quality improvement are becoming an important component of the training, continuing education, and credentialing for health care professionals. Both the American Board of Medical Specialties and state licensing boards require physicians to become competent in quality improvement and be able to demonstrate with data that they can measure and improve the quality of care. Look at the American Board of Internal Medicine's new charter on professionalism (www.abim.org) to see how that organization describes the quality imperative. The American Academy of Pediatrics (www.aap.org), the American Academy of Family Physicians (www.aafp.org), and the American College of Physicians (www.acponline.org) have been extremely proactive about quality, and their respective Web sites contain information that you might want to use in your practice. For example, the American Academy of Pediatrics EQIPP tool offers physicians assistance in managing patients with ADHD, asthma, and other conditions. The American Academy of Family Physicians Quality Initiative includes criteria for performance measures and a practice enhancement program.

The American College of Surgeons (www.facs.org) offers four programs directed toward quality improvement. These are the National Surgical Quality Improvement Program (ACS NSQIP) and accreditation of bariatric surgery, trauma, and cancer centers (Petty, 2005).

If you would like to participate in training or continuing education that focuses on quality and quality improvement, I recommend the programs offered by the American College of Physician Executives (www.acpe.org) and by the Institute for Health Care Improvement (www.ihp.org). Both of these organizations have trained thousands of physicians, and their curricula are a good combination of theory and practice. Your own specialty society may also offer training.

Many of the organizations and associations that I have listed in this article hold regular meetings for which you can get CME credit. I highly recommend attending a meeting that is not limited to your specialty. You'll gain broad exposure to quality efforts throughout the country and/or state and have the opportunity to network with a wide variety of colleagues. For example, here in North Carolina the Quality Council of North Carolina

holds an annual spring symposium that brings together health care professionals in medicine, nursing, research, management, and administration. The Carolinas Center for Medical Excellence (formerly Medical Review of North Carolina), our state's Quality Improvement Organization (QIO), sponsors the annual Ralph E. Snyder Conference each fall. The North Carolina Healthcare and Communications Alliance, Inc, (NCHICA) annual meeting is in the fall.

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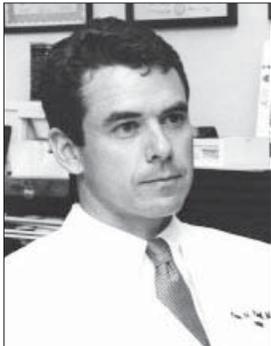
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Lessons of Katrina

Personal Experience with SMAT Team II, Waveland, Mississippi, September 2-10, 2005

Peter N. Purcell, MD



Dr Purcell

The following is an account of my experience "on the ground" in the Katrina disaster area, and how a similar storm may affect us, the local medical community.

On September 11, 2005, I returned from a nine-day deployment to Waveland, Mississippi, as a trauma surgeon with SMAT-II, the North Carolina State Medical Assistance Team. SMAT was originally created as a medical unit to deal with disasters occurring in North Carolina, but due to the unprecedented magnitude of the Katrina disaster, the governor of Mississippi asked Governor Easley for emergency medical assistance and SMAT was activated. Following are my impressions of the unit, our mission, and the relief effort as I experienced it. I should emphasize that these impressions are mine and not necessarily anybody else's from SMAT, FEMA, or any other organization. I did not function as any type of administrator—just as a "foot soldier"—a doctor on the ground delivering medical care. My impressions were formed from my experiences during this time and may not represent other parts of the relief effort.

SMAT

SMAT consists of approximately 200 medical per-

sonnel, including 10 physicians (four emergency physicians, three trauma surgeons, one orthoped, and two anesthesiologists). Equipment to set up a 122-bed, totally self-contained hospital (two operating rooms, four ICU beds, eight step-down beds, and 110 ward beds) is included with SMAT and was deployed on this mission. I'm proud to say that on this initial deployment three of the 10 physicians were members of the medical staff of New Hanover Health Network—Dr John Tseng from the ED, Dr Mike Hahn from anesthesiology, and myself from surgery.

We left Wilmington at 0500 Friday morning, joined with the other SMAT teams from around the state in Charlotte, and left Charlotte Friday night in a convoy of 30 vehicles and many tons of medical equipment. After almost 48 hours of travel (with delays caused by fuel shortages, vehicle breakdowns, and administrative delays from Washington) we arrived at our location, the parking lot of a destroyed shopping center.

We spent the next 10 hours preparing the site and setting up the hospital. As there was absolutely no remaining infrastructure left in the area (power, water, food, many roads, and most homes simply gone) we operated as a completely self-contained unit. We cleared our new home of glass and other debris (vital to prevent injuries from helicopter landings) and set up a large facility consisting of an OR/ICU/step-down unit, patient tents, triage tent, acute care tent, pharmacy, decontamination unit, command and control unit, helipad, and many storage units for equipment. All power came from gen-

"I did not function as any type of administrator—just as a foot soldier"

erators; all water was bottled or prepared. Unfortunately, because of the urgency of the mission, we had no sleeping quarters or meal preparation facility, so sleeping was on the ground or in vehicles and meals were mostly MRE's. One thing I did not expect was the noise: generators were everywhere, and hundreds of helicopters flew overhead day and night.

Security was provided by a six-member SWAT Team, with reinforcements from local and regional law-enforcement. Patrols were 24/7 and armed with automatic weapons. As you can imagine, a hospital in a devastated area is an attractive target for the desperate, because it has large quantities of water, gasoline, and morphine.

During our first five days in operation, we treated almost 1,200 patients. Presenting problems ranged from prescription refills to infectious diseases, unknown rashes, lacerations, puncture wounds, MP's, abscesses, pneumonias, major trauma, and more. Most patients were treated and released. Many patients who required major procedures and/or resuscitation were treated and stabilized, then aeromedically evacuated to tertiary centers in the northern parts of the surrounding states.



The Triage Unit where Katrina patients received initial care. Patients with simpler ambulatory problems were treated and released in Triage.

Waveland

Conditions in Waveland and surrounding Gulfport and Biloxi are difficult to describe. Having been through several hurricanes here in Wilmington, up to Category 3, I assumed I knew pretty well what hurricanes did, but I was wrong. The best I can describe the area is that it reminded me of those movies we saw in grade school of explosions of nuclear bombs and the fake "towns" getting blown away by the blast. The difference in this storm and what I've seen here in the Wilmington area is that many of the buildings—houses, stores, shopping centers, large concrete structures—were simply gone. In some cases, debris was present but often there was nothing left but the foundation—the buildings and everything left inside were gone—presumably blown many miles inland or washed inland and then out to sea by the storm surge. Our hospital was about two miles inland and the storm surge there was at least six feet, as shown by the thick layer of mud coating the rooms of the buildings left standing.

Because most buildings were uninhabitable, people were living in tents, vehicles, or simply in the open. Hygiene was basically nonexistent; everyone quickly became covered in filth. Some people had vehicles but

gasoline was rationed; most people were traveling on foot. A curfew was strictly enforced. Many bodies had not been recovered—we found seven in the shopping center during my stay. Alligators were plentiful and were feeding on the dead, so obviously many people will not be recovered.

Gulf Coast versus New Orleans

We did not get much news on the ground, but on returning I was surprised by the media attention that New Orleans had received. While the flooding there was devastating, it should be remembered that the devastating eastern part of the storm struck the coast from east of New Orleans to Mobile, resulting in Category 4 wind damage and a horrifying storm surge to a heavily-populated, vulnerable coastal region that geographically resembles the Cape Fear coast. While media coverage made it appear that the damage was concentrated in New Orleans, most of the devastation there was due to the flooding that occurred after the storm. The Gulf Coast from east of New Orleans to the Florida Panhandle, however, was devastated by the wind and the storm surge; and two weeks after the storm many of the residents were still dying from lack of food, water, housing, and medicine. Restoration of power and water was simply a distant dream. I don't know if the media coverage of the New Orleans story caused diversion of help from the Gulf Coast to the city, but I can't help but wonder if this huge media blitz of the New Orleans flood hurt residents of the coastal area.

Coordination Among Government Agencies

In essence, there appeared to be no coordination among government agencies. When I was deployed, I supposed there was a central "war room" in Washington coordinating the deployment of relief forces. I quickly decided this was not the case. From my point of view, we were on our own. Resupplies came from local scrounging and donations from home hospitals. There were several medical facilities in the area—DMAT, EMEDS, FL-1, and a mobile dialysis unit from Missouri, but we only learned about them when members of these units drove by and saw our sign and came to talk to us. Other groups learned of us by word of mouth or by seeing our sign.

A huge number of government agencies were involved in the medical relief effort—NCOEMS, NCEM,

"Having been through several hurricanes here in Wilmington. . . I assumed I knew pretty well what hurricanes did, but I was wrong"

NCPH, SORT, CDC, NIH, FEMA, HHS, and all of the military branches—but there seemed to be a total lack of coordination among the agencies. No one was in charge, which obviously resulted in huge problems with deployment, resupply, and informing the population of the presence and location of medical aid. Further, there were medical resources left in the communities and they seemed to be completely out of the loop and on their own.

One unexpected problem was a significant number of physician “loners” who came to the area with no training or mission and tried to “set up shop” and provide care. Many of these were shut down by authorities and would then go from one unit to another volunteering their services—with no documentation of their training or qualifications. Some ended up working as volunteers at food stations, some apparently left, but they added to the confusion.

What Is Not Getting to the Gulf Coast

Two weeks after the storm, the area was still short of safe food and water. Fuel was strictly rationed. Other than satellite phones, communication was spotty and nearly impossible for those who could not drive out of the area. Body recovery was incomplete.

