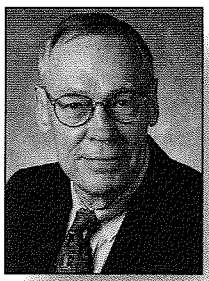
Primum Non Nocere

No.1 1997

forum

NC MEDICAL BOARD



President's Message

George C. Barrett, MD

What If . . . ?

Foolish the doctor who despises the knowledge acquired by the ancients.

I swear by Apollo the physician...to hold my teacher in this art equal to my own parents;...to consider his family as my own brothers and to teach them the art, if they want to learn it,...without fee or indenture;...and to indentured pupils who have taken the physician's oath....

Hippocrates (c 460-357 BC)

My message in the December issue of the *Forum* stimulated several comments ranging from "I wanted to be at that dinner" to "What port did you serve?" More to the point, however, one of the most insightful came from a colleague who said she felt threatened by the prospect of having her skills evaluated by the North Carolina Medical Board, being found deficient, and having no place to turn for an effective, focused educational opportunity.

Viewed in a non-punitive context, there will be no Board review of competence or performance until a problem arises that justifies such a review. Post-licensure competence and performance should be monitored by the profession. Peer review, be it by colleagues or through specialty boards or self-assessment centers, should be an integral part of that effort. Documented computer-based continuing medical education is just one of several avenues by which the licensed physician might approach his or her identified deficiencies.

Assessment and Referral

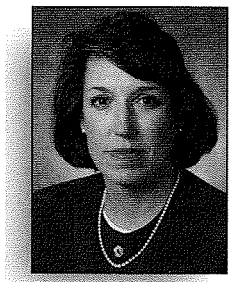
My colleague's concerns are well founded, for at each of its meetings your Board confronts at least one physician brought to its attention by deficiencies in such areas as record keeping, communication skills, diagnostic acumen, medical knowledge, or technical ability. Evaluation is needed. But where do we turn? And where does the physician turn? In the absence of relevant continuing medical education programs, assessing a physician and

"Post-licensure competence and performance should be monitored by the profession."

continued on page 2

In This Issue of the Forum

Item	Page
President's Message: *What If?*	1
Assistant Executive Director's Message: *Annual Physician Registraton: An Update*	1
NCMB Adopts New Position Statement on the Retired Physician	3
NCMB Datalink	3
Leaving or Closing a Medical Practice: Notification and Records	4
Board Calendar	4
A Personal View: *Some Thoughts on Managed Care, Finances, and Ethics*	5
Do Physicians Really Want Their Day in Court? Absolutely Not!	6
PA and NP Prescribing: A Clarification	7
The RTL Is Restricted to a Specific Training Program	7
Big-Hearted Physician Assistants Look to Removal of Obstacles to Care	8
From the NC Board of Pharmacy: *Ordering Pharmaceuticals Prescriptions by Fax*	8
Reporting of Changes in Staff Privileges	9
Gov Hunt Names Dr Kanof to NCMB	9
A Review: *Fundamentals of Complementary & Alternative Medicine*	10
Board Orders/Consent Orders/Other Board Actions: November 1996-January 1997	11
NCMB Roster on Diskette: Order Form	16
Change of Address Form	16



From the Assistant Executive Director

Helen Diane Meelheim,JD

Annual Physician Registration: An Update

The 1997 annual registration of physicians is coming to a close. As I am sure you recall, this marked the beginning of the new annual registration system (replacing our previous biennial system) and introduced our simplified registration form. (I should add, by the way, that the $200 biennial fee was appropriately reduced to an annual fee of $100.)

Only a Few Problems

The simplified form seems to have proven easy to use for most registrants. Minor problems were expected, of course, and did arise on occasion: some forms seem to have mysteriously disappeared from a few physicians' mail, requiring several extra copies to be sent out, some forms arrived at the Board without checks attached, and some incomplete forms were filed.

Some physicians who did not wish to continue practice in the state or wanted to retire had to deal with the fact that failure to register leads to suspension—an unpleasant word. However, in such a case, the suspension is administrative in nature, is not punitive, and is not reported as a disciplinary action.

One unique problem involved a physician with the Centers for Disease Control who could not be paid until his new certificate arrived at his duty site in Africa!

At this writing, more than 22,000 new registration certificates have been mailed to those who have registered. Their forms have been scanned and the data have been processed.

Period of Transition

On February 20, the Board sent a "reminder" notice to some 800 physicians who simply did not respond to the registra-

continued on page 10

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forum

NC MEDICAL BOARD

Raleigh, NC **Vol. II, No. 1, 1997**

The *Forum* of the North Carolina Medical Board is published four times a year. We welcome letters and comments. Letters must be typewritten, should include the writer's full name, address, and telephone number, and should be as brief as possible. Those selected for publication will be edited in accord with available space and editorial standards. Letters should be sent to the editor at the address noted below.

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President's Message

continued from page 1

identifying deficiencies that could be effectively addressed through education can lead the Board, which must act to protect the public, to end the career of a physician who might otherwise be salvaged. Such a result, though necessary in the circumstances, diminishes the profession and denies the public the potential benefit of that physician's services.

In the United States, there are five referral programs that vary somewhat in their level of activity:

- Physician Initiated Continuing Medical Education, affiliated with the University of Wisconsin;
- Colorado Personalized Education for Physicians, an independent program;
- Individualized Physician Renewal Program, affiliated with the Oregon Medical Society;
- Clinical Enhancement Program, affiliated with East Carolina University Medical School; and
- Physician Prescribed Educational Program, of the State University of New York, Syracuse.

Two programs are active in Canada:

- Physician Review and Enhancement Program, operated by the College of Physicians and Surgeons of Ontario; and
- Clinical Assessment and Enhancement Program, of Manitoba.

Each of these programs uses similar assessment tools:

- development of a profile of the physician's practice;
- medical and (when indicated) psychiatric evaluation;
- written and/or computer-based multiple choice examination;
- chart review (which may be a part of profile development);
- structured oral examination;
- standardized patient simulations;
- Myers-Briggs personality inventory; and
- an office visit (when indicated).

Each program develops educational opportunities designed to correct the identified areas of deficiency. They are essentially prescriptive—designed for the individual, just as medical therapy is aimed at correcting an identified medical problem.

Complications

As described on paper, these programs would appear to address any concern a physician review organization, a hospital board of trustees, or a medical regulatory board might have. Unfortunately, there are no standards that assure the referring agency or individual of a commonality of approach, interpretation of evaluation data, or therapy design.

What if you are a primary care physician who failed the recertification examination? You also misdiagnosed MIs as PEs several times during the past two years. Hospital review decided you had to be evaluated and obtain focused education following the evaluation. Geographically, East Carolina operates the program nearest you; however, currently they have no primary care physicians with time to work with you after evaluation. Wisconsin and Colorado are too costly. SUNY-Syracuse is full. You don't live in Oregon. Where do you turn?

What if the North Carolina Medical Board, after extensive review of your office charts, concludes your record keeping is horrible (not unusual, sorry to say), your prescribing practices are antiquated, and your communication skills are limited? All this came to the attention of the Board as the result of a complaint that was otherwise incidental and had no merit. The Board wants you and your practice evaluated. You are the only physician in a community of 8,000 in western North Carolina. East Carolina is across the state. Your patients do not want you to leave (practice the art and you will be loved). What do you do? What does the Board do?

"The referral programs now functioning are marginally funded, if at all."

These are not hypothetical questions. They are real. Physicians, hospitals, managed care organizations, review organizations, and medical regulatory boards face them frequently. The referral programs now functioning are marginally funded, if at all. The infrastructure required to establish and support the programs is costly and use of the programs is not indicative of the need for their services.

A Glance Back

What if we turned the clock back to the mid-eighteenth century? We would find medical licensure coming into vogue, says Ester Smith, PhD, in a literature review of medical regulation. *(Medical Regulation Literature Review 1986-1993: Preliminary Recommendations for Future Research.* U.S.

continued on page 3

President's Message

continued from page 2

DHHS, HRSA, Division of Quality Assurance, Bureau of Health Professions, 1994.) Then, during the administration of President Andrew Jackson, licensure fell into disfavor and most states did away with medical boards for some years, while medical education, still a somewhat unrefined and variable process, remained an unreliable indicator of a physician's abilities. Despite the waxing and waning of interest in licensure, we would find the best of the profession committed to advancing the quality of medical education. In fact, the weaknesses in medical education were the catalyst for the formation of many medical societies and the American Medical Association. According to Dr Smith's review, their main function was often to correct for inadequate medical education and to refine the standards for that education. The societies enhanced relations between the public and the profession as well, possibly as a result of their concern for quality education.

"Increasingly, the public and purchasers of health care want assurance of a doctor's competence and performance."

Until the middle of the twentieth century, county medical societies had a role in continuing medical education, especially in rural areas. With the increasing complexity of medicine and specialization, this role became impractical and passed to specialty societies and academic institutions.

Education Following Licensure

Now return to 1997. Increasingly, the public and purchasers of health care want assurance of a doctor's competence and performance. Is it not time for members of the profession, collectively and independently, to recall the pledge of Hippocrates to teach our brothers (and, now, sisters)? As a profession, should we not identify avenues to assure the public of our resolve to practice with reasonable skill and safety and thus be worthy of their trust? Should we not support our state medical society's initiative to identify effective means of assuring post-licensure competence and performance? Is correcting deficiencies in medical knowledge and practice not as important to the public as therapy for chemical impairment? Does not the geographic distribution of our Area Health Education Centers (AHEC) program place North Carolina in an ideal position to provide focused, personalized education? Historically, we have been deeply concerned with medical education and, as a professional community, we have contributed to developing one of the world's most respected medical education systems. Given that, and given the need and the opportunity, is this not the time for our corporate energy to be concentrated on education after licensure and specialty certification?

