Primum Non Nocere

No. 2, 2004

forum

NC MEDICAL BOARD

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President's Message

Introspection and Safety

Stephen M. Herring, MD

Medical Boards seek out and study factors and parameters that affect the delivery of health care, both positive and negative. One human factor that is accepted as a significant negative factor is the lack of introspection. Introspection is defined as the contemplation of one's own thoughts, feelings, actions, and sensations. In a broader sense, and in this context, it is self-examination, which should continue throughout the career of the provider, just as continuing medical education should become an integral part of the physician's life. When any provider fails to admit or understand, or simply ignores, the human condition of imperfection, no effort will be made to improve and to "do it better" the next time—no progress or advance will be achieved.

In the field of aviation, there is a particular aircraft, and a very good one, that is known as the "flying casket" because physicians, and surgeons in particular, have developed a reputation, deserved or not, for crashing the aircraft in almost unbelievable situations and ways. Flight instructors believe that they have identified a distinct pattern here. So well known is this sad reputation that professional pilots and flight instructors cringe and roll their eyes when the words "pilot" and "surgeon" are said in the same sentence.

Some years ago, there was a well-known, talented, and respected surgeon that learned to fly. This surgeon's remarkable ability in his chosen career was unquestioned, and his personal contributions to the field of medicine were widely recognized as enormous. Albeit brilliant, this surgeon also had a persona that was interpreted by most of those who knew him as arrogant. The time came when he chose to fly an aircraft that was beyond his experience level in weather conditions that were far beyond his skill level. On that occasion, he was briefed by the weather service and was told that flying into the prevailing poor weather conditions under visual flight rules was not advised. He paid no attention, and his medical brilliance did him no good from that point on—or down. The flight lasted less than four minutes and abruptly ended a distinguished career. Despite crashing into a congested area, very fortunately he did not kill anyone he had so thoughtlessly—and arrogantly—placed at risk on the ground.

Two generally unrelated groups, medical regulators and flight instructors, have collectively reached the same independent conclusion regarding behavior patterns and safety: confidence, the state or quality of being certain, is an asset; arrogance, the state of self-assumption and presumption, is a detriment. It is a recurring theme and pattern in medicine and aviation. The story of the prominent surgeon whose flight lasted less than four minutes, which is based on a report from the National Transportation Safety Board database, illustrates a particularly tragic intersection of the two.

I believe many professional medical societies and other health care groups and organizations recognize the potential danger that can result from arrogance and a lack of introspection, and I know some have published statements warning of the serious problems those personal weaknesses can cause. All groups and organizations in the field of health care should address such issues, and every person involved in health care should encourage and support the process.

At the same time, while we know the physician that always reports perfect results and the pilot that always reports perfect flights share serious and sometimes fatal flaws, that both are dangerous to others and to themselves, it's important to remember that neither is common.

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forum

NC MEDICAL BOARD

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North Carolina Medical Board

Publisher
NC Medical Board

Editor
Dale G Breaden

Assistant Editor
Dena M. Marshall

Street Address
1203 Front Street
Raleigh, NC 27609

Mailing Address
PO Box 20007
Raleigh, NC 27619

Telephone
(919) 326-1100
(800) 253-9653

Fax
(919) 326-0036

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

NC Severe Acute Respiratory Syndrome (SARS) Response Plan

Kathy Dail, RN, MEd, Nurse Epidemiologist, General Communicable Disease Branch
Debbie Crane, Director, Public Affairs Department of NC Health and Human Services

The North Carolina State SARS Response Plan is now posted on the NC DHHS/DPH Web page, making it available to public health officials, health care providers, and others. State health director Dr Leah Devlin announced that the plan formalizes what North Carolina has already been doing—noting that the state's efforts last summer paid off when a SARS case was diagnosed in North Carolina and the disease controlled with no one else infected.

"In June [2003], North Carolina recorded one of only eight confirmed SARS cases in the United States," she explained. "While only one person was actually infected with the SARS virus, many health workers, family members, or other contacts of this person were exposed. Also, there was a great deal of effort to keep the public informed. Public health at the state and local level, health care providers, and others worked on the case. Of course, there was also an enormous amount of work done in investigating potential SARS cases as well."

"All of the lessons learned from this experience in North Carolina as well as on the national and international scene have been captured in the SARS plan. The plan outlines clearly a solid framework for all of the players—the health departments, hospitals, other providers—in detecting any SARS case early and providing an aggressive and effective response," she explained. "We are closely following the international scene as SARS has reemerged in China. We know that SARS is again a possibility in North Carolina and we want to make sure that the work of public health and our partners is well coordinated in an investigation so that the effect on the public is minimized."

State epidemiologist Dr Jeffrey Engel says that the plan is particularly important because it gives health care providers clear guidance on what to look for and how to deal with potential SARS cases. "Our first line of defense is the patient-provider encounter and early suspicion of the diagnosis of SARS," he said. "Rapid recognition, isolation of the patient, and reporting to public health is the key to containing this disease."

North Carolina health care providers enjoy a special Web link that directs them to the plan and to CDC guidance and NC State Laboratory of Public Health forms and consents (*http://www.dhhs.state.nc.us/dph/sars/state_sars_plan.htm*).

The state plan mirrors the CDC national plan, making it easy to accommodate changes to the document. Perhaps the greatest strength of the plan is that community providers with actual SARS experience were major contributors, including Wake and Orange County Health Departments and UNC Hospitals. The plan covers surveillance for the disease, preparedness in health care facilities, containing the disease, managing international travel risk, laboratory diagnosis, infection control, and communication.

The plan will evolve as more is learned about SARS.

Reprinted from the December 2003-February 2004 issue of *EpiNotes*, a publication of the NCDHHS Division of Public Health.

Using Information Technology to Improve Patient Care and Communication: A Practical Guide—Part 2

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

Ms Satinsky

In Part 1 of this article, which appeared in *Forum* #1, 2004, I presented a practical guide to help you understand ways in which information technology may be able to help you improve patient care and communication in your practice. I directed my comments there particularly to those of you who are in smaller and solo practices and who may, for one reason or another, question the value of technology for your patients and for yourselves. I described common applications and suggested steps you can take to determine if information technology can help you.

Here, in Part 2 of the article, I present several short profiles of medical practices that now use information technology to impact patient care and communication. The majority of the examples are of North Carolina physicians, and most of these practices are at the very early stages of using information technology to communicate with patients. Knowing that a major issue will be your return on investment over time, I've also included examples of practices in other states that have been able to document the financial impact of their decisions. Read these descriptions to learn what your colleagues are doing, what challenges they face, how they make their decisions, and how they monitor their success in meeting their goals. Following the practice profiles, I include comments about the experiences of several patients of physicians who have adopted the use of information technology to improve patient care and communication.

Practice Profiles

I've presented the practice profiles detailed below in alphabetical order. Here's a brief list of them and a few points I think are important about each.

- ***Blue Ridge Family Physicians (Raleigh, NC):*** methodology for selecting vendor for practice management system (PMS) and electronic medical records (EMR) and approach to interconnectivity among vendors
- ***Central Utah Multi-Specialty Clinic (Provo, UT):*** national recognition for innovative information technology use
- ***Duke University Health System (Durham, NC):*** progressive introduction of multiple information technology products, flexibility in honoring preferences of individual departments, and balance between centralization and decentralization
- ***Eagle Physicians and Associates (Greensboro, NC):*** creative use of its Web site for interaction with patients and approach to trying innovations in small practices prior to system-wide implementation
- ***Hillsborough Medical Group (Hillsborough, NC):*** use of information technology to support a solo practitioner and his staff
- ***LeBauer HealthCare (Greensboro, NC):*** approach to moving away from multiple legacy systems within its many medical specialty departments
- ***Medoff Medical (Greensboro, NC):*** use of information technology by a solo practitioner who both provides patient care and engages in clinical research
- ***Mobile-Medicine.Net (Marietta, GA):*** new style practice
- ***Northern Virginia Family Practice Associates (Alexandria, VA):*** significant cost savings through pre-registration and appointment management
- ***Sandy Springs Internal Medicine (Atlanta, GA):*** customized pre-registration and other interactive systems
- ***Triangle Orthopaedic Associates (Durham, NC):*** selection and implementation of EMR in a single specialty practice with multiple offices
- ***West Columbia Family Medicine (Lexington, SC):*** on-line visits, significant return on investment

"Learn what your colleagues are doing, what challenges they face, how they make their decisions, and how they monitor their success"

Blue Ridge Family Physicians (2002)

Blue Ridge Family Physicians in Raleigh has four physician partners, three physician assistants, and 30 staff members. The practice was formerly part of the primary care physician network owned by Rex Healthcare. When Rex offered these physicians the opportunity to buy back their practices, Blue Ridge accepted the offer.

The practice's most pressing need was for a practice management system (PMS) that would handle routine business functions such as scheduling, patient registration, billing and collections, and managed care, and that would also allow the practice to add additional applications. The physicians worked closely with their practice administrator and with an experienced outside consultant to make sure they selected one or more systems that would meet their needs.

During the PMS vendor selection process, Blue Ridge considered several companies, some of which were large and prominent and had been in business for many years. Important criteria in vendor selection

were:

- corporate financial stability,
- willingness to work with Blue Ridge on customized options,
- technical support,
- frequency of system upgrades,
- system comprehensiveness,
- user references and experiences,
- cost.

Blue Ridge selected a small company that offered a comprehensive PMS, including an electronic medical record. The vendor was willing to collaborate with the practice in developing clinical templates and other software functions that met the practice's needs. Blue Ridge pays a monthly fee for the number of system users as well as an access fee to the system. Maintenance and system upgrade fees are included in the monthly fee.

"The key to the continued success of this system will be recurring training and education for users"

Blue Ridge contracted with a separate hardware and network company to select the computers, small business server, wiring, and installation that would be compatible with the PMS. To make the purchase more affordable, Blue Ridge applied for a bank loan to finance the cost of the hardware equipment. Many other practices rely on the vendor to help with hardware selection and financing. Blue Ridge financed the project with its own bank loan, thus retaining more leverage than it would have had with reliance on vendor financing.

Blue Ridge is pleased with its progress. The practice attributes the success of its implementation to the cooperation and coordination among the PMS vendor, the hardware/network company, the telecommunications vendor, the external consultant, and the staff. The three companies talk with each other regularly to resolve problems as they arise and to incorporate new applications as they are chosen. The PMS vendor tailored its training to a wide variety of skill sets within the practice. The key to the continued success of this system will be recurring training and education for users as questions arise and skill sets grow.

Once the PMS has been in operation for a few more months, Blue Ridge will add applications such as fax software and a lab results reporting system.

The next major project will be building a comprehensive Web site that interfaces with the PMS system. Blue Ridge wants its Web site to accomplish the following:

- provide general information on the practice;
- allow patients to schedule non-emergent appointments;
- send appointment reminders and health alerts for preventive healthcare services;
- notify patients that lab results are available—and that patients can call the office to get them;
- provide general educational information about health maintenance, disease states, and drug interactions, plus links to educational Web sites that are endorsed by the physicians;
- allow pharmacies to request prescription refills;
- allow patients and specialist offices to request referrals;
- allow patients to pay bills on line.

The functions listed above focus on one-sided communication. At this point in its planning, Blue Ridge is comfortable with electronic communication from the practice to its patients. In general, however, it is wary about electronic patient care because of the potential malpractice risks and requirements for HIPAA compliance.

(Joanna Herath, former practice manager, and Helen Clark, consultant, provided information for this profile.)

Central Utah Multi-Specialty Clinic (2004)

Central Utah Multi-Specialty Clinic, in Provo, UT, has 59 physicians and 30 mid-level practitioners in eight locations. The practice's leadership is very supportive of information technology solutions; and, within the past three years, the practice has introduced a new practice management system, electronic medical records, and a Web site. Physicians and patients have the option of using the appointment reminder feature. Although not all physicians use it, that feature has reduced the number of no-show visits in the practice by 50 percent and increased monthly revenue by $20,000. In the future, the practice plans to extend the appointment reminder feature beyond office visits to scheduled procedures and surgeries.

Jamie Steck, director of information technology at Central Utah, says his practice has received national recognition for its innovative information technology solutions. He expects to add more solutions to the current practice Web site. .