Hygiene Difficulties

Lack of hygiene was posing real public health problems. Bathroom facilities, other than portable latrines, were nonexistent. Constant contact with sewage, as you would expect, was resulting in epidemics of infectious diarrhea and gastroenteritis, which placed a strain on the resources of the medical units. We quickly instituted a strict hand washing policy, not only among staff, with hand washing stations (bleach and sanitizer) throughout the unit, but for patients, who were required to wash in triage before being seen. This seemed to help, but it was a significant problem that probably got worse.

Need for Local Preparation

My personal feeling is that the local medical community, while as devastated as anyone else by the storm, could have been more effective afterward with more preparation—a logistical plan, established radio communications, some state and federal contacts, and cached supplies. I may be wrong, but the local response seemed very feeble in the area. Part of this was clearly

due to the fact that the regional medical center was almost completely destroyed.

Lessons for the New Hanover Medical Community

The point of this long discourse was to summarize some lessons for our medical community and maybe salvage some good from this disaster. These are some of the things I learned.

1. We should not count on the federal government for much help—they may be able to enforce de facto martial law with military units, but supervising the deployment of medical care seems to be completely beyond the capability of HHS, DHS, FEMA, and the others, at least for now. Therefore, we, the local medical community, should have a well-established plan for providing medical care to the area after a disaster of this magnitude.
2. A Category 4 or 5 storm will probably destroy many medical offices and could incapacitate New Hanover



Katrina victims receive care from SMAT members in the Emergency Department (ED). Many patients were treated in Triage, while many more received definitive care in the ED. Sicker patients were admitted to the Inpatient Unit.

Regional Medical Center. We should be prepared for this possibility and be ready to run a hospital in tents.

3. Basic public health issues—sanitation, toilet facilities—will quickly become as important to health care providers as the ability to treat wounds and other diseases.
4. Within a few days of the event, thousands of chronically ill patients will begin to run out of their prescription medications and come to emergency facilities to get prescription refills. If they are mixed in with patients presenting with acute illness/injuries, the system will be quickly overwhelmed.
5. Providing medical care under disaster conditions is exhausting. In addition to long hours, the food is bad, it is difficult to sleep, in hot/humid conditions dehydration is a constant problem, and there is no place to “decompress.” Imagine caring for a few dozen patients today, all of whom have just lost their home, all their belongings, and at least one immediate family member. Strict work schedules must be in place and enforced. Sleeping and dining facilities for providers should be planned in advance.
6. There needs to be oversight. Someone must be in charge, with the ability to enforce decisions

“Supervising the deployment of medical care seems to be completely beyond the capability of HHS, DHS, FEMA, and the others, at least for now”

“The Katrina aftermath has some urgent lessons for us, the medical community, and we should make sure we have our response to a . . . storm planned in advance”

- made by team leaders. Control must be strict.
7. Communication: Cell-phone coverage will be gone. Communication needs to be by VHF radio; frequencies need to be established beforehand. Separate channels for medical, administrative, security, etc, need to be agreed upon.
 8. Supplies: Basic medical supplies, including medications, should be stored and, after the event, rationed. We can't count on resupply for at least a week after the storm.
 9. Providers will be much more effective if they are working within an emergency system, as they can be moved and resupplied. Patient movement is a real problem; many people will get to a medical facility on foot and will not be able to travel more than two to three miles.
 10. Providing medical care in a disaster is a fluid situation—needs change quickly, information filters in and changes the tactical situation hourly, and rumors flourish. Everyone involved needs to anticipate that plans will have to be modified constantly and on the fly.
 11. The Gulf Coast region, to me, looks very much like the Cape Fear coast—small beach towns, inland rural areas, many retirees. We should look at the situation there now and analyze it carefully, as a similar storm could cause exactly the same devastation here if we are not ready.

Conclusion

Again, my impressions are the result of my experiences only, and some may be incorrect, as I did not see the “big picture.” I do think, however, that the Katrina aftermath has some urgent lessons for us, the medical community, and we should make sure we have our response to a Category 4 or 5 storm planned in advance. After the storm, or while we are awaiting word on evacuation, will be far too late.

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GOVERNOR'S INSTITUTE ON ALCOHOL & SUBSTANCE ABUSE, INC.

Alcohol Screening and Brief Intervention in Women

Sara B. McEwen, MD, MPH, and Jacob A. Lohr, MD



Dr McEwen

There are more deaths, illnesses, and disabilities from substance abuse than from any other preventable health condition. Alcohol abuse has been associated with a host of medical problems (eg, gastritis, hepatitis, hypertension, sexual dysfunction), fatal and nonfatal injuries from motor vehicle accidents, violent crime, suicide attempts, burns, and drownings, psychiatric disorders, and risky sexual practices. In addition, *alcohol use during pregnancy is known to cause fetal alcohol syndrome, the leading cause of mental retardation. There is no “safe” level of alcohol consumption during pregnancy and even brief exposures to small amounts of alcohol may kill brain cells in a developing fetus.* Despite this, alcohol use during pregnancy is not uncommon: in a recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 10% of pregnant women reported drinking alcohol during the past month and 4% reported binge use. Pregnant women should be informed of the harmful effects of alcohol and advised

to abstain. In addition, because much of the damage from alcohol is done before the mother is even aware of her pregnancy, nonpregnant women contemplating pregnancy should be counseled to abstain as well. In accord with the U.S. Surgeon General's advisory, both the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists have issued recommendations that pregnant and preconceptional women be abstinent. According to a May 2004 ACOG policy statement, *ob/gyns have an ethical obligation to learn and use a protocol for universal screening questions, brief intervention, and referral to treatment in order to provide patients and their families with medical care that is state-of-the-art, comprehensive, and effective.*

Physicians have been slow to implement universal screening, and rates of detection and referral to treatment among nonpregnant women remain low. In fact, American women are less likely than men to be screened or referred for substance abuse and depen-



Dr Lohr

dence. Under-recognition of prenatal alcohol and drug effects is also common despite the fact that fetal alcohol syndrome (FAS) is the leading cause of mental retardation in the U.S. Many physicians report significant barriers to screening: they are concerned about the consequences of legally mandated reporting, they lack familiarity with treatment resources, and they do not feel they have the time required to make an appropriate referral.

Harm to the Woman

Substance abuse is a major health problem for American women across all socioeconomic, racial, ethnic, and age categories. An estimated four million women drink in a way that threatens their health, safety, and well-being. Besides being associated with the usual alcohol-associated medical problems and susceptibility to injury, drinking poses an increased risk for women because they develop alcohol-related disease more quickly and at lower levels of alcohol consumption than men. Heavy drinking is associated with a higher risk of cardiac and liver problems for women than men. In fact, female alcoholic death rates are 50% to 100% higher than those of male alcoholics, including alcohol related accidents, heart disease and stroke, and cirrhosis.

Substance abuse is often co-morbid with mental illness. Depression and anxiety are especially common in women with alcohol problems. Women who suffered childhood sexual abuse are also more likely to have substance use issues. Research indicates that alcohol problems are more likely to develop and/or surface late in life in women compared with men. Often, these problems are mistaken for other conditions associated with aging and not appropriately addressed.

Harm to the Fetus /Infant

Fetal alcohol spectrum disorders (FASD) consist of the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. Children with FASD often have problems with learning, memory, attention, impulsivity, problem solving, speech, and hearing. They are at increased risk for academic problems, problems with the law, substance abuse, and mental health disorders. A subcategory of FASD is fetal alcohol syndrome (FAS), the leading cause of mental retardation in the U.S. FAS is characterized by distinctive facial anomalies, stunted physical and emotional development, and central nervous system problems. The exact number of cases of FASD is unknown. According to the CDC, there are between 0.3 and 1.5 cases of FAS for every 1,000 live births in the U.S. and there are about four times as many cases of FASD. Although there is no cure for FASD, early identification is important so that affected children can receive specialized services.

Screening

Screening helps identify individuals who have begun to develop or who are at risk for developing alcohol and/or other drug (AOD) related problems, and this is particularly important in pregnant and preconceptional women. While there are a variety of screening tools available (including the NIAAA quantity/frequency questions, CAGE, AUDIT C, SMAST, and TWEAK), most have not been well studied in women or in obstetrical populations. Because women are more likely to be hidden drinkers and often underreport alcohol use, tests to detect alcohol use in women must include questions about tolerance. There are several challenges to determining a pregnant woman's level of alcohol consumption: (1) women often decrease their drinking upon learning they are pregnant (and significant exposure may have already occurred), (2) women often underreport their consumption, and (3) many of the usual screening tests were developed and validated in other populations. The T-ACE is a simple four-question test, based on the CAGE, which has been tested in diverse obstetric samples. T-ACE is a proven and efficient tool for identifying a range of alcohol use in women. Pregnant women should be questioned about any alcohol use and counseled to abstain.

Brief Intervention (BI)

Brief physician advice has been shown to be both powerful and feasible in a clinical office setting. Brief interventions, which aim to reduce risk, alcohol-related problems, and alcohol-medication interactions, are short counseling sessions that may last only five minutes. They are designed to fit into the normal flow of a busy practice and are consistent with mainstream, patient-centered care. BI's often incorporate the six elements proposed by Miller and Sanchez summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy. For "at-risk" or "harmful" nonpregnant drinkers who are not dependent, goal setting within safe limits and a follow-up plan are all that may be needed. For those patients who are dependent or drinking during pregnancy, the BI is a negotiation process to seek further assessment and referral to a specialized clinician or treatment program.

Treatment

Referral to treatment, especially if combined with training in parenting skills, is the clinically appropriate professional action, both medically and ethically, when a patient is found to be dependent or in need of intervention beyond the BI. The good news is that treatment does work. The rate of abstinence from drugs of abuse after treatment is now comparable to the level of medication compliance in diabetes, hypertension, or other chronic illnesses. Treatment is both more effective and less expensive than restrictive poli-

"Substance abuse is a major health problem for American women across all socioeconomic, racial, ethnic, and age categories"

cies (eg, incarceration) and results in a mean saving of \$4,644 in medical expenses per mother/infant pair. The lifetime medical and welfare costs of a baby with FAS are calculated at \$5 million.