The American Medical Accreditation Program (AMAP) has suggested there is a recognition of the need for accountability. The Interprofessional Workgroup on Health Professions Regulation, in its Definition of Competence report, has called for not only entry-level assessment, but also assessment of continued competence. The group has recommended a system "in which the regulatory board can intervene before there is a serious complaint or harm to a consumer." My interpretation of these statements is that the questions I have posed above are being answered in the affirmative.

One definition of the profession of medicine says, in part, that "medicine sets its own standards, determines admission to the profession, and judges its own members accused of transgressions against the profession's ethical code...." What if you took that definition seriously? And what if you took the Hippocratic Oath seriously, sharing your time, perhaps through the AHEC program, teaching your colleagues who were in need of a mentor? This could be a key to developing successful assessment and personalized education programs, programs that would unlock a future of significant professional growth in the community of medicine and improved medical care for patients.

Think about it. What if ...? ♦

NCMB DataLink: A Key Information Service

The North Carolina Medical Board's 24-hour on-line verification system, DataLink, provides subscribers a wide range of information on North Carolina physicians, nurse practitioners, and physician assistants. Its data are updated twice weekly. Hospitals, various health care institutions, and others needing quick access to such information for credentials verification and other purposes should seriously consider the use of DataLink.

The NCMB's DataLink will assist in cost containment for users by providing on-line access at any time that might be convenient for them and by decreasing the need for telephone or written verifications. More information can be accessed at a reduced cost.

For more information, contact Ms Diane Meelheim or Ms Rebecca Manning at the NCMB: Telephone (919) 828-1212.

NCMB Adopts New Position Statement on the Retired Physician

At its meeting on January 24, 1997, the North Carolina Medical Board adopted the following position statement concerning retirement by physicians.

The Retired Physician

The retirement of a physician is defined by the North Carolina Medical Board as the total and complete cessation of the practice of medicine and/or surgery by the physician in any form or setting. According to the Board's definition, the retired physician is not required to maintain a currently registered license and SHALL NOT:

- provide patient services;
- order tests or therapies;
- prescribe, dispense, or administer drugs;
- perform any other medical and/or surgical acts; or
- receive income from the provision of medical and/or surgical services performed following retirement.

The North Carolina Medical Board is aware that a number of physicians consider themselves "retired," but still hold a currently registered medical license (full, volunteer, or limited) and provide professional medical and/or surgical services to patients on a regular or occasional basis. Such physicians customarily serve the needs of previous patients, friends, nursing home residents, free clinics, emergency rooms, community health programs, etc. The Board commends those physicians for their willingness to continue service following "retirement," but it recognizes such service is not the "complete cessation of the practice of medicine" and therefore must be joined with an undiminished awareness of professional responsibility. That responsibility means that such physicians SHOULD:

- practice within their areas of professional competence;
- prepare and keep medical records in accord with good professional practice; and
- maintain their competence through an active continuing medical education effort.

The Board also reminds "retired" physicians with currently registered licenses that all federal and state laws and rules relating to the practice of medicine and/or surgery apply to them, that the position statements of the Board are as relevant to them as to physicians in full and regular practice, and that they continue to be subject to the risks of liability for any medical and/or surgical acts they perform. ♦

Leaving or Closing a Medical Practice: Notification and Records

James A. Wilson, JD
Director, NCMB Legal Department

Lately, the Legal Department of the North Carolina Medical Board has been receiving frequent calls and questions about the obligations of physicians when one or more of them depart a group or close a practice. From time to time, we also receive calls from survivors of a recently deceased physician about how to wind up the practice. Since the last *Forum*, we have been asked by a widow what to do with her recently-deceased husband's patient records, we have received a complaint that a medical group would not give a departing physician's patients his new address, and we have had patients call expecting the Board to have the records of their retired or deceased former physicians.

Professional Obligation

There is no single set of laws directly addressing all considerations in such circumstances, and not all considerations are addressed by laws. There are, however, some well established professional obligations. Principally, as always, physicians must continue to consider how their actions affect their patients. Issues of particular interest to the Board are medical records and notice to patients.

Whenever a physician leaves a practice, including by retirement or death, the physician's patients should be notified. Many times, this is done by a newspaper announcement and by individual letter to current patients. If the departing physician will continue in practice, patients should be notified of the physician's new address and telephone number. Patients should be given an opportunity to choose who will be their physician thereafter. Patient records should remain available to patients, and patients should be told how to access and transfer their records. A medical group should not interfere in any way with the discharge of any of these obligations.

"A medical group should not interfere in any way with the discharge of any of these obligations."

When a solo practitioner dies, the estate may wish to make an announcement that patients may pick up copies of records. After a few months, the estate may wish to transfer the records to a nearby physician with a similar practice, in which case it should again notify patients. Extra care may be appropriate for psychiatric records. There is law, developed in cases from other states, that the estate may not destroy the records.

Planning Ahead

Whenever a physician leaves a practice, for whatever reason, the physicians involved have much to consider. Physicians involved may want to seek help from lawyers and accountants, and such occasions also warrant a call to the malpractice insurance company. Planning ahead is unpleasant, but much like buying life insurance or writing a will, can save a great deal of worry. Groups can develop policies, before they are needed, on how they will notify a departing physician's patients. They can make sure that the physician's new address is given out and that patients have access to their records and an opportunity to chose whether to stay with the group or go with the departing physician. Solo practitioners can make arrangements and leave instructions on notifying patients and preserving access to patient records. Planning ahead will save everyone involved a little anguish during a stressful time and will help ensure continuity of care for patients. ♦

North Carolina Medical Board Meeting Calendar, Application Deadlines, Examinations May 1997-December 1997

Board Meetings are open to the public, though some portions are closed under state law:

North Carolina Medical Board	**May 21-24, 1997**
May Meeting Deadlines:	
Nurse Practitioner Approval Applications	April 7, 1997
Physician Assistant Applications	March 25, 1997
Physician Licensure Applications	May 6, 1997
North Carolina Medical Board	**July 16-19, 1997**
July Meeting Deadlines:	
Nurse Practitioner Approval Applications	June 9, 1997
Physician Assistant Applications	June 3, 1997
Physician Licensure Applications	July 8, 1997
North Carolina Medical Board	**September 17-20, 1997**
September Meeting Deadlines:	
Nurse Practitioner Approval Applications	August 4, 1997
Physician Assistant Applications	August 5, 1997
Physician Licensure Applications	September 2, 1997
North Carolina Medical Board	**November 19-22, 1997**
November Meeting Deadlines:	
Nurse Practitioner Approval Applications	September 29, 1997
Physician Assistant Applications	September 30, 1997
Physician Licensure Applications	November 4, 1997

Residents Please Note USMLE Schedule

☛ Examinations Schedule

United States Medical Licensing Examination (USMLE) Step 3

May 13-14, 1997 Sitting
Deadline for receipt of application was February 12,1997
December 2-3,1997 Sitting
Deadline for receipt of application: September 4, 1997
May 12-13, 1998 Sitting
Deadline for receipt of application: February 11, 1998

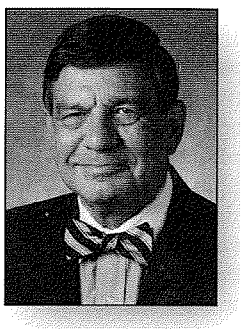
Special Purpose Examination (SPEX)

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 400 Fuller Wiser Road, Suite 300, Euless, TX 76039 or telephone (817) 868-4000.

A Personal View

Some Thoughts on Managed Care, Finances, and Ethics

Walter M. Roufail, MD
Past President, NCMB



Dr Roufail

Quite recently, I had occasion to respond to a letter challenging the North Carolina Medical Board to involve itself with the financial clauses of managed care organizations' contracts that might interfere with the ethical boundaries of the patient/physician relationship and with the ability of physicians to offer their skills to all potential patients. To summarize my answer, I reminded the writer that:

- the Board is a de facto state agency;
- its responsibilities and powers are delineated in the Medical Practice Act;
- nowhere in the Medical Practice Act is there any mention of the Board's reviewing, discussing, or adjudicating financial contracts between patients, physicians, and third-party payers.

An exception would be the conviction for fraud and abuse or for gross exploitation of patients by a few physicians whose financial greed overcomes their ethics. The experience of the Board with those physicians has been sadly ineffective (because they can usually afford to muster a retinue of trial lawyers, whom they publicly profess to abhor!).

An Imperfect System That Seemed to Work

Apart from the constraints imposed on the Board by legal restrictions, I shall venture some personal thoughts about the issues involved.

Both financial remuneration and ethics have been a part of medicine since antiquity. It is true that today, in the United States, the financial realities are quite different, but the ethical principles, I believe, remain the same.

We all refer to the Golden Age of Medicine when the physician's autonomy was supreme, when you charged what you thought you were worth and you hoped the community and your colleagues would concur. Then, the most effective marketing tool was the perception of your skills and professional demeanor by your colleagues and patients.