(Jamie Steck, director of information technology, provided information for this profile. The Web site is www.cumcmds.com.*)*

Duke University Health System (2002)

The Duke University Health System includes physicians who practice in two settings. Most physicians are part of the faculty practice plan, the Private Diagnostic Clinic (PDC), and see patients in primary care or specialty PDC clinics. Other physicians are part of Duke University Associated Physicians (DUAP), and see patients in their private offices. Duke uses information technology to help physicians in both the PDC and DUAP provide better care and communication to patients.

Duke uses a practice management system (PMS) that is suited to its size and complexity. The PMS allows the addition of many applications that have a direct impact on patient care. Although all clinics use a core suite of practice management tools, such as scheduling and billing, they vary in their use of applications related to physician-patient communication. Here are examples.

- A call center module allows clinic triage staff to automatically ask patients why they are calling. By responding to prompts, patients indicate if they are calling for immediate medical advice, to

make or change an appointment, or to request a prescription refill. The system automatically stamps the date and time of all correspondence noted in the system. Central intake staff for each participating clinic take direct phone calls from patients as well as messages left on the dedicated answering system. They check the messages at regular intervals and respond appropriately.

- An automated telephone appointment reminder system supplements paper reminder and mailing systems This system calls to remind a patient of the date, time, and place of an appointment several days before the actual appointment date. Patients who do not like the automatic reminder or who have difficulty using it can request not to be notified in this way.
- A Web-based product called the Duke Patient Channel allows existing patients to make on-line requests for appointments and prescription refills, send on-line messages to participating physicians, pay bills, and enter new insurance information. About 60 percent of the PDC clinics use this system. The Patient Channel is extremely secure, and patients are steadily accepting on-line tools for non-acute requests for healthcare. Staff finds the on-line system helpful in two ways. First, the system automatically categorizes requests and electronically routes the task to appropriate resources. Second, it increases efficiency by allowing staff to batch the inquiries and respond to many requests for the same service (eg, requests for appointments) rather than to a variety of individualized requests.

Duke's clinical information system will also impact patient care. Already seven years in the making at the time of my interview with Duke representatives, the project combines inpatient and outpatient information from multiple clinical service units (eg, heart center, oncology) into a single clinical data repository. Physicians and other clinicians can practice medicine by accessing the database and by calling up patient information that may have come from as many as 100 interfaces and 30 million documents. The system has allowed Duke to eliminate its reliance on paper medical records. Patients benefit because their physicians can so easily call up accurate information.

With respect to information technology decision-making, Duke has a central information technology group that interfaces with groups within each clinical area. The Health System attempts to keep a balance between centralization and decentralization.

(Dr Michael L. Russell, MD, associate chief information officer, and Roman Perun, manager, Internal Consulting, PRMO Information Systems, and Duke University Health System, provided information for this profile.)

Eagle Physicians and Associates, PA (2002)

Eagle Physicians and Associates, PA, is an independent, physician-owned multi-discipline group practice located in the Triad area. It was formed by 33 private physicians who practiced in five long-established small group practices and who wanted to remain independent from large insurance companies, national corporations, and hospital systems. More than 80 physicians and other providers see patients in 14 sites in the Greensboro area. Eagle's Board of Directors consists entirely of physicians who practice medicine in Guilford County.

"The project combines inpatient and outpatient information from multiple clinical service units into a single clinical data repository"

A major impetus for Eagle's formation in 1995 was to increase physicians' leverage with managed care companies. As the practices worked through details of the merger, they realized that becoming a true merged practice would require centralization of functions like information technology. Important milestones in Eagle's information technology development have been:

- purchase of a central computer for billing and management purposes,
- addition of data warehouse capability that has enhanced both the practice's ability to slice and dice information and its flexibility in reporting,
- upgrade of the practice Web site to allow patient interactivity.

Eagle is moving more slowly with its use of electronic medical records (EMR). Rather than introduce the technology into the entire practice without a trial, it will use one of the smallest practices to pilot the EMR concept.

Eagle's revamped Web site already includes many features that have reduced both demands on office staff and operating costs. For example, patients can obtain information on office locations, providers, specialties, insurance plans, hospital care, and frequently asked questions. A patient education section of the Web site updates patients on current issues such as flu shots for children and HRT for women. The practice deliberately features controversial issues and articles written by its own physicians as a strategy for encouraging patients to regard the practice as a reliable health information resource.

The planned upgrade of the Web site to allow patient interactivity is expected to reduce operating costs even further. Unlike the earlier Web site upgrades that concentrated on staff activities, these upgrades will begin to deal with physician functions. The practice wants to activate the interactive capability before it reaches the point where it can't meet patient needs.

Among the Web-based applications that Eagle will activate are: pre-registration, requests for appointments, reports of lab results, appointment confirmations, e-mail instructions for procedures, and on-line capability for patients to interact with customer service representatives with questions about bills.

Eagle will have the ability to use the Web for virtual office visits. It is comfortable with on-line medicine for a specific group of established patients with established problems such as urinary tract, sinus, and yeast infections. Patients who use the virtual office visit capability will pay by credit card on-line prior to

receipt of advice; instructions for billing are provided. The practice is not comfortable with virtual office visits for new patients or for existing patients with new problems. These patients will be asked to make an appointment to come into the office for a face-to-face visit with a physician or other provider.

Eagle's process for making information technology decisions has been thoughtful and inclusive. The Information Technology Committee includes six physicians, four information technology professionals, the director of Operations, and several practice managers. When the practice did its strategic information technology planning several years ago, the information technology group was divided into three subcommittees that worked on the Web, the server, and centralized services such as transcription, scheduling, phone triage, and EMR. These three committees did the groundwork that resulted in the plan that Eagle has today.

"The way to successfully combine high-quality patient care with good business sense is through the use of technology"

The process by which Eagle enhanced its Web capability included not only representatives of the Information Technology Committee and its selected vendor. A Total Quality Management Subcommittee that includes physicians and the director of Operations reviews everything that goes on the Web site.

With respect to implementation, Eagle has the luxury of being able to test out new applications in some of the smaller practices before involving all its offices.

The problems that Eagle has experienced in its information technology upgrades have been minor compared to the benefits the practice has recognized. The practice's attempt to have physicians capture hospital charges with hand held devices did not work because posting the electronic charges still required human intervention and the effort was not worth the investment. Also, as sometimes happens, at the crucial moment when the practice planned to unveil its new Web site at a large provider meeting, Internet connectivity failed to work. Nonetheless, Eagle feels that the way to successfully combine high-quality patient care with good business sense is through the use of technology.

(Mary Pat Whaley, formerly chief operating officer, Eagle Physicians and Associates, PA, provided information for this profile. The Web site is www.eaglemds.com.*)*

Hillsborough Medical Group, PA (2002)

Hillsborough Medical Group, PA, is a small primary care practice with one physician and two part-time family nurse practitioners. Although small in size, the practice has aggressively pursued information technology solutions that address its particular issues. Philip Singer, MD, the physician, has taken a leadership role in investigating options.

The practice has recently purchased an electronic medical records (EMR) system in order to achieve the following goals.

- Reduce practice overhead costs by:
  (1) eliminating the need for paper charts and their storage,
  (2) eliminating transcription costs,
  (3) improving the efficiency of work flow by making clinical information immediately available to staff.
- Provide a structure for clinical information that will help standardize care provided by all practitioners.

In Dr Singer's opinion, it was important to use the same vendor for both the EMR and the practice management system (PMS). The EMR vendor that he preferred had recently acquired its own PMS product and was experiencing growth problems. Installation of the PMS did not go smoothly. Out of frustration, Dr Singer brought in another vendor that also failed to meet his needs. He then went back to the original vendor.

The functions of Dr Singer's EMR system that enable him to improve patient care include capturing information at the point of care with a touch-screen notepad computer, having all clinical information about the patient, including scanned reports and correspondence, organized and accessible, and providing a system to record all interactions with the patient, including phone calls, prescription refills, and referrals. The system interfaces with the reference lab, allowing direct importation of test results to the patient chart. With respect to prescriptions, there is a comprehensive on-line formulary, and prescription orders and refills can be faxed directly to the pharmacy.

Dr Singer's fact-finding process involved visiting and talking with other practices. He arranged to accompany physicians as they used the system and to talk directly with patients about their response to use of technology. He was particularly interested in whether or not the physician's use of technology interfered with personal communications. Patients had a positive response, and Dr Singer was reassured. Although his personal response to the new technology has been positive, his mid-level practitioners have been slower to embrace the innovations.

Dr Singer is comfortable with his existing telephone and mail systems that communicate lab results to patients. He is reluctant to use e-mail for patient care because of privacy and reimbursement issues.

(Dr Philip Singer provided information for this profile.)

LeBauer HealthCare (2002)

LeBauer HealthCare is a multi-specialty practice in the Greensboro area. Fifty-two physicians and two psychologists provide care in eight sites. The specialties represented are cardiology, family practice, gastroenterology, internal medicine, internal medicine/pediatrics, pulmonology, and behavioral medicine. Although the practice merged with the Moses Cone Health System in 1999, it retains its ability to manage its information technology and has its own full-time information technology director.

Strategic and operational planning for information technology at LeBauer is complex. Because cardiolo-

gy, gastroenterology, and pulmonology are technology driven, physicians in these specialties have always taken a particular interest in the practice's overall information technology direction. The medical director and other physician leaders collaborate with the information technology director to provide guidance and direction.

As in many large practices, over the years LeBauer has put in place multiple freestanding information technology applications that vary in quality and do not always communicate with each other. A major challenge is to introduce compatibility into existing systems while identifying new and appropriate solutions.

The information technology applications now in place at LeBauer include the following:

- digital dictation;
- a practice management system (PMS) that has many business applications such as accounting, scheduling, and managed care (the internal laboratory system and an external laboratory system now interface with the PMS);
- varying use of palm devices and PDAs (personal data assistants) that organize and manage information and access data on hospitalized patients;
- independent systems in gastroenterology and cardiology;
- varying use of e-mail for intra-office and physician/patient communications.

Physicians vary in their use of e-mail for communication within the practice and between themselves and patients. Some physicians are very comfortable answering questions and providing information on line, provided that their patients don't need an office visit. Similarly, some but not all physicians use Internet databases such as Scientific American Medicine, MD Consult, and UpToDate to enhance patient care. Patients are generally receptive to the introduction of these resources into the physician-patient encounter and enjoy working with their physicians to find reliable on-line information.

Within the past two years, the information technology director has encouraged the practice to combine its many separate applications into a single system. The practice has purchased its own server, and the lab system now interfaces with the PMS The practice is linked to the hospital information system so physicians can quickly access information on transcription notes, test results, and other relevant facts for their hospitalized patients.

Moving forward, LeBauer's priorities are to:

- activate the electronic prescription module of the PMS;
- meld the transcription system into the PMS;
- introduce EMR into the practice and, over time, pilot test it with the pulmonary physicians, and then transition more than 135,000 active charts into electronic form;
- upgrade the current telephone answering system to be more efficient;
- standardize the e-mail system using guidelines available from the AMA and AMIA;
- formally train physicians and staff;
- upgrade the current Web site to provide more information for patients.

(Dr Michael Norins, medical director, and Eric Johnson, IT director, at LeBauer HealthCare provided information for this profile.)

Medoff Medical (2002)

Jeffrey Medoff, MD, opened his solo gastroenterology practice in Greensboro in March 1999. He had previously been part of a large multi-specialty clinic that was bought by the Moses Cone Health System.

Medoff Medical includes two businesses: consultation in gastroenterology and a separate clinical research company. One of Dr Medoff's motivations for leaving the larger group of which he had been a part was to balance the revenue generated from both businesses so he could focus on his patients' needs and his research interest.

As a solo practitioner who spends a portion of his time seeing patients and who contracts with just three managed care companies, Dr Medoff's need for information technology is different from that of physicians who see a high volume of patients and/or who are dealing with many managed care companies. He uses it to enhance staff and physician accessibility to patients and to keep overhead as low as possible. Dr Medoff has built his information technology support gradually, and he now has systems that support patient scheduling, accounting, and billing functions. He can access patient records from locations outside his office to review demographic information. His new PDA (personal data assistant) has PC-based software and will allow him to download patient information directly into the hospital database. He is currently reviewing electronic medical record systems so he can reduce the high cost of out-sourced transcription services. He uses e-mail regularly to communicate with pharmaceutical companies and contract research organizations, but he is unlikely to use e-mail to communicate directly with patients.