Programs that provide comprehensive, family-centered care are recommended for women who require specialized substance abuse treatment. Such programs are more effective for women and are better at attracting and retaining them. The most effective programs are those that take into account women's psychosocial issues, social relationships, communication styles, and spiritual needs/factors.

Guidance for Physicians

Every clinical encounter is an opportunity for intervention. Through policy statements, ACOG has highlighted the importance of screening, early diag-

nosis, and treatment for patients with alcohol and other drug use. Despite the fact that the present health care delivery system poses a number of barriers to universal screening, brief intervention, and referral to treatment for substance abuse and dependence, obstetricians/gynecologists and other physicians treating women must make a substantial effort to:

- learn established techniques for screening, brief intervention, and referral—a team approach may be useful in this regard;
- treat the patient with dignity and respect;
- protect confidentiality;
- balance competing obligations carefully, consulting with other physicians or an ethicist if indicated; and
- participate in the policy process at institutional, state, and national levels.

“The most effective programs are those that take into account women’s psychosocial issues, social relationships, communication styles, and spiritual needs/factors”

SCREENING FOR ALCOHOL PROBLEMS IN WOMEN

PREGNANT WOMEN AND WOMEN OF CHILD BEARING AGE:

Do you ever drink? (Yes answer is a positive screen)

- Both pregnant and non pregnant women need to be informed that there is no safe level of consumption during pregnancy.
- Women anticipating becoming pregnant should be counseled to abstain from alcohol to avoid early exposure.

OTHER WOMEN:

T-ACE (score of 2 or more indicates a positive screen)

T Tolerance: How many drinks does it take to make you feel high?

(More than 2 is a positive response – score 2 pts)

A Have people Annoyed you by criticizing your drinking?

(If yes – score 1 pt)

C Have you ever felt you ought to Cut down on your drinking?

(If yes – score 1 pt)

E Eye opener: Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

(If yes – score 1 pt)

TWEAK (score of 2 or more indicates a positive screen)

T Tolerance: How many drinks can you hold?

(If 5 or more, score 2 pts)

W Have close friends or relatives Worried or complained about your drinking in the past year? (If yes, score 2 pts)

E Eye opener: Do you sometimes take a drink in the morning when you get up? (If yes, score 1 pt)

A Amnesia: Has a friend or family member ever told you about things you said or did while drinking that you could not remember?

(If yes, score 1 pt)

K (C) Do you sometimes feel the need to Cut down on your drinking?

(If yes, 1 pt)

NIAAA QUANTITY AND FREQUENCY QUESTIONS

On average, how many days per week do you drink alcohol?

On a typical day when you drink, how many drinks do you have?

(positive score >7 drinks per week for women)

What is the maximum number of drinks you had on any given occasion during the last month? (positive score >3 for women)

Sara B. McEwen, MD, MPH, is consultant to the Governor's Institute on Alcohol and Substance Abuse and the Division of Mental Health, Development Disabilities, and Substance Abuse Services. Jacob A. Lohr, MD, is executive director of the Governor's Institute on Alcohol and Substance Abuse. This is the fourth in a series of articles addressing substance abuse/dependence issues. Other articles in the series will address prescription drug dependence, SA in physicians, and the Physicians' Leadership Council's Action Plan.

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

November—December—2005/January 2006

DEFINITIONS:

Annulment:

Retrospective and prospective cancellation of the practitioner's authorization to practice.

Conditions:

A term used in this report to indicate restrictions, requirements, or limitations placed on the practitioner.

Consent Order:

An order of the Board stating an agreement between the Board and the practitioner regarding the annulment, revocation, suspension, or surrender of the authorization to practice, or the conditions placed on the authorization to practice, or other action taken by the Board relative to the practitioner. (A method for resolving a dispute without a formal hearing.)

Denial:

Final decision denying an application for practice authorization or a request for reconsideration/modification of a previous Board action.

Dismissal:

Board action dismissing a contested case.

Inactive Medical License:

To be "active," a medical license must be registered on or near the physician's birthday each year. By not registering his or her license, the physician allows the license to become "inactive." The holder of an inactive license may not practice medicine in North Carolina. Licensees will often elect this status when they retire or do not intend to practice in the state. (Not related to the "voluntary surrender" noted below.)

NA:

Information not available or not applicable.

NCPHP:

North Carolina Physicians Health Program.

RTL:

Resident Training License. (Issued to those in post-graduate medical training who have not yet qualified for a full medical license.)

Revocation:

Cancellation of the authorization to practice. Authorization may not be reissued for at least two years.

Stay:

The full or partial stopping or halting of a legal action, such

as a suspension, on certain stipulated grounds.

Summary Suspension:

Immediate withdrawal of the authorization to practice prior to the initiation of further proceedings, which are to begin within a reasonable time. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)

Suspension:

Withdrawal of the authorization to practice for a stipulated period of time or indefinitely.

Temporary/Dated License:

License to practice for a specific period of time. Often accompanied by conditions contained in a Consent Order. May be issued as an element of a Board or Consent Order or subsequent to the expiration of a previously issued temporary license.

Voluntary Surrender:

The practitioner's relinquishing of the authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner. (Not related to the "inactive" medical license noted above.)

ANNULMENTS

NONE

REVOICATIONS

BARR-HAIRSTON, Deborah Winifred, DO

Location: Yanceyville, NC (Caswell Co)
 DOB: 3/17/1966
 License #: 2001-00639
 Specialty: FP (as reported by physician)
 Medical Ed: Tulsa Oklahoma School of Osteopathic Medicine (1993)
 Cause: Dr Barr-Hairston was convicted of a felony in the U.S. District Court, Western District of Virginia, in U.S.A. v. Deborah Barr-Hairston, case number 4:04CR0008.
 Action: 11/03/2005. Entry of Revocation issued: Dr Barr-Hairston's North Carolina medical license was revoked by the operation of law as of 8/16/2005.

CHEEK, John Christopher, MD

Location: Smithfield, NC (Johnston Co)
 DOB: 3/03/1957
 License #: 0097-01906
 Specialty: GP/CN (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1984)
 Cause: Dr Cheek was convicted of a felony in the Wilson County District Court on 5/10/2005 in State v. John Christopher Cheek, case number 04 CRS 055471.
 Action: 11/03/2005. Entry of Revocation issued: Dr Cheek's North Carolina medical license is hereby revoked.

GREENE, Garland Vestal, III, MD

Location: Norfolk, VA
 DOB: 11/12/1956
 License #: 0000-31516
 Specialty: IM/EM (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1985)
 Cause: In June 2004, the Virginia Board entered a Consent Order that found Dr Greene provided substandard care by failing to perform thorough and comprehensive evaluations of chronic pain complaints by Patients A, C, D, I, and J upon their initial presentation to him. It also noted instances of his failure to document information related to patient substance abuse and his reversal of treatment plans. His medical record keeping was found to be grossly inadequate. Without being registered with the DEA for the purpose, he provided detoxification services for several

patients. Dr Greene was also found to have had a sexual relationship with two patients. As a result, the Virginia Consent Order suspended Dr Greene's Virginia medical license.

Action: 12/08/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/19/2005: Dr Greene's North Carolina medical license is revoked.

GILMER, Vince Donald

Location: Fletcher, NC (Henderson Co)
 DOB: 9/05/1962
 License #: 2000-01139
 Specialty: FP (as reported by physician)
 Medical Ed: University of South Alabama (1997)
 Cause: Dr Gilmer was convicted of a felony in the case of Commonwealth of Virginia v. Vince Donald Gilmer, case number 05-0162.
 Action: 1/11/2006. Entry of Revocation issued: Dr Gilmer's North Carolina medical license is revoked by operation of law as of 1/05/2006.

MATTHEWS, Richard Eugene, MD

Location: Norfolk, VA
 DOB: 12/20/1945
 License #: 0000-22252
 Specialty: GP/EM (as reported by physician)
 Medical Ed: Medical College of Virginia (1970)
 Cause: Dr Matthews was convicted of a felony in the Circuit Court of the City of Norfolk for the Commonwealth of Virginia, case number CR04001972-00.
 Action: 11/09/2005. Entry of Revocation issued: Dr Matthews' North Carolina medical license is revoked by the operation of law as of 11/07/2005.

SUSPENSIONS

CASEY, William Joseph, Jr, MD

Location: Tucson, AZ
 DOB: 6/25/1945
 License #: 0000-16841
 Specialty: NA
 Medical Ed: Bowman Gray School of Medicine (1970)
 Cause: In December 2004, the Arizona Medical Board entered into an Interim Consent Agreement with Dr Casey based on information he had relapsed into drinking alcohol after he had agreed to a Confidential Stipulated Rehabilitation Agreement. Under the Interim Consent Agreement, he may not practice medicine prior to completion of an inpatient or residential evaluation/treatment

program.
 Action: 11/03/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/17/2005: Dr Casey's North Carolina medical license is indefinitely suspended as of the date of this Order.

ROBINSON, Richard Walter, MD

Location: Knoxville, TN
 DOB: 10/07/1934
 License #: 0000-15264
 Specialty: NA
 Medical Ed: Albany Medical College (1962)
 Cause: In July 2004, the Tennessee Board of Medical Examiners placed Dr Robinson's medical license on probation for five years for prescribing drugs to two patients without documenting appropriate patient history and physical examination. Tennessee further found he had entered a sexual relationship with one of the patients during the course of the physician/patient relationship. In December 2004, based on the Tennessee action, the New York Office of Professional Medical Conduct entered into a Consent Order with Dr Robinson in which he agreed never to activate his registration in New York or seek a medical license in New York.

