

forum

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

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President's Message

Paul Saperstein

On Assuming the Presidency of the NCMB

It has been an honor and a pleasure to be elected president of the North Carolina Medical Board. The vote of confidence shown by the other eleven members of the Board in placing the position of the presidency with a non-physician is a tribute to their integrity, as it indicates no apprehension about leadership by someone outside their own profession. Hopefully, their action will go a long way toward dispelling the myth, believed by some individuals with limited understanding of the Board's operation, that the Medical Board often "protects its own" when it comes to disciplinary matters.

When I attended my first Board meeting a little over four years ago in Raleigh, I was unsure as to how I would be received. But from the first moment on, all the other Board members welcomed and mentored me without reservation. Even though our educational backgrounds are different, they eagerly sought my advice and counsel. It was apparent to me that what the Board members felt to be of uppermost importance was that the integrity that has historically been associated with the Board should be continued with each new generation of its members.

As we meet each month, I am always amazed at the countless hours Board members devote in carrying out the functions and duties required by their individual roles in the licensing and disciplining organization of medical practice in the state of North Carolina. Every member takes each committee assignment with the utmost dedication; their tireless efforts and downright hard work contribute to making the Board the exceptional organization it is.

To give our constituents (physicians, PAs, NPs, and the public) a better understanding of the Board's activities, I will try to spotlight various areas of the Board's operations in upcoming numbers of the *Forum*. We tend to be like a lot of the bureaucracy; how-

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Andrew W. Watry

From the Executive Director

An Ounce of Prevention: Early Intervention and Helpful Hints

As much as I hate to admit it, I don't think most of our physician licensees, when reading the *Forum*, start with the articles. I have heard from several physicians that the first thing they do is page to the section on Board actions to see if there are any names they recognize. I am proud of the fact that this Board recognizes the importance of supporting a quality publication to communicate with its licensees on a variety of issues. So, although you may be getting to this article after scanning the Board action list, that is okay. It provides a segue for the purpose of this article.

The Importance of Prevention

The Board is here, first and foremost, to protect the citizens of North Carolina through the medical regulatory process. That is done essentially two ways: (1) through an effective program of vigilance and accessibility, identifying substandard medical practices that violate the Medical Practice Act, and, where required, applying appropriate sanctions after full due process; and (2) doing what we can to prevent the problems and medical misadventures that precipitate disciplinary actions. This article is targeted to the second category. I will address the first category in later numbers of the *Forum*.

In the medical regulatory marketplace, the principal measure of the effectiveness of a board tends to be the number of disciplinary

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Primum Non Nocere

forum

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

Raleigh, NC

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The *Forum* of the North Carolina Medical Board is published four times a year. Articles appearing in the *Forum*, including letters and reviews, represent the opinions of the authors and do not necessarily reflect the views of the North Carolina Medical Board, its members or staff, or the institutions or organizations with which the authors are affiliated. Official statements, policies, positions, or reports of the Board are clearly identified.

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.

North Carolina Medical Board

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Assuming the Presidency

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ever, through the dedication of the entire staff and, as I mentioned before, the hard work of the Board's members, the work continues to be done on a timely basis.

We like to get feedback from our constituents. You may contact us by mail, telephone, fax, or e-mail at the Board office in Raleigh (see addresses and numbers on page 2 of this *Forum*). Also, please feel free to get in touch with me personally at my office in High Point.

(336) 889-2001

or

CPICOWORLDNET.ATT.NET

We look forward to hearing from you. ♦

North Carolina Medical Board



1-800-253-9653

An Ounce of Prevention

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actions taken by that board. Many national consumer groups and federal government critics tend to rate boards based on a "notches in the gunbelt" standard: those medical boards with the most "serious disciplinary actions," meaning revocations, suspensions, and formal probations, tend to be rated as the best, and, conversely, those with the fewest such actions are rated as ineffective. (We don't even have formal probation as a disciplinary option under our statute — we use consent orders to achieve much the same purpose, however.) The use of one number to evaluate the work of a medical board is a bit like rating the criminal justice system on the basis of the number of people executed each year. This is troubling to those of us heavily invested in this process because we know it is far too simplistic. The number of public board sanctions is a useful indicator of medical board productivity, but taking this single measure and projecting from it how safe consumers are in a given state is a big stretch with no relevant data to support it.

If you rate medical boards by the definition of "serious disciplinary actions" used by many consumer groups and federal government critics, this Board doesn't stand anywhere near the top of the list. However, we have in this state a renowned and highly respected medical culture. There are facilities here to which people from all over the

“Even an ounce of effective prevention can significantly reduce the need for heavy doses of serious discipline.”

world come to receive specialized medical care. Clearly, there is a lot more to the medical regulatory process and its ability to protect the public than a simplistic counting of "serious disciplinary actions." It's not the same as measuring the performance of a company in terms of sales and profits. If we are carrying out our mission of providing optimal public protection, we should be doing everything we can to prevent the problems that lead to complaints and disciplinary actions. Even an ounce of effective prevention can significantly reduce the need for heavy doses of "serious discipline."

Early Intervention

Each of the Board actions listed in the *Forum* involves an element of human tragedy. There is tragedy for any patients involved. There is also tragedy for the licensee. Imagine the consequence of having your name in the Board actions section of this publication. I suspect it would be devastating.

There are many Board interventions that don't result in public postings of Board action, do not meet the parameters of "serious disciplinary action" counted by consumer groups and government critics, but are almost as devastating to licensees. There are anonymous referrals to the North Carolina Physicians Health Program of chemically impaired physicians. Additionally, at the November 1998 meeting of the Board, to cite just one example, 48 physicians were asked to appear before members of the Board for confidential investigative interviews to explain possible violations of the Medical Practice Act that did not appear to rise to the level of prosecutable cases requiring public hearings. Many if not most of these physicians lost quite a few nights of sleep in anticipation of this experience. These interviews are effective mechanisms for redirecting behavior in many instances.

In the final analysis, we provide the best

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An Ounce of Prevention

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service to the citizens of North Carolina by minimizing, to the extent practicable, those problems and events that lead to disciplinary hearings for violation of the Medical Practice Act, while ensuring those violations that do occur are handled appropriately.

The following are some of the mechanisms in place or being developed for early intervention.

• **Assessment/Remediation.** The Board is working on a program that, outside the traditional disciplinary/prosecution process, would identify substandard medical skills in practitioners before they result in public complaints, removal from hospital staffs, etc.

“The Board is working on a program that would identify substandard medical skills in practitioners before they result in public complaints, removal from hospital staffs, etc.”

These individuals would be offered the opportunity to participate in an assessment/remediation program that, if successful, would help identify substandard skills through a clinical assessment model and then work with the practitioners on a

prescription for remediation through one of our state’s medical schools. This follows the model of the North Carolina Physicians Health Program by providing incentives for early identification and intervention before patients are exposed to substandard care that results in disciplinary action. The focus is on prevention. The Board is providing start up funding for development of this program.

• **Improving Referral Sources.** Certain referral sources are more productive than others in terms of identifying substandard medical practice. For example, when a physician or nurse has enough concern to contact the Board about a peer, that source tends to be a reliable indicator of true substandard medical care. The Board is working on developing these sources of information by possibly improving immunity provisions, meeting with medical society and hospital staffs to lower barriers to such reporting, and improving accessibility of the Board through mechanisms such as a statewide toll-free telephone number.

• **Improving Coordination and Monitoring of Marker Information.** The Board monitors markers such as malpractice settlements, hospital staff changes, etc. The vast majority of these markers do not warrant Board action when individually considered, but when evaluated with other markers may

point to problems. For example, a physician who resigns three hospital staffs at the same time and subsequently establishes an address in another location, does not necessarily show markers of a problem. A physician who resigns three hospital staffs at different times in the same community and maintains the same address, and also suffers a couple of malpractice settlements, has markers indicating there may be a problem that needs to be investigated further.

Avoiding Problems: A Few Hints

Now, let me offer some helpful hints in the spirit of helping physicians avoid the problems that may land their names in the Board action section of the *Forum*. Though at least 95 percent of the licensed physicians in this state are conducting medical practices in such a way that they will likely never be called before the Board, there are things that can be done to minimize exposure, including the following.

• **Avoid Professional Isolation.** If you look back at a sample of people who have suffered public disciplinary actions after full due process, professional isolation is a recurring theme. There are several things that can be done to avoid this, including insuring appropriate back-up, affiliation with professional associations, and full participation in continuing medical education. The Board will soon be posting continuing medical education requirements. The value of participation in programs that involve association with professional colleagues cannot be overstated.

• **Pay Particular Attention to Communication with Patients.** We receive over 600 public complaints a year. The most obvious recurring pattern in these complaints is failed communication between physicians and patients.

“The most obvious recurring pattern in complaints is failed communication between physicians and patients.”

From my perspective, if the physicians who were the subject of these complaints were more careful about their communication with their patients, they could have prevented a large number of these complaints. My friends involved in writing insurance for medical malpractice tell me there is little correlation between bad outcomes and malpractice suits and settlements. However, there is strong correlation between poor communication skills and these suits and settlements. That correlation also applies in patient complaints to the Board. I know an obstetrician who made it through an entire career without ever being sued, largely because he had

excellent communication skills. Even when a poor medical outcome occurred, which happens to all physicians at some time, he communicated with patients so effectively and sincerely that they had no inclination to complain about or sue him.

• **Submit Your Name as a Peer Review Volunteer.** We received excellent response to our solicitation for expert reviewers in the last *Forum*. One of the unintended benefits of serving as an expert reviewer of problems encountered by other physicians is that you may experience a “there but for the grace of God go I” reaction. You would of course receive the same benefit from serving as a reviewer for another entity such as a hospital or medical society complaint committee. I have heard from several physicians, including some who serve on medical boards, that they have altered their behavior in their medical practices and benefited from what they learned as expert reviewers.

• **Consider Your Medical License an Important Asset That Needs to be Protected.** There are patients that would put your license in jeopardy. For example, there are drug-seeking patients that seek to divert controlled substances. Even *Stadol* and *Ritalin* have street value. You need to strike a very delicate balance between being compassionate and medicating patients appropriately and identifying those that attempt to deceive you. I recognize that this is much more easily said than done.

• **Maintain appropriate medical records.** I mentioned previously that 48 physicians were invited to the last Board meeting to explain certain events in their practices. Those that had good medical records to explain what occurred, regardless of outcome, fared much better than those that didn’t. In one of its position statements, *Medical Record Documentation*, the Board publishes what it expects in a good medical record. If you are not familiar with that statement or with the SOAP method of record keeping that it endorses, I would encourage you to call the Board and ask for a copy of it.

Share Your Concerns

National consumer groups are critical of medical boards because there are “only” about 2,500 to 4,500 so-called “serious disciplinary actions” taken annually in this country. This variation in numbers depends on who is counting and what is defined as serious action. Regardless of the counting mechanism, however, each disciplinary action represents a tragedy for one or more patients and the physician named. A great deal of pain can be avoided through pre-

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An Ounce of Prevention

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venting such actions by identifying unprofessional behavior or other problems as early as possible and intervening before harm is done. Success in that effort is far more important than numbers of actions or rankings. We solicit your assistance as a licensee

"A great deal of pain can be avoided by identifying unprofessional behavior or other problems as early as possible and intervening before harm is done."

in helping us in prevention and intervention when you believe a colleague is headed for trouble.

The Board has recently adopted a position statement that makes a point of the importance of the licensee's participation in prevention and intervention. You will find it on page 6 of this *Forum*. Meanwhile, I would like to assure you that you can feel comfortable sharing your concerns about a colleague on a confidential basis with any of the Board's members or the Board's medical coordinator, Jesse Roberts, MD. Your decision to do so may go far to saving a colleague and protecting his or her patients. The trust the public places in you and in us requires we meet this obligation as effectively as we can. ♦

Last Call for Physicians to Volunteer for the World's Largest 1999 Sporting Event: The Special Olympics World Games

The Special Olympics World Games, which will be held in the Triangle from June 26 to July 4, 1999, needs your help in staffing its medical teams with physicians who are comfortable providing primary care for general medical needs and the assessment and treatment of athletic injuries. A minimum of one day's service, a North Carolina medical license, and a CPR certificate are required. Physicians interested in volunteering should contact Gail Kelley in the North Carolina Office of Rural Health and Resource Development, DHHS, before February 15. Telephone: (919)733-2040; fax: (919) 733-2981; e-mail: gkellerh@dhr.state.nc.us.

Breaching the Culture and Language Barrier

Wilton Craig Kennedy, PA-C



Mr Kennedy with clinic patient

Imagine traveling with your family to a foreign country and one of your family members becomes ill. You rush to the hospital only to discover that none of the attending staff members speaks any English. While labs and X-rays are ordered, no one is able to understand you well enough to gather the relevant history of the present illness. Eventually, a housekeeper is located who speaks enough broken English (he was a semi-pro baseball player for two seasons in Baton Rouge) to muddle through the exam. Sound like a nightmare? Well, for thousands of migrant and seasonal farm workers, it's a reality.

Migrant Health Care Centers

From the Fraser fir farms of Watauga County to the tobacco fields of Wayne County, and most agricultural enterprises in between, our cash crops are harvested by farm workers, the vast majority Hispanic. These workers provide a cheap yet dependable source of labor on which our economy has become dependent. By traveling from state to state following the harvest of different crops, their work enables the rest of us to purchase fresh produce at an affordable price and allows farmers to get their crops harvested while maintaining their bottom line. But this type of work and lifestyle doesn't come without a cost.

President Truman's words in 1951 still ring true in 1998: "We depend on misfortune to build up our force of migratory workers and when the supply is low because we do not have enough misfortune at home,

"From the Fraser fir farms of Watauga County to the tobacco fields of Wayne County, our cash crops are harvested by farm workers, the vast majority Hispanic."

we rely on misfortune abroad to replenish the supply." Recently, the Department of Labor declared agriculture to be the second most dangerous occupation in the U.S., second only to mining. The economy is enjoying such unprecedented buoyancy and low unemployment that people are unwilling to consider the dangerous and low paying work of agriculture. While many protest that immigration displaces American workers, the reality is quite different. We are unwilling to work in these conditions for these wages. For better or worse, they need the work and we need their labor.

As you might imagine, the intense heat of the summer contributes to the disproportionately high rates of heat stress and dehydration among farm workers. They suffer from high rates of injuries, occupational illnesses, muscular skeletal disorders, dermatoses, and pesticide exposure. Unfortunately, Hispanics also have high rates of diabetes and hypertension. Most continue to work in spite of these conditions, only seeking care when their pain or symptoms become unbearable. A premium is placed on working daily to maintain a steady income. Interruptions from work are seen as an inconvenience and a distraction, a threat to their livelihood.

For the last five years, I have had the opportunity, indeed the pleasure, of working with this population in a community health center in western North Carolina. Migrant health centers were built in response to the Migrant Health Act of 1962. Blue Ridge Health Center in Hendersonville was established in 1972 to provide limited health services to the area's apple pickers, who traveled up from Florida every fall. Since then, it has grown to include several sites and is open year round. While farm workers account for only ten-to-fifteen percent of our patients, we are still very much dedicated to serving their needs and the needs of their families. Today, there are more than 150 migrant health centers nationwide.

Cultural Barriers

Miguel (not his real name) is a typical patient. A thirty-five year old father of three, he has been traveling between Florida and North Carolina for the last 15 years following the tomato and apple crops. He can make up to fifty dollars a day when conditions are right. He makes more when his wife and kids help out in the fields, as they frequently do. He thinks it's a decent living

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Breaching the Barrier

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and for him it is, considering the alternative. His family does not have health insurance, nor do they qualify for any government benefits.

“Clinicians caring for Hispanics, as well as other culturally diverse groups, should have an understanding of folk medicines in order to overcome cultural barriers.”

Because he works on small to medium sized farms and for a crew leader, he is exempt from workman's compensation. Although he infrequently comes in for his own care, he frequently accompanies his wife and children. His wife suffered from preeclampsia and his children, like most children, have the usual childhood illnesses. Except for chronic back pain and well controlled diabetes, he's healthy. He has started to develop bilateral pterygiums, which are more aggravating than anything else. He has been treated with preventative INH for tuberculosis and knows that his lifestyle places him at risk.

Comprehensive treatment for him and his family involves an understanding of “alternative” medicine. For generations, he and his family have combined conventional medicine with their own system of folk medicine. Clinicians caring for Hispanics, as well as other culturally diverse groups, should have an understanding of these folk medicines in order to overcome cultural barriers. Inquiring about and possibly incorporating some of these practices into the treatment of such patients will improve compliance, outcomes, and patient satisfaction. Ignoring them or mocking them will ensure the opposite. As a general rule, the patients will not rush to your office at the first sign of illness, but will attempt a home remedy or two before seeking your professional advice. In fact, they may have seen a *curandero* to get his opinion and treatment first.

Miguel typifies my migrant patients in many ways. Cultural beliefs haven't prevented him from seeking medical attention, but breaking through the barriers makes him very appreciative and grateful for the care he receives. It also helps the clinician provide better care and feel better about the care he or she is providing.

Language Barriers

My co-workers in accounts receivable at the Blue Ridge Health Center tell me that farm workers, as a group, are less frequently delinquent in their accounts than others. However, one of the most frustrating exper-

iences in the health care profession involves those patients who have no transportation and few resources for keeping appointments and referrals to health care specialists that we help them set up. Most farm workers do not have an automobile or any other resources for keeping appointments and lack English for communicating their situation. Language barriers and lack of resources can cause appointments to be missed.