"A major challenge is to introduce compatibility into existing systems while identifying new and appropriate solutions"

Reliance on an experienced external consultant has enabled Dr Medoff to build his information technology capabilities on an incremental basis. The consultant makes sure that systems purchased from different vendors are integrated with each other. As the liaison between vendors and the practice, the consultant ensures that training and technical assistance meet the needs of all staff.

Given the small size of Medoff Medical, Dr Medoff has been able to put in place patient communication systems that are not technology driven and that give patients excellent access to staff and to Dr Medoff himself. He educates his patients so that they have a good understanding of their medical conditions. Patients who call during office hours speak directly to a staff member; there is no telephone triage system. Dr Medoff himself is on call 24/7. After hours,

patients hear a voice message that prompts them to indicate an emergency need. Once the phone system picks up an emergency need, it pages Dr Medoff immediately, regardless of where he is within the United States. The system continues to page him every five minutes until he responds to the page. He then calls the patient directly.

Because this telephone communication system works so well, Dr Medoff has no need for e-mail communication with patients. Aside from lack of need, he has concerns about the time it takes to answer e-mail, reimbursement, and confidentiality issues.

Dr Medoff offers the following advice to physicians who want to use information technology in their practices.

- Go slowly and thoughtfully.
- Regardless of how much you like technology, don't try to make decisions for your practice yourself. Look for an external consultant with experience in the medical field. Find someone who is not selling a product and who can provide an honest opinion of various products on the market.
- Use technology to enhance, not reduce, physician-patient contact.

(Dr Jeffrey Medoff of Medoff Medical provided information for this profile.)

Mobile-Medicine.Net (2004)

Dr Frenesa K. Hall's innovative concierge practice in Atlanta, GA, Mobile-Medicine.Net, provides care to patients at work or home rather than office-based, insurance-driven medicine. She depends on her Web site to run her practice and is particularly satisfied with the pre-registration feature. In Dr Hall's opinion, patients provide more complete information when not under time pressure to provide details. By saving time spent directly with Dr Hall, they also save money, since in this practice patients are responsible for their own payments.

"Use technology to enhance, not reduce, physician-patient contact"

A lab test-reporting feature works particularly well for her. When she receives information for a particular patient, she records her comments. The patient can retrieve her interpretation through the physician's Web site or by telephone. Dr Hall also appreciates the low cost of this service—less than a stamp.

Dr Hall said, "I'm thrilled with our Web site. It enhances my ability to maintain a mobile practice, enabling better quality of patient information than we would otherwise receive, and to document patient-generated information."

(Dr Frenesa K. Hall provided information for this profile. The Web site is www.mobile-medicine.net*.)*

Northern Virginia Family Practice Associates (2004)

Northern Virginia Family Practice Associates (NVFPA), Alexandria, VA, is a busy practice located in the Washington, DC, metropolitan area. The community is very computer literate. The introduction of an interactive Web site met the needs of both the practice and patients. The practice was struggling with a large volume of write-offs related to incorrect insurance information. By introducing a pre-registration function, it has dramatically reduced the percentage of write-offs and greatly improved its accounts receivable.

Prior to implementing pre-registration, the average daily write-off for the practice was $1,000 due to incorrect insurance information. Now that pre-registration is in place and is in use by 95 percent of the patients, the write-off amount is almost non-existent—about $1,000 a year. Using the information it gets both from patients and from the on-line eligibility checks that many insurers now offer, the practice can easily verify information before patients come into the office. Eligibility checking reduces collection costs and insures the practice gets paid in a timely manner for work performed.

An appointment management function is also in place, and the practice plans to phase in the use of other functions such as prescription renewals, on-line bill payment, and, eventually, virtual office visits.

Mary Dooher, MSN, practice administrator at NVFPA, says, "Our patients love the user-friendly Web site format as well as its interactive and educational features. In addition, the Web site is great for marketing our family practice."

(Mary Dooher, MSN, practice administrator, provided information for this profile. The Web site is www.nvafamilypractice.com*).*

Sandy Springs Internal Medicine (2004)

Sandy Springs Internal Medicine is located in Atlanta, GA. The practice has 35 staff members. The information technology that supports the practice includes a practice management system, a document management system, electronic medical records, and multiple Web-based functions.

Initially, Sandy Springs had a practice Web site that was not HIPAA-compliant for e-mail communications. It overcame that deficiency by introducing a new system and it is now able to assure patient privacy and security. The practice has also streamlined many other administrative functions once done by highly paid staff.

Sandy Springs' pre-registration system has been customized to meet its needs. Its forms for patient history, review of systems, family history, and insurance are on the Web site. Patients complete the forms at their convenience prior to coming to the office.

(Bret Smith, practice manager, provided information for this profile. The Web site is www.sandyspringsim.com*).*

Triangle Orthopaedic Associates, PA (2002)

Triangle Orthopaedic Associates (TOA), PA, is an orthopaedic surgical practice specializing in orthopaedic medicine and musculoskeletal disease. Its 20 physicians are fellowship trained in all orthopaedic subspecialties. The surgeons and other clinical staff practice in nine locations throughout the Piedmont.

The practice offers a comprehensive array of services, including orthopaedic surgery, physical medicine and rehabilitation, physical therapy, aquatic therapy, imaging, and orthotics and prosthetics.

Information technology is very important to the practice, provided that technology can meet a recognized need and that it doesn't conflict with important practice values. Ten years ago, TOA computerized its office notes. As the practice expanded in scope, number of locations, and volume of patients, it decided to upgrade information technology again so that physicians could obtain medical records and imaging remotely. Digital imaging is now in place, and after a two year search for a vendor, a Windows-based electronic medical record (EMR) system was implemented. The practice has revised its original Web site and now has the capacity to activate features that allow patients to schedule appointments, pay bills, fill out registration information, and send comments. The practice does not expect to use its Web site for on-line communications with physicians and other clinicians regarding test results and on-line responses to questions. The existing call triaging system allowing patients to talk directly with a staff member works very well, and the practice prides itself on its personalized human touch in responding to patients.

Triangle Orthopaedics uses a team approach to make its information technology decisions. Its information technology team includes one or more physicians, the practice administrator, and a full-time information technology manager. The small group regularly seeks input and buy-in from other physicians and staff. Because of the size and importance of the EMR conversion, TOA engaged a specialty consulting firm that provided assistance with work flow analysis, preparation of a request for a proposal, vendor site visits, visits to other practices, vendor selection, and project management.

Because TOA has a number of information technology applications, staff training is a priority. For the EMR implementation, the training sessions were for all staff and lasted for an entire week. Going forward, the practice believes it can improve its staff training by training fewer people for shorter time intervals so the office is not decimated during the training sessions. Training and availability of applications must be carefully timed so that staff can return from training and immediately use the applications at their desks. If they are trained in advance of the availability of an application, they are likely to forget what they learned.

A goal for all TOA's information technology innovations has been dollar savings. Implementation of all of the projects is relatively recent, and when I wrote this profile, financial results were not yet measurable.

The practice has experienced several obstacles in its selection and implementation of technology applications.

- With respect to the upgrade from automatic charting to EMR, the practice attempted to find a vendor specializing in orthopaedics. This approach didn't produce the desired result, so the goal became to find an application that would lend itself to easy customization for the practice.
- Vendor instability was also a problem. The practice is particularly leery of vendors that are financed with venture capital and that have not been in business for more than two years.
- As might be expected in a practice with 20 physicians, reaction to the new EMR has not been unanimously positive. Some of the surgeons do not want to take the time it takes to learn the new system and input information. Thus, although the upgrade may save the practice dollars, it may not save time for individual physicians.

(Richard F. Bruch, MD, Deborah Wilkins, formerly with the practice, and Tim Miller of Triangle Orthopaedic Associates, provided information for this profile. The Web site is www.triangleortho.com*.)*

West Columbia Family Medicine (2004)

Allen Wenner, MD, is one of three physicians at West Columbia Family Medicine in Lexington, South Carolina, that uses "virtual" office visits for patient communications. The practice initiated virtual office visits by encouraging existing patients with chronic conditions to use electronic communication. The physicians quickly realized that patients couldn't easily make the distinction between chronic and acute conditions. In order to be more responsive to patients' requests, the practice is now adding the capability to respond to both chronic and acute needs within a reasonable time frame—two hours during office hours, four hours after office hours, and the next morning for questions sent in after 9:00 PM. The practice believes improving access to physicians and allowing them to respond quickly greatly enhances the quality of care for patients.

"Information technology offers contemporary solutions for problems physicians are only beginning to recognize they can solve"

Financially, the return on investment has been dramatic. On average, physicians take eight seconds to respond to an electronic question, and the charge for the on-line service is $50. The practice is moving toward handling up to 18 on-line inquiries per day. At $50 per inquiry, that is an increase in revenue of $900 per day. The practice also generates additional revenue by seeing 20 more patients in the office.

Dr Wenner, who is also a software design consultant, is a sophisticated user of information technology solutions in medical practice settings. He believes information technology offers contemporary solutions for problems physicians are only beginning to recognize they can solve.

(Dr. Allen Wenner provided information for this profile. The Web site is www.columbiasdoctor.com*.)*

Patient Perspectives

The Bowers Family (2002):

Mr Ben Bowers and his wife, Eugenia, residents of

Greensboro, have used e-mail for the past six months to communicate with their primary care physician. Mrs Bowers had a stroke in late April and spent seven weeks in the hospital and required other levels of care within the Moses Cone Health System. After she returned home, Mr Bowers, who has retired from running the newsroom at a major Greensboro newspaper, assumed responsibility for her care.

The Bowers' physician at LeBauer HealthCare has taken a number of steps to help Mr Bowers care for his wife. He makes house calls on a regular basis so that the Bowers do not have to struggle with office visits more often than is absolutely necessary. At their physician's suggestion, Mr Bowers communicates by e-mail to ask questions about prescriptions, to confirm the date and time of house calls, to obtain authorization for occupational and physical therapy, to coordinate visits to specialists and testing, and to obtain advice and support for his own high blood pressure.

"Each practice has unique needs, budgets, and visions for the future"

Use of e-mail enables Mr Bowers to communicate directly with his physician in a manner that he finds quick and efficient. Without going through office clerks and nurses, he knows he will get a response from his physician within a few hours after he sends his question or concern. E-mail allows him to keep a record of all communications with his physician in case he wants to recap his questions and the physician's answers.

The Author, Ms Satinsky (2004):

I'm a healthy female in her 50s. For the past five years, I've seen my physicians for preventive care and for various athletic injuries incurred when my ambition surpasses my abilities. My primary care physician is part of a medical practice that does not use technology for patient care and communication, and my gynecologist is part of a large practice that relies heavily on information technology. I'm in a good position to contrast the experiences that I have with both physicians.

When I call my primary care physician for an appointment, for a prescription refill, or to get medical advice, I talk first with the telephone receptionist, then with a nurse, and less often with the physician himself. If I schedule an office visit, I talk with three more people. In some cases, I give the practice the same information six times. I am not able to leave a voice-mail message after office hours or on weekends unless I need urgent care.

In contrast, when I want to contact my gynecologist, I have several choices. For routine telephone calls, I call a main number, and I'm prompted to specify my need for medical advice, an appointment, or a prescription refill. Using this system, I either talk with a human being or get a call back very quickly. My physician has encouraged me to use e-mail to communicate with him about routine questions, and he responds quickly to any inquiries I make. I also have the option of using the practice's secure, Web-based communication tool.

I get outstanding medical care from both my primary care physician and from my gynecologist. Nonetheless, if I ever decided to change primary care physicians, I would look for a good physician in a practice that made communication easier for patients.

Conclusion

I think that using information technology to improve patient care and communication is a critical component of medical practice management. If you have read all of the profiles, you may be struck by the same observation that I had—that no two practices took the same approach. That's as it should be, as each practice has unique needs, budgets, and visions for the future. I encourage you to join your colleagues in determining what's right for your practice.

The author wishes to thank Stephen N. Malik, CEO, MedFusion, Raleigh, NC, for his assistance and suggestions.

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Watch the *Forum* for Ms Satinsky's article on electronic medical records, currently scheduled for publication in *Forum* #3, 2004.