Action: 11/03/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/17/2005: Dr Robinson's North Carolina medical license is indefinitely suspended as of the date of this Order.

TEMPLETON, Horace Wayne, MD

Location: Mapleton, GA
 DOB: 9/17/1945
 License #: 0000-17607
 Specialty: NA
 Medical Ed: University of Virginia (1971)
 Cause: The Georgia Board entered into a Consent Order with Dr Templeton based on information he committed acts or omissions that constituted gross negligence. It suspended his Georgia license indefinitely.

Action: 12/08/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/20/2005: Dr Templeton's North Carolina medical license is suspended indefinitely.

See Consent Orders:

DERBES, Lawrence Joseph, MD
FORTKORT, Peter Thomas, MD
GARDNER, James Eric, MD
METZGER, Deborah Ann, MD
SUTTON, Frank Morrison, Jr, MD

SUMMARY SUSPENSIONS

BIZZELL, Aleecia Rich, Nurse Practitioner

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 2/23/1973
 License #: 0002-01269
 NP Education: Duke University (1999)
 Cause: Ms Bizzell may possess a mental or physical condition that renders her unable to function as a nurse practitioner as shown by the Board's Notice of Charges and Allegations, Notice of Hearing dated 12/20/2005.

Action: 12/20/2005. Order of Summary Suspension of Approval issued: Ms Bizzell's approval to perform medical acts, tasks, and functions is suspended on service of this Order.

CONSENT ORDERS

AUSTERMEHLE, Paul Edward, Physician Assistant

Location: Doylestown, PA
 DOB: 8/04/1966
 License #: 0001-02541
 PA Education: Philadelphia College Textile (1997)
 Cause: On application for reinstatement of PA license. Mr Austermehle has a history of diverting controlled substances for his own use. In December 2004, he entered into a deferred prosecution judgment with the Buncombe County District Court regarding five counts of obtaining controlled substances by fraud. In April 2005, he entered a Consent Order with the Board in which his PA license was suspended indefinitely. As a condition of the Consent Order, he entered into a contract with the NCPHP and the Penn-

sylvania Physicians Health Program.

Action: 12/15/2005. Consent Order executed: Mr Austermehle is issued a PA license; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within two weeks of such use, noting the prescriber and the pharmacy filling the prescription; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

BAHADORI, Reza, MD

Location: Raleigh, NC (Wake Co)
 DOB: 5/22/1934
 License #: 0000-32463
 Specialty: GYN/FPG (as reported by physician)
 Medical Ed: University of Tabriz, Iran (1961)
 Cause: Dr Bahadori admits that on occasion he has asked explicit questions of some female patients. While he had no inappropriate intent, he now realizes those questions made his patients feel uncomfortable and were not medically indicated or necessary. Expert review of six of his patient charts found deficiencies in his management of all six patients, particularly regarding record-keeping practices. In at least one instance, he was found to have inaccurately charted that a patient suffered a miscarriage when she had not.

Action: 1/20/2006. Consent Order executed: Dr Bahadori shall retire from medical practice effective 4/01/2006, at which time his license will be placed on inactive status.

CARLSON, James Lennart, MD

Location: Cerro Gordo, NC (Columbus Co)
 DOB: 11/20/1959
 License #: 2002-00010
 Specialty: FP (as reported by physician)
 Medical Ed: Medical College of Wisconsin (1991)
 Cause: Amendment of previous Consent Order of 5/14/2003.
 Action: 9/30/2005. Amended Consent Order executed: Lifts requirement in previous Consent Order of 5/14/2003 for use of a chaperon during examinations.

CASSIDY, John Francis, Physician Assistant

Location: Lenoir, NC (Caldwell Co)
 DOB: 9/22/1962
 License #: 0001-03164
 PA Education: NA
 Cause: On 7/23/2004, Mr Cassidy changed his address from Greenville, NC, to Lenoir, NC, and did not file an Intent to Practice form with the Board or otherwise disclose his primary supervising physician. It was learned by the Board that no Intent to Practice Form had even been filed with the Board designating Mr Cassidy's current supervising physician. He practiced as a PA even though he had not received an acknowledgement from the Board that a current Notification of Intent to Practice Form had been received as required.

Action: 1/18/2006. Consent Order executed: Mr Cassidy is reprimanded.

CHAMPION, Lawrence Andrew, MD

Location: Durham, NC (Durham, NC)
 DOB: 3/24/1947
 License #: 0000-19912
 Specialty: P (as reported by physician)
 Medical Ed: University of Wisconsin (1973)
 Cause: In June 2004, Dr Champion was charged with driving under the influence and had a tested blood alcohol level of .22. In November 2004, he pled guilty to the DUI. He has successfully completed substance abuse treatment and has made excellent progress in addressing his use of alcohol. He has abstained from alcohol since June 2004.

Action: 1/20/2006. Non-Disciplinary Consent Order executed: No disciplinary action is imposed; Dr Champion shall, unless lawfully prescribed by someone else, refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

CONIGLIO, Gerald Anthony, MD

Location: Mt Morris, NY
 DOB: 5/21/1946
 License #: 0000-33220
 Specialty: OS/EM (as reported by physician)
 Medical Ed: State University of New York, Buffalo (1972)
 Cause: Nevada State Board of Medical Examiners denied Dr Coniglio's application for a Nevada medical license in June 2005.
 Action: 1/31/2006. Consent Order executed: Dr Coniglio is reprimanded.

CORBETT, Patricia Odham, Nurse Practitioner

Location: Holly Ridge, NC (Onslow Co)
 DOB: 3/16/1971
 Approval #: 0050-01162
 NP Education: University of North Carolina, Wilmington (2005)
 Cause: In June 1991, Ms Corbett pled guilty to a felony forgery charge in Tennessee that resulted in a sentence of 10 years, suspended, with one year of probation, which was served without any violation. As a result of this, she was reprimanded by the Alabama Nursing Board in 1993.
 Action: 12/13/2005. Consent Order executed: Ms Corbett is reprimanded; she is granted approval to practice as a nurse practitioner in North Carolina.

DERBES, Lawrence Joseph, MD

Location: High Point, NC (Guilford Co)
 DOB: 7/30/1959
 License #: 0098-01235
 Specialty: IM (as reported by physician)
 Medical Ed: Louisiana State University (1985)
 Cause: Dr Derbes North Carolina medical license was made inactive on 7/20/1999. In September and October 2005, Dr Derbes wrote prescriptions for several controlled substances for a family member. It is unlawful to prescribe for another person unless properly licensed and registered.
 Action: 1/30/2006. Consent Order executed: Dr Derbes inactive license is suspended for six months; suspension is stayed subject to conditions; should Dr Derbes obtain a North Carolina license, he shall comply with the Board's position statement relating to prescribing go family members; he shall maintain and abide by an NCPHP contract; must comply with other conditions.

FORTKORT, Peter Thomas, MD

Location: Shelby, NC (Cleveland Co)
 DOB: 3/10/1962
 License #: 0095-00577
 Specialty: IM (as reported by physician)
 Medical Ed: Georgetown University (1991)
 Cause: In or about 1999, Dr Fortkort established a physician-patient relationship with Patient A who sought his care for treatment of pain. He began writing numerous prescriptions for her and later for her husband at her request, though her husband was not Dr Fortkort's patient. For many of these prescriptions, there does not exist a medical record documenting the prescriptions or their justification. Before she became his patient, Dr Fortkort and Patient A developed a romantic relationship and this clouded his judgment about his prescribing to her and her husband. In October 2004, Patient A pled guilty to various drug crimes and received a 20 day jail sentence. Dr Fortkort has been evaluated by and received several weeks treatment at the Professional Renewal Center, during which time, from 10/21/2005 to the present, he had voluntarily ceased medical practice. The PRC has given its opinion he is fit to return to work.
 Action: 1/20/2006. Consent Order executed: Dr Fortkort's North Carolina medical license is suspended for two years effective 10/21/2005; suspension is stayed as of the date of this Consent Order; the Board agrees that the time from 10/21/2005 to the present, the period Dr Fortkort has been out of practice, constitutes the period of active suspension; he shall continue any recommended therapeutic follow-up; within one year he shall attend the Vanderbilt University CME course on prescribing; he shall maintain and abide by a contract with the NCPHP.

FOSTER, Augustus Hunter, Jr, MD

Location: Sebring, FL
 DOB: 4/08/1927
 License #: 0000-11680

Specialty: EM/ABS (as reported by physician)
 Medical Ed: Loma Linda University (1951)
 Cause: Pursuant to a Consent Order of 4/21/2003, the Florida Board levied a fine against Dr Foster, ordered him to complete five hours of CME in emergency medicine within one year, and prohibited him from practice of emergency medicine unless he submits to a competency evaluation and appears before the Florida Board with the evaluation and recommendations. This action was based on the Board's learning Dr Foster had practiced below the standard of care in failing to follow up on ischemia identified in a patient. In August 2005, the Florida Board reprimanded Dr Foster and placed conditions on his license for failing to comply with the CME requirements set in the previous Consent Order. He was given one more year to achieve the required CME.
 Action: 1/24/2006. Consent Order executed: Dr Foster is reprimanded; he shall comply in all respects with the Florida Consent Order of 2003 and the Order of 2005; must comply with other conditions.

GARDNER, James Eric, MD

Location: Pinehurst, NC (Moore Co)
 DOB: 9/18/1970
 License #: 2002-00116
 Specialty: VS/GS (as reported by physician)
 Medical Ed: University of Tennessee (1996)
 Cause: Dr Gardner has had a problem with substance abuse, which has involved inappropriate prescribing and prescribing to himself. He surrendered his North Carolina medical license in September 2005. He has completed residential treatment and is a participant in the NCPHP.
 Action: 1/20/2006. Consent Order executed: Dr Gardner's North Carolina medical license is suspended indefinitely.