Regardless of these difficulties, I have found that working with the Hispanic population has provided me with a unique opportunity and challenge to provide care to an appreciative and very underserved population. The gratitude that I have received has been unparalleled by any other patient population to which I've provided health care services. Learning some Spanish has enabled me, as a physician assistant, to more fully understand the Hispanic client's needs. I believe we, as health care professionals, have not fully met the challenges of such a diverse and complex population. Hispanics represent the fastest growing minority in America. If you don't already have Spanish speaking patients in your practice, you probably will soon.

While proficiency in another language may take years to develop, the ability to speak at least a little of the language of your patient conveys a strong message that will not go unnoticed by the patient. By developing an ear for the language, you will become more efficient and effective when using an interpreter. There is nothing more frustrating than to have a long detailed answer from a patient translated as a “yes” or “no.” In addition, confidentiality of the patient/provider relationship can be compromised when the interpreter is a family member, friend, or untrained staff member. Often the interpreter has limited or inadequate medical terminology to effectively communicate and understand what is relevant to the diagnostic and information-gathering process of the medical interview, exam, and treatment.

“I have found that working with the Hispanic population has provided me with a unique opportunity and challenge to provide care to an appreciative and very underserved population.”

Resources Available

Fortunately for us working in North Carolina, there are resources available to assist physicians, PAs and NPs, nurses, EMTs, and others working toward understanding our patients among the Hispanic

population. The North Carolina Health Alliance was formed in 1994 to coordinate and streamline access to health care for our farm workers. One of the administering agencies is the Division of Community Health in the North Carolina Department of Health and Human Services, which operates a fee for service reimbursement program. Other administering agencies include the Office of Rural Health and the North Carolina Primary Health Care Association. (See the accompanying list of other national organizations committed to helping provide care to farm workers.)

Even though these are valuable resources for health care providers, there are other modes of education available. Some recommend use of the *Listen & Learn Spanish* tapes (ISBN 0-486-99918-1, Dover Publications, Inc., 31 East Second Street, Mineola, NY 11501). This resource uses both a tape in English and Spanish and a fully indexed manual of every word spoken. These can be listened to by individuals or groups. They are ideal for self-study at home or in a car and deal with practical phrases.

Another step in the right direction is the use of such tapes and phrase books as *Speedy Medical/Nursing Spanish*, which has common medical phrases grouped together to assist health care professionals with various phrases, questions and answers for specific areas. There are sections for taking histories of different anatomic system disorders, physical examination phrases, medication phrases for dosing, surgical pre/post operative phrases, hygienic and medical assessment phrases. They are grouped together: the same phrase in English and Spanish with the phonetic pronunciation. These *Speedy Spanish for Medical Personnel* (ISBN 0-9615829-9-5) and *Speedy Spanish for Nursing Personnel* tapes and phrase books are available from Baja Books, Box 4151, Santa Barbara, CA 93140.

One of the better resources available for medical Spanish study is the curriculum series *Hablar El Idioma De Su Cliente™* “*Speaking Your Client's Language*,” developed by Bess Ives Kennedy. She says:

My idea is that health care can and will become more language accessible to Hispanics only if opportunities for intensive language study are more readily accessible to medical professionals on-site at their agencies, at local AHEC's, in universities, and at community colleges. Medical professionals need instruction that is practical, adaptable, situational, culturally sensitive. They need instruction to facilitate the acquisition of language, not just memorization of job-specific

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phrases. Providers need to be able to understand what the client says and be aware of cultural issues. Teaching culture is just as important as teaching the language. By learning both, medical professionals can more fully understand their patients and speak their language.

Ms Kennedy designed the curriculum to address these needs as well as the material needs of instructors. At the summer NCAPA conference, Ms Kennedy held a Level I introductory workshop for CME credit. It has been adopted as the core curriculum for classes sponsored by the Area Health Education Centers (AHECs) in both North and South Carolina funded by the Duke Endowment Immigrant Health Initiative. It has also been used by the Emory University Physician Assistant Program in Atlanta, at the Physician Assistant Program at the University of Colorado, and by community colleges and health care agencies across North Carolina.

“Seriously consider the cultural barriers that can affect the quality of medical care and use the resources available to incorporate some medical Spanish in your practice.”

Presently, the Level I curriculum consists of a study packet that includes a student workbook, study guide, and program cassette (ISBN 0-9660225-4-8) and an instructor's packet that includes the instructor's manual, instructor's aid, student workbook, program cassette, and tests (ISBN 0-9660225-5-6). The course is adaptable to classroom study, small group study, and self-study (by those with some basic knowledge of Spanish). It consists of 10 lessons, requiring a minimum of 20 hours of study. The above publications are available from Manzana Publications, PO Box 1512, Flat Rock, NC 28731. Any of the given publications can be purchased separately. For information about a class in your area, contact your local AHEC or Bess Ives Kennedy with Manzana Publications and Program Services at (828) 685-0360 or at e-mail: manzana@brinet.com.

My hope is that you will seriously consider the cultural barriers that can affect the quality of medical care and use the resources available to incorporate some medical Spanish in your practice to better serve this patient population. ♦

Migrant Health Resource List

Migrant Clinicians Network, MCN
Migrant Health Provider Orientation Manual; Streamline; Web site @ www.migrantclinician.org
PO Box 164285
Austin, TX 78716
(512) 327-2017

Manzana Publications and Program Services
Hablar El Idioma De Su Cliente “Speaking Your Client’s Language” Medical Spanish Language Curriculum
PO Box 1512
Flat Rock, NC 28731
(828) 685-0360

The National Coalition of Hispanic Health and Human Services Organization, COSSMHO
Delivering Preventive Health Care to Hispanics: A Manual for Providers
1030 15th Street, NW, Suite 1053
Washington, DC 20005
(202) 371-2100

The National Center for Farmworker Health, NCFH
NCFH Resource Catalog; Newslime
1515 Capital of Texas
Highway South, Suite 220
Austin, TX 78746

The National Rural Health Association, HRHA
One West Armour Boulevard,
Suite 301
Kansas City, MO 64111
(816) 756-3140

The National Association of Community Health Centers, Inc
1330 New Hampshire Ave., NW
Washington, DC 20036
(202) 659-8008

Farmworkers Legal Services of North Carolina
128 East Hargett Street, Suite 202
PO Box 26626
Raleigh, NC 27611
(919) 856-2180

NCMB Adopts Position Statement on Professional Obligation to Report

At its November meeting, the North Carolina Medical Board adopted a position statement on the physician's professional obligation to report incompetence, impairment, and unethical conduct of colleagues. The full text of the statement appears below.

NCMB Position Statement

PROFESSIONAL OBLIGATION TO REPORT INCOMPETENCE, IMPAIRMENT, AND UNETHICAL CONDUCT

It is the position of the North Carolina Medical Board that physicians have a professional obligation to act when confronted with an impaired or incompetent colleague or one who has engaged in unethical conduct.

When appropriate, an offer of personal assistance to the colleague may be the most compassionate and effective intervention. When this would not be appropriate or sufficient to address the problem, physicians have a duty to report the matter to the institution best positioned to deal with the problem. For example, impaired physicians and physician assistants should be reported to the North Carolina Physicians Health program. Incompetent physicians should be reported to the clinical authority empowered to take appropriate action. Physicians also may report to the North Carolina Medical Board, and when there is no other institution reasonably likely to be able to deal with the problem, this will be the only way of discharging the duty to report.

This duty is subordinate to the duty to maintain patient confidences. In other words, when the colleague is a patient or when matters concerning a colleague are brought to the physician's attention by a patient, the physician must give appropriate consideration to preserving the patient's confidences in deciding whether to report the colleague. ♦

The North Carolina Board of Nursing: Moving Toward Multistate Regulation

Polly Johnson, RN, MSN
Executive Director, North Carolina Board of Nursing



Ms Johnson

As we move into the next millennium, we are being challenged with providing safe, effective nursing care in a new environment driven by cost-containment as well as an explosion in information technology. With the developments in telecommunications plus the growth of multistate health care networks and systems, the delivery of nursing care is increasingly occurring across state lines both electronically and physically.

Mutual Recognition

Legal authorization to practice across state lines is required for telenursing, as well as for the more traditional practice modalities.

In order to meet our regulatory mandate of public protection while facilitating nursing practice across state lines, a mutual recognition model for nursing licensure has been developed by the National Council of State Boards of Nursing. The main characteristics of this mutual recognition model for nursing regulation include:

- an Interstate Compact for Nurse Licensure must be adopted by the legislature in each state wishing to participate in (be party to) this mutual recognition model;
- each state maintains authority for licensure, practice standards, and discipline;
- the nursing license (RN or LPN) is obtained in the state of residence and recognized by other states that have adopted the Interstate Compact for Nurse Licensure, ie, the nurse does not have to obtain an additional license in order to practice in another party state;
- the nurse is held accountable for knowing and complying with the nursing practice laws and regulations in each state where the client receives nursing care, physically or electronically;

- a centralized information system (database) containing relevant licensure and disciplinary information enables information sharing, tracking, and coordination among states where an individual nurse may practice; and
- public protection is provided through established agreements related to jurisdiction, discipline, and information sharing among party states.

Interstate Compact for Nurse Licensure

In 1999, we will be seeking legislative enactment of the *Interstate Compact for Nurse Licensure* in North Carolina. This is the legal agreement between two or more states that will allow RNs and LPNs to hold a license in their state of residency (home state), and

"In 1999, we will be seeking legislative enactment of the Interstate Compact for Nurse Licensure in North Carolina."

have the privilege to practice in all other states that have enacted the same compact. The *Interstate Compact for Nurse Licensure* establishes the processes for sharing information among states to assure that nurses are appropriately licensed and competent to provide safe care to the public, and for taking action against any licensee when that person is not competent to practice. (An example of a current interstate compact that most people benefit from is the driver's license compact.)

If you wish to have further information about the mutual recognition model of licensure and the interstate compact, you may access the National Council of State Boards of Nursing Web site at <http://www.ncsbn.org>. You may also visit the North Carolina Board of Nursing's Web site at <http://www.ncbon.com> or contact the Board office for a copy of the model interstate compact and commonly asked questions and answers on the compact. These are truly exciting and challenging times as we move forward in our efforts to reform the regulation of nursing practice.

In the meantime, each nurse is required to hold a license in each state in which he/she practices, whether that practice is done on-site, via telephone or other electronic media. ♦

Reprinted from the *Bulletin* of the North Carolina Board of Nursing, Fall 1998

Dr Vanderberry Retires from NCPHP, Honored by NCMB and NCMS

Bryant D. Paris, Jr
Executive Director Emeritus, NCMB



Dr Vanderberry speaking to Board after receiving plaque

Robert C. Vanderberry, MD, retired on October 4, 1998, after serving 10 years as medical director of the North Carolina Physicians Health Program (NCPHP). The NCPHP initially grew out of the North Carolina Medical Society's (NCMS) Committee on Physicians Health and Effectiveness. The NCPHP has become a model for programs in other states under Dr Vanderberry's direction.

NCPHP was designed to rehabilitate physicians and physician assistants who are disabled by chemical dependency and mental illness. More than 800 physicians and PAs have benefited from the program's activity.

Dr Vanderberry has worked closely with the four medical schools, Area Health Education Center programs, and hospitals throughout the state to assist in identifying and rehabilitating the impaired, and to develop an individual recovery program to enhance full recovery.

He was recently honored with the 1998 Caduceus Club Award, which is given annually to those who have distinguished themselves by outstanding contributions to the health care profession. At the recent meeting of the NCMS, he was also honored by having a scholarship fund established in his name to assist physicians who need financial assistance during a period of remediation.

On the evening of November 19, during its regular bimonthly meeting, the North Carolina Medical Board took special notice of Dr Vanderberry's long and dedicated service with the NCPHP and to the medical profession. On behalf of the Board, Charles E. Trado, MD, president of the Board, presented Dr Vanderberry a special plaque that read, in part:

He saved physicians' lives,
He saved physicians' families,
And through his contributions,
Made it possible, again, for these physicians
To save their patients. ♦

It's Not a Matter of Fair, It's a Matter of Reality

A North Carolina Physician

All of a sudden, I feel a lot like Kerry Collins. I'm not 6' 5" tall and athletic with an arm like a cannon, but I'm in touch with the side of Collins that says: "That's none of your business." But it is. And because it is, it changes lives.

A Different Standard

Collins is 25 and, when he's not on the football field, he is apparently an overindulgent and under-disciplined young, incompletely mature adult. But he is held to a different standard. Most of us at 25 were overindulgent and under disciplined, and that was called growing up. Sometimes it went without great criticism, sometimes it resulted in legal skirmishes or having to answer to parents, with severe embarrassment. But rarely did it become public, or recorded, or something we have to explain for the rest of our lives.

Collins went from multimillionaire to third-string backup quarterback in one week. His turmoil is discussed publically on ESPN, in magazines, on the evening news. Whenever we now recall his name, he will not only be a first-round draft pick commanding millions but also a troubled talent not realizing his potential. What he felt was private behavior, none of our business, has become his *persona*. There is a different standard for superstars, fair or not.

There is also a very different standard for doctors, fair or not. I crossed that line in the total privacy of my home. I didn't hurt anyone. It had no relationship to my public dignity or responsibilities. It was none of their business, I felt. But, boy oh boy, did it rock my staid secure world.

From Private Indiscretion to Public Flaw

One evening, in an attempt to enhance some feelings, I smoked a marijuana cigarette. It was a totally isolated, foolish, unproductive reversion back to the 70s, when I was 25 years younger and circumstances were far different. It had been decades since those different times. Three days later, I stared a random drug tester in the face and my heart dropped. All of the dignity and respect of my life suddenly became contaminated with a momentary stupid act. And now the privacy of my behavior was public, at least in a closed circle.

I now had to, was absolutely mandated to, address this isolated act as a character flaw. The rules of my employment made a private indiscretion a public accountable flaw that must be answered in a protocol response.

I was told I could not see patients until "the matter had been dealt with." This mandated an EAP consultation, an employee health consultation, an outside confirmatory consultation with a substance abuse counselor, and, then, an assigned course of counseling with a contracted counselor for six hours. I was only able (allowed) to return to my patient care when several outside authorities signed off on my ability to do so. The explanation of why I was not on the job while obviously not physically ill was left to my best explanation. Maybe it remained private, but probably not.

A representative of the North Carolina Medical Board came to my office to assess my status. Random drug testing follows every time anyone in our office is tested. I was mandated to be evaluated by the North Carolina Physicians Health Program. Finally, I had to appear before the Medical Board, which made the determination that I was of no danger to my patients or myself.

There Is No Privacy

I must say that at every juncture, each intervention was discrete and totally professional. Every authority was an advocate and interested in my well-being. But there is no way that intervention by the battery of intervenors can go overlooked by peers and staff.

Needless to say, my isolated foray into forbidden waters will never again be even contemplated, certainly not repeated. I write this article to underline that what was a "totally private" indiscretion is now a file in several offices. What was a totally unblemished record of dignity and exemplary service is now contaminated.

There is no privacy in the life of a high-profile community leader like a physician. Domestic altercations, alcohol or substance abuse, arrests, malpractice proceedings, bankruptcy, or financial defaults that would otherwise be private in less public persons are delicious fodder for our communities.

If ever we think our private indiscretions are none of anybody's business, we must realize that different rules apply. Ask Kerry Collins. It's not a matter of fair, it's a matter of reality. ♦

Mr Paul Saperstein of Greensboro Elected President of North Carolina Medical Board: First Public Member to Hold The Post

Paul Saperstein New NCMB President



Mr Saperstein

On November 1, Mr Paul Saperstein, of Greensboro, took office as president of the NC Medical Board, succeeding Charles E. Trado, MD, of Hickory, who will continue as a member of the Board for another year.

The first public member of the Board to be elected its president, Mr Saperstein was appointed by Governor Hunt in 1993 and served previously as secretary/treasurer and as vice president of the Board. He has been a member of a number of Board committees, including the Investigative, Complaints, Physician Assistant, and Telemedicine Committees, and has chaired the Operations and Executive Committees.

A graduate of North Carolina State University, he is president and chief executive officer of Concept Plastics, Inc, including its Craft-Tex and Ladybug divisions, in High Point. He founded Concept Plastics, Inc, which is one of the nation's largest manufacturers of custom-molded polyester, in 1970. In the 1980s, he was also president and chief executive officer of Case Casard Furniture Manufacturing Corporation. Over the years, he has been active in a wide variety of community organizations and groups.

Wayne W. VonSeggen, PA-C, Vice President



Mr VonSeggen

Wayne W. VonSeggen, PA-C, of Winston-Salem, assumed the post of vice president of the NC Medical Board on November 1, replacing Mr Saperstein in that position. Mr VonSeggen, a native of

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New Officers

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Iowa, has been a physician assistant for over 21 years and currently works with Dr George Franck at the Employee Health Center at Wake Forest University Baptist Medical Center in Winston-Salem. He received his BA degree in chemistry and zoology from Olivet Nazarene University in Illinois, with graduate work in anatomy at the University of Iowa, and completed the Physician Assistant Program at Bowman Gray School of Medicine of Wake Forest University. He is a fellow member of the American Academy of Physician Assistants, a charter member of the North Carolina Academy of Physician Assistants, and an associate member of the North Carolina Medical Society, participating with the Bioethics Committee.