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Ms Satinsky is president of Satinsky Consulting, LLC. She earned her BA in history from Brown University, her MA in political science from the University of Pennsylvania, and her MBA in healthcare administration from the Wharton School of the University of Pennsylvania. She is the author of two books: *The Foundation of Integrated Care: Facing the Challenges of Change* (American Hospital Publishing, 1997) and *An Executive Guide to Case Management Strategies* (American Hospital Publishing, 1995). *Forum* #4, 2002, featured her article Managing the Implementation of HIPAA and the Privacy Rule. Forum #2, 2003, featured her article How to Determine If Your Practice Could Use a Professional Practice Administrator. *Forum* #1, 2004, featured the first part of this series, Using Information Technology to Improve Patient Care and Communication: A Practical Guide - Part 1. An adjunct faculty member at the University of North Carolina School of Public Health, Ms Satinsky is a member of the Medical Group Management Association.

She may be reached at (919) 383-5998 or *margie@satinskyconsulting.com*.

The North Carolina Medical Board Presents a Caring, On-Line Primer About the Humanity Essential to Medical Practice

Fondly, Carolyn: Letters to a Young Physician

On its Web site, the North Carolina Medical Board proudly offers *Fondly, Carolyn: Letters to a Young Physician*, by Carolyn E. Hart, MD, of Charlotte, NC, as a service to all medical students, residents, faculty, mentors, and other physicians and health care professionals concerned about the humanity essential to professionalism and the practice of medicine.

As director of medical education at Charlotte Memorial Hospital and Medical Center (now Carolinas Medical Center) from 1962 to 1984, I would have made Dr Hart's series of letters to a young physician mandatory reading for all interns and residents on a yearly basis. This requirement would have served to enhance and guide their efforts in becoming complete (or, as Izaak Walton said, Compleat) practicing physicians. Thank you, Dr Hart! And, I have mailed copies of the *Fondly, Carolyn* series to my eldest grandson, who is currently in an orthopedic surgery residency.

Bryant L. Galusha, MD
Former President, Federation of State Medical Boards
Former Executive Vice President, Federation of State Medical Boards
Former Member, National Board of Medical Examiners
Former President, North Carolina Medical Board

This correspondence should be required reading for medical students and residents in all specialties. They incorporate the concepts of professionalism, how to be a caring and culturally competent physician, and how to advocate for your patients and your profession. As medicine has become more complex, it has become increasingly more difficult for the mentors and teachers involved in medical education to have the opportunities to pass these values on to their trainees. These letters could be an invaluable resource.

Barbara S. Schneidman, MD, MPH
Former Associate Vice President, American Board of Medical Specialties
Former President, Federation of State Medical Boards
Former Member, Accreditation Council for Continuing Medical Education
Former Chair, Washington State Board of Medical Examiners

Many of us professionals on today's fast track may think we have all the answers to life's challenges. And we don't like to be preached to. But deep inside, we quietly yearn for new insights about ourselves and a better understanding of our values and relationships. Dr Carolyn Hart's intimate *Fondly, Carolyn* letters come as a breath of fresh air for us all. Each of the letters in the series is filled with friendly suggestions, which, while ostensibly addressed to a new physician, bring thoughtful advice and guidance to us all. She asks: Do you really desire a truly fulfilling, happy, and healthy life? Consider the five cornerstones of that life she shares with us in her letters: trust in a higher power, a calling, a loving relationship with another adult, an avocation, and physical exercise. I urge you to read the *Fondly, Carolyn* letters—read and act!

E.K. Fretwell, PhD
Member, North Carolina Medical Board
Chancellor Emeritus, University of North Carolina, Charlotte
Former Interim President, University of Massachusetts System

To access *Fondly, Carolyn*, simply go to the Board's Web site: *www.ncmedboard.org*. The text can be easily downloaded and printed out in the free Adobe format.

We owe special thanks to Dr Hart for preparing a revised version of the *Letters to a Young Physician* series, which appeared in its original form in the Mecklenburg County Medical Society's publication, *Mecklenburg Medicine*, in 2002. We also thank her and *Mecklenburg Medicine* for graciously permitting publication of the revised version in the *Forum* in 2002 and, now, its publication on the NCMB's Web site.

Please let us know if you have any questions. Telephone Dale Breaden, NCMB Department of Public Affairs, at (919)326-1109, ext 230, or Dena Marshall at (919)326-1109, ext 271. E-mail: *dale.breaden@ncmedboard.org*.

North Carolina's Allied Health Care Professionals

Robin Hunter-Buskey, PA-C, NCMB Member

Ms Hunter-Buskey

North Carolina's health care environment is continuously evolving to include a blend of medical providers. This blend includes not only physicians, but also physician assistants (PAs), nurse practitioners (NPs), and, most recently, clinical pharmacist practitioners (CPPs). As allied health care professionals, PAs, NPs, and CPPs work alongside licensed physicians, improving access to medical care services necessary to meet the needs of North Carolina and its residents.

The state of North Carolina has established regulations that govern the practice of PAs, NPs, and CPPs. To be granted a license or approval to practice, each practitioner is responsible for fulfilling certain criteria and complying with regulations specific to his or her chosen profession. All three are responsible for establishing and maintaining a relationship between themselves and a designated supervisory physician. This supervision must be continuous, and, although it is not necessary that the supervising physician be present when the practitioner is providing care, it is required the supervisor be readily accessible. This requirement, among others, assures public safety in the delivery of medical care by all practitioners, and requires they take responsibility for their patients in a variety of settings. The scope of that responsibility must be delineated in terms that are consistent with the applicable statutes and rules and that are understandable to colleagues, the public, and regulatory agencies.

(Following the sections below is a boxed guide to the documents that practitioners in each field must keep at their practice site and to other materials that are useful to keep on site.)

"The PA's intent to practice agreement with his or her supervisory physician is the most important and fundamental document required"

Physician Assistants

A PA is an individual licensed by, and registered with, the North Carolina Medical Board to perform medical acts, tasks, or functions under the supervision of a physician licensed by the Board. A PA must have 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. (21 NCAC 32S .0101)

On completion of her or his medical education, and before performing any medical tasks in North Carolina, the PA must obtain a valid North Carolina license. This requires that the PA successfully complete the examination of the National Commission on Certification of Physician Assistants, receive acknowledgement of his or her intent to practice agreement with a primary supervising physician, and have a specific practice location approved by the Board. With all criteria met, and following action by the Medical Board, the PA will be issued a license.

The PA's intent to practice agreement with his or her supervisory physician is the most important and fundamental document required before practicing in North Carolina. There is no fee for this documentation, which includes the name, practice address, and telephone number for both the PA and the primary supervising physician. (21 NCAC 32S .0112—Notification of Intent to Practice)

Additional supervision requirements include having a written practice agreement that outlines the scope of practice for the PA. This document must be clearly identified in writing and maintained at each practice setting. The scope of practice describes the tasks delegated to the PA, the relationship the PA has with a primary supervising physician, and the process for evaluating the PA's performance. The practice agreement must be signed by the supervising physician and the PA, and, along with numerous other documents, must be readily available to the Board or its representatives upon request. Although the scope of practice is defined by the PA and her or his supervising physician, it is important to note that the primary supervising physician has responsibilities beyond continuous availability and support. According to a recently enacted rule change, a PA and supervising physician must meet every six months to discuss, among other things, clinical practice issues. However, for PAs in a new practice arrangement, the PA and supervising physician must meet monthly for the first six months. These meetings must be documented and the record of such meetings must be available for inspection by Board agents upon request (21 NCAC 32S .0110).

PAs may treat patients with prescription medications as long as they comply with North Carolina standard rules. Administrative rule 21 NCAC 32S .0109 reads: "a PA is authorized to prescribe, order, procure, dispense, and administer drugs and medical devices subject to conditions." Conditions include the requirement that there must be a written statement on prescriptive authority in which the supervising physician and the PA acknowledge they are both familiar with the laws and rules regarding prescribing. The written statement on prescribing must be reviewed periodically. Each prescription written by a PA must include, in addition to other information, the PA's name, practice address, telephone number, and license number, as well as the responsible physician's name and telephone number.

Nurse Practitioners

Subchapter 32M—Approval of Nurse Practitioners of the North Carolina Medical Board's rules, defines an NP as:

> "a currently licensed nurse approved to perform medical acts, consultation, collaboration, and evaluation of the medical acts performed... under an agreement with a licensed physician for ongoing supervision. . . ."

To be approved to practice as an NP, the NP must first have completed an approved course of study. It is also necessary she or he pass a certification examination by a national credentialing body. (However, as noted below, an NP may practice temporarily for six months while waiting to take the required examination or while awaiting the test results.) Before beginning employment, it is necessary that an NP receive written confirmation of approval to practice from the North Carolina Board of Nursing and the North Carolina Medical Board.

Each NP applying for approval may be granted interim status while the Boards complete the processing of his or her application. The practice of an NP with interim status is subject to several limitations: there are no prescribing privileges; all notations in patient charts must be countersigned within two working days; and there must be documentation of weekly face-to-face consultation with the primary supervising physician. An NP with interim approval may practice for a period not to exceed six months.

For an NP who has met all other requirements for approval to practice but who is awaiting notification of successful completion of the national certification examination, temporary approval may be granted. In temporary status, an NP has limited privileges, including review and countersignature of notations by the supervising physician on every NP patient contact within seven days for the first six months, face-to-face consultation with the supervising physician weekly for a month, and, afterwards, face-to-face consultation monthly for a minimum of five months. Effective August 1, 2004, temporary approval is granted for a maximum of six months. Any NP being approved to practice for the first time is subject to the guidelines outlined for temporary approval status. Should an NP have a lapse in practice, change primary supervising physicians, or change written protocols, she or he is required to follow the temporary status guidelines for a minimum of six months and to notify both Boards of the changes.

Initially, as with PAs, there must be a defined collaborative practice agreement that is site-specific and serves as a guideline in defining the scope of the NP's practice. It must include a drug and device agreement and a predetermined plan for emergencies. Should a clinical practice issue arise not included in the collaborative practice agreement, the NP and the supervising physician are required to consult and document the action taken. Collaborative practice agreements must be reviewed annually. On request by the Board of Nursing and the Medical Board, the NP must also demonstrate the ability to perform the medical acts outlined in the agreement.

In addition, the administrative rules further require a Quality Improvement Process (QIP) to be reviewed every six months. The NP and supervising physician team must develop a process that includes the description of a clinical problem, evaluation of the treatment used, and a plan to improve outcomes. All consultations between the NP and the supervising physician, including the QIP, should be signed by both and kept for review by the Boards upon request.

Clinical Pharmacist Practitioners

CPPs are newly appointed health professionals in our state authorized by the legislature to provide drug therapy management to patients under the supervision of a licensed physician. To practice, a CPP must obtain approval from both the North Carolina Board of Pharmacy and the North Carolina Medical Board. Like PAs and NPs, CPPs are required to produce a signed agreement with their supervising physician, as well as maintain a copy at each practice setting. The agreement shall be specific in regard to the physician, pharmacist, patient, and disease. In the agreement, the CPP must specify the predetermined drug therapy (including diagnosis and product selection by the patient's physician), any modifications that may be permitted, dosage forms, dosage schedules, and tests that may be ordered. In addition, weekly quality control meetings must be scheduled to review and countersign all orders.

"Before beginning employment, it is necessary that an NP receive written confirmation of approval to practice"

To apply for approval, the CPP candidate must hold a current, unrestricted North Carolina pharmacy license and must meet one of the following qualifications: (1) he or she may be certified by the Board of Pharmaceutical Specialties, be a certified geriatric pharmacist, or have completed an American Society of Health System Pharmacists' residency program with two years clinical experience approved by the Boards; (2) he or she may hold the academic degree of doctor of pharmacy with three years clinical experience approved by the Boards; (3) he or she may hold the academic degree of bachelor of science in pharmacy with five years clinical experience approved by the Boards and have completed two NCCPC or ACPE approved certification programs. Submission of an application and an endorsement by the Pharmacy Board is required, along with appropriate fees, and, as noted earlier, a signed supervising physician agreement (21 NCAC 32T .0101). The supervising physician is responsible for ongoing supervision and evaluation of the drug therapy management performed by the CPP, and shall review and countersign each order written by the CPP within seven days.

Conclusion

PAs, NPs, and CPPs make a vital contribution to the well-being and health care management of the public. In each field, an individual's approval to practice may

be restricted, denied, or terminated should the Medical Board determine she or he has violated the related laws and rules governing that field.

While practicing, these professionals must wear an identification tag displaying their professional title. North Carolina Administrative Code 32S .0113 states it is "unethical and dishonorable to represent oneself as a physician." Only an individual licensed and approved by the North Carolina Medical Board may legally identify himself or herself as a physician and serve as a supervisor for physician extenders.