GENTRY, James Henry, MD

Location: Raleigh, NC (Wake Co)
 DOB: 6/22/1930
 License #: 2003-00789
 Specialty: OPH (as reported by physician)
 Medical Ed: University of Colorado School of Medicine (1955)
 Cause: In 2003, Dr Gentry allowed his Colorado medical license to go inactive. Colorado requires anyone who goes inactive for two years or more to be examined by the Center for Personalized Education for Professionals in that state prior to reinstatement. When Dr Gentry applied for reinstatement, he was given the choice to be examined by the CPEP or agree not to perform surgery as part of his medical practice. In August 2005, he signed an agreement with the Colorado Board wherein his license was reinstated and he agreed not to perform surgery. He plans to spend part of the year in North Carolina and part in Colorado. The North Carolina Board wishes to act in keeping with the Colorado action.
 Action: 1/12/2006. Non-Disciplinary Consent Order executed: Dr Gentry agrees not to perform surgery as part of his medical practice.

GUALTEROS, Oscar Mauricio, MD

Location: Southern Pines, NC (Moore Co)
 DOB: 5/11/1964
 License #: 0099-00236
 Specialty: IM (as reported by physician)
 Medical Ed: University of Navarra, Spain (1991)
 Cause: In November 2000, Dr Gualteros and the Board entered into a Consent Order based on a finding that he had inappropriate physical contact with patients. In June 2001, he entered into another Consent Order with the Board based on a finding that he had improperly touched a female nurse and requiring him to have a chaperone present during all encounters with female patients. In 2005, he had an inappropriate and unprofessional interaction with a female patient, including inappropriate physical contact. He has reported to the NCPHP and has undergone professional counseling and treatment. He agrees to fully comply with the chaperone requirements of his previous Consent Orders as he closes his practice.
 Action: 1/20/2006. Consent Order executed: Dr Gualteros is issued a license to practice to expire 2/17/2006; Dr Gualteros surrenders his North Carolina medical license as of 2/18/2006; he will close his practice in an orderly and professional manner.

HARDY, Stephen Carl, MD

Location: Weddington, NC (Mecklenburg Co)

DOB: 7/11/1957
License #: 0000-35911
Specialty: N (as reported by physician)
Medical Ed: University of Virginia (1985)
Cause: On application for reinstatement of license. In February 2004, Dr Hardy retired from practice and placed his license on inactive status. He suffered from clinical depression and chemical dependency following his divorce. He has been successfully treated for these disorders and has a contract with the NCPHP, which reports he has complied with the contract and is healthy to practice medicine.
Action: 1/09/2006. Consent Order executed: Dr Hardy's North Carolina medical license is reinstated to expire on the date shown thereon [5/09/2006]; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; he shall not register with the DEA to handle controlled substances until the Board endorses his application for registration; must comply with other conditions.

HUCKS-FOLLISS, Anthony George, MD

Location: Pinehurst, NC (Moore Co)
DOB: 5/30/1941
License #: 0000-20290
Specialty: NS (as reported by physician)
Medical Ed: University of Virginia (1969)
Cause: On request for reinstatement of license. Dr Hucks-Folliss failed to meet the annual license registration requirement as established by law. As a result, the Board placed his license on inactive status 9/14/2005. He has met with the Board and now appreciates the importance of timely registration.
Action: 12/28/2005. Consent Order executed: Dr Hucks-Folliss is reprimanded and his North Carolina medical license is reinstated effective on the date of this Order.

IRVIN, John David, MD

Location: Wilmington, NC (New Hanover Co)
DOB: 4/02/1952
License #: 0094-01419
Specialty: FP (as reported by physician)
Medical Ed: Case Western Reserve University (1979)
Cause: Between April 2003 and August 2005, Dr Irvin wrote prescriptions for controlled substances for a family member. He failed to record all these prescriptions in the patient chart. Prescribing for family members and failing to keep medical records is inappropriate.
Action: 1/20/2006. Non-Disciplinary Consent Order executed: No disciplinary action is imposed; Dr Irvin shall strictly comply with the Board's Position Statements on "Self-Treatment and Treatment of Family Members . . .," "Writing of Prescriptions," and "Medical Record Documentation."

KINNALLY, Steven Joseph, Physician Assistant

Location: Clayton, NC (Johnston Co)
DOB: 11/11/1952
License #: 0010-00347
PA Education: University of Washington, Seattle (2001)
Cause: In October 2004, Mr Kinnally was charged in Minnesota with practicing medicine without a license based on his issuance of a prescription for a Schedule II controlled substance. He issued the prescription to an acquaintance without first performing an examination or maintaining a medical record. He signed the name of this supervising physician on the prescription. In October 2005, he pled guilty to one count of practicing medicine without a license, a misdemeanor, and was fined \$700. As a result, his hospital privileges were suspended at St Luke's Hospital in Duluth.
Action: 11/30/2005. Consent Order executed: The Board issues Mr Kinnally a PA license to expire on 11/30/2006; for the next year, he shall meet with his supervising physician on a monthly basis to have his supervising physician review and countersign a random selection of his charts; he shall arrange to have his supervising physician submit quarterly reports to the Board president regarding Mr Kinnally's performance over that year; must comply with other conditions.

LERNER, Don Neal, MD

Location: Jacksonville, FL
DOB: 5/16/1956
License #: 0097-00093
Specialty: OTO (as reported by physician)
Medical Ed: University of Miami School of Medicine (1988)
Cause: On 4/12/2005, the Florida Board of Medicine issued a Final Order adopting a counter Consent Agreement with Dr Lerner whereby he was fined and required to perform community service on allegations, which he neither admitted nor denied, that he had written a prescription for himself using a false name.
Action: 1/25/2006. Consent Order executed: Dr Lerner is reprimanded.

LILLY, Josiah Kenneth, III, MD

Location: Charleston, WV
DOB: 4/03/1945
License #: 0000-34876
Specialty: APN/AM (as reported by physician)
Medical Ed: West Virginia University (1971)
Cause: In June 2005, the West Virginia Board of Medicine entered a Consent Order reprimanding Dr Lilly for unprofessional conduct for allowing a child, without patient consent, to witness a medical procedure he was performing, though the conduct was unintentional.
Action: 1/31/2006. Consent Order executed: Dr Lilly is reprimanded.

METZGER, Deborah Ann, MD

Location: Farmington, CT
DOB: 3/04/1951
License #: 0000-28273
Specialty: OB/GYN (as reported by physician)
Medical Ed: University of Texas, Houston (1982)
Cause: In November 2004, Dr Metzger's California medical license was revoked by the California Board, with revocation being stayed and Dr Metzger being placed on probation for five years pursuant to terms and conditions. Dr Metzger had no contact with patients in North Carolina.
Action: 12/28/2005. Consent Order executed: Dr Metzger's North Carolina medical license is suspended indefinitely and she agrees not to apply for reinstatement for at least two years; however, suspension is stayed.

NEWBROUGH, David Chester, Physician Assistant

Location: Elizabeth City, NC (Pasquotank Co)
DOB: 10/29/1945
License #: 0001-00258
PA Education: Bowman Gray (1977)
Cause: It was discovered during a random site visit on 9/26/2005 that Mr Newbrough had not filed a Notification of Intent to Practice Form since his former primary supervising physician had left the practice on or about 5/01/2005. He had also failed to file a Notification of Intent to Practice Form for his volunteer practice at the Community Care Clinic. It was also learned that no Notification of Intent to Practice Form had even been filed with the Board designating either of Mr Newbrough's current supervising physicians. During the same site visit, he could not produce a current list of backup physicians or documentation of CME credits obtained in the past two years. During an interview on 9/27/2005, he admitted he failed to meet with his supervising physician for a quality improvement meeting and had inadvertently violated the prescribing restriction limiting PA-written prescriptions to a 30 day supply of Schedule II, IIN, II, or IIIN controlled substances. He has now addressed all the documentation deficiencies of his supervisory arrangements.
Action: 1/25/2006. Consent Order executed: Mr Newbrough is reprimanded.

OLSEN, Thomas George, MD

Location: Dayton, OH
DOB: 7/11/1946
License #: 2004-00152
Specialty: D/DMP (as reported by physician)
Medical Ed: Indiana University School of Medicine (1972)
Cause: On or about 6/08/2005, Dr Olsen and the State Medical Board of Ohio signed a Consent Agreement in which Dr Olsen admitted submitting a false statement understating his income and failing to advise the Ohio Board that he had been found guilty of Driving

Under the Influence of Alcohol or Drugs. Dr Olsen agreed that his license would be reprimanded and subject to probation for three years, he would perform 600 hours of community service providing free patient visits, he would complete an ethics course, and he would fulfill other obligations.

Action: 1/25/2006. Consent Order executed: Dr Olsen is reprimanded.

PARR, Monique Sylvia, MD

Location: North Potomac, MD
 DOB: 9/13/1949
 License #: 2005-01793
 Specialty: PD (as reported by physician)
 Medical Ed: University of Washington School of Medicine (1975)
 Cause: Dr Parr has not practiced clinical medicine since 2003 and does not intend to return to clinical practice at this time. She plans to practice only in an administrative setting with Medco Health Solutions.

Action: Non-Disciplinary Consent Order executed: Dr Parr is granted a limited administrative license that requires she limit her practice in North Carolina to administrative medicine only.