Mr VonSeggen has served as president of the North Carolina Academy of Physician Assistants, has coauthored the results of three state-wide surveys of the PA profession, and plays an active role in several professional organizations. He has served on the Board since 1994, acting as chair of the PA Committee, nominating members of the PA Advisory Committee to the Board, and as a member of several other key committees, including the Licensing, Investigations, EMS, and Scope of Practice Committees.

Elizabeth P. Kanof, MD, Secretary/Treasurer



Dr Kanof

Also on November 1, Elizabeth P. Kanof, MD, of Raleigh, became secretary/treasurer of the NC Medical Board, replacing Mrs Martha K. Walston, of Wilson. Dr Kanof was appointed to the Board in 1996.

Dr Kanof, a native of New York, received 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. She holds appointments as assistant clinical professor of dermatology at the Duke University School of Medicine and as adjunct 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 has served on or chaired numerous Medical Society committees. Over the years, she has also been a participant in a wide range of community and charitable groups.

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 served on the Board's Malpractice, Physician Assistant, Physicians Health Program, and Liaison Committees, and has been chair of its Complaints, Scope of Practice, and Alternative Medicine Committees. ♦

Bryant D. Paris, Jr, Executive Director Emeritus of NCMB, Presented John H. Anderson Award by NC Medical Society



Bryant D. Paris, Jr, (left) receiving Anderson Award from George C. Barrett, MD

On November 13, 1998, at the 144th Annual Meeting of its House of Delegates, the North Carolina Medical Society presented its prestigious John Huske Anderson Award to the executive director emeritus of the North Carolina Medical Board, Bryant D. Paris, Jr.

In presenting the award to Mr Paris, George C. Barrett, MD, a former president of the North Carolina Medical Board and currently vice president of the Federation of State Medical Boards, made the following comments.

It is an honor to have the opportunity to present the John Huske Anderson Award, for this award, by mandate of the House of Delegates, is presented to "those laymen whose contributions have had a positive impact on the medical profession and the public health in the manner exemplified by John Huske Anderson."

The very fact that the membership of our society recognized many years ago that the destiny of our profession is

inextricably related to other professions and to the public in general, and that we benefit from the interaction between professions, helps explain the wonderful quality of medical care the citizens of our state receive.

That said, the person to be honored this year does raise questions that should be addressed:

- How could he be a lawyer without a law degree?
- How could he be a physician without a medical degree?
- How could he teach students without teaching experience?
- How could he be a disciplinarian who loves and has empathy with those disciplined?
- How did he acquire a vision of what modern medical boards should be before his peers understood their role in medical regulation?

The answer lies in identifying one who has natural ability and had John Huske Anderson as a mentor, one who

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John H. Anderson Award

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understood the feeling John Anderson had for our profession and who made plain the responsibility regulators had to the profession and to those who sought care from members of the profession.

Such a person is Bryant D. Paris, Jr. He brought the North Carolina Medical Board to a status that is still the envy of most of his counterparts around the country. His innovative successes are too numerous to list in a short time. A brief list includes creating physician extender rules, guiding changes in the Medical Practice Act, assisting in the development of the Physicians Health Program, and adding investigators, full-time attorneys, and a medical coordinator to the staff. Most of all, Bryant Paris knew, as did John Anderson, that the public is best protected when there is creative tension coupled with professional respect between the regulatory board and organized medicine.

Thus, "Pete" Paris has left a legacy of integrity, self-effacement, and dedication to professionalism. And, most importantly, that legacy includes the preservation of trust in our profession. That is what Bryant Paris has succeeded in doing. I know John Huske Anderson is beaming today as we present this award, named for him, to Mr Paris.

John Anderson and Bryant Paris have understood, as too few do, the absolute necessity for preserving the covenant of trust so essential to us as we practice this moral enterprise we call medicine. This understanding of the crucial importance of trust in our profession and in individual physicians is the positive impact that John Anderson's disciple, Bryant D. Paris, Jr, has had on our profession and on the public. All else pales before that seismic contribution.

Accepting the award, Mr Paris, joined on the dais by his wife, Patsy, and his son, Bryant, shared the following thoughts with the assembled delegates of the Medical Society.

You have honored me more than you know, and more than I am able to express. I am deeply touched. I attribute my being honored today to the influence of many of your peers and others.

I have learned the value of tenacity and hard work from Drs Joyce Reynolds, Pat Pagter, Tom Fitz, David Citron, and George Barrett. Even today, Dr Barrett "toils in the fields" to improve the medical profession. You should have him tell you of his activi-

ties.

I have learned the value of parenting or mentoring, as appropriate, from Drs Charles Wilkerson, Jack Koontz, Joe Hooper, Harold Godwin, George Johnson, Hector Henry, Charles Trado, Simmons Patterson, and Eben Alexander.

I have learned of your professional caring and compassion from Drs Rose Pully, John Nance, Bruce Blackmon, Charles Duckett, Liz Kanof, and a host of other physicians who have served on the Medical Board. I have learned compassion from this House as well.

I have learned of and developed a deep respect for your profession from Mr Jim Barnes, Dr Bryant Galusha, and Dr Joe Combs.

And what did I learn from my mentor, John Huske Anderson? When I first came to know him, in 1965, I began to learn all of these attributes and values from him. And I learned something greater from John and that is a love of your profession, the love that a parent has for a child, the love that would cause an outsider to want you to be the very best you could be.

I am here today, too, because of the continuous encouragement of my wife, Patsy, and my son, Bryant, who have asked me, when I have faced some dilemma, lawsuit, or media interview: "What would Mr Anderson do?"

So you now say to me, the profession and the public, that my "contributions have had a positive impact on the medical profession and the public health in the manner exemplified by John Huske Anderson."

Again, thank you. I am greatly honored and deeply touched. But I say to you that if my contributions have had a positive impact on the medical profession and the public health, it is because of John Huske Anderson. ♦

Audio Tape of "End-of-Life Decisions Forum" Available

Description and How to Order:

AUDIO TAPE

Order the Following Directly from the North Carolina Medical Board

End-of-Life Decisions Forum [4 hours; 1998]

Transcription of a conference developed and presented by the staffs of the North Carolina Medical Board, the North Carolina Board of Nursing, and the North Carolina Board of

Pharmacy. Held in Raleigh, North Carolina, on October 23, 1998, the conference was designed to provide a forum for health care regulators, professionals, and policy makers to explore the ethical, legal, and other issues surrounding end-of-life decisions and to initiate a continuing process for addressing such issues. Speakers included Lawrence O. Gostin, JD, LLD (Hon), Co-Director of the Johns Hopkins University and Georgetown University Program on Law and Public Health; George C. Barrett, MD, Vice President of the Federation of State Medical Boards and past president of the North Carolina Medical Board; Anne Dellinger, JD, Professor of Public Law and Government at the University of North Carolina; Bill Campbell, PhD, Dean of the University of North Carolina School of Pharmacy; David A. Swankin, JD, President of the Citizen Advocacy Center; Nancy M.P. King, JD, Associate Professor of Social Medicine at the University of North Carolina; Sharon Dixon, RN, MPH, Senior Vice President of Clinical Services at the Hospice of Charlotte; Joseph A. Buckwalter, MD, President of the North Carolina Hemlock Society; Cathy Clabby, MA, Medical Reporter for the Raleigh News and Observer; and the executive directors of the three host boards. Question and answer periods and reports of small-group discussions are included. **On two 120 - minute audio cassettes. Available from the NCMB's Public Affairs Office for \$10.00 (which includes mailing charge). (Please inquire for costs if requesting shipping outside the U.S.)**

Informative Video Tapes

Descriptions and How to Order:

Order the Following Two Directly from the North Carolina Medical Board

The Magic Kiss: Sexual Misconduct and Boundary Violations [114 minutes; 1997] A seminar conducted at the offices of the NCMB by Barbara S. Schneidman, MD, MPH, then Associate Vice President of the American Board of Medical Specialties and now Director of the AMA Office of Medical Education. Introduced by George C. Barrett, MD, Immediate Past president of the NCMB and now Vice President of the Federation of State Medical Boards. This is the presentation Dr Schneidman has made before a number of state medical boards and other medical groups over the past several years. **THE ONLY TAPE AVAILABLE OF DR SCHNEIDMAN'S SEMINAR ON SEXUAL MISCONDUCT. Available from the NCMB's Public Affairs Office for \$10.00 (which includes mailing charge). (Please inquire for costs if requesting shipping outside the U.S.)**

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Video Tapes

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Edmund D. Pellegrino: "Why Do We Speak of Responsibility?" [25 minutes; 1994]

Distinguished medical ethicist discusses the duties of medical board members, the ethics of medical practice, and the role of medical educators. Dr Pellegrino is Director of the Center for Clinical Bioethics at Georgetown University Medical Center. Available from the NCMB's Public Affairs Office for \$12.95 (which includes mailing charge). (Please inquire for costs if requesting shipping outside the U.S.)

Order the Following Two Only from the NC Agency for Public Telecommunications

116 West Jones Street, #G-10
Raleigh, NC 27603-8003
Telephone (919) 733-6341

Health Connections: Patient-Doctor Boundaries [60 minutes; 1997]

A discussion and call-in Q&A session on sexual misconduct and related subjects. Features **Barbara S. Schneidman, MD, MPH**, then Associate Vice President of the American Board of Medical Specialties and now Director of the AMA Office of Medical Education; **George C. Barrett, MD**, Immediate Past President of the NCMB and now Vice President of the Federation of State Medical Boards; **Margaret H. Nusbaum, DO**, Clinical Assistant Professor, Family Medicine, University of North Carolina School of Medicine; and **Dale Alexander, PhD**, Director, Behavioral Science, Family Medicine Department, University of North Carolina School of Medicine. (Original television production.) **Request Health Connections program dated 7/17/97 when ordering from address noted above. Price: \$7.94 (which includes mailing charge).** (Please inquire for costs if requesting shipping outside the U.S.)

Health Connections: Pain Management [60 minutes; 1997]

A discussion and call-in Q&A session on the management of chronic pain and the NCMB's position statement on that subject. Features **Charles E. Trado, MD**, President of the NCMB, who chaired development of the NCMB's statement; **William S. Blau, MD**, Assistant Professor, Anesthesiology, and Director, Pain Medicine, Anesthesiology Department, University of North Carolina School of Medicine; and **Sunil Dogra, MD**, Clinical Assistant Professor, Anesthesiology, and Attending Physician, Pain Clinic, University of North Carolina School of Medicine. (Original television production.) **Request Health Connections program dated 2/06/97 when ordering from address noted above. Price: \$7.94 (which includes mailing charge).** (Please inquire for costs if requesting shipping outside the U.S.) ♦

REVIEWS

Hospice Care: Two Valuable Resources Available

Judi Lund Person, MPH, Executive Director
Hospice for the Carolinas



Ms Lund Person

Hospice Care: A Physician's Guide

"Rarely in the course of a patient's disease and treatment is there one moment when the focus clearly shifts from curative to palliative. Just as disease is a process, so is preparing a patient for the time when treatment for cure is no longer an option. Preparing a patient begins with an honest discussion of the disease and its outcomes." The newly published book, *Hospice Care: A Physician's Guide*, opens with these words. For many physicians, telling patients bad news and talking with them about their choices at the end of life is difficult, uncomfortable work. This book is a wonderful resource on preparing patients for hospice care, for talking with families and answering patient and family questions about care, pain and symptom management, and what lies ahead.

According to a 1996 Gallup survey, nine out of ten Americans have said they would prefer to be cared for at home if they are terminally ill. More than 90% of hospice care in North Carolina is provided to patients in their own homes, but hospice care can be provided in a variety of other settings as well, such as hospitals, assisted living facilities, long term care facilities, hospice residences, or hospice inpatient facilities. In North Carolina, there are 59 beds available to hospice patients in hospice residences, a "home away from home" for patients who have no caregiver, or a frail or elderly caregiver, at home. In addition, there are 104 beds available in hospice inpatient facilities, intended to provide short-term pain and symptom management for patients who need acute inpatient services. The book describes the services that can be expected in each setting where hospice care is provided.

It also discusses how to refer to hospice and the support that is available from the hospice team to the physician. "Most physicians would say hospice care is worth the investment," said Michael Levy, MD, PhD, director of the supportive oncology program at the Fox Chase Cancer Center in

Philadelphia. "In many cases the doctor doesn't get calls or go to the ER in the middle of the night because hospice takes the calls and the hospice nurse goes out to the home."

There is a discussion of the services covered under the remarkably inclusive Medicare/Medicaid Hospice Benefit. For many patients, payment of prescription drugs related to the terminal illness is one of the most important benefits provided by the Medicare/Medicaid Hospice Benefit. The patient's attending physician works with the hospice to develop an individualized plan of care for the patient and his or her family. Based on that plan of care, intermittent visits by the hospice nurse, social worker, chaplain, and home health aide or homemaker are made. Medical equipment and supplies are covered, as are therapies and counseling services. The patient's family receives bereavement counseling for up to a year after the death of the patient, provided by the hospice program.

For those physician offices that have had some confusion about billing issues for hospice patients, the book provides specific physician billing guidelines. A helpful chart is included with what should be billed to Medicare-Part B and what should be billed to the hospice, and includes billing instructions for attending, covering and consulting physicians.

Nearly half the book is devoted to medical guidelines for determining prognosis in selected non-cancer diseases. The guidelines were developed by a group of hospice physicians from throughout the country and published by the National Hospice Organization. They are designed to assist physicians in determining appropriate hospice referrals for patients with heart disease, pulmonary disease, dementia, HIV disease, liver disease, renal disease, stroke and coma, and amyotrophic lateral sclerosis. The guidelines provide a helpful construct for physicians reviewing patients who would benefit from receiving hospice services.

Hospice for the Carolinas received a generous grant from Faulding Laboratories, the makers of Kadian morphine sulfate sustained release capsules, headquartered in Raleigh, to print *Hospice Care: A Physician's Guide*. It

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Reviews

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is published by Hospice for the Carolinas under an agreement with the National Hospice Organization, which holds the copyright

A complimentary copy of *Hospice Care: A Physician's Guide* can be obtained by calling your local hospice or by calling or sending the form below to Hospice for the Carolinas. Multiple copies may also be ordered using this form.

1998/99 North Carolina Home Care & Hospice Directory

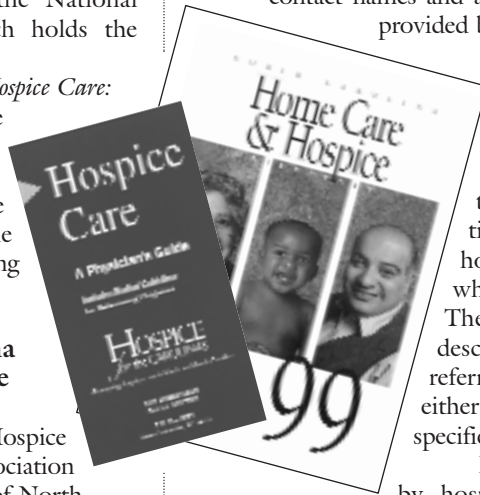
For more than ten years, Hospice for the Carolinas and the Association for Home and Hospice Care of North Carolina (formerly the North Carolina Association for Home Care) have collaborated to produce a statewide directory of home health, home care, and hospice services. Published by AHHC, the 1998-99 *North Carolina Home Care and Hospice Directory* is improved and expanded, allow-

ing the user to determine the type of service needed by a patient, turn to the home care or hospice section and identify what providers serve the county. The listings also specify contact names and a list of services provided by the agency.

A section in the beginning of the directory provides additional information on what is home care and what is hospice. The detailed description of the referral process for either service is also specified.

Frequently used by hospital discharge

planners, insurance case managers, patient advocates, and physician office staff, the directory is an invaluable resource guide for physician offices making referrals to hospice and home care agencies. Copies of the *Directory* may be ordered using the form below. ♦



LETTERS TO THE EDITOR

Conference and Course on Complementary/Alternative Medicine

To the Editor: I read [Mr Watry's] editorial [A Regulatory Perspective on Alternative Medicine] in the NC Medical Board *Forum* [No. 3, 1998] with great interest. I have been interested in these issues for some time and co-direct a course on complementary/alternative medicine here at UNC. This last weekend, I co-organized a three-day conference on herbal and nutritional supplements at UNC that was attended by over 250 people (75% practicing physicians).

One of our speakers was Dr John La Puma from Chicago, who gave a presentation on the ethics of alternative medicine. Another keynote speech concerned regulatory issues and standardization of preparations.

The aim of our conference was to inform health professionals and offer an evidence-based approach to current herbal therapies. I would certainly be interested in working with the Board on any initiatives to address this growing challenge.

Peter Curtis, MD

Professor, Department of Family Medicine
University of NC School of Medicine
Chapel Hill, NC

Patients Switch Because of Good Results

To the Editor: I read with great interest the article by Andrew W. Watry, A Regulatory Perspective on Alternative Medicine [*Forum* No. 3, 1998].

He made many good points and the creation of a special committee on alternative medicine is a big step in the right direction.