"Supervising physicians are not only accountable for their own actions, but for the actions of the practitioners they are supervising"

Physicians who are in post-graduate training or resident training programs are not eligible to supervise PAs, NPs, or CPPs. Among a variety of additional responsibilities, supervising physicians are not only accountable for their own actions, but for the actions of the practitioners they are supervising. In North Carolina, all practitioners are expected to practice within the standards of care in our state. Failure to function in accordance with any provisions outlined in NCGS 90-14(a) of the Medical Practice Act or administrative rules may result in the Board initiating an investigation and/or disciplinary action against the offending physician.

Each year, practitioners are required to register and pay all appropriate fees. Should a practitioner make a change in his or her supervising physician, scope of practice, practice address, public address, or name, it is necessary to inform the Board within 15 days so the Board's records may reflect a practitioner's most current information. In addition, all practitioners in these three health care professions are responsible for accumulating credit hours for continuing education.

Guidelines for specific requirements for each individual practitioner, as well as information on licensing, rules, and statutes, can be found by visiting the Board's Web site at *www.ncmedboard.org*.

The author wishes to thank Michael E. Norins, MD, NCMB member; Marcus Jimison, JD, NCMB staff; Alexa K. Mallard, NCMB staff; and Dena M. Marshall, NCMB staff, for their assistance in preparation of this article.

PA documents <u>you must have on site</u>

- Proof of licensure and registration
- Statement of supervisory arrangement with primary supervising physician
- Signed and dated record of meetings between MD and PA relevant to clinical problems and QI measures
- List of all back-up supervising physicians, signed and dated by physicians and PA
- CME documentation
- Written prescribing instructions
- DEA Registration and Pharmacy Permit, if held

Suggested materials to keep on site

- NCGS 90-18.1
- Administrative Rules (NCAC 32S)
- Intent to practice acknowledgement
- Copies of correspondence with Board
- Blank intent to practice form
- Valid prescription blank

NP documents <u>you must have on site</u>

- Proof of RN licensure, registration, and approval to practice
- Signed and dated list of all backup supervising physicians
- Collaborative Practice Agreement with documentation of annual protocol review
- CE documentation
- Quality Improvement Process document as well as documentation of nurse practitioner – physician consultation meetings
- DEA Registration and Pharmacy Permit, if held

Suggested materials to keep on site

- Valid prescription blank
- NCGS 90-18.2, NCGS 90-171.19, et. seq
- Administrative Rules
- Acknowledgement/Approval to practice by both Boards
- Copies of correspondence to and from the Board

CPP documents <u>you must have on site</u>

- Signed CPP agreement with the primary supervising physician
- CE documentation

Suggested materials to keep on site

- NCGS, et seq.
- Administrative Rules
- Acknowledgement/Approval to practice by both Boards
- Copies of correspondence to and from the Board

REVIEW

Patient-Centered Care

E. K. Fretwell, PhD
Member, NCMB

Dr Fretwell

Is patient-centered care a cliche, or is it a significant concept whose time has come? That's the question thoughtfully presented and answered in *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*.

In 1993, when the first edition of this stimulating book came out, patient-centered care (PCC) was a relatively new concept, stimulated by recent studies such as those found in this book, which was sponsored by the Picker/Commonwealth Program for PCC. The observations and recommendations it presents are based on extensive nationwide research using, among other techniques, questionnaires, focus groups, and institutional visits. Participants included patients and former patients, their families, and many categories of health workers.

While quality in patient care obviously includes technical excellence, it is becoming increasingly clear that there must be a significant emphasis on the subjective experience of patients and their families. As its title, *Through the Patient's Eyes*, suggests, this book addresses three principal questions that arise from that emphasis.

- How do patients' interactions with health care providers, institutions, and systems affect their experience of illness and well-being?
- How do those systems work, or fail to work, to meet patients' needs?
- How can health care providers, managers, and planners incorporate the patients' perspectives to improve health care quality?

Is attention to patients' desires and needs merely a "touchy-feely" form of coddling patients? Hardly! Drawing on extensive research, the highly-qualified authors and editors repeatedly point out practical and observable results.

- Family members, close friends, and significant others can have a far greater impact on patients' experience of illness, and on their long-term health and happiness, than any health care professional.
- Family involvement in programs of prevention, treatment, and rehabilitation has been shown to speed patients' rate of recovery and lower the risk of mortality.
- Patients who are able to take a more active part in their care have a better recovery.
- Improved patient/provider communication on the non-technical issues has a significant impact on patient satisfaction and a positive effect on health outcomes.
- Addressing patients' emotional needs can be cost effective. Patients who have such support leave the hospital earlier.
- In outpatient situations where families trained as case managers are used, less time is required by social workers. These patients are more likely to adhere to medical regimes when they are encouraged by family members' expectations.

What, then, are perceived by the authors as the primary dimensions of PCC? They list seven:

1. respect for patients' values;
2. coordination and integration of care;
3. information, communication, and education;
4. physical comfort;
5. emotional support and alleviation of fear;
6. involvement of family and friends;
7. transition and continuity.

Each of the 12 chapters of the book, written by physicians and other experienced health professionals, focuses on one of the planks that make up the basic platform of PCC. The first nine provide observations and suggested action. They relate to the individuality of patients, how patients perceive their caregivers, the importance of communication, the improvement of PCC education, minimizing physical trauma, needs for emotional support, the role of families and other caregivers, and the need for continuity of care following hospital discharge.

The final three chapters may be of greatest interest. They are presented as "essays with broader focus, addressing questions about PCC and the larger environment of health care." Questions addressed: What makes some hospitals more patient centered than others? How can doctors become more involved in PCC? How does PCC fit in with health care policy standards and regulations?

Health policy specialists Margaret Gerties and Marc Roberts provide some hard-nosed observations for hospital management people: "Whether hospitals know it or not, their reputations for PCC precede them."

Increasingly, well-informed patients are making their own choices of hospitals, the authors report. They are as aware of those that are known for their kindness and sensitivity as they are of those claiming technical expertise in a particular clinical specialty. And patients balance these considerations when they weigh their alternatives.

Almost all of the top-performing hospitals, a survey reports, and non-teaching hospitals are located in small, relatively homogeneous communities. In con-

"It is becoming increasingly clear that there must be a significant emphasis on the subjective experience of patients and their families"

trast, large, urban academic health centers, facing a wide variety of demands, are seen as the less attractive options for patients. Management of the latter is particularly challenged. "Byzantine lines of authority and governance typically connect the administration of the hospital with the medical school, the parent university, and, in public institutions, spread out to involve civil service systems, government bureaucracies, and even legislative processes."

It should surprise no one that the quality of management in all settings is absolutely critical. "Whether expressed in religious, social, or medical terms, the mission of service [must be] clearly articulated and modeled by top management and [must] permeate every facet of institutional life."

The Mayo Clinic, one of the centers visited, sees its three-part mission concerning patient care, research, and education as a tricycle, with patient care as the lead "wheel" pulling the other two.

Selective hiring at all levels is vital. The rural work ethic in new employees is cited as being desirable, but many large urban hospitals have to search hard to locate this luxury. Interview procedures for new hires would do well to gauge qualities of "compassion, openness to new ways of doing things, (and) the ability to work as part of a team."

" 'Even the top performing hospitals we visited were not very successful in involving physicians in internal administrative operations, decision-making, or strategic planning' "

A successful patient care hospital does not develop solely by a few lofty proclamations. "Everyone must be involved," the authors insist, "not just the yea-sayers, and they must be involved in a way that seriously addresses their interests and concerns." Achieving the mission requires hard work over a period of time!

What of the top executive? "Those whose career paths require quick successes are bound to be frustrated; they may be able to create a flashy stir, but they are unlikely to leave behind an organization with the capacity to carry through its mission."

In brief, managers must be committed to asking patients regularly to evaluate total performance of the hospital. It is no understatement that those who deliver the services are the ones who will ultimately determine the quality of performance. And the role of middle management, both as an inspirer and as a potential inhibitor, should be noted.

The management of patient care systems clearly requires the involvement of physicians, but the authors report that "even the top performing hospitals we visited were not very successful in involving physicians in internal administrative operations, decision-making, or strategic planning." There may be justifiable reasons for this, but the problem remains.

Thomas Delbanco, MD, of Boston's Beth Israel Hospital and Harvard Medical, director of the Picker/Commonwealth Program, in his concluding chapter, finds that doctors were "exasperated" when they were only rarely involved in efforts to improve the patient's experience. Doctors reported their belief that hospital managers and nurses were excluding them from addressing clinical issues and, as a result, physicians saw so many hassles that they had "neither the energy nor the time to tackle the issues" addressed in this book.

Useful strategies for addressing these problems include:

- invitations by hospital staff to doctors to work with them in active and collaborative ways;
- using focus groups of patients to show doctors what patients say;
- convening focus groups of doctors who would then encourage nurses, social workers, and administrators to review issues raised by doctors;
- encouraging doctors and patients to improve the way they communicate;
- sharing testimonials from patients that describe and praise specific beneficial actions by doctors.

And an admonition: hospitals need to understand what it is to be a doctor.

Even though most of the findings are at least 10 years old, this volume is a "must read" for all those—physicians, other health professionals, patients, family members, and concerned citizens—who care about the quality of health care in these challenging times.

Through the Patient's Eyes:
Understanding and Promoting Patient-Centered Care
M. Gerteis, S. Edgman-Levitan, J. Daley, T.L. Delbanco, eds
Jossey-Bass/John Wiley & Sons, Inc, San Francisco, 1993
317 pages, $28 (paperback edition, 2002)
[Includes: bibliographies, name and subject indices]

The several authors are successful in presenting their message clearly. They write with a minimum of medical jargon and provide a continuity of style and a unity of approach not always found in a many-authored report. General organization of the volume is excellent, and subheadings, individual chapter summaries, and extensive bibliographies are provided.

Clearly, an updated volume would be valuable. Although the final chapter contains positive and upbeat themes, I found myself, as a laymen, wanting more detailed answers to two crucial questions:

- Where has there been significant movement, of a positive nature, toward patient-centered care over the decade since the original book was written and what can be learned from resulting successes and failures?
- At a time of increased demands for care, shortages of personnel and facilities, cascading costs of health care and insurance (often billed to the patient), what hopes are there for expanding rather than rationing truly patient-centered care?

Any recent pertinent findings from the Picker/Commonwealth efforts should be widely circulated and all elements of the health care enterprise should be encouraged to "buy in" and seek solutions.

Altogether, the Picker/Commonwealth Program for Patient-Centered Care has made a significant contribution to the national dialogue on health care and deserves our thanks and encouragement.

NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
February - March - April 2004

DEFINITIONS

Annulment:
Retrospective and prospective cancellation of the authorization to practice.

Conditions:
A term used for this report to indicate restrictions or requirements placed on the licensee/license.

Consent Order:
An order of the Board and an agreement between the Board and the practitioner regarding the annulment, revocation, or suspension of the authorization to practice or the conditions and/or limitations placed on the authorization to practice. (A method for resolving disputes through informal procedures.)

Denial:
Final decision denying an application for practice authorization 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 or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.

ANNULMENTS

NONE

REVOCATIONS

CAUGHEY, Michael Thomas, MD
Location: Virginia Beach, VA
DOB: 1/06/1956
License #: 0000-35606
Specialty: EM/IM (as reported by physician)
Medical Ed: Eastern Virginia (1990)
Cause: Felony conviction of Dr Caughey in Commonwealth of Virginia v. Michael Thomas Caughey, case number CR 02-3350 and CR 02-3704. No request for a hearing was received from Dr Caughey within 60 days of his being notified of this potential action.
Action: 4/21/2004. Entry of Revocation issued; Dr Caughey's North Carolina license is revoked by operation of law as of 4/19/2004.

McCONVILLE, Robert N., Physician Assistant
Location: Shalotte, NC (Brunswick Co)
DOB: 12/23/1968
License #: 0001-02280
PA Education: Gannon University (1993)
Cause: Mr McConville was convicted of a felony in Monroe County and Brighton Town Court, New York, on or about 5/13/1996.
Action: 2/04/2004. Entry of Revocation issued: Mr McConville's PA license is revoked.

