Primum Non Nocere

No. 2, 2006

forum

NC MEDICAL BOARD

Pregnant or Parenting and Under Eighteen
Page 5

From the Executive Director

General Assembly Makes Important Changes to Medical Practice Act

R. David Henderson

At the request of the North Carolina Medical Board, the General Assembly recently enacted several changes to the Medical Practice Act (MPA) that will strengthen the Board's authority to regulate medicine in North Carolina. The purpose of this article is to summarize some of the changes to the MPA.* A complete description of the changes can be found at the Board's Web site: *www.ncmedboard.org*.

Additional Disciplinary Options

Under current law, the Board has had limited disciplinary options following a hearing. In many cases, this did not give the Board the flexibility it needed to impose appropriate discipline. Under the revised law, the Board will have additional disciplinary options, such as probation (with or without conditions), public reprimands, monetary penalties, public letters of concern, free medical services, and completion of treatment programs or training.

Reentry Provisions

As discussed in the last number of the *Forum*, the Board is increasingly concerned about license applicants who have not practiced medicine for over two years. The revised law will allow the Board to deny a license to an applicant who has been out of practice for more than two years or impose conditions on reentering the practice of medicine.

Immunity from Liability

In many cases, the Board depends on North Carolina physicians to review patient records in connection with complaints of substandard care and reports of liability insurance payments. Under the revised law, opinions rendered by these reviewers are immune from civil liability so long as they are made in good faith and without fraud or malice. Furthermore, the physician under investigation will not know the name of the reviewer unless there is a hearing and the reviewer decides to testify at that hearing.

Hearing Panels

With few exceptions, the entire Board (12 members) conducts all license denial and disciplinary hearings. This has limited the number of cases the Board can consider. Under the revised law, a "hearing committee" of three or more Board members may conduct a hearing. Following a hearing, the hearing committee's findings, conclusions, and recommendation are reported to the full Board. Each party may file written exceptions to the recommendation and make oral arguments to the Board prior to the Board reaching a final decision.

In This Issue of the FORUM

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NC MEDICAL BOARD

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We welcome letters to the editor addressing topics covered in the *Forum*. They will be published in edited form depending on available space. A letter should include the writer's full name, address, and telephone number.

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Change in Staff Privileges

The law currently requires hospitals and other health care institutions to report to the Board any change in staff privileges. The revised law requires these reports be made within 30 days of the date the action takes effect. It also specifies reports are required in the following instances: (1) a summary action, whether or not the action has been finally determined; (2) any action that has been finally determined by the governing body of the institution; (3) any resignation or voluntary reduction of privileges (unless due to completing postgraduate training); or (4) any action reportable pursuant to the Health Care Quality Improvement Act of 1986, as amended. Violations of this law may result in a penalty of $250 for the first offense and $500 for each subsequent offense.

Reports of Professional Liability Insurance Payments

Current law requires insurance companies or trust funds that provide professional liability insurance for physicians to report to the Board any payment "affecting or involving a physician." Under the revised law, payments affecting or involving a physician assistant must also be reported. Violations of this law may result in a penalty of $250 for the first offense and $500 for each subsequent offense.

Reports to/Cooperation with Law Enforcement

Under the revised law, the Board is required to report to the appropriate law enforcement agency any information that indicates a physician may have committed a crime. In addition, the Board must cooperate with law enforcement agencies investigating physicians by providing information relevant to a criminal investigation.

Physician's Duty to Report Certain Arrests

Under the revised law, physicians must report to the Board any felony arrest or indictment, any arrest for driving while impaired, or any arrest or indictment for the possession, use, or sale of any controlled substance. This report must be made within 30 days of the arrest or indictment.

Conclusion

Although the North Carolina Medical Board is widely recognized for its effectiveness and commitment to protecting the public, its members and staff continually strive to improve all aspects of its operation. These revisions of the MPA will help us do that.

As always, I welcome your comments or questions. I can be reached at *david.henderson@ncmedboard.org* or at 1-800-253-9653, ext. 218.

*The changes to the Medical Practice Act apply to both physicians and physician assistants. Once signed by the Governor, the changes will be effective October 1, 2006.

SANTIAGO ATITLAN

The Call of Something Different—Part 4: The Best of Times, the Worst of Times

Drs Bernadette and Jack Page

Dr Bernadette (Bernie) Page

Dr John (Jack) Page

March 1, 2006: "It was the best of times, it was the worst of times." With all apologies to Dickens, such is also our life here at the *hospitalito*. We are making enormous strides in some directions while losing ground in others. But—we are truly going two steps forward for each one back. That is progress Latin America style.

We have an administrator. Since the concept of reopening the hospital developed some three or four years ago, the *Comite* (board of directors) has been running the hospital and making every decision. They are very slow and revisit issues over and over again. Some rightly regret being involved in every hiring, the determination of what supplies to order from whom, and being called at all hours of the day and night because we have no water or electricity or have other organizational emergencies. Now, all roads lead to Jose Reanda, a 40-year-old Tz'tujil who has worked as a health care administrator for years, primarily in the public sector. After finishing a one-year consulting job in Guatemala City, he joined our team on January 1, 2006, and is slowly discovering the opportunities and developing some of the solutions. He and his wife and two sons live in Santiago Atitlan, and he is dedicated to making the *hospitalito* a success for the community and his family. He gets things done administratively while the doctors can focus on getting things done clinically. That is as it should be: professionals in both roles.