I would hasten to add that one of the biggest reasons that patients are turning to complementary therapies was not mentioned. It is true that there is general dissatisfaction with today's version of traditional medicine, but the biggest reason that patients "switch" is because of good results.

It matters little to the patient with trigeminal neuralgia if acupuncture is found effective within the pages of the *New England Journal of Medicine* or not. What matters is the pain relief the patient experiences with bimonthly acupuncture treatments in place of debilitating drug therapy.

To miss this point is to misunderstand the entire phenomenon. Many forms of alternative medicine can successfully address problems Western medicine cannot.

It is therefore incumbent on the traditional practitioner to become informed about what works and what does not.

I see a not-too-distant future where most traditional practitioners embrace and use what we today call "alternative" medicine; more properly, complementary therapies, an interesting amalgam of the best of both worlds. ♦

Richard J. House, MD, LAC
Goldensboro, NC

Order Form for

Hospice Care: A Physician's Guide and 1998-99 North Carolina Home Care and Hospice Directory

Mail to: Hospice for the Carolinas
1011 Dresser Court
Raleigh, NC 27609-7323
Telephone: (919) 878-1717

Please send me the following items marked below.

- A single complimentary copy of *Hospice Care: A Physician's Guide*
- Extra copies of *Hospice Care* at \$9.95 each, including tax, shipping and handling
(I enclose \$ _____ for _____ copies)
- 1998-99 *North Carolina Home Care and Hospice Directory* at \$24.95, plus \$5.00 shipping and handling per copy. (NC residents please add 6% of \$24.95 for sales tax.)
(I enclose \$ _____ for _____ copies)

Name: _____

Address: _____
(UPS will not ship to PO box)

City: _____ State: _____ Zip: _____

Physician specialty: _____

Credit Card info if ordering by credit card:
(Name as it appears on the credit card) _____

Credit Card Type: MC/VISA Credit Card Number: _____

Expiration date: _____

Amended Board Rules Proposed for Fees, NPs, and PAs; New Rule Proposed for CME

The North Carolina Medical Board, following hearings on October 30, 1998, approved proposed amended rules on registration fees, nurse practitioners, and physician assistants. It also approved a proposed new rule for continuing medical education. The proposed rules must now be considered and approved by the Rules Review Commission and presented to the General Assembly before taking effect. Their final disposition will be noted in the *Forum*. **The proposed rules are not in force and are presented below for information.**

(Though every effort has been made to ensure the accuracy of the following material, it is not presented here as a legal reference and the North Carolina Medical Board cannot assume responsibility for any errors contained herein.)

CHAPTER 32. BOARD OF MEDICAL EXAMINERS

SUBCHAPTER 32F - ANNUAL REGISTRATION

.0103 Fee

Each physician shall pay an annual registration fee of one hundred dollars (\$100.00) to the Board every year in accordance with G.S. 90-15.1; except, each physician holding a resident's training license shall pay an annual registration fee of fifteen dollars (\$15.00), and every physician who holds a special volunteer license shall pay an annual registration fee of ten dollars (\$10.00), and every physician who holds a limited volunteer license shall pay no fee.

SUBCHAPTER 32M - APPROVAL OF NURSE PRACTITIONERS

.0101 Definitions

The following definitions apply to this Subchapter:

- (1) "Medical Board" means the North Carolina Medical Board.
- (2) "Board of Nursing" means the Board of Nursing of the State of North Carolina.
- (3) "Joint Subcommittee" means the subcommittee composed of members of the Board of Nursing and Members of the Medical Board to whom responsibility is given by G.S. 90-6 and G. S. 90-171.23(b)(14) to develop rules to govern the performance of medical acts by nurse practitioners in North Carolina.
- (4) "Nurse Practitioner or NP" means a currently licensed registered nurse approved to perform medical acts under an agreement with a licensed physician for ongoing supervision, consultation, collaboration and evaluation of the medical acts performed. Only a registered nurse approved by the Medical Board and the Board of Nursing may legally identify oneself as a Nurse Practitioner. It is understood that the nurse practitioner, by virtue of RN licensure, is independently accountable for those nursing acts which he or she may perform.
- (5) "Nurse Practitioner Applicant" means a registered nurse who may function prior to full approval as a Nurse Practitioner in accordance with Rule .0102 (b)(4) of this Subchapter.
- (6) "Supervision" means the physician's function of overseeing medical acts performed by the nurse practitioner.
- (7) "Collaborative practice agreement" means the arrangement for nurse practitioner-physician continuous availability to each other for on-going supervision, consultation, collaboration, referral and evaluation of care provided by the nurse practitioner.
- (8) "Primary Supervising Physician" means the licensed physician who, by signing the nurse practitioner application, is held accountable for the on-going supervision, consultation, collaboration and evaluation of the medical acts performed by the nurse practitioner as defined in the site specific written protocols.
 - (a) The primary supervising physician shall assume the responsibility of assuring the Boards that the nurse practitioner is qualified to perform those medical acts described in the site specific written protocols.
 - (b) A physician in a graduate medical education program, whether fully licensed or holding only a resident's training

license, shall not be named as a primary supervising physician.

- (c) A physician in a graduate medical education program who is also practicing in a non-training situation may supervise a nurse practitioner in the non-training situation if fully licensed.
- (9) "Back-up Supervising Physician" means the licensed physician who, by signing an agreement with the nurse practitioner and the primary supervising physician(s), shall be held accountable for supervision, consultation, collaboration and evaluation of medical acts by the nurse practitioner in accordance with the site specific written protocols when the Primary Supervising Physician is not available.
 - (a) The signed and dated agreements for each back-up supervising physician(s) shall be maintained at each practice site.
 - (b) A physician in a graduate medical education program, whether fully licensed or holding only a resident's training license, shall not be named as a back-up supervising physician.
 - (c) A physician in a graduate medical education program who is also practicing in a non-training situation may be a back-up supervising physician to a nurse practitioner in the non-training situation if fully licensed and has signed an agreement with the nurse practitioner and the primary supervising physician.
- (10) "Approval" means authorization by the Medical Board and the Board of Nursing for a registered nurse to practice as a nurse practitioner in accordance with this Subchapter.
- (11) "Written protocols" means the signed and dated set of written practice guidelines maintained at each practice site which describe the prescribing privileges, treatments, tests and procedures that define the scope of the nurse practitioner's medical acts in that setting. Clinical practice issues that are not covered by the written protocols require nurse practitioner/physician consultation, and documentation related to the treatment plan.
- (12) "Volunteer practice" means practice without expectation of compensation or payment (monetary, in kind or otherwise) to the nurse practitioner either directly or indirectly.
- (13) "Disaster" means a state of disaster as defined in North Carolina General Statute 166A-4(3) and proclaimed by the Governor, or by the General Assembly pursuant to North Carolina General Statute 166A-6.
- (14) "Interim Status" means the privilege granted by the Boards to a new graduate of an approved nurse practitioner educational program or a registered nurse seeking initial approval in North Carolina with limited privileges, as defined in Rule .0003(b)(4) of this Subchapter, while awaiting final approval to practice as a nurse practitioner.
- (15) "Temporary Approval" means authorization by the Medical Board and the Board of Nursing for a registered nurse to practice as a nurse practitioner in accordance with this Rule for a period not to exceed 18 months while awaiting notification of successful completion of the national certification examination.
- (16) "National Credentialing Body" means one of the following credentialing bodies that offers certification and re-certification in the nurse practitioner's specialty area of practice: American Nurses Credentialing Center (ANCC); American Academy of Nurse Practitioners (AANP); National Certification Corporation of the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC); and the National Certification Board of Pediatric Nurse Practitioners and Nurses (PNP/N).

.0102 SCOPE OF PRACTICE

The nurse practitioner shall be responsible and accountable for the continuous and comprehensive management of a broad range of personal health services for which the nurse practitioner is educationally prepared and for which competency has been maintained, with physician supervision and collaboration as described in 21 NCAC

32M.0108. These services include but are not restricted to:

- (1) promotion and maintenance of health;
- (2) prevention of illness and disability;
- (3) diagnosing, treating and managing acute and chronic illnesses;
- (4) guidance and counseling for both individuals and families;
- (5) prescribing, administering and dispensing therapeutic measures, tests, procedures and drugs;
- (6) planning for situations beyond the nurse practitioner's expertise, and consulting with and referring to other health care providers as appropriate; and
- (7) evaluating health outcomes.

.0103 NURSE PRACTITIONER APPROVAL

(a) Qualifications for nurse practitioner approval. A registered nurse shall be approved by the Medical Board and the Board of Nursing before the applicant may practice as a nurse practitioner. The Boards may grant approval to practice as a nurse practitioner to an applicant who:

- (1) is currently licensed as a registered nurse by the Board of Nursing;
- (2) has successfully completed an approved educational program as outlined in Rule .0103 of this Subchapter; or, as of January 1, 2000, meets the certification requirements set forth in Rule .0103(c) of this Subchapter;
- (3) has an unrestricted license to practice as a registered nurse and, if applicable, an unrestricted approval to practice as a nurse practitioner unless the Boards consider such condition and agree to approval;
- (4) submits any information deemed necessary to evaluate the application;
- (5) has a collaborative practice agreement with a primary supervising physician; and
- (6) pays the appropriate fee.

(b) Application for nurse practitioner approval.

- (1) Application for nurse practitioner approval shall be made upon the appropriate forms and shall be submitted jointly by the nurse practitioner and primary supervising physician(s).
- (2) Applications for first-time approval in North Carolina shall be submitted to the Board of Nursing and then approved by both Boards as follows:
 - (A) the Board of Nursing will verify compliance with Subparagraphs (a)(1) - (4) of this Rule;
 - (B) the Medical Board will verify compliance with Subparagraphs (a)(4) - (6) of this Rule; and
 - (C) the appropriate Board will notify applicant of final approval status.
- (3) Applications for approval of changes in practice arrangements for a nurse practitioner currently approved to practice in North Carolina:
 - (A) addition or change of primary supervising physician shall be submitted to the Medical Board;
 - (B) request for change(s) in the scope of practice shall be submitted to the Joint Subcommittee; and
 - (C) the appropriate Board will notify applicant of final approval status.
- (4) Interim status for nurse practitioner applicant may be granted to a registered nurse who is a new graduate of an approved nurse practitioner educational program as set forth in Rule .0103 of this Subchapter; or a registered nurse seeking first time approval to practice as a nurse practitioner in North Carolina who has worked previously as a nurse practitioner in another state and who meets the nurse practitioner educational requirements as set forth in Rule .0103 of this Subchapter; and with the following limitations:
 - (A) no prescribing privileges;
 - (B) primary or back-up physicians shall be continuously available for appropriate ongoing supervision, consultation, collaboration and countersigning of notations of medical acts in all patient charts within two working days of nurse practitioner applicant-patient contact;
 - (C) face-to-face consultation with the primary supervising physician shall be weekly with documentation

of consultation consistent with Rule .0108(d)(4) of this Subchapter; and

- (D) may not exceed a period of six months.
- (5) Beginning January 1, 2000, first time applicants who meet the qualifications for approval, but are awaiting certification from a national credentialing body approved by the Board of Nursing, may be granted a temporary approval to practice as a nurse practitioner. Temporary approval is valid for a period not to exceed 18 months from the date temporary approval is granted or until the results of the applicant's certification examination are available, whichever comes first.
- (6) The registered nurse who was previously approved to practice as a nurse practitioner in this state shall:
 - (A) meet the nurse practitioner approval requirements as stipulated in Subparagraphs (a)(1), (a)(3) - (a)(6) of this rule;
 - (B) complete the appropriate application;
 - (C) receive notification of approval; and
 - (D) meet the consultation requirements as outlined in Rule .0108(d)(3) and (4) of this Subchapter.
- (7) If for any reason a nurse practitioner discontinues working within the approved nurse practitioner-supervising physician(s) arrangement, the Boards shall be notified in writing and the nurse practitioner's approval shall automatically terminate or be placed on an inactive status until such time as a new application is approved in accordance with this Subchapter. Special consideration may be given in an emergency situation.
- (8) Volunteer Approval for Nurse Practitioners. The Boards may grant approval to practice in a volunteer capacity to a nurse practitioner who has met the qualifications as outlined in Rule .0102(a)(1) - (6) of this Subchapter.

.0104 REQUIREMENTS FOR APPROVAL OF NURSE PRACTITIONER EDUCATIONAL PROGRAMS

- (a) A nurse practitioner applicant who completed a nurse practitioner educational program prior to December 31, 1999 shall provide evidence of successful completion of a course of formal education which contains a core curriculum including 400 contact hours of didactic education and 400 contact hours of preceptorship or supervised clinical experience.
 - (1) The core curriculum shall contain as a minimum the following components:
 - (A) health assessment and diagnostic reasoning including:
 - (i) historical data;
 - (ii) physical examination data;
 - (iii) organization of data base;
 - (B) pharmacology;
 - (C) pathophysiology;
 - (D) clinical management of common health care problems and diseases related to:
 - (i) respiratory system;
 - (ii) cardiovascular system;
 - (iii) gastrointestinal system;
 - (iv) genitourinary system;
 - (v) integumentary system;
 - (vi) hematologic and immune systems;
 - (vii) endocrine system;
 - (viii) musculoskeletal system;
 - (ix) infectious diseases;
 - (x) nervous system;
 - (xi) behavioral, mental health and substance abuse problems;
 - (E) clinical preventative services including health promotion and prevention of disease;
 - (F) client education related to Parts (a)(1)(D) and (E) of this Rule; and
 - (G) role development including legal, ethical, economical, health policy and interdisciplinary collaboration issues.
 - (2) Nurse practitioner applicants who may be exempt from components of the core curriculum requirements listed in Subparagraph (a)(1) of this Rule are:
 - (A) Any nurse practitioner approved in North Carolina prior to January 18, 1981, is permanently exempt from the

core curriculum requirement.

- (B) A nurse practitioner certified by a national credentialing body approved who also provides evidence of satisfying Parts (a)(1)(A) - (C) of this Rule shall be exempt from core curriculum requirements in Parts (a)(1)(D) - (G) of this Rule. Evidence of satisfying Parts (a)(1)(A) - (C) of this Rule shall include, but may not be limited to:
 - (i) a narrative of course content; and
 - (ii) contact hours.
 - (C) A nurse practitioner seeking initial approval after January 1, 1998 shall be exempt from the core curriculum requirements if certified as a nurse practitioner in his/her specialty by a national credentialing body and when initial certification was obtained after January 1, 1998.
 - (D) A nurse practitioner applicant, whose formal education does not meet all of the stipulations in Subparagraph (b) of this Rule, may appeal to the Joint Subcommittee on the basis of other education and experience.
- (b) Instead of educational program approval, all nurse practitioner applicants who are applying for, or have received, first time approval to practice as a nurse practitioner on or after January 1, 2000 shall be certified by a national credentialing body or be awaiting initial certification by a national credentialing body for a period not to exceed 18 months from date temporary approval is granted.

.0105 ANNUAL RENEWAL

- (a) Each registered nurse who is approved as a nurse practitioner in this state shall annually renew each approval with the Medical Board no later than 30 days after the nurse practitioner's birthday by:
 - (1) Verifying current RN licensure;
 - (2) Submitting the fee required in Rule .0011 of this Subchapter; and
 - (3) Completing the renewal form.
- (b) For the nurse practitioner who had first time approval to practice after January 1, 2000, provide evidence of certification or recertification by a national credentialing body.
- (c) If the nurse practitioner has not renewed within 60 days of the nurse practitioner's birthday, the approval to practice as a nurse practitioner will lapse.

.0106 CONTINUING EDUCATION (CE)

In order to maintain nurse practitioner approval to practice, beginning no sooner than two years after initial approval has been granted, the nurse practitioner shall earn 30 hours of continuing education every two years. At least three hours of continuing education every two years shall be the study of the medical and social effects of substance abuse including abuse of prescription drugs, controlled substances, and illicit drugs. Continuing Education hours are those hours for which approval has been granted by the American Nurses Credentialing Center (ANCC) and Accreditation Council on Continuing Medical Education (ACCME), or other national credentialing bodies. Documentation shall be maintained by the nurse practitioner at each practice site and made available upon request to either Board.

.0107 INACTIVE STATUS

- (a) Any nurse practitioner who wishes to place his or her approval on an inactive status may notify the Boards by completing the form supplied by the Boards;
- (b) The registered nurse with inactive nurse practitioner status shall not practice as a nurse practitioner.
- (c) The registered nurse with inactive nurse practitioner status who reapplies for approval to practice shall be required to meet the qualifications for approval as stipulated in Rule .0102(a)(1), (a)(3), (a)(6) and (b)(1).

.0108 PRESCRIBING AUTHORITY

- (a) The prescribing stipulations contained in this Rule apply to writing prescriptions and ordering the administration of medications.
- (b) Prescribing and dispensing stipulations are as follows:
 - (1) Drugs and devices that may be prescribed by the nurse practitioner in each practice site shall be included in the written protocols as outlined in Rule 0108(b) of this Subchapter.