POLO, James Michael, MD

Location: New Bern, NC (Craven Co)
 DOB: 5/18/1963
 License #: 0099-00647
 Specialty: D (as reported by physician)
 Medical Ed: U. S. University of Health Sciences (1990)
 Cause: In November 2003, Dr Polo ordered two vials of Botox made by Toxin Research International (called Tri-tox hereafter). Toxin Research International marketed the product to physicians practicing cosmetic medicine and Dr Polo says he was told by a representative of the company that Tri-tox was safe and being used on humans. In fact, Tri-tox was not and has not been approved for human use by the FDA and it was labeled "For Research Purposes Only: Not For Human Use." After receiving the Tri-tox, Dr Polo tested it on himself and experienced no problem. He then administered it to several patients, including a family member. Only one patient was aware the Tri-tox was not FDA approved. By administering Tri-tox to patients without first informing them the product was not FDA approved and by using an inadequate consent form for one patient, Dr Polo engaged in unprofessional conduct. By providing medical treatment for himself and a family member, he also engaged in unprofessional conduct. All involved patients have now been informed and none has indicated a problem.

Action: 1/12/2006. Consent Order executed: Dr Polo is reprimanded.

ROGERS, Bruce William, MD

Location: Clayton, NC (Johnston Co)
 DOB: 8/11/1947
 License #: 0000-32563
 Specialty: FP/EM (as reported by physician)
 Medical Ed: Medical College of Pennsylvania (1982)
 Cause: Application for reissuance of license. Dr Rogers has had a problem with substance abuse, detailed in a Consent Order of 4/27/2005 in which his license was indefinitely suspended. He voluntarily stopped practicing in September 2003. He has completed four months of residential treatment for chemical dependence and has a contract with the NCPHP. The NCPHP reports he is compliant with the contract.

Action: 12/14/2005. Consent Order executed: the Board reissues Dr Rogers' license to expire on the date shown on the license [4/13/2006]; unless lawfully prescribed by someone else, he shall refrain from the use of mind- or mood-altering substances, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; he shall either have a physician colleague observe his practice for the first four months after he resumes and deliver a letter to the Board each month describing his or her observations and commenting on Dr Rogers' skill, or he shall take and pass the FSMB Special Purpose Examination; he shall not prescribe or deal with controlled substances in Schedules II, II-N, III, or III-N; must comply with other conditions.

ROLLINS, Curtis Edward, MD

Location: Winston Salem, NC (Forsyth Co)

DOB: 6/17/1959
 License #: 2005-01895
 Specialty: P/PPF (as reported by the physician)
 Medical Ed: Medical University of South Carolina College of Medicine (1992)

Cause: On application for a medical license. Dr Rollins has a history of substance abuse and dependence. In January 2001, he used his employment as the medical examiner in Coconino County, Arizona, to obtain narcotic medications for his own use. He also obtained narcotic medications for his use by issuing prescriptions for his dog. In July 2001, he was indicted and charged with several crimes related to drug possession in Arizona. He entered treatment at the Talbott Recovery Campus in Atlanta in March 2001 and remained in inpatient treatment until his discharge on 8/11/2001. He reports he has been clean and sober since March 2001. To resolve the Arizona criminal charges, he pled guilty to one count of possession of drug paraphernalia and one count of possession or use of narcotic drugs in February 2002. He was placed on unsupervised probation for a period of one year relating to his guilty plea to possession of drug paraphernalia. Acceptance of the plea agreement for possession or use of narcotic drugs was deferred for one year to allow Dr Rollins to complete the California Physician Diversion Program. He subsequently moved to California, where he entered the California Physician Diversion Program to be monitored from August 2001 to August 2006. He signed a Consent Order with the Arizona Board relating to these events that placed his Arizona license on probation for five years and reprimanded him. He is now under contract with the NCPHP, which specifies he will be monitored in accord with the California requirements. He is agreeable to extension of the NCPHP contract.

Action: 12/05/2005. Consent Order executed: Dr Rollins is issued a North Carolina medical license; unless lawfully prescribed by someone else, he shall refrain from the use of mind- or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

ROULHAC, Maurice Raynard, MD

Location: Fayetteville, NC (Cumberland Co)
 DOB: 2/26/1962
 License #: 0093-00304
 Specialty: VS/GS (as reported by physician)
 Medical Ed: University of South Florida (1987)
 Cause: Dr Roulhac pre-signed prescription blanks and left them with members of his staff for use by one of his staff members. When he determined a patient needed a prescription, he would instruct the staff member to complete the pre-signed blank and give it to the patient. He discontinued this practice when a former staff member mentioned it was unlawful and threatened to report him. He asserts he never authorized his staff to use the pre-signed blanks without checking with him each time.

Action: 1/20/2006. Consent Order executed: Dr Roulhac is reprimanded; he shall comply with the Board's Position Statement on "Writing of Prescriptions."

SCOTT, Duncan R. Campbell, II, MD

Location: Asheville, NC (Buncombe Co)
 DOB: 1/27/1958
 License #: 0098-01052
 Specialty: AN/APN (as reported by physician)
 Medical Ed: Medical University of South Carolina (1993)
 Cause: In or around 1998 or 1999, Dr Scott treated Patient A for severe back pain, writing numerous prescriptions for Schedule II substances. He did not keep an accurate patient chart for Patient A and did not keep accurate records of the prescriptions written.

Action: 1/18/2006. Consent Order executed: Dr Scott is reprimanded; he agrees to attend a prescribing course within six months and furnish proof of his attendance to the Board.

STADIEM, Michael David, MD

Location: Cary, NC (Wake Co)
 DOB: 10/04/1950
 License #: 0000-23233
 Specialty: FP (as reported by physician)

Medical Ed: University of Pennsylvania (1976)
Cause: In 1993, Dr Stadiem began pain management treatment for Patient A for a serious back injury. In the course of treatment, he engaged in boundary violations with Patient A by way of inappropriate conversations. Those conversations involved discussions of his personal and marital life and were for his benefit, not that of the patient. Since the mid-1990s, Dr Stadiem has undergone psychotherapy with Elliot Silverstein, PhD, to address his behavior as it relates to maintaining appropriate patient-physician boundaries.

Action: 11/18/2005. Consent Order executed: Dr Stadiem's North Carolina medical license is placed on probation for nine months from the date of this Consent Order; he is reprimanded for engaging in boundary violations with Patient A; he shall ensure a female chaperone who has read this Consent Order is present any time he examines a female patient who is either unclothed or whose breasts or genitals are to be examined; the presence of the chaperone shall be documented; he shall maintain appropriate patient-physician boundaries at all times; within 90 days of this Consent Order, he shall undergo evaluation by Christopher Norris, PhD, and shall ensure Dr Norris provides a written report to the Board and to Dr Silverstein; he shall comply with all recommendations made by Dr Norris; he shall post a copies of "Principles of Medical Practice" on his office walls; during probation, he shall require three members of his staff who have read this Consent Order to complete a "Staff Surveillance Form," which shall be forwarded to Dr Silverstein for inclusion in quarterly reports to the Board; he shall continue his therapy with Dr Silverstein or such other person as may be approved by the president of the Board; must comply with other conditions.

SUTTON, Frank Morrison, Jr, MD

Location: Kinston, NC (Lenoir Co)
DOB: 7/31/1970
License #: 2003-01065
Specialty: AN (as reported by physician)
Medical Ed: Wake Forest University School of Medicine (1997)
Cause: In a Consent Order of 8/18/2205, Dr Sutton admitted to engaging in unprofessional conduct [related to prescribing]. That Consent Order limited him to prescribing controlled substances only to patients to whom anesthesia or pain management services were being provided at Lenoir Memorial Hospital. He has asked that Consent Order be amended to allow him to prescribe controlled substances to such patients at any hospital or ambulatory surgical facility licensed by North Carolina.

Action: 12/22/2005. Amended Consent Order executed: Dr Sutton's license is suspended for 12 months beginning 10/15/2005; all but 30 days of the suspension shall be stayed on conditions; he shall prescribe controlled substances only to those patients to whom anesthesia or pain management services are provided at a hospital or ambulatory surgical facility licensed by North Carolina; he shall strictly comply with the Board's position statements related to prescribing; must comply with other conditions.

TIRONA, Francisco P., MD

Location: Sanford, NC (Lee Co)
DOB: 1/29/1967
License #: 0098-01786
Specialty: IM (as reported by physician)
Medical Ed: University of Santo Thomas, Philippines (1991)
Cause: Between May and September 2004, Dr Tirona prescribed Percocet® and Xanax® to a patient but did not document the prescriptions in the patient's chart describing the patient's history, diagnosis, etc. On September 30, 2004, he prescribed Percocet® to the patient on the prescription blank of a clinic at which he no longer worked and that prescription was not documented in the patient's chart.

Action: 1/20/2006. Consent Order executed: Dr Tirona is reprimanded; he shall comply with the Board's Position Statement on "Medical Record Documentation"; must comply with other conditions.

VIRMANI, Ashutosh, MD

Location: Charlotte, NC (Mecklenburg Co)
DOB: 8/06/1953
License #: 0000-38567
Specialty: OB/GYN (as reported by physician)
Medical Ed: University of Medicine and Dentistry of New Jersey, Newark (1985)

Cause: While practicing as an independent contractor with a clinic he did not own, operate, or manage, and whose employees were employed by the clinic and whose protocols were set by the owners, Dr Virmani pre-signed prescriptions at the beginning of each day from March to August 2004. The prescriptions were prepared by the clinic staff for dispensing during the day per the protocol. The prescriptions were filled out with the names and dosages of medications, but not the patients' names. As each patient left the practice, the staff would place his or her name on the prescription in accord with standing orders. Dr Virmani did not write the prescriptions for particular patients and relied on staff to complete the prescriptions for medications he has previously authorized for existing patients. Without his knowledge, a member of the office staff obtained several pre-signed prescriptions and used them to obtain medication for non-patients. When he learned what was happening, he told the clinic's owners and steps were taken to secure the prescriptions and prevent their future misuse. Action included terminating the involved staff, securing blank prescription pads, and authorizing each individual patient prescription. Pre-signing prescriptions is unprofessional conduct.