SUSPENSIONS

LUSTGARTEN, Gary James, MD
Location: North Miami Beach, FL
DOB: 2/26/1941
License #: 0000-25725
Specialty: NS (as reported by physician)
Medical Ed: University of Iowa (1965)
Cause: On April 17, 2003, after hearing an appeal of a previous action of the Board concerning Dr Lustgarten, Judge D. Stephens, Wake County Superior Court, affirmed a portion of the Board's earlier findings in Dr Lustgarten's case, which stated Dr Lustgarten had testified without a good faith or evidentiary basis that a physician in a malpractice action had falsified medical records. Judge Stephens remanded the case to the Board for a new Phase Two hearing. That hearing was held on November 21, 2003, and was limited to determining appropriate discipline for Dr Lustgarten's unprofessional conduct in testifying without a good faith or evidentiary basis that the physician in question falsified medical records.
Action: 3/30/2004. Findings of Fact and Order of Discipline Following Second Hearing: Dr Lustgarten's license is suspended for one year; he shall deliver his license and registration certificate to the Board's office within 30 days.

LUTZ, Robert Paul, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 5/05/1948
License #: 0000-27387
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1982)
Cause: At a hearing on 1/23/2004, the Board found Dr Lutz suffers from ADD and bipolar disorder. He has been prescribed medication to control his bipolar disorder. On 6/06/2003, he was hired as a locum tenens at an urgent care facility in Jacksonville. On that day, the staff of the facility saw him appearing disheveled and on more than one occasion acting in a strange and inappropriate manner. He left the facility for a time saying he had to get a prescription filled. He returned saying he had taken his medication. During the day, he discussed his intimate problems with staff, requested a hug from a nurse, and told one female patient he admired her ring and asked her to go to his car with him so he could show her his ring. He disputed the last point, saying he asked the woman to go with him to his car to show her a rock that contained a green stone. The female patient complained to the staff about the incident. In another situation, Dr Lutz was asked to examine a patient who complained about an injured foot. Dr Lutz removed the patient's footwear and threw it across the room. He then chastised the patient, saying there was nothing wrong with him and that he was "lazy." In fact, the patient had a broken foot. The urgent care administrator asked Dr Lutz to leave and not return the next day. On 9/16/2003, Dr Lutz entered the home of a woman in Watauga County. He was naked when he entered

the home. He sat on the floor beside a couch where the woman was sitting. She asked him if he could speak and he shook his head "no" and then flashed symbols with his hands. He then said in a loud voice that he could only talk when he was mad and that he hated many things, including the woman and God. The woman called her son-in-law, who called his wife, who in turn called the Watauga County Sheriff's Department. Dr Lutz was arrested that day and charged with indecent exposure. Dr Lutz testified that he felt sorry about making the woman uncomfortable and that he was engaging in "anger speak" when he started talking to her. He further said he felt as though he was in control of his mental faculties when he appeared at the woman's home naked and started talking in "anger speak." Dr Lutz has had prior dealings with the Board that raised concerns about his fitness to practice. In June 1995, he was involuntarily committed to a hospital experiencing domestic difficulties. That same year, he was convicted of misdemeanor assault on a police officer. In July 1995, he surrendered his license to the Board as a result of the 1995 incidents. The Board concluded Dr Lutz is unable to practice with reasonable skill and safety and that his behavior constitutes unprofessional conduct.

Action: 3/12/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Lutz' license is suspended indefinitely; he may not make application for reinstatement for six months from the date of the Order; should he submit an application, he must first submit himself to the NCPHP and secure the NCPHP's advocacy for his reinstatement before the Board will consider it. However, the Board reserves the right to deny such application not withstanding any position the NCPHP may take.

See Consent Orders:
DIAMOND, Patrick Francis, MD
EATON, Hubert Arthur, Jr, MD
GAFFNEY, Mary Elizabeth, DO
GUTHRIE, Stephen Day, MD
HARBIEH, Jamil George, Physician Assistant
KEITH, Douglas Charles, MD
MOIR, Ronald Jeffrey, MD
NUSCHKE, Randell Allen, MD
PHELPS, Charles Ray, II, MD
PIERCE, Charles Grainger, MD
WILSON, Lawrence Steven, MD

SUMMARY SUSPENSIONS

AMSELLEM, David, MD
Location: Goldsboro, NC (Wayne Co)
DOB: 6/06/1946
License #: 0000-20869
Specialty: PYM/N (as reported by physician)
Medical Ed: University of Montpellier, France (1973)
Cause: Dr Amsellem may be unable to practice medicine with reasonable skill and safety, to wit: he has a history of psychotic disorder, specifically, schizophrenia.
Action: 3/10/2004. Summary Suspension of medical license.

CONSENT ORDERS

ADIX, Michael Lee, DO
Location: Kings Mountain, NC (Cleveland Co)
DOB: 3/08/1955
License #: 0094-01112
Specialty: IM/EM (as reported by physician)
Medical Ed: University of Health Sciences, Osteopathic (1984)
Cause: Relative to the Notice of Charges and Allegations filed 8/21/2003. In a complaint, a former employee of Dr Adix alleged some patients were receiving excessive amounts of controlled substances. The Board ordered him to produce medical records on five patients. These were reviewed by an expert who criticized Dr Adix's prescribing for the patients. Dr Adix continued to care for the five patients after he was ordered to produce the records. In the interim between the order to produce and the Board's issuance of charges, Dr Adix discharged four of the patients when he became convinced they were not following the agreed conditions for their care and for his prescribing for them. As for the fifth patient, Dr Adix has involved physical therapists, a neurosurgeon, and a pain clinic in her care. Dr Adix's prescribing for these patients reflected he was not as attuned as he might have been to the possibility a patient might abuse the prescribed drugs. Pain patients represent only a small fraction of his patient population and his prescribing for them can be improved by his attending specialized CME on the subject. His prescribing practices on the five patients reviewed constituted unprofessional conduct.
Action: 4/22/2004. Consent Order executed: Dr Adix is reprimanded; at his own expense he shall attend Vanderbilt University's Prescribing Controlled Drugs CME program; must comply with other conditions.

BALL, Alan Ray, Physician Assistant
Location: Hayesville, NC (Clay Co)
DOB: 8/15/1955
License #: 0001-01778
PA Education: Emory University (1979)
Cause: At the time he began treating patients in June 2000 at his clinic in Hayesville, Mr Ball did not have a supervising physician as required by law. He did not receive Board approval for a supervising physician until October 2000 nor did he have a statement of supervisory arrangements with a supervising physician on site.
Action: 2/26/2004. Consent Order executed: Mr Ball is reprimanded; he shall obey all laws and notify the Board within 10 days of change in his residence or practice address.

DIAMOND, Patrick Francis, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 5/15/1946
License #: 0098-00042
Specialty: FP (as reported by physician)
Medical Ed: Autonomous University Tamaulipas, Mexico (1987)
Cause: Relative to the Notice of Charges and Allegations against Dr Diamond dated 8/05/2003. In 1998, the Board issued him a temporary license. In June 1999, the Board summarily suspended his license and filed charges against him based on evidence he prescribed Nubain® for himself. He admitted he had a substance abuse and chemical dependence problem and, in August 1999, he signed a Consent Order to resolve the charges. In November 1999, he surrendered his temporary license after he relapsed by taking Nubain®. In the fall of 2000, his license was reinstated pursuant to a Consent Order that required he continue his involvement with the NCPHP, not work more than 30 hours a week, and submit to random drug screens. In October 2001, he signed a third Consent Order increasing his allowed work hours to 40. In meeting with the Board in February 2003, he was admonished for his refusal of drug screens and his lack of attendance at recovery meetings. During 2003, he moved his office from Burgaw to Wilmington. Just prior to that, he was charged by the Burgaw police with Interfering with a Utility Meter and Disorderly Conduct, both misdemeanors, for reconnecting his water service, which had been disconnected for nonpayment. The Disorderly Conduct charge arose from his directing profanity at a city employee when confronted about the water meter. In May 2003, he was granted a deferred prosecution for the Interfering charge pursuant to a plea agreement. That agreement provided he must serve 12 months unsupervised probation, pay $400 in fines and costs, complete eight hours community service, and issue a letter of apology to the Town of Burgaw and the town employee he cursed. In spring 2003, he was difficult to locate for the monitoring required in his Consent Order. He did not inform the NCPHP of his new address and telephone number and the NCPHP could not reach him. In May 2003, the NCPHP field coordinator spoke with Dr Diamond and told him he would have to use a daily telephone contact system with the NCPHP to see if he were scheduled for drug screen that day. This approach provides stricter monitoring of NCPHP participants. Dr Diamond initially said he would be unable to use this system. As a result of Dr Diamond's actions, the NCPHP concluded he was in violation of his NCPHP contract. The Board voted to summarily suspend Dr Diamond's license or allow him to voluntarily surrender his license. He surrendered his license of 6/27/2003. By his actions, he violated his 2001 Consent Order. His behavior toward the NCPHP staff and personnel of the Town of

Burgaw and his prosecution for disorderly conduct and interfering with a utility meter constituted unprofessional conduct.

Action: 2/19/2004. Consent Order executed: Dr Diamond's license is suspended indefinitely; he may make application for reinstatement no sooner than 12 months form the date of his surrender of his license, which was 6/27/2003; prior to making any application, he shall make a full apology, acceptable to the Board's president, to the Town of Burgaw employee he cursed; he must also
sign, maintain, and abide by a contract with the NCPHP; must comply with other conditions.

EATON, Hubert Arthur, Jr, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 5/25/1943
License #: 0000-17858
Specialty: IM (as reported by physician)
Medical Ed: Meharry Medical College (1969)
Cause: Dr Eaton prescribed an excessive dosage of Adderrall XR™ to a nine-year-old child and the child was subsequently found to suffer from side effects of that dosage, including anorexia, sedation, and insomnia. Also, Dr Eaton admits he gave his wife prescriptions he had written for large quantities of hydrocodone and Adderrall XR™, prescriptions written to someone else. His wife presented those prescriptions to numerous pharmacies in the Wilmington area. Dr Eaton admits his purpose was to obtain controlled substances for his own use. In February 2003, Mrs Eaton obtained 360 dosage units of hydrocodone and 120 of Adderrall XR™ from four different pharmacies. In August 2003, Dr Eaton was convicted in New Hanover County District Court of two counts of misdemeanor Obtaining Controlled Substances by Fraud and was placed on supervised probation for two years. In 2000, Dr Eaton diverted drug samples for his own use. He also ingested controlled substances containing hydrocodone during office hours. He also routinely advised his staff to issue prescriptions for controlled substances to patients for their payment of a $55 fee. He did not perform adequate examinations of those patients. He routinely pre-signed prescriptions and failed to maintain adequate patient records. In July 1999, New Hanover Regional Medical Center notified the Board that Dr Eaton had voluntarily relinquished his hospital privileges for the third time in a calendar year due to delinquent medical records. In July 2000, the Board was notified Dr Eaton had been decredentialed by Blue Cross-Blue Shield for failure to meet minimum medical record standards. In July 2001, United Healthcare notified the Board it had terminated Dr Eaton from its provider network. Dr Eaton was summarily suspended by the Board in May 2003. In January 2004, Dr Eaton completed a 12-week residential substance abuse program at the Farley Center in Williamsburg, VA, and signed a five-year contract with the NCPHP.
Action: 2/19/2004. Consent Order executed: Dr Eaton's license is suspended indefinitely, suspension being retroactive to May 15, 2003, and continuing indefinitely; he shall not reapply for at least one year from the date of his suspension; he shall surrender his DEA license and shall not prescribe controlled substances until authorized by the Board.

GAFFNEY, Mary Elizabeth, DO
Location: Charlotte, NC (Mecklenburg Co)
DOB: 6/08/1965
License #: 0096-01319
Specialty: FP/EM (as reported by physician)
Medical Ed: Michigan State University (1991)
Cause: Related to Charges and Allegations preferred against her in January 2004. In February 2002, following discussions with Dr Gaffney regarding treatment of Patient A and the quality of her medical records, the Board requested Dr Gaffney implement a new record-keeping system as she had said she planned to do. It also invited her to an interview in December 2002 to discuss implementation of her electronic records system. She postponed that interview and asked it be rescheduled for March 2003, saying the record system should be in place by that time. Continuing correspondence with her indicated the system was not implemented as 2003 went forward, and she continued to postpone interviews with the Board. She failed to appear at a scheduled interview in September 2003. At that point, the Board ordered her to appear in January 2004. This order was hand-delivered to her. She did not appear for the January interview but faxed a message late in the interview day saying she was still negotiating for the EMR system. As a result, the Board determined her failure to comply with the Boards' Order to Appear constituted unprofessional conduct.
Action: 3/19/2004. Consent Order executed: Dr Gaffney's license is suspended for 90 days, with all but 30 days being stayed; suspension shall begin on May 19, 2004. The 60 days of stayed suspension is contingent on the following terms and conditions: Dr Gaffney shall be fully compliant with all Board Orders, requirements, and recommendations in the future; she shall write an article for the NCMB Forum describing her experience and encouraging physicians to respond to the Board's requests and to respect the Board's authority; she shall follow up her initial evaluation with Dr Hillsman and obtain from him a referral to a psychotherapist in Charlotte who is approved by the NCPHP to provide a brief trial of directed psychotherapy as determined by Dr Hillsman; must comply with other conditions.