- (2) Controlled Substances (Schedules 2, 2N, 3, 3N, 4, 5) defined by the State and Federal Controlled Substances Acts may be procured, prescribed or ordered as established in written protocols, providing all of the following requirements are met:
 - (A) the nurse practitioner has an assigned DEA number which is entered on each prescription for a controlled substance;
 - (B) dosage units for schedules 2, 2N, 3 and 3N are limited to a 30 day supply; and
 - (C) the prescription or order for schedules 2, 2N, 3 and 3N may not be refilled.
- (3) The nurse practitioner may prescribe a drug not included in the site-specific written protocols only as follows:
 - (A) upon a specific written or verbal order obtained from a primary or back-up supervising physician before the prescription or order is issued by the nurse practitioner; and
 - (B) the written or verbal order as described in Part (b)(3)(A) of this Rule shall be entered into the patient record with a notation that it is issued on the specific order of a primary or back-up supervising physician and signed by the nurse practitioner and the physician.
- (4) Refills may be issued for a period not to exceed one year except for schedules 2, 2N, 3 and 3N controlled substances which may not be refilled.
- (5) Each prescription shall be noted on the patient's chart and include the following information:
 - (A) medication and dosage;
 - (B) amount prescribed;
 - (C) directions for use;
 - (D) number of refills; and
 - (E) signature of nurse practitioner.
- (6) The prescribing number assigned by the Medical Board to the nurse practitioner must appear on all prescriptions issued by the nurse practitioner.
- (7) Prescription Format:
 - (A) All prescriptions issued by the nurse practitioner shall contain the supervising physician(s) name, the name of the patient, and the nurse practitioner's name, telephone number, and prescribing number.
 - (B) The nurse practitioner's assigned DEA number shall be written on the prescription form when a controlled substance is prescribed as defined in Subparagraph (b)(2) of this Rule.
- (c) The nurse practitioner may obtain approval to dispense the drugs and devices included in the written protocols for each practice site from the Board of Pharmacy, and dispense in accordance with 21 NCAC 46.1700, which is hereby incorporated by reference including subsequent amendments of the referenced materials.

.0109 QUALITY ASSURANCE STANDARDS FOR A COLLABORATIVE PRACTICE AGREEMENT

- (a) Availability: The primary or back-up supervising physician(s) and the nurse practitioner shall be continuously available to each other for consultation by direct communication or telecommunication.
- (b) Written Protocols:
 - (1) Written protocols shall be agreed upon and signed by both the primary supervising physician and the nurse practitioner, and maintained in each practice site.
 - (2) Written protocols shall be reviewed at least yearly, and this review shall be acknowledged by a dated signature sheet, signed by both the primary supervising physician and the nurse practitioner, appended to the written protocol and available for inspection by members or agents of either board.
 - (3) The written protocols shall include the drugs, devices, medical treatment, tests and procedures that may be prescribed, ordered and implemented by the nurse practitioner consistent with Rule .0107 of this Subchapter, and which are appropriate for the diagnosis and treatment of the most commonly encountered health problems in that practice setting.
 - (4) The written protocols shall include a pre-determined plan for emergency services.
 - (5) The nurse practitioner shall be prepared to demonstrate the ability to perform medical acts as outlined in the written pro-

- ocols upon request by members or agents of either Board.
- (c) **Quality Improvement Process:**
- (1) The primary supervising physician and the nurse practitioner shall develop a process for the on-going review of the care provided in each practice site to include a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problems.
 - (2) This plan shall include a description of the clinical problem(s), an evaluation of the current treatment interventions, and if needed, a plan for improving outcomes within an identified time-frame.
 - (3) The quality improvement process shall include scheduled meetings between the primary supervising physician and the nurse practitioner at least every six months. Documentation for each meeting shall:
 - (A) identify clinical problems discussed, including progress toward improving outcomes as stated in Subparagraph (c)(2) of this Rule, and recommendations, if any, for changes in treatment plan(s).
 - (B) be signed and dated by those who attended; and
 - (C) be available for review by members or agents of either Board for the previous five calendar years and be retained by both the nurse practitioner and physician.
- (d) **Nurse Practitioner-Physician Consultation.** The following requirements establish the minimum standards for consultation between the nurse practitioner/primary or back-up supervising physician(s):
- (1) The nurse practitioner with temporary approval shall have:
 - (A) review and countersigning of notations of medical acts by a primary or back-up supervising physician within seven days of nurse practitioner-patient contact for the first six months of collaboration. This time-frame includes the period of interim status.
 - (B) face-to-face consultation with the primary supervising physician on a weekly basis for one month after temporary approval is achieved and at least monthly throughout the period of temporary approval.
 - (2) The nurse practitioner with first time approval to practice shall have:
 - (A) review and countersigning of notations of medical acts by a primary or back-up supervising physician within seven days of nurse practitioner-patient contact for the first six months of collaborative agreement. This time-frame includes the period of interim status.
 - (B) face-to-face consultation with the primary supervising physician on a weekly basis for one month after full approval is received and at least monthly for a period no less than the succeeding five months.
 - (3) The nurse practitioner previously approved to practice in North Carolina who changes primary supervising physician shall have face-to-face consultation with the primary supervising physician weekly for one month and then monthly for the succeeding five months.
 - (4) Documentation of consultation shall:
 - (A) identify clinical issues discussed and actions taken;
 - (B) be signed and dated by those who attended; and
 - (C) be available for review by members or agents of either Board for the previous five calendar years and be retained by both the nurse practitioner and physician.

.0110 METHOD OF IDENTIFICATION

The nurse practitioner shall wear an appropriate name tag spelling out the words "Nurse Practitioner."

.0111 DISCIPLINARY ACTION

The approval of a nurse practitioner may be restricted, denied or terminated by the Medical Board and the registered nurse license may be restricted, denied, or terminated by the Board of Nursing, if, after due notice and hearing in accordance with provisions of Article 3A of G.S. 150B, the appropriate Board shall find one or more of the following:

- (1) that the nurse practitioner has held himself/herself out or permitted another to represent the nurse practitioner as a licensed physician;
- (2) that the nurse practitioner has engaged or attempted to engage in the performance of medical acts other than according to the written protocols and collaborative practice agreement;

- (3) that the nurse practitioner has been convicted in any court of a criminal offense;
- (4) that the nurse practitioner is adjudicated mentally incompetent or that the nurse practitioner's mental or physical condition renders the nurse practitioner unable to safely function as a nurse practitioner; or
- (5) that the nurse practitioner has failed to comply with any of the provisions of this Subchapter.

.0112 FEES

- (a) An application fee of one hundred dollars (\$100.00) shall be paid at the time of initial application for approval and each subsequent application for approval to practice. All initial, subsequent and volunteer application fees shall be equally divided between the Board of Nursing and the Medical Board. No other fees shall be shared. Application fee shall be twenty dollars (\$20.00) for the volunteer approval.
- (b) The fee for annual renewal of approval shall be fifty dollars (\$50.00).
- (c) The fee for annual renewal of volunteer approval shall be ten dollars (\$10.00).
- (d) No portion of any fee in this Rule shall be refundable.

.0113 PRACTICE DURING A DISASTER

A nurse practitioner approved to practice in the State or another state is authorized to perform medical acts, tasks, or functions as a nurse practitioner under the supervision of a physician licensed to practice medicine in North Carolina during a disaster within a county in which a state of disaster has been declared or counties contiguous to a county in which a state of disaster has been declared. The nurse practitioner shall notify the Boards in writing of the names, practice locations and telephone numbers for the nurse practitioner and each primary supervising physician within 15 days of the first performance of medical acts, tasks, or functions as a nurse practitioner during the disaster. Teams of physician(s) and nurse practitioner(s) practicing pursuant to this rule shall not be required to maintain on-site documentation describing supervisory arrangements and instructions for prescriptive authority as otherwise required pursuant to Rules .0008 and .0009.

SUBCHAPTER 32S - PHYSICIAN ASSISTANT REGULATIONS

.0101 DEFINITIONS

The following definitions apply to this Subchapter:

- (1) "Board" means the North Carolina Medical Board.
- (2) "Physician Assistant" means a person licensed by and registered with the Board to perform medical acts, tasks, or functions under the supervision of a physician licensed by the Board, who performs tasks traditionally performed by the physician, and who has graduated from a physician assistant or surgeon assistant program accredited by the Commission on Accreditation of Allied Health Education Programs, or its predecessor or successor agencies.
- (3) "Physician Assistant License" means the document issued by the Board showing approval for the physician assistant to perform medical acts, tasks, or functions under North Carolina law.
- (4) "Registering" means paying the annual fee and providing the information requested by the Board as outlined in Rule .0105 of this Subchapter.
- (5) "Supervising Physician" means a physician who is licensed by the Board and who is not prohibited by the Board from supervising physician assistants. The physician may serve as a primary supervising physician or as a back-up supervising physician.
 - (a) The "Primary Supervising Physician" is the physician who, by signing the application to the Board, accepts full responsibility for the physician assistant's medical activities and professional conduct at all times, whether the physician personally is providing supervision or the supervision is being provided by a Back-up Supervising Physician. The Primary Supervising Physician shall assume total responsibility for assuring the Board that the physician assistant is qualified by education and training to perform all medical acts required of the physician assistant and shall assume total responsibility for the physician assistant's performance in the particular field or fields in which the physician assistant is expected to perform medical acts.

- (b) The "Back-up Supervising Physician" means the physician who, by signing the statement required in Rule .0110 of this Subchapter, accepts the responsibility for supervision of the physician assistant's activities in the absence of the Primary Supervising Physician. The Back-up Supervising Physician is responsible for the activities of the physician assistant only when providing supervision.
- (6) "Supervising" means overseeing the activities of, and accepting the responsibility for, the medical services rendered by a physician assistant.
- (7) "Volunteer practice" means performance of medical acts, tasks, or functions without expectation of any form of payment or compensation.
- (8) "Examination" means the Physician Assistant National Certifying Examination or another examination as approved by the Board.

.0102 QUALIFICATIONS FOR LICENSE

Except as otherwise provided in this Subchapter, an individual shall obtain a license from the Board before the individual may practice as a physician assistant. The Board may grant a license as a physician assistant to an applicant who has met all the following criteria:

- (1) submits a completed application on forms provided by the Board;
- (2) pays the fee established by Rule .0117(1) in this Subchapter;
- (3) has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Commission on Accreditation of Allied Health Education Programs or its predecessor or successor agencies and; if licensed in North Carolina after June 1, 1994, has successfully completed a licensing examination approved by the Board;
- (4) certifies that he or she is mentally and physically able to engage safely in practice as a physician assistant;
- (5) has no license, certificate, or registration as a physician assistant currently under discipline, revocation, suspension or probation for cause resulting from the applicant's practice as a physician assistant;
- (6) has good moral character; and
- (7) submits to the Board any other information the Board deems necessary to evaluate the applicant's qualifications; and
- (8) if two years or more have passed since graduation from an approved program, the applicant must submit documentation of the completion of at least 100 hours of continuing medication education (CME) during the preceding two years.

.0103 TEMPORARY LICENSE

- (a) During the years prior to 2002, the Board may grant a temporary license, valid for a period not to exceed one year, to an applicant who meets the qualifications for a license except that the applicant has not yet passed a licensing examination approved by the Board. The Board shall not grant a temporary license to an applicant who has twice failed a licensing examination approved by the Board.
- (b) A temporary license becomes void at the time the Board grants the physician assistant a full license or at the expiration date shown on the temporary license.
- (c) A temporary license shall expire 30 days after the physician assistant receives notice of non-passing scores on the second attempt of taking a licensing examination approved by the Board or at the expiration date of the temporary license, whichever is sooner. The licensee must notify the Board within 15 days upon the receipt of scores.

.0104 INACTIVE LICENSE STATUS

By notifying the Board in writing any physician assistant may elect to place his or her license on an inactive status. A physician assistant with an inactive license shall not practice as a physician assistant. Any physician assistant who engages in practice while his or her license is on inactive status shall be considered to be practicing without a license, which shall be grounds for discipline under G.S. 90-14 (a) (7). A physician assistant requesting reactivation from inactive status shall be required to pay the current renewal fee, to provide documentation to the Board verifying completion of continuing medical education during the preceding two years as required in Rule .0106 of this Subchapter, and shall be required to meet the criteria for renewal as specified in 21 NCAC 32S

.0105.

.0105 ANNUAL REGISTRATION

Each person who holds a license as a physician assistant in this state shall register his or her Physician Assistant license each year no later than 30 days after his or her birthday by:

- (1) completing the Board's registration form; and
- (2) providing any information required by the Board; and
- (3) submitting the fee required in Rule .0117 of this Subchapter.

.0106 CONTINUING MEDICAL EDUCATION

In order to maintain physician assistant licensure, documentation must be maintained by the physician assistant of 100 hours of continuing medical education (CME) completed for every two year period, at least 40 hours of which must be American Academy of Physician Assistants Category I CME or the equivalent. CME documentation must be available for inspection by the Board or an agent of the Board upon request.

Any physician assistant who prescribes controlled substances shall complete at least three hours of CME every two years on the medical and social effects of the misuse and abuse of alcohol, nicotine, prescription drugs (including controlled substances), and illicit drugs.

.0107 EXEMPTION FROM LICENSE

Nothing in this Subchapter shall be construed to require licensure under 21 NCAC 32S of:

- (1) a physician assistant student enrolled in a physician assistant or surgeon assistant educational program accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organizations; or
- (2) a physician assistant employed in the service of the federal government while performing duties incident to that employment; or
- (3) agents or employees of physicians who perform delegated tasks in the office of a physician but who are not rendering services as a physician assistant or identifying themselves as a physician assistant.

.0108 SCOPE OF PRACTICE

- (a) Physician assistants perform medical acts, tasks or functions with physician supervision. Physician assistants perform those duties and responsibilities, including the prescribing and dispensing of drugs and medical devices, that are delegated by their supervising physician(s).
- (b) Physician assistants shall be considered the agents of their supervising physicians in the performance of all medical practice-related activities, including but not limited to, the ordering of diagnostic, therapeutic and other medical services.

.0109 PRESCRIPTIVE AUTHORITY

A physician assistant is authorized to prescribe, order, procure, dispense and administer drugs and medical devices subject to the following conditions:

- (1) The physician assistant and the supervising physician(s) shall acknowledge that each is familiar with the laws and rules regarding prescribing and shall agree to comply with these laws and rules by incorporating the laws and rules into the written prescribing instructions required for each approved practice site; and
- (2) The physician assistant has received from the supervising physician written instructions for prescribing, ordering, and administering drugs and medical devices and a written policy for periodic review by the physician of these instructions and policy; and
- (3) In order to compound and dispense drugs, the physician assistant must obtain approval from the Board of Pharmacy and must carry out the functions of compounding and dispensing by current Board of Pharmacy rules and any applicable federal guidelines; and
- (4) In order to prescribe controlled substances, both the physician assistant and the supervising physician must have a valid DEA registration and the physician assistant shall prescribe in accordance with information provided by the Medical Board and the DEA. All prescriptions for substances falling within schedules II, IIN, III, and IIIN, as defined in the federal Controlled Substances Act, shall not exceed a legitimate 30 day supply; and

- (5) Each prescription issued by the physician assistant shall contain, in addition to other information required by law, the following:
 - (a) the physician assistant's name, practice address, telephone number; and
 - (b) the physician's assistant's license number and, if applicable, the physician assistant's DEA number for controlled substances prescription; and
 - (c) the responsible supervising physician's (primary or back-up) name and telephone number; and
- (6) Documentation of each prescription must be noted on the patient's record and must include the following information:
 - (a) medication name and dosage, amount prescribed, directions for use, number of refills, and
 - (b) signature of physician assistant with supervising physician's co-signature according to the site specific rule in 32S.0110.
- (7) Physician Assistants who request, receive, and dispense professional medication samples to patients must comply with all applicable state and federal regulations.

.0110 SUPERVISION OF PHYSICIAN ASSISTANTS

A physician assistant may perform medical acts, tasks, or functions only under the supervision of a physician. Supervision shall be continuous but, except as otherwise provided in these Rules, shall not be construed as requiring the physical presence of the supervising physician at the time and place that the services are rendered.

It is the obligation of each team of physician(s) and physician assistant(s) to ensure that the physician assistant's scope of practice is identified; that delegation of medical tasks is appropriate to the skills of the supervising physician(s) as well as the physician assistant's level of competence; that the relationship of, and access to, each supervising physician is defined; and that a process for evaluation of the physician assistant's performance is established. A statement clearly describing these supervisory arrangements in all settings must be signed by each supervising physician and the physician assistant and shall be kept on file at all practice sites. This statement describing supervisory arrangements and instructions for prescriptive authority shall be available upon request by the Board or its representatives.

The time interval between the physician assistant's contact with the patient and the chart review and countersigning by the supervising physician may be a maximum of seven days for outpatient (clinic/office) charts. Entries by a physician assistant into patient charts of inpatients (hospital, long term care institutions) must comply with the rules and regulations of the institution; but, at a minimum, the initial work up and treatment plan and the discharge summary must be countersigned by the supervising physician within seven days of the time of generation of these notes. In the acute inpatient setting, the initial work-up, orders, and treatment plan must be signed and dated within two working days.