Helping Hands

For the last two weeks, we have been especially blessed with helping hands. Mark Lepore, the doctor on duty during the mudslide, has returned to help us for a month. Mark is a family practitioner from the same Ventura program that Leah, one of the three full-time doctors, graduated from. He speaks Spanish well, teaches well, and provides excellent care. Who would have hoped he would return to us. We also have a family practice doctor, who did a year's fellowship in child and maternal health, volunteering, with his wife and five kids, for two months. He is from rural Michigan and does C-sections, so he provides needed relief to Leah without compromising the care we provide the community. And the rural health center he usually works at has 50 percent migrant workers as patients, so his Spanish is excellent.

We also have had four family practice residents from a program in Santa Rosa, California, here at different times in the last five weeks. Like Leah and Mark's program in Ventura, it is focused on preparing family doctors to work where there is no surgeon, obstetrician, or orthopedist, whether in the U.S. or elsewhere. Each of them took night call, which requires comfort with OB, emergencies, and admitted patients. They did a great job. One of them has already obtained certification in tropical medicine and was a wonderful teaching source for all of us. And the medical students, most recently four from Duke, the University of Arizona, the University of Wisconsin, and Albany Medical College, kept all of us on our toes, reminding us all of the first times we saw the amazing things the human body can do if we doctors don't get in the way too often.

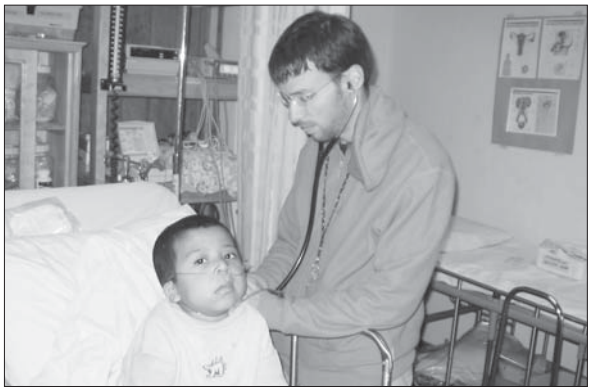
"With our Tz'tujil nursing staff, we provided a level of care never before available to the people of Santiago Atitlan"

Recently, we had a prolapsed cord in a woman with a prolonged labor who needed a C-section at 2:00 AM. Present to help were two family practitioners trained to do C-sections, a family practitioner who cared for the newborn, an emergency physician who supervised the medical student providing the spinal anesthesia, and a family practice resident actually performing the C-section. And with our Tz'tujil nursing staff, we provided a level of care never before available to the people of Santiago Atitlan. Now, our challenge is to incorporate the Tz'tujil doctors in our team to make the program sustainable.

We continue to struggle with getting the right drugs—in time—in Guatemala. Some of this has been an education for the American providers who have good drugs here that for various reasons are not licensed for use in the U.S. Our students from Australia and Germany have shared with us good agents that are available in Guatemala and that we were simply not aware of. But we have also developed some good and recurring sources from the U.S. We routinely fly in Duramorph®, for prolonged pain control when given intrathecal, doxycycline (very expensive in Guatemala), prednisone in 10 mg dose (only available in 1 or 5 mg doses here!), and midazolam. Physician volunteers bring these agents to us, and some volunteer groups going elsewhere in Guatemala, usually surgical teams,

bring them in and share their leftovers with us. It is enough, and now we almost always have the right drug for the right patient at the right time. What we still have to do is get the systems in place to obtain these drugs with much less outside help to make the entire program sustainable.

We have been doing more and more obstetrics as our services become better known. Most of the women are delivered still by *comadronas* (midwives) in their homes, but we are getting up to a rate of about 200-plus deliveries a year. We have also been doing more and more gynecological surgery thanks to our "half-time" volunteer who retired from practice in Logan, Utah. So we have developed our own standing orders, stealing without remorse from the many locations we have all come from. For our nurses, challenged by the much more aggressive way Americans have of handling things, we are providing uniform ways of doing things, legibility and help to the medical professionals who are supporting us for shorter periods of time. And more important than all the above, we are guaranteeing the patients the very best quality of care we can offer.



Four-year-old boy, in the ER, being admitted by Mark Lepore, the doctor on duty when the mudslide hit the old hospital.