However, with that faintly remembered freedom came significant responsibilities. Hospital privileges were conditioned on pro bono services offered to the less fortunate in the community, both on an outpatient and inpatient basis. This required mandatory rotations through the emergency room, which were less than financially rewarding at the time. I do not recall there were any differences in treatment for those who could or could not pay. The system, for all its imperfections, seemed to work. The public and the politicians called it "the best health care system in the world."

Although the perception of "the best system" might have been enhanced by the breakthroughs in diagnostic and therapeutic discoveries, I am convinced that it was rooted in the community-based physician who had and honored a contract between himself and his patients, regardless of their economic status or ability to pay. This is unique and remains, albeit to a lesser extent, the hallmark of American medicine.

Gone Are the Days

Corporate medicine has clouded origins. Some would put it squarely at the passage of Medicare in 1965, followed shortly by the Medicaid program. Physicians were now paid for services they had provided without charge. The windfall became an expected part of income and, at least at the beginning, a lucrative one. For the first time, medical services had a specific price tag imposed by federal agencies, followed shortly by state agencies.

With the growth in medical technology and the willingness of both government and private insurers to pay for it, the cost of medical services has spiraled over the past three decades. Whether this has resulted in substantial improvement in the quality of life and the health outcome for our patients is debatable. The great strides achieved through technology in cardiovascular disease, for example, have to be weighed against the futile, senseless, and often cruel prolongation of life by a few weeks or months.

Comes now business and the "bottom line" mentality. Business has dealt with medical costs as one would expect it would: streamlining, downsizing, and cost cutting. The point that medical services are different has received a polite acknowledgment, but, in essence, our patient/physician relationships are traded both on the commodity market and the New York Stock Exchange, and are determined by the decisions of HCFA and the U.S. Congress.

In a free society, a radical shift in delivery systems cannot occur without the acquiescence of all parties, including organized (but mostly fractured) medicine. Once the medical profession equates medical services to business transactions and subject to market forces, there is very little ground for organized medicine to wave the flag of patient advocacy. In every community and every physician's office, there is active competition for "covered lives" and protection of income. Gone are the days when collegial gatherings of physicians were always meant to share clinical experiences. The buzz in the doctors' lounges is how to deal with the new financial realities.

"Once the medical profession equates medical services to business transactions..., there is very little ground for organized medicine to wave the flag of patient advocacy."

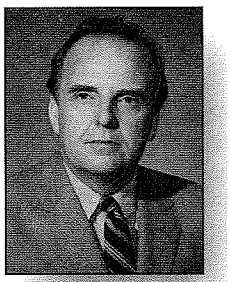
Ethics and Finances Should Be Dissociated

I suggest that in this country the medical profession has tried assiduously to dissociate finances and ethics over the course of its history. Now that reality has entwined them both, we are in search of a viable solution to the problem.

I propose that the separation between ethics and finances be restored. Ethics should be in the realm of the profession, as with the guilds of old. Financial arrangements, contracts, with either patients or third-party payers should be honored as such. However, should ethics be breached because of financial considerations, which I believe would be a major ethical infraction, the state medical board should take the moral leadership of educating, rehabilitating, and, if necessary, sanctioning all health professionals responsible for the breach of the trust patients have placed in the system. ♦

Do Physicians Really Want Their Day in Court? Absolutely Not!

Edward E. Hollowell, JD



Mr Hollowell

Representing physicians before the North Carolina Medical Board presents advocacy challenges and opportunities for attorneys. But are the challenges and opportunities different than any other type of representation attorneys provide for their clients? I think so. Let me share with you a few of the challenges and opportunities I have experienced in representing physicians before the Board over many years.

The Stakes Are High

There are indeed several challenges for the attorney. The first is the tremendous risk involved to the physician. The physician's professional reputation as well as his or her medical license may be in jeopardy. A physician whose professional reputation is tarnished faces severe consequences during the remainder of his or her professional career. Loss of license is professionally and economically devastating. All physicians I have known who have lost their licenses have suffered economic as well as professional devastation. Homes are lost, marriages broken, lives often shattered.

I have asked medical students, residents, and practicing physicians many times: "What is the greatest legal threat to you in the practice of medicine today?" The great majority respond: "Why, malpractice of course." While I do not want to minimize the ever increasing threat of malpractice litigation, let me draw an analogy. It would be very disheartening to a physician to be involved in a malpractice trial and have the jury return a verdict of $1.2 million at 3:00 PM on a Friday. That would tend to spoil the physician's weekend. However, what really happens? The physician's liability carrier pays the judgment and, on Monday morning, the physician returns to the office and continues medical practice.

"The attorney must be straight with clients and tell them what they must hear and not what they want to hear."

But what if, on the same Friday afternoon, a physician were summoned to the Board and the Board requested the surrender of his or her license? Not only would that spoil a weekend, it would mean no return to medical practice on Monday morning. The physician would be unemployed and, most likely, unemployable. Yes, the stakes are high.

Sensitizing the Physician Client

How, then, does an attorney sensitize clients to the tremendous risk involved in any proceeding involving their medical license that could have a negative result for their license and professional career? First, the attorney must be straight with clients and tell them what they must hear and not what they want to hear. A physician's license is not only the gateway to financial stability, but also to professional achievement. An adverse malpractice claim resulting from the failure to use due care cannot be compared to an error in judgment in a sexual boundary violation that results in the loss of the medical license and the tarnishing of the professional reputation. There isn't any comparison.

The second challenge for an attorney representing physicians before the Board is to assure that the clients understand the nature of the proceedings before the Board. Many physicians believe their fellow physicians are not going to take any action against them. They must be fully briefed on the legal duty of the Board and its members—physicians and non-physicians. While the proceedings before the Board are not punitive in nature, they can be adversarial. Physicians involved in such proceedings must understand that the supposed "good ol' boy network" is not going to save them. The members of the Board are honorable men and women, and they are going to carry out their statutory responsibility of protecting the public against unfit physicians.

I admonish medical students, residents, and the physicians I represent that any time a physician receives a notification from the Board, that notification must be taken very seriously. I contend that physicians should employ attorneys to represent them before the Board. My experience indicates the best opportunity a physician has is to "nip the concerns of the Board in the bud." If a physician attempts to go it alone at the early stages of a proceeding before the Board, including an informal conference or pre-charge negotiation, and experiences an adverse result, the only thing his or her attorney can then do is resort to damage control. By comparison, I would not dare think of becoming involved in a proceeding before the North Carolina State Bar that could result in tarnishing my professional reputation or the loss of my license without being represented by counsel.

Thirdly, an attorney representing a physician before the Board must be sure the client understands and appreciates the power of the Board. Under the Medical Practice Act, the Board is empowered to discipline physicians, which includes the suspension and revocation of licenses.

Many physicians wrongly believe that if they lose before the Board, they will win the day at the appellate level. Attorneys must advise their clients carefully that appealing decisions of the Board is a weak reed to rely on. The Board has the advantage in the evidentiary rules and in the doctrine of judicial deference. Although I do not have statistics, I am of the opinion that the Board prevails in the great majority of appeals to the Superior Court from the Board and from the Superior Court to the Court of Appeals.

"An attorney representing a physician before the Board must be sure the client understands and appreciates the power of the Board."

Attorneys cannot permit their clients to labor under the misapprehension that, once they get their case out of the hands of their "persecutors," the real truth will come out. The system just does not work that way. Appeals are based on the record and are not usually successful. Attorneys must, therefore, make every effort to convince their clients, if possible, to reach an accord with the Board at the first level of inquiry.

Attorneys Are Not Like St George

Attorneys are quite often faced with a more subtle problem in representing physicians before the Board. They are deemed by many to be like St George, ready to draw their "swords" of procedural due process to slay "the dragon" who dares threaten their clients. Attorneys must avoid the temptation to saddle their noble steed, Discovery, and ride off to "out paper" the "bad guys." The Board is not swayed by theatrics or intimidation. However, in trying to encour-

Continued on page 7

Day in Court

continued from page 6

age their clients to seek an early resolution, attorneys must be careful to avoid having their clients conclude they are unwilling to fight "to the death."

Attorneys, then, walk a tightrope in balancing the need to show firm resolve with the need not to push the Board into a response that may cast their clients into the "bottomless pit of appellate no return." Attorneys must maintain the confidence of their clients, avoiding the possibility of that confidence being lost when they fail to push on without regard for consequences.

Opportunities and Responsibilities

I have reviewed some of the challenges, but what about the opportunities? Attorneys representing physicians before the Board have a unique opportunity to help their clients deal with the trauma of appearing before the Board and with the devastating effects of the damage to professional reputation and the economic disaster resulting from the loss of license. How can attorneys help their clients other than by following the motto of the infantry: "Close and destroy the enemy?" First, the attorney should convince the client to seek a resolution with the Board at the earliest possible opportunity. He or she must demonstrate that winning before the Board requires resolution rather than confrontation.

Many times, physicians who become involved in proceedings before the Board have other difficulties. In such cases, attorneys can help their clients by referring them to the North Carolina Physicians Health Program to help develop a support team. In many cases, the issues the Board is concerned with may result from other problems, such as chemical dependency, mental health problems, sexual boundary violations, and cognitive deficit problems. Attorneys have a responsibility to their clients to advocate for them, but advocacy certainly is not blind. Attorneys have a greater duty to aid their clients in seeking help for the problems that may be making them subjects of concern and inquiry by the Board. Attorneys, then, in marshaling professionals to join their clients' support team, have an opportunity to impact favorably on the present and long term condition and situation of clients. The skillful attorney combines informed advocacy for the client with building a support team that will help the client respond positively to the concerns of the Board, lessen the damage to his or her professional reputation, and minimize encroachment on his or her medical license.