.0111 SUPERVISING PHYSICIANS

- (a) A physician wishing to serve as a primary supervising physician must:
 - (1) notify the Board of the physician's intent to serve as a primary supervising physician for a physician assistant; and,
 - (2) submit a statement to the Board that the physician is willing and qualified to exercise supervision of the physician assistant in accordance with rules adopted by the Board and that the physician will retain professional responsibility for the care rendered by the physician assistant within the scope of the supervisory arrangements established pursuant to rule .0110 of this Subchapter.
- (b) A physician wishing to serve as a back-up supervising physician must be licensed to practice medicine by the Board and not prohibited by the Board from supervising a physician assistant and be approved by the primary supervising physician as a person willing and qualified to assume responsibility for the care rendered by the physician assistant in the absence of the primary supervising physician. An ongoing list of all approved back-up supervising physicians, signed and dated by each back-up supervising physician, the primary supervising physician, and the physician assistant, must be retained as part of the inspectable supervisory arrangements statement described in Rule .0110 of this Subchapter.
- (c) It is the responsibility of the supervising physicians to ensure that the physician assistant has adequate back-up for any procedure

performed by the physician assistant in any practice location (office, home, hospital, etc.).

.0112 NOTIFICATION OF INTENT TO PRACTICE

- (a) Prior to the performance of any medical acts, tasks, or functions under the supervision of any primary supervising physician, a physician assistant licensed by the Board shall submit notification of such intent on forms provided by the Board. The physician assistant shall not commence practice until acknowledgement of the notification of intent to practice form is received from the Board. Such notification of intent to practice shall include:
 - (1) the name, practice addresses, and telephone number of the physician assistant; and
 - (2) the name, practice addresses, and telephone number of the primary supervising physician(s).
- (b) The physician assistant shall notify the Board of any changes or additions in a previously approved practice setting within 15 days of the occurrence.

.0113 VIOLATIONS

- (a) The Board may deny, annul, suspend, or revoke the license, or other authority to function as a physician assistant in this State, of any person who has been found by the Board to have committed any of the following acts of misconduct or violations, or for any of the following reasons:
 - (1) Immoral, dishonorable, or unethical conduct;
 - (2) Failure to function in accordance with the rules of this Subchapter or with the applicable laws of the State of North Carolina governing physician assistants;
 - (3) Making false statements or representations to the Board, or willfully concealing from the Board material information in connection with an application for a license or notification of intent to practice as a physician assistant;
 - (4) Representing oneself as a physician;
 - (5) Being unable to function as a physician assistant with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material, or by reason of any physical or mental abnormality. The Board may require a licensed physician assistant to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician assistant. The results of the examination shall be admissible in evidence in a hearing before the Board;
 - (6) Any departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of practice or otherwise and whether committed within or without North Carolina;
 - (7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine or practice as a physician assistant, or a conviction of a felony;
 - (8) By false representations has obtained or attempted to obtain professional practice as a physician assistant, money, or anything of value;
 - (9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician assistant has been educated;
 - (10) Adjudication of mental incompetency;
 - (11) Lack of professional competence to practice as a physician assistant with a reasonable degree of skill and safety for patients. The Board may, upon reasonable grounds, require a physician assistant to submit to inquiries or examinations, written or oral, by members of the Board, physician assistants, or physicians licensed to practice medicine, as the Board deems necessary to determine the qualifications of such license;
 - (12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient and/or the entity providing compensation to the physician assistant or the employer of

the physician assistant on behalf of the patient;

- (13) Having a license or other authority to practice as a physician assistant revoked, suspended, restricted, or acted against, or having a license denied by a licensing authority of any jurisdiction. For purposes of this Subchapter, any other licensing authority's acceptance of a license or other authority to practice which was voluntarily relinquished or surrendered by a physician assistant is considered an action against a license or the authority to practice as a physician assistant;
- (14) The failure to respond, within a reasonable period of time and in a reasonable manner, as determined by the Board, to inquiries from the Board concerning any matter affecting the license or practice of the physician assistant.

.0114 DISCIPLINARY AUTHORITY

- (a) For any of the foregoing reasons, the Board may deny the issuance of a license to an applicant, may revoke a license issued to the physician assistant, may suspend such a license for a period of time, and may impose conditions upon the continued practice of the physician assistant.
- (b) The Board may also, after such period of suspension as the Board may deem advisable, limit the physician assistant's practice with respect to the scope or location of his/her practice. The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or rescinded.
- (c) The Board shall refer to the North Carolina Academy of Physician Assistants Health Committee all physician assistants whose health and effectiveness have been significantly impaired.

.0115 TITLE AND PRACTICE PROTECTION

- (a) Any person not approved under this Subchapter is in violation of G.S. 90-18 and is subject to penalties applicable to the unlicensed practice of medicine if he or she:
- (1) falsely identifies himself or herself as a physician assistant;
 - (2) use any combination or abbreviation of the term "physician assistant" to indicate or imply that he or she is a physician assistant; or
 - (3) acts as a physician assistant without being approved by the Board.
- (b) An unlicensed physician shall not be permitted to use the title of "physician assistant" or to practice as a physician assistant unless he or she fulfills the requirements of this Subchapter.

.0116 IDENTIFICATION REQUIREMENTS

A physician assistant licensed under this Subchapter shall keep proof of current licensure and registration available for inspection at the primary place of practice and shall, when engaged in professional activities, wear a name tag identifying the licensee as a "physician assistant."

.0117 FEES

The Board requires the following fees:

- (1) Physician Assistant License Fee - one hundred and fifty dollars (\$150.00), except that an applicant for a physician assistant limited volunteer license pursuant to N.C. Gen. Stat. 90-12.1 need not submit an application fee.
- (2) Annual Registration Fee - seventy-five dollars (\$75.00), except that any physician assistant who holds a limited volunteer license issued pursuant to G.S. 90-12.1 or who submits a statement to the Board confirming that the physician assistant is currently exclusively engaged in volunteer practice and has engaged exclusively in volunteer practice during the preceding year shall submit a reduced registration fee of twenty-five dollars (\$25.00).

.0118 PRACTICE DURING A DISASTER

A physician assistant licensed in this State or in any other state is authorized to perform acts, tasks, or functions as a physician assistant under the supervision of a physician licensed to practice medicine in North Carolina during a disaster within a county in which a state of disaster has been declared or counties contiguous to a county in which a state of disaster has been declared (in accordance with GS 166A-4(3) or GS 166A-6). The physician assistant shall notify the Board in writing of the names, practice locations, and telephone numbers for the physician assistant and each primary supervising physician within 15 days of the first performance of medical acts, tasks, or functions as a physician

assistant during the disaster. A team of physician(s) and physician assistant(s) practicing pursuant to this Rule shall not be required to maintain on-site documentation describing supervisory arrangements and instructions for prescriptive authority as otherwise required in Rules .0109 and .0110 of this Subchapter.

SUBCHAPTER 32R - CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

.0101 CONTINUING MEDICAL EDUCATION (CME) REQUIRED

- (a) CME is defined as knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of healthcare to the public. CME should maintain, develop, or improve the physician's knowledge, skills, professional performance and relationships which physicians use to provide services for their patients, their practice, the public, or the profession.
- (b) Each person licensed to practice medicine in the State of North Carolina shall complete no less than fifty (50) hours of practice relevant CME annually in order to enhance current medical competence, performance or patient care outcome. Twenty (20) hours shall be in the physician-initiated category and thirty (30) hours shall be in the educational provider-initiated category. General medical reading is not applicable to physician-initiated CME.

.0102 APPROVED CATEGORIES OF CME

- (a) Physician-Initiated CME:
- (1) Practice based self-study;
 - (2) Colleague consultations;
 - (3) Office based outcomes research;
 - (4) Study initiated by patient inquiries;
 - (5) Study of community health problems;
 - (6) Successful specialty board examination for certification or recertification;
 - (7) Teaching (professional, patient/public health);
 - (8) Mentoring;
 - (9) Morbidity and Mortality (M&M) conference;
 - (10) Journal clubs;
 - (11) Creation of generic patient care pathways and guidelines;
 - (12) Competency Assessment.
- (b) Educational Provider-Initiated CME: All education offered by institutions or organizations accredited by the Accreditation Council for Continuing Medical Education (ACCME) and reciprocatng organizations or American Osteopathic Association (AOA).
- (1) Formal Courses
 - (2) Scientific/clinical presentations, or publications
 - (3) Enduring material (Audio-Video)
 - (4) Skill development

.0103 EXCEPTIONS

- (a) A licensee currently enrolled in an AOA or Accreditation Council on Graduate Medical Education. (ACGME) accredited graduate medical education program is exempt from the requirements of .0101.
- (b) A licensee shall have one year of exemption from the requirements of .0101 after having received initial licensure.

.0104 REPORTING

At the time of annual registration each Licensee shall report on the Board's annual registration form the number of hours of practice-relevant CME obtained in compliance with section .0101 of this SubChapter. CME hours must be documented by categories for three consecutive years and may be inspected by the Board or its agents.

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

August-September-October 1998

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/licensee.

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 or a motion/request for reconsideration/modification of a previous Board action.

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program

RTL:

Resident Training License.

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 pending an investigation or in lieu of disciplinary action.

ANNULMENTS

NONE

REVOICATIONS

BLAND, James Henry, MD

Location: Minot, ND
 DOB: 8/15/57
 License #: 00-33619
 Specialty: P (as reported by physician)
 Medical Ed: Eastern Virginia Medical School (1983)
 Cause: On 9/05/96, the North Dakota Board permanently suspended Dr Bland's license in North Dakota, which is grounds for action by the North Carolina Board.
 Action: 10/08/98 (following a hearing on Notice of Charges dated 7/18/98). Board Order issued: Dr Bland's license to practice in North Carolina is revoked.

HENDERSON, Richard Winn, MD

Location: Knoxville, TN
 DOB: 10/03/48
 License #: 00-21964
 Specialty: FP/EM (as reported by physician)
 Medical Ed: University of Alabama School of Medicine (1972)
 Cause: On 7/18/90, Dr Henderson was indicted by the Grand Jury for the U.S. District Court for the Eastern District of Tennessee, Northern Division, for promising money to an assistant U.S. Attorney in an attempt to influence and induce a decision not to investigate or prosecute Dr Henderson for the unlawful distribution and dispensing of controlled substances. On 7/18/90, the Tennessee Board summarily suspended Dr Henderson's Tennessee medical license based on the indictment. On 1/10/91, a judgment was entered against Dr Henderson in the case of U.S. of A. v. Richard Winn Henderson. Pursuant to the judgment, Dr Henderson was found guilty as charged in the indictment and sentenced to 33 months in prison, to be followed by supervised release for three years. On 10/23/91, the North Carolina Board preferred charges against Dr Henderson based on his conviction, the order of summary suspension by the Tennessee Board, and his alleged prescribing irregularities. On 1/14/92, Dr Henderson entered into an Agreed Order with the Tennessee Board whereby his license in Tennessee was revoked. On 10/08/92, the North Carolina Board summarily suspended Dr Henderson's license to practice in North Carolina. Dr Henderson's conviction and the action of the Tennessee Board are grounds for action by the North Carolina Board.
 Action: 10/05/98 (following a hearing on 9/17/98). Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Henderson's license to practice in North Carolina is revoked and he shall surrender his wall certificate within ten days of his receipt of this order.

SUSPENSIONS

PRENTICE, Robert John, MD

Location: Galesburg, IL
 DOB: 7/29/44
 License #: 00-17159
 Specialty: ORS (as reported by physician)
 Medical Ed: Loyola University-Stritch School of Medicine (1969)
 Cause: On 8/26/97, Dr Prentice and the Illinois Board entered into a Consent Order in which Dr Prentice admitted he had prescribed controlled substances for other than medically accepted therapeutic purposes and that on a number of occasions had not adequately considered and discussed with his orthopedic patients treatment options for long term pain management other than the prescription of controlled substances. Under the Consent Order, his license in Illinois was placed on probation for two years. The action of the Illinois Board is grounds for action by the North Carolina Board.
 Action: 10/05/98. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Prentice's license to practice in North Carolina is suspended indefinitely; he shall surrender his wall certificate to the Board within ten days of receipt of this order.

See Consent Orders:

LUCAS, Charles Clement, MD
MANGUM, Richard Arnold, MD
RIDDLE, William Mark, MD
WORLAX, Frank, MD

SUMMARY SUSPENSIONS

SIDLER, Leonard Oscar, Jr, MD

Location: High Point, NC (Guilford Co)
 DOB: 3/08/49
 License #: 00-23972
 Specialty: ESM/IM (as reported by physician)
 Medical Ed: Emory University (1974)
 Cause: Dr Sidler may be unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality.
 Action: 8/07/98. Order of Summary Suspension of License and Notice of Charges and Allegations issued, effective 8/10/98.

CONSENT ORDERS

AQUILINA, Joseph Nicholas, MD

Location: Saginaw, MI
 DOB: 3/07/35
 License #: 00-38581
 Specialty: U (as reported by physician)
 Medical Ed: University of Munich, West Germany (1962)

Cause: Reprimand by the Michigan Board of Medicine for failure to keep adequate records.
 Action: 8/11/98. Consent Order executed: Dr Aquilina is reprimanded.

BRANCH, Robert Donald, Jr, Physician Assistant

Location: Kinston, NC (Lenoir Co)
 DOB: 7/07/58
 License #: 1-02026
 Education: University of Texas (1995)
 Cause: Consideration of extending Mr Branch's temporary PA license. The Board issued him a temporary license with conditions under a Consent Order of 9/26/95, with modifications by Consent Orders of 12/17/96, and 4/03/97. Further modifications are now agreed to.

Action: 8/11/98. Consent Order executed: Mr Branch is issued a PA license to expire on the date shown on the license (5/31/99); he shall cause his primary supervising physicians to submit written bimonthly reports to the Board regarding his status; with any Notice of Intent to Practice he submits, he shall provide a written statement from his supervising physician, and his employer, if other than his primary supervisor, that he has notified them of his criminal history and of his Consent Orders with the Board; at the request of the Board, he shall provide bodily fluids or tissues for screening of controlled substance use; must comply with other conditions. The terms in the numbered paragraphs of this Consent Order supersede those in any prior Consent Order, save those imposing any reprimand and those regarding the public nature of the Consent Order.

BYRUM, Christopher Edwards, MD

Location: Lake Wylie, SC
 DOB: 10/19/53
 License #: 00-35599
 Specialty: P (as reported by physician)
 Medical Ed: University of Virginia (1988)
 Cause: Request for reinstatement of Dr Byrum's license, which was surrendered 1/28/93 after the Board learned he had diverted and abused Demerol by writing prescriptions in his wife's name. He was issued a temporary license 3/01/93 pursuant to a Consent Order; the Consent Order was terminated and a full and unrestricted license issued 9/15/94; on 3/27/98, he surrendered his license again after the Board learned he had diverted and abused various oral narcotic analgesics by writing prescriptions in the names of his wife and stepson. Dr Byrum entered a treatment/recovery center in March 1998 and remained through June 1998; he returned for two further weeks of treatment in August 1998; he has signed a five-year relapse contract with the NCPHP and reports he has been involved in an active recovery program since his release from the treatment center.

Action: 10/08/98. Consent Order executed: Dr Byrum is issued a license to expire on the date shown on the license (1/31/99); he shall practice only in a setting approved in writing by the president of the Board; unless lawfully prescribed for him by someone else, he shall refrain from use of all mind or mood altering substances and all controlled substances and from the use of alcohol; he shall notify the Board within two weeks of any use of such medication or alcohol, and this notification shall include identification of the prescriber and the pharmacy filling the prescription; he shall supply bodily fluids and tissue samples at the request of the Board for screening purposes; he shall maintain and abide by a contract with NCPHP; he shall not register with the U.S. DEA to prescribe controlled substances and shall not purchase, administer, prescribe, dispense, or order any controlled substances; he shall obtain a medical evaluation from a physician approved in writing by the president of the Board and shall have the evaluation submitted to the Board by 12/31/98; he shall obtain a psychiatric evaluation from a physician approved in writing by the president of the Board and he shall have the evaluation submitted to the Board by 12/31/98; he shall provide a copy of this Consent Order to all prospective employers; he shall obtain and document to the Board 50 hours of Category I CME each year; must comply with other conditions.

ENGLEMAN, James Donald, Jr, MD

Location: Greenville, NC (Pitt Co)
 DOB: 4/05/60
 License #: 00-32696
 Specialty: FP (as reported by physician)
 Medical Ed: University of Louisville (1985)
 Cause: Request for reinstatement of Dr Engleman's license, which was

surrendered 8/06/88. A temporary license was issued to him 9/18/93 subject to conditions; he surrendered that license 6/12/95 after having relapsed in his use of opiates; he has not practiced since June 1995. He reports he has not consumed any alcohol or prescription medication, other than that prescribed for him by someone else, since June 1995; on 6/30/98, he signed a new contract with NCPHP; he reports he has been active in AA and Caduceus meetings in Greenville and has recently completed a family practice mini-fellowship at East Carolina University School of Medicine.

Action: 10/08/98. Consent Order executed: Dr Engleman is issued a license to expire on the date shown on the license (4/12/99); he shall practice only in a setting approved in writing by the president of the Board; no practice setting shall be considered for approval until he submits proof of his successful completion of the ECU family practice mini-fellowship; he shall not work more than 30 hours a week; he shall arrange and pay for a physician monitor who shall be approved in writing by the president of the Board; the monitor shall review Dr Engleman's practice, including medical records, on a regular basis and report to the Board quarterly; unless lawfully prescribed for him by someone else, he shall refrain from use of all mind or mood altering substances and all controlled substances and from the use of alcohol; he shall notify the Board within two weeks of any use of such medication or alcohol in violation of this paragraph, and this notification shall include identification of the prescriber and the pharmacy filling the prescription; he shall supply bodily fluids and tissue samples at the request of the Board for screening purposes; he shall maintain and abide by a contract with NCPHP; he shall attend AA, NA, and/or Caduceus meetings as recommended by NCPHP; he shall maintain a monthly log of all controlled substances he prescribes, orders, or administers and shall submit a copy of the log to the Board each month; he shall continue his psychotherapy with his current therapist or such other person as may be approved in writing by the president of the Board and he shall direct the therapist to report to the Board quarterly on Dr Engleman's progress; he shall obtain and document to the Board 50 hours of Category I CME each year; must comply with other conditions.