Action: 12/29/2005. Consent Order executed: Dr Virmani is reprimanded and shall comply with the Board's Position Statement on Writing of Prescriptions.

WHITE, Steven William, Physician Assistant

Location: Cameron, NC (Harnett Co)
DOB: 12/19/1962
License #: 0001-02116
PA Education: Midwestern University (1996)
Cause: Mr White entered a Consent Order with the Board on 12/03/2003, and that Consent Order was amended on 12/13/2004. Under a Consent Order of 6/01/2005, he agreed to obtain an assessment prior to 9/21/2005 at a center dedicated to the health of health care practitioners and to enter and maintain a contract with the NCPHP. He met with the Board in September 2005 and the Board authorized an amendment to the 6/01/2005 Consent Order due to his having obtained the required assessment.

Action: 1/13/2006. Amended Consent Order executed: Mr White must contract with the NCPHP and abide by that contract; he is issued a license to expire on the date shown on the license [3/31/2006]; he shall appear for an informal interview with the Board in March 2006; all other terms, conditions, and provisions of the numbered paragraphs of the 12/03/2003 Consent Order remain in effect.

WHITNEY, Douglas Terry, Physician Assistant

Location: Fort Bragg, NC (Cumberland Co)
DOB: 1/14/1947
License #: 0001-00152
PA Education: Bowman Gray (1976)
Cause: On 10/08/2004, the New York Board for Professional Medical Conduct entered a Consent Order with Mr Whitney in which he agreed not to contest four charges of professional misconduct concerning practicing beyond the scope of practice allowed by law and failing to maintain adequate records. He agreed to a censure and reprimand, a fine, and conditions on his license.

Action: 1/20/2006. Consent Order executed: Mr Whitney is reprimanded.

WILMIT, Samuel Theodore, MD

Location: Tuxedo Park, NY
DOB: 11/11/1936
License #: 2005-01795
Specialty: PD/AM (as reported by physician)
Medical Ed: Tufts University School of Medicine (1961)
Cause: Dr Wilmit is now licensed in New York and has never been licensed in North Carolina. He has not practiced clinical medicine since 7/2002 and does not intend to return to clinical practice at this time. His plan is to practice only in an administrative setting. He is now medical director for United Healthcare, a position that requires a medical license.

Action: 11/14/2005. Non-Disciplinary Consent Order executed: Dr Wilmit is granted an administrative license that requires he limit his practice to administrative medicine and not engage in the clinical practice of medicine.

YANUCK, Michael David, MD

Location: Palm Harbor, FL
DOB: 8/10/1962

License #: 2006-00003
 Specialty: FP (as reported by physician)
 Medical Ed: Albany Medical College (1987)
 Cause: On application for a license. Dr Yanuck is now licensed in Florida. He has not practiced clinical medicine since 1999 and does not intend to return to clinical practice at this time. He plans to practice only in an administrative setting, consulting in a non-clinical situation.
 Action: 1/06/2006. Non-Disciplinary Consent Order executed: Dr Yanuck is granted an administrative medical license that requires he limit his practice to administrative medicine only.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL**COOPER VAUGHN, Margaret Vivian, MD**

Location: Riverside, CA
 DOB: 7/30/1968
 License #: NA
 Specialty: OB/GYN (as reported by physician)
 Medical Ed: Rush Medical College of Rush University (1998)
 Cause: Dr Cooper Vaughn has not practiced medicine in a clinical setting since July 2002.
 Action: 12/09/2005. Denial of Dr Cooper Vaughn's application for medical license in North Carolina.

DESPER, Beatrice Smith, MD

Location: Covington, LA
 DOB: 1/12/1943
 License #: NA
 Specialty: OB/GYN (as reported by physician)
 Medical Ed: Tufts University School of Medicine (1979)
 Cause: The Connecticut Department of Public Health reprimanded Dr Desper in January 2003.
 Action: 12/08/2005. Denial of Dr Desper's application for medical license in North Carolina.

TAYLOR, Dennis Absher, Nurse Practitioner

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 1/10/1958
 Approval #: NA
 NP Education: Seton Hall University (2005)
 Cause: The Board found Mr Taylor not qualified based on NCGS 90-14(a)(1), (6), (7), and (8).
 Action: 12/08/2005. Denial of Mr Taylor's application for approval as a nurse practitioner in North Carolina. [As of 12/16/2005, licensee requested hearing.]

TURTON, William Edward, MD

Location: Irvington, IN
 DOB: 6/04/1962
 License #: NA
 Specialty: IM (as reported by physician)
 Medical Ed: University of Western Ontario Faculty of Medicine and Dentistry (1989)
 Cause: Dr Turton was reprimanded and his license was suspended by the College of Physicians and Surgeons of Ontario for an improper sexual relationship with a patient.
 Action: 12/06/2005. Denial of Dr Turton's application for medical license in North Carolina.

WALLS, Ronald George, MD

Location: Watchung, NJ
 DOB: 11/04/1962
 License #: NA
 Specialty: US (as reported by physician)
 Medical Ed: Hahnemann Medical College, Philadelphia (1992)
 Cause: Dr Walls failed to satisfy the Board of his qualifications because he failed to provide materials regarding satisfactory completion of his residency, materials he said he would provide. The Board considers that failure a false statement or representation to the Board or willful concealment of material information.
 Action: 11/14/2005. Denial of Dr Walls' request to withdraw his license application and denial of his application for medical license in

North Carolina.

WALTER, Steven Wayne, MD

Location: Cary, NC (Wake Co)
 DOB: 12/19/1957
 License #: NA
 Specialty: IM (as reported by physician)
 Medical Ed: Medical College of Ohio (1983)
 Cause: The Board finds Dr Walter is unable to practice medicine with reasonable skill and safety by reason of illness, excessive use of drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. Additionally, the states of Ohio and Virginia have taken public action against his medical license in the past.
 Action: 11/15/2005. Denial of Dr Walter's application for medical license in North Carolina. [As of 11/23/2005, licensee requested hearing.]

SURRENDERS**GUARINO, Clinton Toms Andrews, MD**

Location: Hickory, NC (Burke Co)
 DOB: 2/04/1966
 License #: 0099-00062
 Specialty: IM (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (1996)
 Action: 12/27/2005. Voluntary surrender of North Carolina Medical license.

ROHR, Michael Snell, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 4/15/1941
 License #: 0000-38423
 Specialty: GS (as reported by physician)
 Medical Ed: Tulane University (1967)
 Action: 11/17/2005. Voluntary surrender of North Carolina medical license.

See Consent Orders:

GUALTEROS, Oscar Mauricio, MD**COURT APPEALS/STAYS**

NONE

CONSENT ORDERS LIFTED**BOZEMAN, Elizabeth Ribadeneyra, MD**

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 1/01/1961
 License #: 2005-00795
 Specialty: FP (as reported by physician)
 Medical Ed: University of South Carolina School of Medicine (1991)
 Action: 1/26/2006. Order issued lifting Consent Order of 5/02/2005.

MAYFIELD, Kelli Burgin, MD

Location: Shelby, NC (Cleveland Co)
 DOB: 8/15/1963
 License #: 0095-00998
 Specialty: FP (as reported by physician)
 Medical Ed: East Tennessee State University (1993)
 Action: 11/22/2005. Order issued lifting Consent Order of 9/13/2002.

MOIR, Ronald Jeffrey, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 12/30/1956
 License #: 0000-31176
 Specialty: AN/ADDM (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1984)
 Action: 12/12/2005. Order issued lifting Consent Order of 3/19/2004.

PARIKH, Prashant Pramod, MD

Location: Lansdale, PA
 DOB: 4/19/1962
 License #: 2005-00796
 Specialty: FP (as reported by physician)
 Medical Ed: Grant Medical College, University of Mumbai (1984)
 Action: 11/22/2005. Order issued lifting Consent Order of 5/09/2005.

PECKINPAUGH, James Matthew, MD

Location: Kannapolis, NC (Cabarrus Co)
 DOB: 11/13/1959
 License #: 0000-39059
 Specialty: FP (as reported by physician)
 Medical Ed: University of Cincinnati (1987)
 Action: 12/08/2005. Order issued lifting Consent Order of 2/25/2003.

THOMPSON, Jill Ellen, MD

Location: Gastonia, NC (Gaston Co)
 DOB: 3/31/1957
 License #: 0093-00608
 Specialty: R/RNR (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1991)
 Action: 12/01/2005. Order issued lifting Consent Order of 1/22/2004.

**TEMPORARY/DATED LICENSES:
 ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES**

BARBER, Robert Anthony, DO

Location: Morehead City, NC (Carteret Co)
 DOB: 9/30/1954
 License #: 2003-00222
 Specialty: FP (as reported by physician)
 Medical Ed: University of Health Sciences College of Osteopathy (1989)
 Action: 11/17/2005. Temporary/dated license extended to expire 5/31/2006.

BLEVINS, Douglas Dane, MD

Location: Durham, NC (Durham Co)
 DOB: 8/31/1950
 License #: 2005-00141
 Specialty: IM/ID (as reported by physician)
 Medical Ed: University of Virginia School of Medicine (1976)
 Action: 11/17/2005. Temporary/dated license extended to expire 2/28/2007.

BREWSTER, Thomas Edmund, MD

Location: Denton, NC (Davidson Co)
 DOB: 11/04/1956
 License #: 0000-28141
 Specialty: GP/EM (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (1983)
 Action: 1/31/2006. Temporary/dated license extended to expire 2/28/2006.