What the Physician Should Really Want

Yes, the stakes are high, the potential consequences are devastating. In my opinion, physicians should seek out experienced attorneys to represent them before the Board. Such attorneys will attempt resolution rather than confrontation. Resolution will expedite the administration of the Board's responsibility to protect the public against unfit physicians and allow consideration of rehabilitation than can lead a physician back into practice when the Board determines he or she is no longer a threat to the safety of the public.

And so, does a physician who is under review by the Board really want his or her day in court? Absolutely not! The last thing he or she wants is a day in court. What is needed is to quickly address and meet the concerns of the Board and resolve issues. To achieve that goal, the physician's best bet, when coming under review by the Board, is to retain an experienced attorney immediately. The physician, with the attorney, can then fashion a proposed resolution. Otherwise, depending on the seriousness of the issues, the physician may well join the ranks of the unemployed. ♦

"The attorney should convince the client to seek a resolution with the Board at the earliest possible opportunity."

Mr Hollowell is an attorney practicing in Raleigh.

Residents Note

RTL Restricted to Specific Training Program

A resident's training license (RTL) is restricted to a specific training program. A physician holding such a license may practice ONLY in that program. The North Carolina Medical Board must be notified and a new training license must be issued before a resident physician may change his or her training program. It is the physician's responsibility to be sure he or she has the correct resident training license before beginning work.

Questions concerning the RTL should be directed to the Board's Licensing Department. ♦

PA and NP Prescribing: A Clarification

Donald R. Pittman
Director, NCMB Investigative Department

An article titled "Physician Assistants and Nurse Practitioners: A Reminder About Prescribing Requirements" appeared in the December 1996 number of the *Forum*. Several questions have been raised about the article's message. With those questions in mind, further clarification is clearly needed.

Physician assistants and nurse practitioners were reminded in the original article that "your prescribing (DEA registration) number" is required to be recorded on your prescription blanks. All North Carolina PAs and NPs have a "prescribing number." For PAs, this number is their medical board assigned license number. For NPs, it is their medical board assigned approval number. All prescription blanks should contain this "prescribing number." (See NCAC 32O.0009(6) for PAs and NCAC 32M.0008(6) and (7)(A) for NPs.)

While there is no requirement for an extender to apply for her or his own DEA registration number, if you choose to do so, that number may be obtained by making application to the Drug Enforcement Administration, United States Department of Justice. Your DEA number may or may not be required to be on all prescription blanks. If your choice of prescribed medication(s) includes a controlled substance as defined by the federal Controlled Substances Act, your Mid-Level Practitioner's DEA registration number is required to be on the prescription blank.

For NPs, this requirement is found in NCAC 32M.0008(7)(B) as well as the CFR code number cited below. For PAs, it is found in NCAC 32O.0009(6) in references to the "law" and "information required by law." As was noted in the December *Forum* article, federal guidelines are in the Code of Federal Regulations (CFR). In 21 CFR 1306.05, it states that all prescriptions for controlled substances shall: (1) be dated as of and signed on the day when issued; (2) bear the full name and address of the patient; and (3) include the name, address, and DEA registration number of the practitioner.

Therefore, if the extender writes a prescription for any legend drug, the prescription blank should contain the extender's "prescribing number." If a controlled substance is prescribed, the prescription blank should contain both the extender's "prescribing number" and DEA registration number. ♦

Big-Hearted Physician Assistants Look to Removal of Obstacles to Care

Suzanne Reich-Atkins, PA-C
Past President, NCAPA

Two evenings each week, the 20 or 30 people who come to the Asheville-Buncombe County Christian Ministry Free Medical Clinic in Asheville, North Carolina, are lucky in one way: they have access to volunteer medical services in a walk-in family-practice clinic that provides care for those who are unable to pay. The patients would be even luckier if Becky Anderson were able to use her clinical skills as a physician assistant (PA). As it is now, she can only do clerical work and take vital signs.

Statutory Solution Being Sought

Becky is employed full-time as a PA in the Veterans Administration system, and, because she works for the federal government, she is not required to hold a license from the North Carolina Medical Board. As current PA regulations read in North Carolina, Becky would have to apply for a license and pay the fee of $150 in order to work in such a volunteer setting. Then, each year thereafter, she would have to pay an additional $75 for annual registration of her PA license. Often, these requirements are financially prohibitive for PAs who wish to give of their time, skills, and energy in a volunteer setting. Fortunately, there may soon be an alternative available for PAs like Becky.

Last year, the General Assembly passed the statutory authority for physicians licensed in a state other than North Carolina to obtain volunteer licenses in North Carolina if they work only in a volunteer setting on an uncompensated basis. This year, PAs hope to follow suit. Through its Legislative Committee and its lobbyist, the North Carolina Academy of Physician Assistants (NCAPA) has included in a bill submitted to the General Assembly statutory language for a PA volunteer license. Our goal is to allow not only federally-employed PAs the opportunity to volunteer, but also retired PAs and out-of-state PAs who might be involved in indigent care or disaster response activities in North Carolina.

This effort will help clinicians like Jeff Hinshaw, a PA employed in a Winston-Salem emergency department who also wants to respond to state-declared disasters and serve in a capacity that uses his special clinical skills.

Increasing Opportunities for Service

Formalizing the ability to volunteer will help retired PAs like Joyce Nichols, who started the Cornwallis Housing Development Health Clinic in Durham. Joyce acts as the coordinator, performing only administrative and educational duties. She points out that the 7,000 patient visits for 199 families in 1996 could be increased in the future if she were able to staff the clinic with more providers—enough to be open every evening, rather than just once a week.

> ***" 'If I could do what I've been trained to do, I could do so much more for the patients.' "***

In addition to the legislative effort, the North Carolina Medical Board and the NCAPA together have been working on draft proposals for new regulations that specifically address the issue of volunteer practice for PAs. These proposals will have to go through the usual bureaucratic channels, including public hearings, in 1997 and legislative review in 1998 before they can be approved.

The success of these combined efforts will increase the opportunities for PAs to extend their clinical skills to areas where the uninsured and the working poor need them. As Becky Anderson says, "If I could do what I've been trained to do, I could do so much more for the patients." PAs with big hearts like that should have no obstacles placed in the way of the health care they want so much to give. ♦

From the NC Board of Pharmacy

David R. Work
Executive Director, NCBP

Ordering Pharmaceuticals

Most medical offices order pharmaceuticals from time-to-time and it is important to understand that different procedures are necessary depending on the product ordered. Physicians who order medical supplies, such as bandages, denatured alcohol, or over-the-counter drugs, can obtain these items by telephone order. They can be supplied from a wholesaler or an individual pharmacy. Prescription legend drugs, such as antibiotics and other similar items that are not controlled substances, can also be obtained in this way.

A physician who desires to obtain controlled substances needs to order these items in one of two specific ways. Drugs in Schedule II, such as morphine, Demerol, and Percodan, must be obtained by executing a Schedule II order form (DEA Form 222). This is in triplicate and it needs to be signed by the physician registrant. One part of the form remains in the doctor's office while the other two portions are presented to the supplier, such as a pharmacy or wholesaler. All Schedule II controlled substances must be obtained in this way without exception. Physicians should not attempt to obtain Schedule II drugs for office use by writing a prescription. This is a specific violation of federal rules on controlled substances.

Other controlled substances can be obtained for office use by filing a written order either with a pharmacy or wholesaler. This needs to be specific as to the drug products ordered and their quantity. There is no special order form required for these items, but using a prescription form made out "for office use" is not appropriate. If you have any questions about the proper procedure for ordering any specific drug, you should contact your local pharmacist, who can be helpful in these situations.

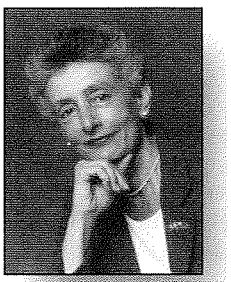
Prescriptions by Fax

It is becoming much more prevalent for prescribers to send prescriptions to pharmacies by facsimile machine. The North Carolina Board of Pharmacy has a rule that provides guidelines for this practice, which can also include refill authorization. The staff of the Pharmacy Board strongly recommends facsimile transmission of prescriptions, instead of telephoning, for several reasons. First of all, it promotes accuracy. Two honest people of good will speaking on the telephone can say Xanax or Zantac and misunderstand each other.

The use of fax technology for transmission of refill authorizations can also eliminate the need for physicians, office personnel, or pharmacists to spend long periods of time "on hold" trying to get confirmation by telephone. Fax records also provide a printed record of what actually was ordered or authorized. It is an excellent verification should questions arise.

Most physician offices and many pharmacies now have facsimile equipment. Common sense tells us it is a useful tool in the practices of both medicine and pharmacy. ♦

Gov Hunt Names Dr Kanof to NCMB



Elizabeth P. Kanof, MD

Bryant D. Paris, Jr, executive director of the North Carolina Medical Board, has announced that Governor James Hunt has appointed Elizabeth P. Kanof, MD, of Raleigh, to the Board. Her term will run until October 31, 1999.

Dr Kanof, a native of New York, took her BA from Mount Holyoke College and her MD from New York University. She did an internship at Kings County Hospital Center and residencies in dermatology at New York University-Bellevue Medical Center and Duke University Medical Center. She is a fellow of the American Academy of Dermatology and a diplomate of the American Board of Dermatology.