FREIBERGER, John Jacob, MD

Location: Durham, NC (Durham Co)
 Chapel Hill, NC (Orange Co)
 DOB: 1/04/52
 License #: 00-27912
 Specialty: AN/CCM (as reported by physician)
 Medical Ed: University of Texas-Southwestern (1979)
 Cause: Application for reinstatement of license. From at least January 1995 through November 1995, while at Durham Regional Hospital, Dr Freiberger diverted numerous dosage units of sufentanil and fentanyl, both controlled substances, by prescribing more than was needed for the patient or by taking the overfill from ampules; he surrendered his license on 11/15/95 after he was confronted by the State Bureau of Investigation and the Board; he surrendered his DEA registration on 4/22/96; on 3/04/96, he was indicted on two felony charges of obtaining controlled substances by diversion; on 9/17/96, he pled guilty to two misdemeanor counts of obtaining controlled substances by diversion; upon his plea, the court sentenced him to 45 days in jail but suspended the sentence and placed him on two years supervised probation followed by three years of unsupervised probation. Dr Freiberger recently completed his period of supervised probation and his probation officer reports he complied with all conditions of his probation; he reports he has not consumed any alcohol or prescription medication, other than that prescribed for him by someone else, since 11/13/95; on 11/14/95, he signed a three-year contract with NCPHP, which he renewed on 2/12/96; NCPHP reports he has been fully compliant with those contracts; he reports that from 11/14/95 through 2/09/96, he attended and successfully completed a chemical treatment program; since that time he has attended three to four recovery meetings per week and met regularly with his NCPHP monitor; he has had numerous drug screens over the past two years, all of which have been negative.

Action: 10/29/98. Consent Order executed: Dr Freiberger is issued a dated license to expire on the date shown on the license (2/28/99); he may not practice anesthesiology; he shall provide a copy of this Consent Order to all prospective employers; unless lawfully prescribed for him by someone else, he shall refrain from use of all mind or mood altering substances and all controlled

substances and from the use of alcohol; he shall notify the Board within two weeks of any use of such medication or alcohol in violation of this paragraph, and this notification shall include identification of the prescriber and the pharmacy filling the prescription; he shall supply bodily fluids and tissue samples at the request of the Board for screening purposes; he shall maintain and abide by a contract with NCPHP; he shall attend AA, NA, and/or Caduceus meetings as recommended by NCPHP; he shall not attempt to reregister or otherwise obtain registration to prescribe controlled substances; he shall not purchase, administer, prescribe, dispense, or order any controlled substances; he shall obtain 50 hours of relevant CME each year, 30 of which shall be Category I; must comply with other conditions.

GORSKI, Karen, Physician Assistant

Location: Huntersville, NC (Mecklenburg Co)
 DOB: 1/08/57
 License #: 1-02145
 Education: State University of New York, Stonybrook (1982)
 Cause: Regarding Ms Gorski's application for a PA license. She signed the license application having answered "no" to a question asking if she ever personally used or consumed any drugs or controlled substances other than those prescribed by a physician or dentist; that answer was false, for while practicing as a PA in Virginia she consumed about 9,140 dosage units of Fioricet, Esigic, and Axocet, about 300 tablets of Triavil, and about 330 tablets of Xanax, none of which were prescribed for her by a physician or dentist; unaware of this, the Board issued her a PA license in August 1996; she admits she obtained that license fraudulently or deceptively and that she fraudulently obtained the drugs noted; she admits she violated the Federal Controlled Substances Law; while working as a PA in North Carolina, she fraudulently obtained a prescription for Fioricet; and on April 17, 1998, she surrendered her PA license. She reports she has attended and successfully completed a treatment program at a relapse prevention center and that for the past few months she has regularly attended AA, NA, and Caduceus meetings; all recent drug and alcohol screens have been negative; she has signed a contract with the NCPHP.

Action: 8/06/98. Consent Order executed: The Board reprimands Ms Gorski for concealing her use of the drugs noted; she is issued a PA license to expire on the date shown on the license (11/30/98); unless lawfully prescribed by someone else, she shall refrain from the use of all mind or mood altering substances and all controlled substances and from alcohol; she shall notify the Board in writing within two weeks of her use of such medication or alcohol and note the prescriber and the pharmacy filling the prescription; she shall supply bodily fluids or tissues as requested by the Board for drug and alcohol screening; she shall maintain and abide by a contract with the NCPHP; she shall attend AA, NA, and Caduceus meetings as recommended by the NCPHP; she shall not register with the U.S. DEA to prescribe controlled substances and shall not purchase, administer, prescribe, dispense, or order any controlled substances; she shall obtain a medical evaluation from a physician approved by the president of the Board and cause a report of that evaluation to be submitted to the Board by October 15, 1998; she must provide a copy of this Consent Order to all current and prospective employers; must comply with other conditions.

HALL, Jesse McRae, Physician Assistant

Location: Fort Bragg, NC (Cumberland and Hoke Cos)
 Lillington, NC (Harnett Co)
 DOB: 6/23/56
 License #: 1-01830
 Education: Ft Sam Houston, TX (1991)
 Cause: Regarding the Summary Suspension and Notice of Charges and Allegations dated 3/26/98. Mr Hall admits that on numerous occasions in 1997 and early 1998 he obtained for his own consumption a quantity of Ritalin, a Schedule II-N controlled substance, by submitting to pharmacies forged prescriptions. He reports he has not used alcohol or any controlled substances since 2/16/98; he signed a contract with NCPHP on 3/05/98; he successfully completed a 28-day inpatient substance abuse program during April and May 1998; he successfully completed NCPHP's Relapse Prevention Workshop and regularly attends AA, NA, and Caduceus meetings; all recent urine screens have been negative.

Action: 10/21/98. Consent Order executed: Mr Hall surrenders his PA license; the Board dissolves the Order of Summary Suspension

and dismisses with prejudice the Notice of charges and Allegations; Mr Hall is issued a PA license to expire on the date shown on the license (1/31/99); unless lawfully prescribed for him by someone else, he shall refrain from use of all mind or mood altering substances and all controlled substances and from the use of alcohol; he shall notify the Board within two weeks of any use of such medication or alcohol in violation of this paragraph, and this notification shall include identification of the prescriber and the pharmacy filling the prescription; he shall supply bodily fluids and tissue samples at the request of the Board for screening purposes; he shall maintain and abide by a contract with the NCPHP; he shall attend AA, NA, and Caduceus meetings as recommended by NCPHP; he shall not register with the DEA; he shall provide a copy of this Consent Order to all current and prospective employers; must comply with other conditions.

HILL, Edward Warren, Jr, Emergency Medical Technician-Intermediate

Location: Tarboro, NC (Edgecombe Co)
 DOB: 6/01/66
 Certification: By the NCMB through the NC Office of Emergency Medical Services
 Cause: Mr Hill, at the request of an ER physician, accepted prescriptions for Lorcet tablets issued in his name by the physician and admits he filled those prescriptions, returning the tablets to the physician for the physician's use.

Action: 9/23/98. Consent Order executed: Mr Hill is reprimanded.

JOHNSON, Harvey Earl, Jr, Emergency Medical Technician-Intermediate

Location: Speed, NC (Edgecombe Co)
 DOB: 9/07/60
 Certification: By the NCMB through the NC Office of Emergency Medical Services
 Cause: Mr Johnson, at the request of an ER physician, accepted prescriptions for Lorcet tablets issued in his name by the physician and admits he filled those prescriptions, returning the tablets to the physician for the physician's use.

Action: 9/14/98. Consent Order executed: Mr Johnson is reprimanded.

LUCAS, Charles Clement, MD

Location: Larchmont, NY
 DOB: 8/30/42
 License #: 00-16905
 Specialty: FP/IM (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1969)
 Cause: The New York State Board for Professional Medical Conduct suspended Dr Lucas' license for three years by an order dated 12/24/96 upon findings of professional misconduct, including being an habitual user of alcohol or being dependent on or an habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs, and practicing while impaired; New York stayed the suspension as long as Dr Lucas complies with terms of probation. He is now practicing in New York pursuant to probation and he has told the North Carolina Board he does not intend to practice in North Carolina until the restrictions are lifted from his New York license.

Action: 10/30/98. Consent Order issued: Dr Lucas' license in North Carolina is suspended until 12/24/99; suspension is stayed so long as Dr Lucas complies with the conditions of this order, including obtaining 50 Category I CME hours relevant to his practice each year, appearing before the Board before practicing in North Carolina, complying with the terms of his New York probation, maintaining and abiding by a contract with NCPHP when he returns to North Carolina; must comply with other conditions.

MANGUM, Richard Arnold, MD

Location: Creedmoor, NC (Granville Co)
 DOB: 9/15/33
 License #: 00-14252
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine, Chapel Hill (1964)

Cause: The Board did not receive reports of a physical and neurological examination of Dr Mangum or of his obtaining CME in pain management as required under his Consent Order of 2/16/95; on 5/21/98, the Board filed charges against him alleging he violated his Consent Order; he filed an Answer on 7/9/98 denying the allegations. Dr Mangum has agreed to take the Special

Action: Purpose Examination of the Federation of State Medical Boards. 8/19/98. Consent Order executed: Dr Mangum's medical license is suspended for three years from the date of this Order; the suspension is stayed for three years so long as he complies with the terms of this Order, which require he take and pass the SPEX by 12/31/98, obtain and document 50 Category I hours of practice-relevant CME each year, practice only in a structured setting approved in writing by the president of the Board, submit to and cooperate with a physical and neurological examination by physicians designated in writing by the president of the Board and with results reported to the Board, and maintain records on all patients for whom he provides care, making those records available for inspection by the Board; must comply with other conditions.

McDERMOTT, Robert William, Jr, MD

Location: Billings, MT
DOB: 4/13/44
License #: 00-28882
Specialty: P (as reported by physician)
Medical Ed: Yale University (1970)
Cause: On or about 11/26/97, Dr McDermott executed a Stipulation and Agreement and Order of Probation with the Montana Board of Medical Examiners [a copy of which is attached to this Consent Order and states, among other things, that he admits he has the illnesses of bipolar disorder and chemical dependency and addiction, and that he used his Montana license and DEA registration to write third-party prescriptions for controlled substances that he diverted to his own use]; that Stipulation is grounds for action by the North Carolina Medical Board.

Action: 10/27/98. Consent Order executed: Dr McDermott shall comply with the terms and conditions set forth in the Montana Stipulation, as it may be amended from time to time; if he returns to North Carolina, (1) he shall refrain from use of all mind or mood altering substances and all controlled substances, unless lawfully prescribed by someone else, and from the use of alcohol, (2) he shall notify the Board within two weeks of any use of such medication or alcohol, and this notification shall include identification of the prescriber and the pharmacy filling the prescription, (3) he shall supply bodily fluids and tissue samples at the request of the Board for screening purposes, (4) he shall maintain and abide by a contract with NCPHP (5) he shall not register with the DEA and shall not purchase, administer, prescribe, dispense, or order any controlled substances; he shall appear before the Board prior to practicing in North Carolina; he shall obtain 50 hours of relevant Category I CME each year; must comply with other conditions.

MYERS, Kenneth Christopher, Emergency Medical Technician-Intermediate

Location: Hobgood, NC (Halifax Co)
 Edgemcombe County, NC, Rescue Squad
DOB: 12/125/71
Certification: By the NCMB through the NC Office of Emergency Medical Services
Cause: Mr Myers helped obtain prescription drugs for someone for whom they had not been prescribed: Mr Myers was prescribed Lorcet tablets for bronchitis by a physician with whom he worked; the physician then asked Mr Myers to share the drug with him; the physician issued several further prescriptions for the drug over the next months, which Mr Myers filled at the physician's request; he then turned over the drug to the physician for the physician's use.
Action: 9/10/98. Consent Order executed: Mr Myers is reprimanded.

PAINE, Karen Nicholson, MD

Location: Garner, NC (Wake Co)
DOB: 7/07/46
License #: 00-20834
Specialty: FP/OM (as reported by physician)
Medical Ed: New York University (1971)
Cause: Request for a modification of the Consent Order of 4/09/97 to permit Dr Paine to fully serve her patients.
Action: 10/15/98. Consent Order executed: Dr Paine is issued a license to expire on the date shown on the license (3/31/99); she shall not practice except in a setting approved in writing by the Board through its president; she shall maintain and abide by a contract with NCPHP; unless lawfully prescribed for her by someone else, she shall refrain from use of all mind or mood altering substances and all controlled substances and from the use of alcohol;

she shall notify the Board within two weeks of any use of such medication or alcohol in violation of this paragraph, and this notification shall include identification of the prescriber and the pharmacy filling the prescription; she shall supply bodily fluids and tissue samples at the request of the Board for screening purposes; she shall not prescribe any drug for her own use; she shall not purchase, administer, prescribe, dispense, or order any controlled substances in Schedules II, II-N, III, or III-N; she may purchase, administer, prescribe, dispense, or order Schedule IV controlled substances, but only pursuant to her practice at the Wake County Alcoholism Treatment Center; she may apply to the DEA only for registration for Schedule IV; she shall obtain and document 50 hours of Category I CME relevant to her practice each year; must comply with other conditions.

PEADEN, Richard Alvis, Emergency Medical Technician-Intermediate

Location: Tarboro, NC (Edgecombe Co)
DOB: 9/17/55
Certification: By the NCMB through the NC Office of Emergency Medical Services
Cause: Mr Peaden helped obtain prescription drugs for someone for whom they had not been prescribed: Mr Peaden was prescribed Lorcet tablets for back pain by a physician; the physician issued him several further prescriptions for the drug over the next months, which Mr Peaden filled; at the physician's request he turned over some of the drug to the physician for the physician's use.
Action: 10/08/98. Consent Order executed: Mr Peaden is reprimanded.

PEADEN, Tammy Turner, Emergency Medical Technician-Intermediate

Location: Tarboro, NC (Edgecombe Co)
DOB: 12/06/58
Certification: By the NCMB through the NC Office of Emergency Medical Services
Cause: Ms Peaden helped obtain prescription drugs for someone for whom they had not been prescribed: Ms Peaden was prescribed Lorcet tablets for back pain and headache by a physician; the physician issued her several further prescriptions for the drug over the next months, which Ms Peaden filled; at the physician's request she turned over some of the drug to the physician for the physician's use.
Action: 10/08/98. Consent Order executed: Ms Peaden is reprimanded.

RIDDLE, William Mark, MD

Location: Greenville, NC (Pitt Co)
DOB: 3/20/56
License #: 00-39871
Specialty: FP/EM (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1985)
Cause: Application for reinstatement of medical license. Dr Riddle's license was surrendered 9/11/97 following his being confronted with his diversion and abuse of controlled substances in a scheme involving approximately 21 people and 224 prescriptions. From 1995 through 1997, while employed as an emergency room physician at Columbia Heritage Hospital in Tarboro, NC, he diverted and abused at least 6,675 dosage units of Lorcet, a schedule III controlled substance, by means of forged prescriptions and by prevailing on health care workers he supervised or worked with to obtain drugs for him at local pharmacies. He surrendered his DEA registration 5/07/98. Dr Riddle reports he has not consumed alcohol or prescription medication, other than that prescribed for him by someone else, since 9/09/97, on which date he signed a contract with the NCPHP; from September through November 1997, he attended and successfully completed a chemical treatment program and has since continued aftercare; he reports he has been active in AA, NA, and Caduceus meetings; he reports he has met with most of those whom he involved in his diversion scheme and now appreciates the extent to which he exploited them.

Action: 10/12/98. Consent Order executed: Dr Riddle's license is suspended from 9/11/97, the date he surrendered his license, though 10/12/98; his license surrender is accepted; he is issued a license to expire on the date shown on the license (11/30/98); he shall practice only in a setting approved in writing by the president of the Board; he shall not work more than 30 hours a week; unless lawfully prescribed for him by someone else, he shall refrain from use of all mind or mood altering substances and all controlled substances and from the use of alcohol; he shall notify the Board within two weeks of any use of such medication or alcohol in violation of this paragraph, and this notification

shall include identification of the prescriber and the pharmacy filling the prescription; he shall supply bodily fluids and tissue samples at the request of the Board for screening purposes; he shall maintain and abide by a contract with NCPHP; he shall attend AA, NA, and/or Caduceus meetings as recommended by NCPHP; he shall not attempt to reregister or otherwise obtain registration to prescribe controlled substances without written permission from the Board; he shall not purchase, administer, prescribe, dispense, or order any controlled substances; he may not, either as a primary or back-up physician, supervise PAs or NPs; he shall obtain and document to the Board 50 hours of Category I CME relevant to his practice each year; 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: Dr Thompson's license was suspended in July 1995 for failure to register and was reinstated in December 1996 pursuant to a Consent Order related to his recovery from substance abuse and his mental health; he has admitted that he relapsed in his recovery from substance abuse by drinking alcohol in June 1998. He was treated and remains in long-term treatment for substance abuse; he continues under the care of his psychiatrist.