GUTHRIE, Stephen Day, MD
Location: Mineola, NY
DOB: 1/31/1945
License #: 0093-00711
Specialty: PS/GS (as reported by physician)
Medical Ed: University of Wisconsin (1975)
Cause: In December 2001, Dr Guthrie entered a Consent Order with the New York State State Board for Professional Medical Conduct in which he admitted professional misconduct in his willfully making or filing a false report, or failing to file a report as required by law or by the Department of Health or Education, and by abusing alcohol. His license was suspended for three years, which suspension was stayed. He was placed on probation for three years. In December 2002, the Wisconsin Medical Examining Board ordered limitations placed on his license based on the New York action.
Action: 4/28/2004. Consent Order executed: Dr Guthrie's North Carolina license is supended for three years, which suspension is stayed conditioned on his compliance with the New York Board and the Order of the Wisconsin Board; must comply with other conditions.

HARBIEH, Jamil George, Physician Assistant
Location: Wilson, NC (Wilson Co)
DOB: 9/25/1967
License #: 0001-03978
PA Education: Alderson Broaddus College PA Program (2003)
Cause: On his application for a PA license in October 2003, Mr Harbieh answered "no" to a question asking if he had ever been convicted of, pled guilty to, pled no contest to, or received a prayer for judgment to a violation of law. However, in 1987, he had pled guilty to a misdemeanor retail theft charge in Pennsylvania. In an interview with the Board, he explained this failure to disclose the information was unintentional. The matter involved a single item not rung up properly when checking out of a retail store. He was 19 at the time and had come to the United States quite recently. His English was not adequate to explain the situation to store personnel. A relative advised him to simply pay the fine and put the matter behind him. He did not recall the incident until December 2003 when traveling to Pennsylvania.
Action: 2/18/2004. Consent Order executed: Mr Harbieh is granted a full and unrestricted license as a physician assistant. That license is suspended for 30 days, suspension being stayed on condition that he abide by all rules and regulations relating to his function as a PA.

HUNLEY, Stephen Orby, MD
Location: Morehead City, NC (Carteret Co)
DOB: 4/20/1966
License #: 0096-01345
Specialty: IM/C (as reported by physician)
Medical Ed: University of Kentucky (1993)
Cause: Dr Hunley began treating Patient A in 2002. Subsequently, he told Patient A on several occasions that he was no longer her treating cardiologist. In April 2003, though he had ended the physician-patient relationship, he wrote her a prescription,

with refills, for diltiazem hydrochloride.
Action: 4/07/2004. Consent Order executed: Dr Hunley is reprimanded; must comply with the Board's position statement on Writing of Prescriptions.

KEARSE, William Oliver, Jr, MD
Location: Lubbock, TX
DOB: 1/22/1944
License #: 0000-15952
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1968)
Cause: Dr Kearse was disciplined by the Texas Board for prescribing controlled substances to two patients in a non-therapeutic manner and that he failed to maintain adequate records on those patients. He had no previous record with the Texas Board and cooperated with its investigation. He was ordered to pay a penalty, restrictions were placed on his license and his prescribing, and additional CME was required of him.
Action: 3/03/2004, Consent Order executed: Dr Kearse is reprimanded; prior to resuming practice in North Carolina, he must submit a complete application and obtain practice site approval from the president of the Board.

KEITH, Douglas Charles, MD
Location: Garner, NC (Wake Co)
DOB: 3/08/1951
License #: 0000-30184
Specialty: FP/OM (as reported by physician)
Medical Ed: Universidad Autonoma Guadalajara, Mexico (1981)
Cause: In the summer of 2002, Dr Keith altered the medical record of several patients who had been examined by his PA. He added check marks to the examination template sheet for specific examinations the PA had not performed. In March 2002, a patient presented to Dr Keith for evaluation of injuries she advised his staff she received after being involved in a motor vehicle accident. Subsequently, Dr Keith made an entry in the patient's record that was inconsistent with the prior entry made by his office staff concerning the etiology of the patient's pain.
Action: 2/18/2004. Consent Order executed: Dr Keith's license is suspended for 60 days, that suspension being stayed immediately.

LOVATO, Frank James, Physician Assistant
Location: Fayetteville, NC (Cumberland Co)
DOB: 12/02/1950
License #: 0001-02071
PA Education: Ft Sam Houston (1983)
Cause: Under a Consent Order of April 2001, Mr Lovato received a six-month stayed suspension of his license due, among other things, to prescribing excessive quantities of narcotics. He violated the Consent Order by failing to submit to the Board a copy of a controlled substance log as required by the Consent Order and by failing to have his supervising physicians send reports of his practice to the Board as required by the Consent Order. He also violated the Consent Order by prescribing controlled substances after the six-month period of stayed suspension and by ceasing to keep a controlled substance log after that time. Further, he did not obtain written permission prior to engaging in practice with an additional supervising physician. He met with the Board in November 2003 to request termination of his Consent Order and said he believed the conditions of the Consent Order did not apply following the six-month period of stayed suspension.
Action: 4/01/2004. Consent Order executed: Mr Lovato is reprimanded for failing to abide by the terms of his April 2001 Consent Order; he shall obtain written permission from the Board prior to engaging in practice with any additional supervising physician; he shall provide a copy of the Consent Order to all his current and prospective supervising physicians; he shall meet with the Board or members of the Board in May 2004 and at other times as requested; he shall cause each of his supervising physicians to send reports of his practice to the Board as requested; must comply with other conditions. (The April 2001 Consent Order is dissolved.)

MOIR, Ronald Jeffrey, MD
Location: Morganton, NC (Burke Co)
DOB: 12/30/1956
License #: 0000-31176
Specialty: AN (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1984)
Cause: Related to the Charges and Allegations preferred against Dr Moir by the Board on 10/24/2003. Dr Moir surrendered his license on 3/20/2003 because, in December 2002, he took benzodiazepine from the drug cart for his own use to self-medicate for his depression. In January 2003, he entered treatment in Georgia for depression and substance abuse. In May 2003, he entered a contract with the NCPHP. He has successfully completed in-patient treatment, has complied with his NCPHP contract, and remains under out-patient care for depression and substance abuse. In July 2003, he pled guilty in North Carolina District Court to misdemeanor charges related to the events of December 2002. On December 31, 2003, the Court entered a Prayer for Judgment Continued on the charges. No final judgment has been entered.
Action: 3/19/2004. Consent Order executed: Dr Moir's license is indefinitely suspended effective 3/20/2003; that suspension is stayed with execution of the Consent Order; he is issued a temporary/dated license to expire on the date shown on the license [6/30/2004]; he shall surrender his DEA registration; he shall only practice in a setting and on a schedule approved by the president of the Board; unless lawfully prescribed for him by someone other than himself, he shall refrain from use of all mind- or mood-altering substances, and shall notify the Board within 10 days of any such use, which notice must include the name of the prescribing physician or dentist and the pharmacy filling the prescription; he shall furnish bodily fluids or tissues for screening at the request of the Board; he shall maintain and abide by his contract with the NCPHP; must comply with other conditions.

NUSCHKE, Randell Allen, MD
Location: Cape May Court House, NJ
DOB: 11/15/1949
License #: 2004-00287
Specialty: IM (as reported by physician)
Medical Ed: University of Guadalajara, Mexico (1981)
Cause: On Dr Nuschke's application for a license. In December 2002, Dr Nuschke applied for a North Carolina license. On his application form, he answered "no" to the question asking if he had ever been convicted of or pled guilty or no contest to a violation of law. During its criminal background check, the Board found Dr Nuschke had been arrested in Pennsylvania and charged with burglary and larceny in 1970. In 1971, he pled guilty to the charge of larceny and was fined $100. The burglary charge was dismissed. Dr Nuschke says he did not intend to mislead the Board by answering the question as he did.
Action: 3/24/2004. Consent Order executed: Dr Nuschke is granted a license, which is suspended for 30 days. Suspension is stayed provided he abides by all laws, rules, and regulations in the future.

PHELPS, Charles Ray, II, MD
Location: Sherman, TX
DOB: 8/28/1950
License #: 0000-23073
Specialty: DR (as reported by physician)
Medical Ed: University of Texas Medical Branch, Galveston (1976)
Cause: In June 2003, the Texas Board restricted Dr Phelps' license and placed him on probation for five years based on his addiction to alcohol and his arrest for driving while impaired.
Action: 4/26/2004. Consent Order executed: Dr Phelps' North Carolina license is suspended for one year, which suspension is stayed on terms and conditions, including his compliance with the Order of the Texas Board.

PIERCE, Charles Grainger, MD
Location: Ahoskie, NC (Hertford Co)
DOB: 4/06/1946
License #: 0000-22162
Specialty: PD (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1975)
Cause: In September 2002, Dr Pierce pled guilty to Making False Statements on an income tax return, a felony, in U.S. District Court in the Eastern District of North Carolina. He was sentenced to five years probation. The Board determined Dr Pierce did not knowingly attempt to defraud the U.S. govern-

ment and he immediately instructed his accountant to re-file the tax returns in question. He has paid all taxes and interest due. The Office of Inspector General reports Dr Pierce has fully cooperated with that office and all other parties and has satisfied all requirements of his Integrity Agreement for the first reporting year. CMS did not conclude that Dr Pierce's conduct warranted exclusion from participation in Medicare and Medicaid programs.

Action: 4/22/2004. Consent Order executed: Dr Pierce's license is suspended for three months, such suspension stayed on condition that he agree to abide by all laws, rules, and regulations in future; that he agree to satisfy all requirements of the Integrity Agreement with the Office of the Inspector General; that he submit to the Board a statement from the OIG verifying those requirements are being satisfied; comply with other conditions.

VAUGHAN, Howell Anderson, Physician Assistant
Location: Knightdale, NC (Wake Co)
DOB: 3/31/1958
License #: 0001-01513
PA Education: Wake Forest University (1992)
Cause: Mr Vaughan has a history of abusing hydrocodone and other controlled substances. In December 1993, he surrendered his license and entered a Consent Order with the Board. Under a Consent Order of January 1995, modified in May 1997, he was reissued his PA license on conditions related to his recovery. Having relapsed, he surrendered his license again in October 1999. In August 2000, he entered another Consent Order. In August 2001, he again relapsed and surrendered his license a third time. In February 2003, he entered another Consent Order with the Board, agreeing to a contract with the NCPHP and to surrender his DEA registration. In July 2003, he wrote several prescriptions for controlled substances to his patients and requested another PA co-sign the prescriptions for patients that PA had not examined. These acts violate his Consent Order of February 2003.
Action: 3/18/2004. Consent Order executed: Mr Vaughan is reprimanded; unless lawfully prescribed for him by someone other than himself, he shall refrain from use of all mind- or mood-altering substances, controlled substances, and alcohol, and shall notify the Board within two weeks of any such use, which notice must include the name of the prescribing physician or dentist and the pharmacy filling the prescription; he shall furnish bodily fluids or tissues for screening at the request of the Board; he shall maintain and abide by his contract with the NCPHP; he shall surrender any DEA registrations and shall not reapply; he shall not order, prescribe, administer, or dispense, or, except as noted above, possess any controlled substances; must comply with other conditions.

VILLEGAS, Henry Alberto, MD
Location: Gainesville, FL
DOB: 8/19/1950
License #: 2004-00180
Specialty: PD (as reported by physician)
Medical Ed: Faculty of Medicine, University of Costa Rica (1977)
Cause: On an application for licensure. The Florida Board, through a consent order in 2002, disciplined Dr Villegas for failing to practice medicine with an acceptable level of care, skill, and treatment.
Action: 3/04/2004. Consent Order executed: Dr Villegas is issued a license in North Carolina; he is reprimanded; must comply with other conditions.