Dr Kanof holds appointments as assistant consulting professor of dermatology at the Duke University School of Medicine and as clinical professor of dermatology at the University of North Carolina School of Medicine.

Very active in organized medicine, Dr Kanof served as president of the Wake County Medical Society in 1984 and of the North Carolina Medical Society in 1994. She currently serves as vice chair of the NCMS Committee on Legislation and as a member of the NCMS Mediation and Domestic Violence Committees. She is also a member of the Board of the NCMS Foundation. Dr Kanof is currently active with CHART (Creating Healthy and Responsible Teens), and, over the years, has been a participant in a wide range of community and charitable groups, including the Raleigh Chamber Music Guild, the American Cancer Society, and the North Carolina Museum of Art.

She has published several articles and, in 1996, was co-author of "Overcoming Barriers to Physician Involvement in Identifying and Referring Victims of Domestic Violence," published in the *Annals of Emergency Medicine*.

Dr Kanof has been named to the Board's Complaint, Malpractice, Physician Assistant, Physicians Health Program, and Liaison Committees, and has been appointed chair of the Scope of Practice Committee, said Mr Paris. "The members and staff of the Board are deeply pleased to welcome so distinguished and committed a physician to the Board." ♦

Reporting of Changes in Staff Privileges by Hospitals and Other Entities

The North Carolina Medical Board has received a number of questions about the law requiring the reporting of changes in medical staff privileges. The following questions and answers are presented to clarify some of the issues surrounding the reporting law.

Q: Is it necessary to notify the Board when a physician requests and is approved for a "staff status change" from "Active" to "Courtesy"?
A: Yes, if it results in a limitation of the physician's privileges; otherwise, no.

Q: Is it necessary to notify the Board when a physician's admitting privileges have been suspended until delinquent medical records have been completed?
A: Yes. The law requires reporting of "any" suspension.

Q: Is it necessary to notify the Board when a physician requests an addition or decrease in clinical privileges?
A: Yes, if the request for a decrease is granted. The law requires reporting of "any" limitation of the physician's privileges or resignation of privileges. The granting of additional privileges need not be reported.

Q: Is it necessary to notify the Board when a physician's staff membership/privileges have been terminated because he or she fails to meet the continued basic qualifications of membership (office for practice, malpractice insurance, etc) as set by the medical staff bylaws?
A: Yes. The law requires reporting of "any revocation, suspension, or limitation[.]"

Q: Is it necessary to notify the Board when a physician's membership/privileges have been revoked due to the Board's Action Report?
A: Yes. Again , the law requires the reporting of "any" revocation. Of course, you may assume the Board is aware of its own actions, but the actions privilege-granting entities take in response thereto may not otherwise come to the Board's attention. The Board frequently uses information about a physician's former privileges and intentions for future privileges in considering the restoration of a license previously revoked.

Q: What information would constitute "other" on the Board's form for reporting privilege changes?
A: "Other" refers only to actions not mentioned elsewhere on the form. It appears on the form only as a convenience for reporting matters that do not fit neatly within another category. The law sets forth the requirements for reporting; the Board does not intend by its form to add to or subtract from those requirements.

Q: Is there a specific time period that the privileging action is to be reported to the Board?
A: The law contains no specific time period. Several entities have told the Board they intend to report monthly. Some actions, such as summary suspension of privileges, may warrant immediate reporting.

Q: What does the Board mean by "summary suspension"?
A: The general reference is to the practice of some entities of suspending a physician's privileges before a "due process hearing" has been conducted. The Board understands some entities use this procedure in emergencies. The Board has also become aware that some of these emergency situations were not reported to the Board until the full due process called for in the entity's bylaws had been completed, sometimes months after the emergency had arisen.

Q: Are hospitals required to report "suspension of admitting privileges for failure to submit a timely request for reappointment application"?
A: If such results in a suspension of admitting privileges, yes, the law requires the reporting of "any" suspension.

Q: Are we required to report "changes in staff status, ie, Active to Consulting, Leave of Absence"?
A: Yes, if such changes constitute suspensions, revocations, limitations, or resignations of privileges. When changes in staff status lessen the physician's ability to treat patients in the institution, they will generally constitute a suspension, revocation, limitation, or resignation, and, therefore, a report will be required.

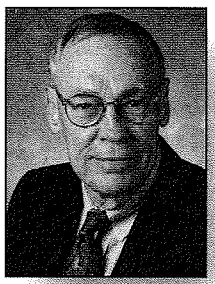
Q: Are we required to report "limitations on requests for renewal of current clinical privileges, pending documentation of training"?
A: Yes, the law requires the reporting of "any" limitation.

Q: What are the repercussions for the physicians on whom reports are made?
A: The reports themselves have no direct repercussions. The General Assembly's requiring of such reports implies that the Board should review them and take whatever action is appropriate under law. The reports and the underlying hospital actions are not reasons under the law for the Board to begin a case against a physician's license. However, the reports may prompt further inquiry and investigation to determine if grounds exist for such a case. The Board suspects that the overwhelming majority of reports will not lead to Board action and that many will warrant little if any investigation. Some, though, will lead the Board to discover evidence of grounds for the initiation of a case. ♦

A Review

Fundamentals of Complementary and Alternative Medicine

George C. Barrett, MD
President, NCMB



Dr Barrett

As public interest and faith in non-traditional health care increases, this book provides a valuable and readable resource for all physicians. Well-referenced and indexed, it is divided into three sections: the Basis and Contexts of Complementary and Alternative Medicine, Complementary Therapy Systems and Approaches, and Integrated and Traditional Systems. The authors practice or represent allopathic, osteopathic, chiropractic, Eastern, and less traditional healing systems.

The editor, Mark S. Micozzi, MD, PhD, believes the terms alternative and complementary medicine to be culturally encoded in our language. The functional definition provided by Harvard Medical School..."practices used for purposes of medical intervention which are not routinely taught at U.S. medical schools nor routinely underwritten by third party payers within the existing U.S. health care system"...is considered exclusionary. He reminds us that because we have not incorporated such practices in our system does not, in and of itself, render them useless. After all, he notes, America did not come into existence at the time of its discovery by Europeans—many indigenous peoples enjoyed complex social systems prior to that time.

Thus, the tone of this book is set: read with an open mind and a willingness to understand why many well-educated, affluent, thoughtful people turn to non-traditional forms of health intervention. As the physician reader gains insight, he or she may well become more understanding and better able to treat the whole person with compassion and with an acceptance that mainstream medicine has limitations for some patients.

Some shared concerns between mainstream and alternative systems are emerging as our biomedical system undergoes reform. We are placing more emphasis on preventive medicine, a goal common to mainstream and alternative medicine. According to the editor, mainstream medicine uses drugs and surgery to prevent disease in those who are only at risk. In complementary medicine, "wellness" is focused on engaging the "inner resources of each individual as an active and conscious participant in the maintenance of his or her own health." Of course, one could argue a wide variation in the time requirements for these two approaches, for the "focus on the whole person as a unique individual provides new challenges to the scientific measurement of the healing encounter."

The chapters on cultural and historical context of various complementary and alternative systems are critical if the reader is to understand the chapter on the contemporary scene. The author of the latter is an allopathic physician who provides an unbiased and forward-looking context for the integration of complementary and mainstream medicine.

The section on Complementary Therapy Systems and Approaches is not intended to be comprehensive. It includes homeopathy, osteopathy, chiropractic, Western herbalism, healing touch, aroma therapy, and light therapy. Note is made of the increasing cooperation between chiropractic and mainstream medicine, but there is no significant recognition of the virtually total integration of osteopathic medicine into the mainstream of American medicine.

Fundamentals of Complementary and Alternative Medicine
Mark S. Micozzi, MD, PhD, editor. Churchill Livingstone, New York, 1996. 303 pages. CD ROM included. $39.95.

Chapters in the section on Integrated and Traditional Systems deal with naturopathy, Chinese traditional medicine and Qigong (breathing and mental exercises combined with physical exercise), Ayurveda, and Curanderismo. The final chapter of the section and of the book is on global health traditions.

C. Everett Koop, MD, ScD, in the forward to this book, writes about the need to take a second look at alternative medicine, to assure communication skills are taught in our medical schools, and to recognize that the system of medicine practiced in the United States may not be sustainable in every country—or even in this country. As Dr Koop states, "Physicians are healers first. As such, they are willing to use any ethical approach or treatment that has been proven to work."

This reviewer agrees with Dr Koop's philosophy and suggests that the final chapter of this book, if studied with an open mind, will make us tolerant of and sensitive to our patients' needs when they do not mesh with our biomedical system. Insight may make us better able to advise and guide the patient to appropriate therapy administered by a qualified practitioner of a complementary, not a competitive, system. ♦

Registration

continued from page 1

tion notice in any manner. So what happens next?

Because 1997 is a transition year under the new registration system required by the Medical Practice Act, there is a mixture of old and new in the "what happens next?" category. Many physicians could not be located during the first mailing and their registration forms were returned to the Board stamped "no forwarding address." These physicians will be delinquent until the 1998 registration period because the Board cannot serve them with a notice of hearing for suspension as the law is currently written. In 1998, however, the law will allow the Board to serve notice of a hearing for suspension at the physician's last known address.

On the other hand, all those who have notified the Board that they do not wish to register this year will receive a certified notice of a hearing for suspension of their license. This hearing will probably be held in May 1997. Again, suspension for failure to register is not a punitive action and it is not reported to the National Practitioner Data Bank, published in the *Forum*, or put in the public file.