Action: 9/18/98. Consent Order executed: Dr Thompson is issued a license to practice medicine expiring on the date shown on the license; he shall not practice medicine but may perform administrative duties related to the practice of medicine after such work is approved in writing by the president of the Board; he shall maintain and abide by a contract with NCPHP; unless lawfully prescribed by someone else, he shall refrain from the use of all mind or mood altering substances and all controlled substances and from alcohol; he shall notify the Board in writing within two weeks of his use of such medication or alcohol and note the prescriber and the pharmacy filling the prescription; he shall supply bodily fluids or tissues as requested by the Board for drug and alcohol screening; he shall continue to see his psychiatrist once each month and his psychologist twice each month and shall cause each to submit reports of his progress to the Board every three months; he shall obtain 50 hours of CME each year, at least 30 of which shall be in Category I; must comply with other conditions.

WALSH, James Aloysius, MD

Location: Hilton Head, SC

DOB: 7/23/35

License #: 00-36285

Specialty: DR/NM (as reported by physician)

Medical Ed: Jefferson Medical College (1961)

Cause: In Colorado, Dr Walsh's ability to evaluate mammograms was questioned; the Colorado Board of Medical Examiners and Dr Walsh entered a Stipulation and Final Agency Order with each other on 10/26/95 that placed Dr Walsh's license on probation for five years. He appears to be in compliance with the Colorado Order; he has documented to the North Carolina Medical Board that he has obtained 89 hours of Category I CME in mammography in the last decade and has read at least 120 medical journal articles on mammography in about that time; he states his intention to obtain further CME on mammography.

Action: 8/14/98. Consent Order executed: for the next five years when practicing on a patient in North Carolina, Dr Walsh shall have a licensed North Carolina physician monitor his practice activities in the office and hospital; the monitoring physician shall submit a CV to the Board for review and a letter stating his willingness to comply with the monitoring requirements set forth in this Consent Order; during any month in which he practices on a patient or patients in North Carolina, Dr Walsh shall have the monitor review at least five random cases, three of which shall be mammograms and two of which shall be other than mammograms; if Dr Walsh has fewer than five patients in a month, the monitor shall review all the cases; if he does not practice on any North Carolina patients, he shall submit quarterly reports to the Board so stating; if Dr Walsh has practiced on a patient in North Carolina during any quarter, the monitor shall submit quarterly reports in accord with the Consent Order on the same schedule; whatever the location of the patients, Dr Walsh shall not interpret more than 20 mammograms in a single day; he shall obtain

and document to the Board 50 hours of CME relevant to his practice each year, at least 30 hours of which must be Category I; must comply with other conditions.

WORIX, Frank, MD

Location: Pembroke, NC (Robeson Co)

DOB: 1/06/39

License #: 00-21384

Specialty: FP (as reported by physician)

Medical Ed: Duke University School of Medicine (1976)

Cause: Dr Worix admits that during the past 20 years, he has had sexual relations with five patients. He has voluntarily entered a cognitive behavioral treatment program; Dr Gene Abel, director of that program, believes that if Dr Worix completes his outpatient treatment and complies with the prescribed practice plan, he will not pose a safety hazard to patients; Dr Worix has entered into a contract with the NCPHP.

Action: 8/19/98. Consent Order executed: Dr Worix's medical license is indefinitely suspended effective 9/19/98; he shall deliver his license and registration certificates to the Board's office by 9/30/98; he shall wind down his practice so continuity of patient care is maintained; must comply with other conditions.

MISCELLANEOUS BOARD ORDERS

BRITT, Robert Carl, MD

Location: Durham, NC (Durham Co)

DOB: 9/20/36

License #: 00-13063

Specialty: M/PUD (as reported by physician)

Medical Ed: University of North Carolina, Chapel Hill (1961)

Cause: Notice of Charges and Allegations issued 6/06/98 regarding verbal and physical assault on a woman, which would constitute dishonorable conduct.

Action: 9/18/98. Order issued following hearing: Board finds that a mutual assault occurred between Dr Britt and the woman and, therefore, that Dr Britt did not engage in dishonorable conduct as alleged; charges against Dr Britt dismissed with prejudice.

PORTER, Dennis Ray, MD

Location: West Palm Beach, FL

DOB: 8/16/55

License #: 00-29989

Specialty: P/CHP (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1982)

Cause: Regarding further proceedings against Dr Porter in the case against him begun by the Notice of Charges of 4/10/97. In March 1997, the Florida Board issued an Emergency Suspension of License against Dr Porter, finding that, among other things, he had issued prescriptions for a fee without performing an examination, signed prescriptions presented him by his office manager without questioning who the prescriptions were for, gave prescriptions for controlled substances to persons without any examination, issued prescriptions in the names of persons he never met or examined, and knowingly prescribed drugs for sale on the street; based on the Florida findings, the North Carolina Board issued an Order of Summary Suspension of License against him and filed a Notice of Charges on 4/10/97; the Florida Board's case against him remains pending. Dr Porter acknowledges he is entitled to a prompt hearing of the North Carolina Board's charges against him but waives that right before completion of the Florida Board's case and agrees that it is in his interest and that of the Board to postpone the resolution of this matter pending resolution of the Florida Board's case against him, subject to the conditions set forth in this Order.

Action: 10/27/98. Tolling Agreement and Order issued: Dr Porter shall not practice in North Carolina until the Board issues its final decision in the case against him begun by the Notice of Charges of 4/10/97; the Board shall not conduct any further proceedings in the case until the Florida Board issues its final decision; Dr Porter must comply with other conditions.

DENIALS OF LICENSE/APPROVAL

HOWELL, George B., MD

Location: Wichita, KS

DOB: 6/16/35

Specialty: FP (as reported by physician)

Medical Ed: University of Arkansas (1962)

Cause: Application for license. Dr Howell failed to satisfy the Board of his qualifications in the following respects: the Texas Board denied his application for license; the Texas Board found he performed "breast and pelvic examinations without adequate indication, including school or sports examinations on junior high school and high school girls"; the Texas Board found he failed to properly treat certain patients; he has engaged in immoral or dishonorable conduct and unprofessional conduct, has failed to demonstrate that he is of good moral character, and has failed to demonstrate that he possesses the professional competence to practice medicine.

Action: 7/24/98. Denial of License Application issued.

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

SURRENDERS

BREWER, Thomas Edmund, Jr, MD

Location: High Point, NC (Guilford Co)
DOB: 11/04/56
License #: 00-28141
Specialty: GP/OM (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1985)
Action: 9/18/98. Voluntary surrender of medical license.

See Consent Orders:

HALL, Jesse McRae, Physician Assistant
RIDDLE, William Mark, MD

CONSENT ORDERS LIFTED

BOTWRIGHT, Gene Robert, MD

Location: Wagram, NC (Scotland Co)
DOB: 8/23/55
License #: 00-36462
Specialty: FP (as reported by physician)
Medical Ed: East Carolina School of Medicine (1990)
Action: 10/13/98. Order issued lifting Consent Order of 12/28/95.

GUFFEY, Neal Hamilton, Jr, MD

Location: Kernersville, NC (Forsyth Co)
DOB: 4/5/59
License #: 95-00489
Specialty: FSM/OM (as reported by physician)
Medical Ed: University of South Carolina (1992)
Action: 10/13/98. Order issued lifting Consent Order of 5/15/95.

HALE, Phillip Douglas, MD

Location: Danville, VA
DOB: 2/05/55
License #: 96-00826
Specialty: FP (as reported by physician)
Medical Ed: Uniformed Services University of the Health Sciences (1982)
Action: 8/17/98. Order issued lifting Consent Order of 6/27/96.

JORDAN, Richard Liming, MD

Location: Jacksonville, NC (Onslow Co)
DOB: 6/14/46
License #: 00-19612
Specialty: FP (as reported by physician)
Medical Ed: Vanderbilt University (1971)
Action: 8/17/98. Order issued lifting Consent Order of 2/25/98.

MELVIN, Shirley Sharrock, MD

Location: Fayetteville, NC (Cumberland Co)
DOB: 2/22/50
License #: 00-21885
Specialty: IM (as reported by physician)
Medical Ed: University of Florida (1977)
Action: 10/13/98. Order issued lifting Consent Order of 5/01/95.

PATTERSON, Robert William, MD

Location: Angier, NC (Harnett Co)
DOB: 4/03/52
License #: 00-23907
Specialty: FP/A (as reported by physician)
Medical Ed: University of North Carolina School of Medicine, Chapel Hill (1978)
Action: 10/13/98. Order issued lifting Consent Order of 2/23/87.

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 School of Medicine (1979)
Action: 8/17/98. Order issued lifting Consent Order of 3/03/98.

SATTLER, Raymond Louis, MD

Location: Roanoke, VA
DOB: 7/16/44
License #: 00-26049
Specialty: P/NS (as reported by physician)
Medical Ed: Case Western Reserve University (1977)
Action: 10/13/97. Order issued lifting Consent Order of 12/22/96.

SYKES, Larry Justain, Jr, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)
DOB: 9/11/46
License #: 1-00388
Education: Fort Sam Houston, TX (1976)
Action: 8/17/98. Order issued lifting Consent Order of 8/22/97.

TEMPORARY/DATED LICENSES:

ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

BLEMINGS, Ginger Dobbins, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)
DOB: 8/30/63
License #: 1-01410
Education: Bowman Gray School of Medicine (1991)
Action: 9/18/98. Temporary/dated license extended to expire 3/31/99.

BOTWRIGHT, Gene Robert, MD

Location: Wagram, NC (Scotland Co)
DOB: 8/23/55
License #: 00-36462
Specialty: FP (as reported by physician)
Medical Ed: East Carolina School of Medicine (1990)
Action: 9/19/98. Full and unrestricted license reinstated.

FULGHUM, Thomas Grady, MD

Location: Erwin, NC (Harnett Co)
DOB: 6/29/57
License #: 00-31987
Specialty: EM/IM (as reported by physician)
Medical Ed: Duke University School of Medicine (1983)
Action: 9/19/98. Temporary/dated license extended to expire 3/31/99.

GLENN, Robert Alan, Physician Assistant

Location: Asheville, NC (Buncombe Co)
DOB: 3/13/59
License #: 1-01972
Education: George Washington University (1989)
Action: 9/18/98. Temporary/dated license extended to expire 3/31/99.

GUFFEY, Neal Hamilton, Jr, MD

Location: Kernersville, NC (Forsyth Co)
DOB: 4/5/59
License #: 95-00489
Specialty: FSM/OM (as reported by physician)
Medical Ed: University of South Carolina (1992)
Action: 9/18/98. Full and unrestricted license reinstated.

HAINES, Richard Littleton, MD

Location: Wilmington, NC (New Hanover Co)
DOB: 8/10/22
License #: 00-28932
Specialty: IM/GER (as reported by physician)
Medical Ed: University of Virginia (1947)
Action: 9/19/98. Temporary/dated license extended to expire 9/30/99.

HAWLEY, John Patrick, Physician Assistant

Location: New Bern, NC (Craven Co)
DOB: 4/27/46
License #: 1-02243
Education: Duke University (1977)
Action: 9/18/98. Temporary/dated license extended to expire 9/30/99.

MORRIS, Robert Harry, Physician Assistant

Location: Lumberton, NC (Robeson Co)
 DOB: 11/18/50
 License #: 1-00110
 Education: Howard University (1975)
 Action: 9/19/98. Temporary/dated license extended to expire 3/31/99.

O'DONNELL, Robert William, MD

Location: Whiteville, NC (Columbus Co)
 DOB: 1/30/42
 License #: 00-29636
 Specialty: P/ADP (as reported by physician)
 Medical Ed: University of Maryland (1974)
 Action: 9/19/98. Temporary/dated license extended to expire 9/30/99.

PAINE, Karen Nicholson, MD

Location: Garner, NC (Wake Co)
 DOB: 7/7/46
 License #: 00-20834
 Specialty: FP/OM (as reported by physician)
 Medical Ed: New York University (1971)
 Action: 9/19/98. Temporary/dated license extended to expire 3/31/99.

POWELL, Thomas Edward, MD

Location: Durham, NC (Durham Co)
 DOB: 7/11/64
 License #: 98-00439

Specialty: GP (as reported by physician)
 Medical Ed: University of Texas, San Antonio (1995)
 Action: 9/18/98. Temporary/dated license extended to expire 3/31/99.

SCONTSAS, George John, MD

Location: Kinston, NC (Lenoir Co)
 DOB: 12/17/48
 License #: 00-32852
 Specialty: N (as reported by physician)
 Medical Ed: University of Virginia (1977)
 Action: 9/18/98. Temporary/dated license extended to expire 3/31/99.

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: 9/18/98. Temporary/dated license extended to expire 11/30/98

DISMISSALS

See Consent Orders:

HALL, Jesse McRae, Physician Assistant

See Miscellaneous Board Orders:

BRITT, Robert Carl, MD

North Carolina Medical Board Meeting Calendar, Application Deadlines, Examinations January 1999 -- November 1999

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

North Carolina Medical Board **January 20-23, 1999**

January Meeting Deadlines:
 Nurse Practitioner Approval Applications December 7, 1998
 Physician Assistant Applications December 2, 1998
 Physician Licensure Applications January 5, 1999

North Carolina Medical Board **March 17-20, 1999**

March Meeting Deadlines:
 Nurse Practitioner Approval Applications February 1, 1999
 Physician Assistant Applications February 3, 1999
 Physician Licensure Applications March 2, 1999

North Carolina Medical Board **May 19-22, 1999**

May Meeting Deadlines:
 Nurse Practitioner Approval Applications April 5, 1999
 Physician Assistant Applications April 1, 1999
 Physician Licensure Applications May 4, 1999

North Carolina Medical Board **July 21-24, 1999**

July Meeting Deadlines:
 Nurse Practitioner Approval Applications June 7, 1999
 Physician Assistant Applications June 8, 1999
 Physician Licensure Applications July 6, 1999

North Carolina Medical Board **September 15-18, 1999**

September Meeting Deadlines:
 Nurse Practitioner Approval Applications August 2, 1999
 Physician Assistant Applications August 3, 1999
 Physician Licensure Applications August 31, 1999

North Carolina Medical Board **November 17-20, 1999**

November Meeting Deadlines:
 Nurse Practitioner Approval Applications October 4, 1999
 Physician Assistant Applications October 6, 1999
 Physician Licensure Applications November 2, 1999

☛ **Residents Please Note USMLE Schedule**

Examinations Schedule

United States Medical Licensing Examination (USMLE) Step 3

May 11-12, 1999 Sitting
 Deadline for receipt of application: February 10, 1999
 December 7-8, 1999 Sitting
 Deadline for receipt of application: September 7, 1999

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

LICENSES RECENTLY MADE INACTIVE (Results from Failure to Register)

MAY 1998

Table with 10 columns: Name (alphabetical), License #, Name (alphabetical), License #, Name (alphabetical), License #, Name (alphabetical), License #, Name (alphabetical), License #. Lists inactive licensees for May 1998.

JUNE 1998

Table with 10 columns: Name (alphabetical), License #, Name (alphabetical), License #, Name (alphabetical), License #, Name (alphabetical), License #, Name (alphabetical), License #. Lists inactive licensees for June 1998.

JULY 1998

Table with 10 columns: Name (alphabetical), License #, Name (alphabetical), License #, Name (alphabetical), License #, Name (alphabetical), License #, Name (alphabetical), License #. Lists inactive licensees for July 1998.

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.

Bulk Rate
US Postage
PAID
Permit No. 1486
Raleigh, NC

Expert Reviewers Needed for NCMB Panel of Medical Advisors

The North Carolina Medical Board evaluates approximately 500 quality-of-care cases each year. These involve issues arising from patient complaints, malpractice claim outcomes, and hospital reports. To do this, the Board draws on the knowledge and experience of the expert reviewers on its Panel of Medical Advisors. They analyze medical records and report their conclusions to the Board for its consideration. On occasion, a reviewer may be asked to offer testimony at one of the Board's formal hearings, but generally evaluations are treated as confidential and are handled by mail. Because the issues involved must be dealt with in a timely manner, evaluation reports are due back from the reviewers within six weeks of their receipt of the case materials. Compensation is provided at the rate of \$125 per hour.

The Board needs to increase the number of expert reviewers on its Panel of Medical Advisors. Physicians interested in considering assisting the Board as expert reviewers should mail the form below, accompanied by a full *curriculum vitae*, to the executive director of the Board at the address noted on the form.

Expert Reviewer Response Form

TO: Andrew W. Watry, Executive Director
North Carolina Medical Board
PO Box 20007
Raleigh, NC 27619

Yes, I am interested in the possibility of participating as an expert reviewer for the North Carolina Medical Board. I am under no obligation but would be willing to consider a request to evaluate medical records and attend a short seminar for expert reviewers. Enclosed find my full *curriculum vitae*.

NAME (Please Print) _____

ADDRESS: _____

NORTH CAROLINA MEDICAL LICENSE #: _____

TELEPHONE: (____) _____ — _____

North Carolina Medical Board
P.O. Box 20007
Raleigh, NC 27619
Address correction requested