COLLINS, Paul Dwayne, MD

Location: Pembroke, NC (Robeson Co)
 DOB: 2/08/1973
 License #: 2005-00139
 Specialty: FP (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (2001)
 Action: 11/17/2005. Temporary/dated license extended to expire 5/31/2006.

DEVIRGILIIS, Juan Carlos, MD

Location: Boone, NC (Watauga Co)
 DOB: 8/29/1957
 License #: 0000-28719
 Specialty: FP/P (as reported by physician)
 Medical Ed: Faculty of Medical Sciences, National University of Argentina (1982)
 Action: 11/17/2005. Temporary/dated license extended to expire 5/31/2006.

EATON, Hubert Arthur, Jr, MD

Location: Wilmington, NC (New Hanover Co)
 DOB: 5/25/1943
 License #: 0000-17858
 Specialty: IM (as reported by physician)
 Medical Ed: Meharry Medical College School of Medicine (1969)
 Action: 1/19/2006. Temporary/dated license extended to expire 9/30/2006.

FOLKERTS, AnnaMaria, Physician Assistant

Location: Elon, NC (Alamance Co)
 DOB: 8/24/1961

License #: 0001-02206
 PA Education: College of West Virginia (1996)
 Action: 11/17/2005. Temporary/dated license extended to expire 5/31/2006.

HARRIS, John Joel, Jr, MD

Location: Bladenboro, NC (Bladen Co)
 DOB: 6/30/1958
 License #: 0000-32114
 Specialty: AN (as reported by physician)
 Medical Ed: University of Tennessee, Memphis (1984)
 Action: 11/17/2005. Temporary/dated license extended to expire 5/31/2006.

HOOPER, Jeffrey Curtis, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 9/21/1964
 License #: 0097-00286
 Specialty: FP (as reported by physician)
 Medical Ed: Vanderbilt University School of Medicine (1995)
 Action: 11/17/2005. Full medical license issued.

LAVINE, Gary Harold, MD

Location: New Bern, NC (Craven Co)
 DOB: 11/04/1964
 License #: 2001-00403
 Specialty: EM (as reported by physician)
 Medical Ed: University of South Alabama (1989)
 Action: 1/19/2006. Full and unrestricted medical license issued.

McCLELLAND, Scott Richard, DO

Location: Wilmington, NC (New Hanover Co)
 DOB: 7/19/1948
 License #: 0000-29064
 Specialty: P (as reported by physician)
 Medical Ed: Kirksville College of Osteopathic Medicine (1980)
 Action: 1/19/2006. Full and unrestricted medical license issued.

MUNCHING, Aaron Albert, Physician Assistant

Location: Wilmington, NC (New Hanover Co)
 DOB: 1/10/1961
 License #: 0010-00016
 PA Education: Alderson Broaddus (1990)
 Action: 11/17/2005. Temporary/dated license extended to expire 5/31/2006.

SMITH, David Lewis, Physician Assistant

Location: La Grange, NC (Lenoir Co)
 DOB: 9/19/1951
 License #: 0001-01503
 PA Education: Alderson Broaddus (1992)
 Action: 1/19/2006. Temporary/dated license extended to expire 7/31/2006.

WADDELL, Roger Dale, MD

Location: Aberdeen, NC (Moore Co)
 DOB: 11/17/1954
 License #: 0000-30105
 Specialty: GP (as reported by physician)
 Medical Ed: University of Colorado School of Medicine (1981)
 Action: 1/19/2006. Temporary/dated license extended to expire 9/30/2006.

WHITMER, Gilbert Gomer, Jr, MD

Location: Dunn, NC (Harnett Co)
 DOB: 9/04/1961
 License #: 0000-36854
 Specialty: OS/OHS (as reported by physician)
 Medical Ed: The Johns Hopkins (1987)
 Action: 11/17/2005. Temporary/dated license extended to expire 3/31/2006.

See Consent Orders:

GUALTEROS, Oscar Mauricio, MD

HARDY, Stephen Carl, MD

KINNALLY, Steven Joseph, Physician Assistant

ROGERS, Bruce William, MD

WHITE, Steven William, Physician Assistant**REENTRY AGREEMENTS****BILHORN, Denise Holloman, MD**

Location: Hickory, NC (Catawba Co)
 DOB: 9/22/1954
 License #: 2006-00001
 Specialty: OB/GYN (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1981)
 Cause: On application for a North Carolina medical license. Dr Bilhorn has not practiced clinical medicine since June 1994. Her CME is current and she agrees to undertake a reentry program. She has been licensed in Minnesota since 1982 and has secured a position with A Woman's View Clinic in Hickory.

Action: 1/03/2006. Reentry Agreement and Order executed: Dr Bilhorn is issued a North Carolina medical license; she shall arrange to have a physician colleague observe her practice for the first year and deliver to the Board three letters at specific times during the observation period reporting on the nature of the observations made and an opinion of Dr Bilhorn's skills; she shall meet with the Board in July 2006 to discuss her transition back in practice.

BOWERS, Howard Edward, Jr, Physician Assistant

Location: Burnsville, NC (Yancey Co)
 DOB: 10/31/1942
 License #: 0010-00212
 PA Education: University of Florida (1977)
 Cause: On application for a PA license. Mr Bowers was in pharmaceutical sales from August 1983 to March 2004. He served in the Florida Army National Guard as a PA from 1981 to 1999. He has not practiced as a PA since 1999.

Action: 12/15/2005. Amended Reentry Agreement and Order executed: Mr Bowers is issued a PA license; he shall arrange to have his supervising physician observe his practice for six months following his resumption of practice; each month during the observation period, his supervising physician shall deliver to the Board a letter reporting in detail on his observations and stating an opinion on the level of Mr Bowers' skill; Mr Bowers must obtain all required CME in a timely manner; must comply with other conditions.

CASHION, Sandra Elise, Physician Assistant

Location: Cary, NC (Wake Co)
 DOB: 9/07/1962
 License #: 0001-00883
 PA Education: Bowman Gray (1995)
 Cause: On application for a North Carolina PA license. Ms Cashion has not practiced as a PA since October 2003. Her CME is current and she agrees to undertake a reentry program.

Action: 1/05/2006. Reentry Agreement and Order executed: Ms Cashion is issued a North Carolina PA license; she shall arrange to have her supervising physician observe her practice for six months and deliver monthly evaluations to the Board describing the observations made and an opinion as to her skills; she shall meet with the Board if and when requested to discuss her transition to practice.

HESS, Philip Joseph, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 5/22/1938
 License #: 0000-21661
 Specialty: CDS/TS (as reported by physician)
 Medical Ed: Ohio State University College of Medicine and Public Health (1968)
 Cause: On application to reactivate his North Carolina medical license, which became inactive in September 2000. He has been out of active practice in the interim and had laser surgery on both eyes in July 2005. He has agreed to undertake a reentry program.

Action: 1/03/2006. Reentry Agreement and Order executed: Dr Hess is issued a North Carolina medical license; he shall arrange to have a physician colleague observe his practice for the first six months and deliver to the Board a report within 30 days of the end of that period describing the observations made and assessing Dr Hess' clinical skills; he shall inform the Board's Director of Investigations when he is scheduled to begin practice and arrange an informal interview to occur six months after that date; he shall not perform surgery as the primary physician, but if his observing physician feels it is safe to do so, he may perform surgery as an assisting physician.

WELLIVER, Gary Evan, MD

Location: Wilmington, NC (New Hanover Co)
 DOB: 6/08/1939
 License #: 0000-27647
 Specialty: OS (as reported by physician)
 Medical Ed: University of Tennessee (1966)
 Cause: Dr Welliver did not practice medicine from April 2003 to March 2005. On resuming practice in 2005, he began shadowing another orthopedic surgeon and seeing patients while being closely monitored. His CME is up to date and he agrees to undertake a program of reentry.

Action: 12/15/2005. Reentry Agreement and Order executed: Dr Welliver shall arrange for a physician colleague to observe his practice for six months; the observing physician shall deliver letters to the Board by March 15 and June 15 describing his or her observations and stating an opinion as to Dr Welliver's skills during each reporting period; must comply with other conditions.

DISMISSALS**RODEZNO, Robert Vincent, Physician Assistant**

Location: Newport, NC (Carteret Co)
 DOB: 7/29/1955
 License #: 0001-02233
 PA Education: Naval School of Health and Science (1993)
 Cause: Death of subject.
 Action: 1/06/2006. Order issued: Notice of Charges and Allegations of 10/28/2004 against Mr Rodezno is dismissed without prejudice; Order of Summary Suspension of 12/16/2004 is terminated.

STADIEM, Michael David, MD

Location: Cary, NC (Wake Co)
 DOB: 10/04/1950
 License #: 0000-23233
 Specialty: FP (as reported by physician)
 Medical Ed: University of Pennsylvania (1976)
 Cause: Consent Order entered 11/18/2005.
 Action: 12/20/2005. The Board's case against Dr Stadiem closed by a Notice of Closure issued by the Office of Administrative Hearings in response to a Notice of Dismissal presented to that Office by the Board on 12/14/2005.

CHANGE OF ADDRESS FORM

Mail Completed form to: North Carolina Medical Board
PO Box 20007, Raleigh, NC 27619

Please print or type: _____ Date: _____

Full Legal name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

Business: _____

Phone: (____) _____ Fax: (____) _____

Home: _____

Phone: (____) _____ Fax: (____) _____

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 60 days of a move.



North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: May 17-19, 2006; June 14-15, 2006; July 19-21, 2006
August 16-17, 2006; September 20-22, 2006

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. If you have additional questions, please e-mail Amy Ingram, the Board's GME Coordinator, at amy.ingram@ncmedboard.org or visit the Board's Web site at <http://www.ncmedboard.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.

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