Registration Questions Needed

The Board staff will continue to look for ways to make the registration process easier, but it is clear that the data being collected on the registration form are needed by a number of state agencies and offices (as well as the Board). It will always be necessary to ask for new and updated information at the time of registration. In the long run, the information gathered will benefit everyone. ♦

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions
November-December 1996-January 1997

DEFINITIONS

Annulment: Retrospective and prospective cancellation of the authorization to practice.
Conditions: A term used for this report to indicate restrictions or requirements placed on the licensee/license.
Consent Order: An order of the Board and an agreement between the Board and the practitioner regarding the annulment, revocation, or suspension of the authorization to practice or the conditions and/or limitations placed on the authorization to practice. (A method for resolving disputes through informal procedures.)
Denial: Final decision denying an application for practice authorization.
NA: Information not available.
NCPHP: North Carolina Physicians Health Program
RTL: Resident Training License.
Request/Motion for Reconsideration/Modification: A request or motion by a practitioner that the Board reconsider or modify a previous action.
Revocation: Cancellation of the authorization to practice.
Summary Suspension: Immediate temporary withdrawal of the authorization to practice pending prompt commencement and determination of further proceedings. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)
Suspension: Temporary withdrawal of the authorization to practice.
Temporary/Dated License: License to practice medicine 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 Dismissal: Board action dismissing a contested case.
Voluntary Surrender: The practitioner's relinquishing of the authorization to practice, frequently pending an investigation or in lieu of disciplinary action.

REVOCATIONS
NONE

SUSPENSIONS

HATCHER, Martin Armstead, Jr, MD
Location: Greensboro, NC (Guilford Co)
DOB: 7/24/35
License #: 00-13467
Specialty: N (as reported by physician)
Medical Ed: Duke University (1962)
Cause: As a result of a hearing before administrative law judge Beecher Gray in March 1996, Dr Hatcher was found to have engaged in sexually exploitive conduct with six female patients during medical examinations of them in his office, thus violating the Medical Practice Act's prohibition of immoral and unprofessional conduct; the North Carolina Medical Board, after reviewing Judge Gray's proposed decision and hearing from the respondent, his counsel, and the Board's counsel, adopted Judge Gray's Findings of Fact and Conclusions of Law.
Action: 2/10/96. Final Agency Decision and Order issued: written exceptions filed by Dr Hatcher to the Proposed Decision of Judge Gray are overruled; respondent's license shall be suspended indefinitely effective 10 days from the date of service of the Board's Order; after one year, the suspension shall be stayed and respondent may resume practice on indefinite probation provided he shall accomplish the following during the one year period: a) provide the Board a complete psychiatric evaluation; b) arrange for and complete an evaluation by Gene Abel, MD, of Atlanta, Georgia, follow whatever recommendations are made by Dr Abel, and authorize Dr Abel to provide the Board a written report of the evaluation; c) prepare and submit to the Board a written protocol for use of chaperons in connection with his examination of female patients upon his resumption of practice; d) complete 10 hours of Category I CME in physician-patient boundary issues and 40 hours in neurology. He shall meet with the Board approximately six months after resuming practice following his one year of active suspension; during the period of indefinite probation following the stay of suspension, failure to comply in any respect with Dr Abel's recommendations shall be grounds for dissolution of the stay and implementation of active suspension.

See Consent Orders:
WANGELIN, Robert Lester, MD

SUMMARY SUSPENSIONS
NONE

CONSENT ORDERS

ANDRINOPOULOS, George C., MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 9/17/42
License #: 00-21146
Specialty: OBG (as reported by physician)
Medical Ed: University of Athens, Greece (1966)
Cause: Dr Andrinopoulos had a sexual relationship with one of his patients that ended in March 1991; he admitted and admits that the brief sexual relationship occurred in his apartment on two occasions after the doctor/patient relationship had been terminated as a practical matter; he asserts there were no sexual intimacies between himself and the patient in his office, that it was his opinion at the time that the relationship was by mutual consent, and that he was not aware at the time that such a relationship was considered a violation of medical ethics. He has furnished the Board additional written information about his practice and has engaged in multiple activities to ensure the Board and the public that he has safely practiced medicine since 1991, that he can safely practice medicine, and that he will continue to safely practice medicine; it appears that he voluntarily arranged to be evaluated by a psychiatrist as recommended by the Board, that he has read recommended publications on professional boundaries, that he has entered into a contract with NCPHP, that he has followed instructions given by NCPHP and engaged in periodic counseling sessions, that reports from the psychiatrist and counselor have been furnished the Board, and that he has undertaken to provide voluntary health services to homeless persons and to perform voluntary services to Habitat for Humanities in its construction projects in the Charlotte area.
Action: 12/05/96. Consent Order executed: Dr Andrinopoulos is reprimanded for his conduct in having the sexual relationship that is the subject of the charges before the Board; he will abide by the terms of his October 6, 1994, contract with NCPHP and abide by any instruction given him by the medical director of the NCPHP; he will perform community service consisting of 26 sessions of volunteer services by providing free health care services to persons seeking medical assistance at a shelter in Charlotte or by providing services in construction projects for Habitat for Humanities in the Charlotte area or by a combination of these two, and he will be allowed credit toward this requirement for the voluntary sessions already performed; must comply with other conditions.

BERLINER, Steven Harvey, MD
Location: Elon College, NC (Alamance Co)
DOB: 9/07/53
License #: 94-00721
Specialty: OBG (as reported by physician)

Board Orders/Consent Orders/Other Board Actions....(cont.)

Medical Ed: State University of New York (1978)
Cause: Consideration for extension of dated license; he has admitted to obtaining controlled substances for his personal use by prescribing them purportedly for his wife; he surrendered his license in March 1996; he was reissued a license pursuant to a Consent Order of August 1996. He met with the Board to discuss his progress in October 1996; a modification of the August Consent Order has been agreed to.
Action: 12/10/96. Consent Order executed: Dr Berliner issued a license to expire on the date specified on the license; he will continue to abide by his contract with NCPHP; unless lawfully prescribed by someone else, he shall refrain from use of any controlled substances; he shall provide samples of bodily fluids or hair on request for analysis to determine if he has used controlled substances; he shall have a chaperon present during all examinations of female patients; he will appear before the Board as requested; must comply with other requirements.

BRANCH, Robert Donald, Jr, Physician Assistant
Location: Kinston, NC (Lenoir Co)
DOB: 7/07/58
License #: 1-02026
Education: University of Texas, Galveston (1995)
Cause: Application to practice under supervision of Elie Osta, MD; Mr Branch entered into a consent order with the Board on 9/26/95, pursuant to which the Board issued him a license as a physician assistant; a modification of the consent order has been agreed to.
Action: 12/17/96. Consent Order executed: Mr Branch is granted approval to practice under primary supervision of Elie Osta, MD; he shall cause his primary supervising physicians to submit written bimonthly reports to the Board regarding his status; he shall provide samples of bodily fluids or hair on request for analysis to determine if he has used controlled substances; he shall notify his primary supervising physicians of his criminal history and his consent orders with the Board, and he shall have them confirm in writing to the Board that he has done so; must comply with other conditions.

HAWLEY, John Patrick, Physician Assistant
Location: Hubert, NC (Onslow Co)
DOB: 4/27/46
License #: 1-02243
Education: Duke University (1977)
Cause: Matter considered as a result of Mr Hawley's application for a PA license. He admits a urine test in June 1996 showed positive results for THC (cannabis); he admits he has smoked marijuana in the past. He obtained a psychological evaluation in July 1996 that did not suggest substance abuse or dependency; he has signed a contract with NCPHP.
Action: 12/11/96. Consent Order executed: Mr Hawley to be issued a PA license to expire on the date shown on the license; he shall appear before the Board again in May and at such other times as the Board requests; he shall maintain and abide by a contract with NCPHP; he shall notify the Board on any change of residence or practice address within 10 days of the change; must comply with other conditions.

LESTER, Allan John, MD
Location: Cary, NC (Wake Co)
DOB: 9/19/44
License #: 00-20159
Specialty: FP/OM (as reported by physician)
Medical Ed: University of Otago, New Zealand (1970)
Cause: Dr Lester and the Board have entered into a number of Consent Orders relating to his history of substance abuse and his recovery appears to be progressing well. Dr Lester and the Board have agreed to changes in the applicable Consent Orders.
Action: 1/24/97. Consent Order executed: dated license issued to expire on date shown on license; he shall maintain a contract with the NCPHP and continue to attend AA meetings; he shall not consume alcohol, controlled substances, or other abusable substances unless lawfully prescribed by someone else; he shall provide blood, hair, urine, and other samples of bodily fluids or tissues upon request to allow analysis by the Board; he shall take the recertification examination of the American Board of Family Practice in July 1997 or, if not allowed to take that examination, he shall take the SPEX at the next opportunity and have scores reported to the Board; must comply with other conditions.

PLUMMER, Charles Wayne, MD
Location: Jamestown, NC (Guilford Co)
DOB: 4/23/52
License #: 00-24982
Specialty: AN (as reported by physician)
Medical Ed: Duke University (1978)
Cause: Dr Plummer admits that in some instances he has prescribed controlled substances without sufficiently evaluating the need for them and in some instances he has not sufficiently documented the need for them.
Action: 11/22/96 (retroactive to 10/1/95). Consent Order executed: for private patients, Dr Plummer shall not purchase, administer, prescribe, dispense, or order controlled substances; he shall appear before the Board at such times as requested; he shall obtain CME in addiction and narcotics abuse and document that CME to the Board prior to 9/30/96; must comply with other conditions.