WALL, ShellyAnn, Physician Assistant
Location: Charlotte, NC (Mecklenburg Co)
DOB: 1/26/1968
License #: 0001-03723
PA Education: Medical College of Ohio PA Program (2002)
Cause: In answering a relevant question on her application for the PA license, Ms Wall failed to note she had been arrested in Biloxi, Mississippi, and was found guilty of misdemeanor charges of disorderly conduct in January 1999 and public drunkenness in March 1999. She was fined $172 and sentenced to time served.
Action: 4/14/2004. Consent Order executed: Ms Wall is reprimanded; must inform Board of any change of residence, work address, or primary supervising physician within 10 days; must comply with other conditions.

WHITE, Dale E., Physician Assistant
Location: Knightdale, NC (Wake Co)
DOB: 11/16/1956
License #: 0001-01583
PA Education: St. Francis College (1992)
Cause: Mr white owns and operates Carolina Express Care in Knightdale, where he employed Howell A. Vaughn, PA. Mr Vaughn practices as a PA pursuant to a Consent Order that prohibits him from prescribing, administering, dispensing, or ordering any controlled substances and ordered him to surrender his controlled substance registration to the DEA. Mr White was aware of the restrictions on Mr Vaughn. Mr Vaughn worked at Carolina Express Care with neither Mr White nor a physician on site. If he determined a patient needed a prescription for a controlled substance, he contacted Mr White by telephone and discussed the patients condition. Mr White would verbally authorize Mr Vaughn to prescribe the medications. Mr Vaughn would stamp his name on the prescription form, sign his name, and note "on order of Dale White, PA-C." Mr White did not personally examine the patients in these cases. By doing this, he violated the rules requiring physician supervision of PAs and requiring DEA registration by both the supervising physician and the PA. Mr White also dispensed pre-packed medications from Carolina Express without holding a permit from the Board of Pharmacy.
Action: 4/23/2004. Consent Order executed: Mr White is reprimanded; must comply with other conditions.

WILSON, Lawrence Steven, MD
Location: Valdese, NC (Burke Co)
DOB: 3/19/1952
License #: 0000-28715
Specialty: U (as reported by physician)
Medical Ed: State University of New York, Upstate-Syracuse (1977)
Cause: Related to the Charges and Allegations preferred against Dr Wilson by the Board on 12/18/2003. Dr Wilson traveled on overnight vacations with Patient A after she became a patient in October 2002. In the summer of 2003, he traveled with her to California, and in June 2003 he and Patient A opened a checking account together. Throughout this time, he continued to treat Patient A. In September 2002, he performed prostate surgery on her father. He wrote prescriptions for her father in the name of her father's wife, knowing the wife and not the father had insurance. In December 2003, Dr Wilson completed a 30-day residential treatment program. He has entered into a three-year contract with the NCPHP.
Action: 3/17/2004. Dr Wilson's license is suspended for six months. Suspension is stayed on the following terms: he shall maintain and abide by his contract with NCPHP and must comply with other conditions.

MISCELLANEOUS ACTIONS
NONE

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

DENIALS OF LICENSE/APPROVAL

MACKEY, William Frederick, Jr, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 10/20/1944
License #: 0000-19801
Specialty: CHP/P (as reported by physician)
Medical Ed: University of Tennessee, Memphis, College of Medicine (1969)
Cause: Matters discussed with him during an interview in January led the Board to deny his application. He is advised to contact the NCPHP prior to making reapplication.
Action: 2/03/2004. Letter issued denying Dr Mackey's application for a medical license. [Dr Mackey has requested a hearing on this denial.]

ROSNER, Michael John, MD
Location: Hendersonville, NC (Henderson Co)
DOB: 12/04/1946

License #: 0000-26865
Specialty: NS/NCC (as reported by physician)
Medical Ed: Virginia Commonwealth University School of Medicine (1972)
Cause: In the Board's Findings of Fact, Conclusions of Law, and Order of Discipline of 2/05/2003, Dr Rosner was found to have engaged in unprofessional conduct by performing surgery not medically indicated. Denial is based on that determination.
Action: 2/16/2004. Letter issued denying Dr Rosner's application for reinstatement of his license. [A hearing was requested on this matter.]

SURRENDERS

GURKIN, Worth Wicker, Jr, MD
Location: Greenville, NC (Pitt Co)
DOB: 3/06/1956
License #: 0000-29117
Specialty: PD (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1982)
Action: 3/11/2004. Voluntary surrender of medical license.

HAMBLETON, Scott Lewis, MD
Location: Shelby, NC (Cleveland Co)
DOB: 4/15/1963
License #: 2000-00444
Specialty: FP/EM (as reported by physician)
Medical Ed: University of Tennessee (1994)
Action: 3/18/2004. Voluntary surrender of medical license.

HEGE, Keith Jerome, Physician Assistant
Location: Yadkinville, NC (Yadkin Co)
DOB: 1/23/1956
License #: 0001-00981
PA Education: Bowman Gray (1986)
Action: 3/12/2004. Voluntary surrender of PA license.

HOOPER, Jeffrey Curtis, MD
Location: Greensboro, NC (Guilford Co)
DOB: 9/21/1964
License #: 0097-00286
Specialty: FP (as reported by physician)
Medical Ed: Vanderbilt School of Medicine (1995)
Action: 3/31/2004. Voluntary surrender of medical license.

JACOBS, Kenneth Lee, MD
Location: Faison, NC (Duplin Co)
DOB: 7/26/1959
License #: 0096-00953
Specialty: OBG (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1992)
Action: 2/02/2004. Voluntary surrender of medical license.

KOMJATHY, Steven Ferenc, MD
Location: Leland, NC (Brunswick Co)
DOB: 5/19/1969
License #: 0097-01440
Specialty: IM/GPM (as reported by physician)
Medical Ed: University of Maryland (1996)
Action: 4/01/2004. Voluntary surrender of medical license.

NGUYEN, Tuong Dai, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 4/11/1967
License #: 2000-00566
Specialty: IM (as reported by physician)
Medical Ed: Temple University (1996)
Action: 2/02/2004. Voluntary surrender of medical license.

WESSEL, Richard Fredrick, MD
Location: Elizabeth City, NC (Pasquotank Co)
DOB: 1/24/1959
License #: 0096-00772
Specialty: C/IM (as reported by physician)
Medical Ed: Eastern Virginia Medical School (1990)
Action: 4/15/2004. Voluntary surrender of medical license.

COURT APPEALS/STAYS
NONE

CONSENT ORDERS LIFTED

BERRY, David Don, MD
Location: Hickory, NC (Catawba Co)
DOB: 4/20/1952
License #: 0000-30288
Specialty: NPM/PD (as reported by physician)
Medical Ed: University of Texas Medical Branch, Galveston (1978)
Action: 4/21/2004. Order issued lifting the Consent Order of 6/19/2002.

LOVETTE, Kenneth Maurice, MD
Location: Tarboro, NC (Edgecombe Co)
DOB: 12/27/1949
License #: 0000-24606
Specialty: GYN (as reported by the physician)
Medical Ed: University of North Carolina School of Medicine (1979)
Action: 3/18/2004. Order issued lifting Consent Order of 8/7/2003.

McINTOSH, John Clarke, MD
Location: Hendersonville, NC (Henderson Co)
DOB: 7/16/1956
License #: 0000-36570
Specialty: PD/PDP (as reported by physician)
Medical Ed: Medical University of South Carolina (1981)
Action: 2/02/2004. Order issued lifting Consent Order of 10/18/2001.

SESSOMS, Rodney Kevin, MD
Location: Clinton, NC (Sampson Co)
DOB: 12/13/1961
License #: 0000-33927
Specialty: IM (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1989)
Action: 2/11/2004. Order issued lifting Consent Order of 1/22/2003.

TAMBERELLI, Wayne Paul, Physician Assistant
Location: Roanoke Rapids, NC (Halifax Co)
DOB: 10/08/1951
License #: 0001-00379
PA Education: Albany Medical College (1977)
Action: 4/21/2004. Order issued lifting Consent Order of 3/06/2003.

WALSH, James Aloysius, MD
Location: Hilton Head, SC
DOB: 7/23/1935
License #: 0000-36285
Specialty: R/NM (as reported by physician)
Medical Ed: Jefferson Medical College (1961)
Action: 3/11/2004. Order issued lifting Consent Order of 8/14/1998.

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

BERRY, David Don, MD
Location: Hickory, NC (Catawba Co)
DOB: 4/20/1952
License #: 0000-30288
Specialty: NPM/PD (as reported by physician)
Medical Ed: University of Texas Medical Branch, Galveston (1978)
Action: 3/18/2004. Full and unrestricted medical license issued.

BREWER, Thomas Edmund, Jr, MD
Location: Denton, NC (Davidson Co)
DOB: 11/04/1956
License #: 0000-28141
Specialty: EM/OM (as reported by physician)
Medical Ed: Wake Forest University School of Medicine (1983)
Action: 2/19/2004. Temporary/dated license extended to expire 6/30/2004.

CARLSON, James Lennart, MD
Location: Cerro Gordo, NC (Columbus Co)
DOB: 11/20/1959
License #: 2002-00010

Specialty: FP (as reported by physician)
Medical Ed: Medical College of Wisconsin (1991)
Action: 2/19/2004. Temporary/dated license extended to expire 8/31/2004.

DONDIEGO, Richard Michael, MD
Location: High Point, NC (Guilford Co)
DOB: 1/15/1955
License #: 0095-01225
Specialty: IM/C (as reported by physician)
Medical Ed: Universidad Central del Caribe School of Medicine, Puerto Rico (1981)
Action: 4/22/2004. Temporary/dated license extended to expire 3/31/2005.

EURE, Luther Haywood, Jr, MD
Location: Reidsville, NC (Rockingham Co)
DOB: 9/11/1963
License #: 0093-00102
Specialty: OBG (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1989)
Action: 3/18/2004. Temporary/dated license extended to expire 9/30/2004.

HEGE, Keith Jerome, Physician Assistant
Location: Yadkinville, NC (Yadkin Co)
DOB: 1/23/1956
License #: 0001-00981
PA Education: Bowman Gray (1986)
Action: 2/19/2004. Temporary/dated license extended to expire 8/31/2004.

LEMAIRE, Pierre-Arnaud Paul, MD
Location: Wilson, NC (Wilson Co)
DOB: 3/24/1960
License #: 0000-39440
Specialty: GS/VS (as reported by physician)
Medical Ed: University of Medicine & Dentistry of New Jersey, R.W. Johnson Med School (1985)
Action: 2/19/2004. Temporary/dated license extended to expire 8/31/2004.

McCLELLAND, Scott Richard, DO
Location: Wilmington, NC (New Hanover Co)
DOB: 7/19/1948
License #: 0000-29064
Specialty: P (as reported by physician)
Medical Ed: Kirksville College of Osteopathy (1980)
Action: 2/19/2004. Temporary/dated license extended to expire 8/31/2004.

STROUD, Joan Marie, Physician Assistant
Location: Gastonia, NC (Gaston Co)
DOB: 4/24/1956
License #: 0001-01476
PA Education: University of Pennsylvania PA Program (1980)
Action: 2/19/2004. Temporary/dated license extended to expire 8/31/2004.

THOMPSON, Robert Bruce, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 2/29/1956
License #: 0000-40006
Specialty: N/APM (as reported by physician)
Medical Ed: University of Miami School of Medicine (1987)
Action: 2/19/2004. Temporary/dated license extended to expire 6/30/2004.

VAUGHAN, Howell Anderson, Physician Assistant
Location: Knightdale, NC (Wake Co)
DOB: 3/31/1958
License #: 0001-01513
PA Education: Wake Forest University (1992)
Action: 3/18/2004. Temporary/dated license extended to expire 9/30/2004.

WARD, David Townsend, MD
Location: Greensboro, NC (Guilford Co)
DOB: 4/07/1960
License #: 0095-00473
Specialty: OTR (as reported by physician)
Medical Ed: West Virginia University (1986)
Action: 4/22/2004. Full and unrestricted license issued.

See Consent Orders:
MOIR, Ronald Jeffrey, MD

DISMISSALS
NONE

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.

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North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: August 18-20, 2004; September 22-24, 2004; October 20-22, 2004
November 17-19, 2004; January 19-21, 2005

Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the North Carolina Medical Board's Web site at *http://www.ncmedboard.org/exam.htm*. If you have additional questions, please e-mail Kelli Singleton, GME/Examination Coordinator, at *kelli.singleton@ncmedboard.org*.

Special Purpose Examination (SPEX)

The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609