SATTLER, Raymond Louis, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 7/16/44
License #: 00-26049
Specialty: NS (as reported by physician)
Medical Ed: Case Western Reserve University (1977)
Cause: Dr Sattler has complied with the terms of his Consent Order of April 8, 1995, has met with the Board to discuss his evolving practice plans, has enrolled in full-time graduate study in health policy and administration at the School of Public Health at the UNC-CH, and has left the clinical practice of medicine. Given his compliance and his demonstration of having learned from his previous difficulties, the Board has determined it is in the public interest to modify the terms of his previous Consent Order.
Action: 12/22/96. Consent Order executed: Dr Sattler shall appear before the Board at its July 1997 meeting and at other times as requested; he shall continue to meet quarterly with a psychiatrist designated by the Board and have quarterly reports on his progress submitted to the Board, with special reports at other times within the discretion of the psychiatrist; he shall continue to have yearly physical examinations with reports submitted to the Board by January 1 of each year; he shall provide written notification to the Board of his intent to reenter the clinical practice of medicine; should he desire to reenter the practice of neurosurgery, he will be required to meet with the Board to obtain approval; he shall not supervise PAs or NPs; must comply with other conditions.

THOMPSON, Robert Bruce, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 2/29/56
License #: 00-40006
Specialty: N/EM (as reported by physician)
Medical Ed: University of Miami (1987)
Cause: Application for a license to practice medicine; original license of 1991 suspended in 1995 for failure to register; Dr Thompson admits he has been diagnosed with chemical dependency, depression, and bipolar disorder; admits he used butorphanol tartrate nasal spray and alprazolam in June 1995; he surrendered his New Jersey license in 1995 due to concerns about his psychiatric and substance abuse problems. He was an active participant in New Jersey impaired physician program; was treated at the Farley Center in 1995 for severe depression and substance abuse; has been in contact with the NCPHP.
Action: 12/06/96. Consent Order executed: Dr Thompson to be issued a license expiring on the date shown on the license; shall maintain and abide by a contract with the NCPHP; shall supply urine, blood, hair, and any other bodily tissues or fluids the Board requires to screen for use of potentially abusable substances; shall have his psychiatrist submit reports to the Board no later than December 20, 1996; shall practice only in a structured setting approved by the president of the Board; must comply with other conditions.

Board Orders/Consent Orders/Other Board Actions....(cont.)

WANGELIN, Robert Lester, MD
Location: Greensboro, NC (Guilford Co)
DOB: 5/21/45
License #: 00-28370
Specialty: P (as reported by physician)
Medical Ed: West Virginia University (1972)
Cause: Dr Wangelin has admitted he had sexual relationships with at least three of his patients, some of which occurred during the existence of their doctor-patient relationships; he has admitted some of these sexual encounters occurred in his office and some at Moses Cone Hospital; he was sanctioned by the NC Psychiatric Association for violations of ethical principles; he admits he has committed unprofessional acts within the meaning of the statute. He has met with the director of the NCPHP and has agreed to follow its recommendations.
Action: 11/18/96. Consent Order executed: his license to practice medicine is suspended one year from the effective date of the Consent Order; shall appear before the Board as requested; at its November meeting, the Board shall consider staying the remainder of the suspension depending on his compliance with the Consent Order; he shall sign and abide by a contract with the NCPHP; he shall continue treatment and supervision by his psychiatrist and cause his psychiatrist to submit reports to the Board monthly; he shall cause his clinical supervisor to submit reports to the Board monthly; he shall cause reports from NCPHP and Dr Abel to be submitted to the Board no later than November 1; must comply with other conditions.

WASHINGTON, Clarence Joseph, III, MD
Location: Cary, NC (Wake Co)
DOB: 1/11/47
License #: 00-32295
Specialty: GYN (as reported by physician)
Medical Ed: University of Michigan (1974)
Cause: Dr Washington failed to answer four requests from the Board that he respond in writing to a complaint made regarding him; he promised a Board investigator in January 1996 to provide a response, but that response was not received until October 1996; the Board preferred charges against him in October 1996 and Dr Washington acknowledged in response that he did not respond in writing in a timely manner but that his failure was unintentional.
Action: 1/25/97. Consent Order executed: Dr Washington is reprimanded.

DENIALS OF LICENSE/APPROVAL

UPDYKE, Jane Arlene Heck, Nurse Practitioner
Location: Scottsville, NY
DOB: 4/24/48
Education: Milton S. Hershey/Penn State NP Program
Cause: Application for a PA license. Ms Updyke has been a PA in New York for 18 years but has not successfully completed an accredited PA educational program, which is a requirement under Board rules.
Action: 1/16/97. Order denying Ms Updyke's application for a PA license.

REQUESTS/MOTIONS FOR RECONSIDERATION/MODIFICATION

GORDON, Mark Anthony, Physician Assistant
Location: Baytown, TX
DOB: 2/21/55
License #: 1-01792
Education: Oklahoma University (1980)
Cause: Letters received from Mr Gordon claiming, among other things, insufficient notice of hearing in 1995 were considered together as motions by the Board. Board determined evidence did not support the motions. (Board Order of 3/07/96 revoked Mr Gordon's license.)
Action: 1/16/97. Order issued denying Mr Gordon's motions to reopen his case and to remove materials from his file.

REECE, Donald Brooks, MD
Location: Morehead City, NC (Carteret Co)
DOB: 11/08/44
License #: 00-18559
Specialty: FP (as reported by physician)
Medical Ed: University of Washington (1971)
Cause: Request from Dr Reece that he be relieved of certain obligations under his 1/22/92 Consent Order concerning the supervision of physician assistants. Board determined his current supervision of physician assistants is deficient regarding written policies and instructions.
Action: 1/23/97. Order issued denying Dr Reece's request that he be relieved of certain obligations in his 1/22/92 Consent Order.

WILLIAMS, Cleveland, MD
Location: St Pauls, NC (Robeson Co)
DOB: 6/20/49
License #: 95-00287
Specialty: OBG/LM (as reported by physician)
Medical Ed: University of Florida (1977)
Cause: Request from Dr Williams that he be relieved of any continuing obligation under his 1996 Consent Order, which required he obtain written approval from the president of the Board prior to changing his practice site. The Board determined no evidence was presented to warrant a change in the 1996 Consent Order.
Action: 1/16/97. Order issued denying Dr Williams' request that he be relieved of his 1/10/96 Consent Order.

VOLUNTARY SURRENDERS

CALLAHAN, Richard Dale, MD
Location: Arden, NC (Buncombe Co)
DOB: 10/19/52
License #: 00-22896
Specialty: ONC/HEM (as reported by physician)
Medical Ed: Pennsylvania State University (1977)
Action: 1/16/97. Voluntary surrender of license.

FOERCH, Jeffry Scott, MD
Location: Durham, NC (Durham Co)
DOB: 10/10/52
License #: 96-00806
Specialty: None reported by physician
Medical Ed: Chicago Medical School (1977)
Action: 12/17/96. Voluntary surrender of license.

GLENN, Robert Alan, Physician Assistant
Location: Fletcher, NC (Henderson Co)
DOB: 3/13/59
License #: 1-01972
Education: George Washington University (1989)
Action: 11/27/96. Voluntary surrender of license.

HOLTKAMP, John Harry, MD
Location: Raleigh, NC (Wake Co)
DOB: 11/20/54
License #: 00-28045
Specialty: CHN/PD (as reported by physician)
Medical Ed: New York University (1980)
Action: 1/17/97. Voluntary surrender of license.

MECHAEL, Shawky Fahmy, MD
Location: Mooresville, NC (Iredell Co)
DOB: 12/10/29
License #: 00-30937
Specialty: OBG (as reported by physician)
Medical Ed: Alexandria University, Egypt (1954)
Action: 1/14/97. Voluntary surrender of license.

PAINE, Karen Nicholson, MD
Location: Hattiesburg, MS
DOB: 7/07/46
License #: 00-20834
Specialty: FP/EM (as reported by physician)
Medical Ed: New York University (1971)
Action: 1/14/97. Voluntary surrender of license.

Board Orders/Consent Orders/Other Board Actions....(cont.)

POLE, Donald Taliaferro, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 8/28/46
License #: 00-22662
Specialty: OBG (as reported by physician)
Medical Ed: University Autonoma Guadalajara, Mex (1973)
Action: 11/14/96. Voluntary surrender of license.

WHEELER, James Hastings, III, MD
Location: Marion, NC (McDowell Co)
DOB: 10/20/59
License #: 00-33912
Specialty: ORS (as reported by physician)
Medical Ed: Medical College of Wisconsin (1977)
Action: 1/27/97. Voluntary surrender of license.

CONSENT ORDERS LIFTED

BARNES, James Allan, Jr, MD
Location: Newton, NC (Catawba Co)
DOB: 2/09/58
License #: 00-39540
Specialty: GYN (as reported by physician)
Medical Ed: Marshall University (1987)
Action: 1/31/97. Order issued lifting Consent Order of 8/31/94.

BLACKWELL, Michael Aldred, MD
Location: Moravian Falls, NC (Wilkes Co)
DOB: 12/01/55
License #: 95-00290
Specialty: None Specified
Medical Ed: East Carolina University (1990)
Action: 1/31/97. Order issued lifting Consent Order of 2/20/95.

COYNE, Mark Dennis, MD
Location: Stoney Creek, NC (Guilford Co)
DOB: 8/12/49
License #: 00-33493
Specialty: EM/FP (as reported by physician)
Medical Ed: Chicago Medical School (1983)
Action: 1/31/97. Order issued lifting several previous Consent Orders.

HALL, Charles Daniel, MD
Location: Supply, NC (Brunswick Co)
DOB 5/25/64
License #: 94-01205
Specialty: N (as reported by physician)
Medical Ed: Duke University (1990)
Action: 1/31/97. Order issued lifting Consent Order of 11/06/95.

REIMAN, Robert Ellis, Jr, MD
Location: Durham, NC (Durham Co)
DOB: 2/14/49
License #: 00-38179
Specialty: NM (as reported by physician)
Medical Ed: Case Western University (1987)
Action: 12/22/96. Order issued lifting Consent Order of 12/13/94.

ROZEMA, Theodore Carl, MD
Location: Landrum, SC
DOB: 4/11/34
License #: 00-19880
Specialty: GP/NTR (as reported by physician)
Medical Ed: Northwestern University (1960)
Action: 1/31/97. Order issued lifting Consent Order of 1/29/90.

TAYLOR, Stanley Douglas, MD
Location: Ft Bragg, NC (Cumberland/Hoke Cos)
DOB: 12/22/47
License #: 00-23340
Specialty: PD/FP (as reported by physician)
Medical Ed: Howard University (1976)
Action: 12/24/96. Order issued lifting Consent Order of 10/29/95.

WILSON, Lawrence Steven, MD
Location: Valdese, NC (Burke Co)
DOB: 3/19/52
License #: 00-28715
Specialty: U (as reported by physician)
Medical Ed: State University of New York-Upstate, Syracuse (1977)
Action: 1/31/97. Order issued lifting Consent Order of 2/21/94.

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

BERLINER, Steven Harvey, MD
Location: Elon College, NC (Alamance Co)
DOB: 9/07/53
License #: 94-00721
Specialty: OBG (as reported by physician)
Medical Ed: State University of New York (1978)
Action: 12/10/96. Issued temporary license to expire 3/31/97.

BOTWRIGHT, Gene Robert, Jr, MD
Location: Laurinburg, NC (Scotland Co)
DOB: 8/23/55
License #: 00-36462
Specialty: FP (as reported by physician)
Medical Ed: East Carolina University (1990)
Action: 11/22/96. Issued temporary license to expire 9/30/97.

EATON, Bernard Thomas, MD
Location: Durham, NC (Durham Co)
DOB: 10/01/52
License #: 00-32314
Specialty: P (as reported by physician)
Medical Ed: University of North Carolina, Chapel Hill (1985)
Action: 11/22/96. Issued temporary license to expire 11/30/97.

FELDMAN, Rhonda Glen, Physician Assistant
Location: Fayetteville, NC (Cumberland Co)
DOB: 10/26/63
License #: 1-01966
Education: Duke University (1995)
Action: 1/24/97. Issued temporary license to expire 1/31/98.

GURKIN, Worth Wicker, Jr, MD
Location: Ahoskie, NC (Hertford Co)
DOB: 3/06/56
License #: 00-29117
Specialty: PD (as reported by physician)
Medical Ed: East Carolina University (1982)
Action: 11/22/96. Issued temporary license to expire 9/30/97.

HARRIS, Donald Philip, MD
Location: Greensboro, NC (Guilford Co)
DOB: 4/09/34
License #: 00-13127
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina, Chapel Hill (1961)
Action: 11/22/96. Issued temporary license to expire 3/31/97.

HUBBARD, Karl Winsor, MD
Location: Elizabeth City, NC (Pasquotank Co)
DOB: 10/15/54
License #: 95-00291
Specialty: ORS (as reported by physician)
Medical Ed: University of Louisville (1982)
Action: 1/23/97. Issued temporary license to expire 1/31/99.

LANDON, Mark Terry, Physician Assistant
Location: Asheboro, NC (Randolph Co)
DOB: 6/11/59
License #: 1-00917
Education: Bowman Gray (1986)
Action: 11/22/96. Issued temporary license to expire 3/31/97.

Board Orders/Consent Orders/Other Board Actions....(cont.)

LESTER, Allan John, MD
Location: Cary, NC (Wake Co)
DOB: 9/19/44
License #: 00-20159
Specialty: FP/OM (as reported by physician)
Medical Ed: University of Otago, New Zealand (1970)
Action: 1/24/97. Issued temporary license to expire 7/31/97.

LOVE, David William, MD
Location: Waynesville, NC (Haywood Co)
DOB: 8/31/60
License #: 00-31326
Specialty: FP (as reported by physician)
Medical Ed: University of Florida (1984)
Action: 1/24/97. Issued temporary license to expire in three years.

McALLISTER, John David, Jr, MD
Location: Raeford, NC (Hoke Co)
DOB: 3/14/49
License #: 00-38271
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina, Chapel Hill (1985)
Action: 11/22/96. Issued temporary license to expire 5/31/97.

MECHAEL, Shawky Fahmy, MD
Location: Mooresville, NC (Iredell Co)
DOB: 12/10/29
License #: 00-30937
Specialty: OBG (as reported by physician)
Medical Ed: Alexandria University, Egypt (1954)
Action: 11/22/96. Issued temporary license to expire 1/31/98.

MEYER, Graham Scott, MD
Location: Fayetteville, NC (Cumberland Co)
DOB: 11/11/58
License #: 95-00405
Specialty: EM/PD (as reported by physician)
Medical Ed: University of Ontario (1986)
Action: 11/22/96. Issued temporary license to expire 3/31/97.

NELSON, Mark Theodore, MD
Location: Vass, NC (Moore Co)
DOB: 11/24/61
License #: 93-00251
Specialty: AN (as reported by physician)
Medical Ed: University of Kansas (1989)
Action: 11/22/96. Issued temporary license to expire 5/31/97.

PATEL, Aneel Nathoobhai, MD
Location: Goldsboro, NC (Wayne Co)
DOB: 8/12/35
License #: 00-34701
Specialty: P/N (as reported by physician)
Medical Ed: Seth GS Medical College, India (1959)
Action: 11/22/96. Issued temporary license to expire 11/30/97.

PULEO, Joel Gregg, MD
Location: Pinehurst, NC (Moore Co)
DOB: 9/15/53
License #: 00-27965
Specialty: OBG (as reported by physician)
Medical Ed: Duke University (1979)
Action: 11/22/96. Issued temporary license to expire 1/31/97.

QURESHI, Aftab Ahmad, MD
Location: Ahoskie, NC (Hertford Co)
DOB: 9/29/40
License #: 00-24494
Specialty: GS/VS (as reported by physician)
Medical Ed: King Edward, Pakistan (1962)
Action: 11/22/96. Issued temporary license to expire 3/31/97.

REESE, Perry, III, MD
Location: Fayetteville, NC (Cumberland Co)
DOB: 8/17/58
License #: 94-00988
Specialty: FP (as reported by physician)
Medical Ed: Wayne State University (1990)
Action: 11/22/96. Issued temporary license to expire 5/31/97.

SELTZER, Stephen Charles, MD
Location: Albemarle, NC (Stanly Co)
DOB: 7/30/49
License #: 00-22828
Specialty: FP (as reported by physician)
Medical Ed: University of Iowa (1974)
Action: 1/24/97. Issued temporary license to expire 1/31/98.

SHANKS, David Edward, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 6/02/41
License #: 00-20440
Specialty: IM/PUD (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1966)
Action: 11/22/96. Issued temporary license to expire 5/31/97.

SHIVE, Robert Macgregor, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 11/02/33
License #: 00-13226
Specialty: P (as reported by physician)
Medical Ed: University of North Carolina, Chapel Hill (1961)
Action: 11/22/96. Issued temporary license to expire 3/31/97.

SMITH, Jeffrey Alan, MD
Location: Monroe, NC (Union Co)
DOB: 12/13/53
License #: 00-34227
Specialty: OM (as reported by physician)
Medical Ed: University of North Carolina, Chapel Hill (1979)
Action: 11/22/96. Issued temporary license to expire 9/30/97.

THOMPSON, Robert Bruce, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 2/29/56
License #: 00-40006
Specialty: N/EM (as reported by physician)
Medical Ed: University of Miami (1987)
Action: 12/06/96. Issued temporary license to expire 1/31/97.
1/24/97. Issued temporary license to expire 3/31/97.

VOLUNTARY DISMISSALS

CREED, Donald Wendell, MD
Location: Elizabethtown, NC (Bladen Co)
DOB: 7/26/45
License #: 00-20780
Specialty: GP (as reported by physician)
Medical Ed: Medical University of South Carolina (1974)
Action: 12/31/96. Notice of Voluntary Dismissal of contested case initiated by a Notice of Charges and Allegations dated 4/15/88. [An indefinite continuance of the hearing on the charges was adopted on 6/9/88.]

HACKNEY, Charles Landis, Physician Assistant
Location: Wilmington, NC (New Hanover Co)
DOB: 2/24/46
License #: 1-00026
Education: Duke University (1974)
Action: 1/02/97. Notice of Voluntary Dismissal Without Prejudice of contested case against Mr Hackney initiated by Notice of Charges dated 12/11/95. His license has expired by its own terms.

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