"Though we may never have CT scanning, MRI, and a comprehensive laboratory, we can render a lot of lifesaving care with a 'do it now' attitude"

Referrals and Growth

And that leads me to referrals. More and more, we are finding out that many of our patients cannot get better help elsewhere. Solola, the national hospital an hour or so away, has pediatricians, surgeons, obstetricians, and an orthopedist. We have a full-time pediatrician who is joining us in March and our two family practitioners work with our gynecologist to provide high-level obstetrical care. Our next priority is to add a general surgeon and a blood bank so we can handle some of the trauma we currently send to Solola. We feel these patients have an unacceptably low survival rate; whether from longer transport times, less sophisticated diagnostic tools, or different styles of medical care we don't know, but we want to get them better care right here and right now. Though we may never have CT scanning, MRI, and a comprehensive laboratory, we can render a lot of lifesaving care with a "do it now" attitude. We are beginning to experience referrals from other communities around the lake for hernia repairs, hysterectomies, anterior repairs, etc. And once we get a functional inhalation anesthesia machine (currently on its way), patients with cholelithiasis will be able to be cared for here as well.

After the *deslave* (mudslide), we received a big bump in donations (which has quickly gone back to baseline) that allowed us to add another guardian (guard, gardener, maintenance man), so they now work every third day for 24 hours (2,920 hours a year). And we have hired an additional nurse, so our staff work every fourth shift instead of every third, cutting their annual hours to 2,190. We have been able to hire a professional nurse (similar to the U.S. registered nurse) to be our Tz'tujil director of nurses. These activities assist the hospital to reach toward some of its goals beyond the medicine: to provide meaningful jobs for Tz'tujils, role models for the youth, decent compensation, and stability for the long-term survival of the *hospitalito*.

The *hospitalito* has gotten a telephone landline. Usually that takes about eight years in rural Guatemala, but help from the pueblo got us put up to the top of the list. With our Internet connection and landline, we can now get our labs, imaging results, and consults via fax or Internet. And we have for the most part solved our problems with water and electricity. Oxfam donated a 5,000-liter water tank they brought to Santiago during the disaster, and we have relocated our 30-or-so car-battery UPS (uninterruptible power supply) to the new hospital. So when the power went out the other night, and we had an elderly woman with respiratory failure on oxygen and nebulizations, the doctor on duty only found out about the problem in the town the next day at morning report. Pretty important for the patient, too!

Looking Ahead

The old hospital remains uninhabited and more and more denuded of equipment and supplies every week. The government made a decision not to make a decision about allowing us to go back. Many people, especially those locally, wanted the area to be designated a cemetery and national shrine to the almost 500 who died in the mudslide. Others want to return. In fact, many residents already have, without permission, and are rebuilding *on top of the two to eight feet of mud left from October.* The reality is that no one can predict when the next mudslide of a deadly nature will occur. In a similar manner, no one can predict when Volcan Atitlan is next going to have an eruption. We can only know that the conditions exist for it to occur again: maybe five years, maybe a hundred. So the government said we cannot move back in until four to six years from now. For a hospital, we cannot remain in the inefficient current structure that long. So we are looking for a new location. Land here is usually cheap by U.S. standards, but like opportunists everywhere, when the *hospitalito* comes looking, the prices go up! We must remain as accessible as possible for the very poorest people we

serve while having good access to utilities and paved roads. It is a bit different site-selection problem from the U.S. So over the next few months, we should be getting our site and then begin the two-year task of constructing the new facility.

This is the fourth in a series of *Forum* articles about Drs Bernadette and Jack Page and their work as they continue their planned two-year stay in Santiago Atitlan, Guatemala. If you would like to contact them, they can be reached at *brpage@yahoo.com* or *jackpage45@yahoo.com*.

Pregnant or Parenting and Under Eighteen

Anne Dellinger, JD
Professor Emerita, Public Law and Government
University of North Carolina at Chapel Hill

Professor Dellinger

What can you do for such a patient, and if she is a mother or plans to be, can you help her get a good start in caring for a child? Naturally, you will offer medical information and treatment, but what about other issues that may strongly affect her health and well-being? For example, do you know whether a minor (someone 17 years old or under) can legally raise a child, have—or refuse to have—an abortion, place a child for adoption, get married, drop out of school or insist on staying? For that matter, can the patient consent to the health care you are ready to give her? Should you be talking with her parents instead of or in addition to her? And if so, what information should you give them? What are her partner's and both their families' legal responsibilities and rights?

Pregnancy and Parenting: A Legal Guide for Adolescents with Special Information for Their Parents discusses these and related issues. The *Guide,* available in Spanish or English, explains federal and North Carolina law in a way that most adolescents and parents can understand. To read it and print free copies, go to *http://www.teenpregnancy.unc.edu* or to *http://www.teenmother.unc.edu*.

Fewer minors become pregnant now than a decade ago, both nationally and in North Carolina. Still, the state recorded 6,409 pregnancies in 10- to 17-year olds in the most recent year (2004) for which the count is available. A large majority of pregnant minors in North Carolina give birth (4,756 in 2004) and keep the baby.

Sad Truths

Many pregnant youngsters encounter serious problems, and those with a child are even more likely to face hardships. These true stories make the point.

- A girl and her brother walked to the U.S. from Latin America to find work. On the way, the girl was raped by the group leader but told no one. Her brother left her in a large North Carolina city with near strangers. Finding herself pregnant, the girl asked a judge for permission for an abortion. The judge refused, not knowing that the law requires judges to give permission to rape victims. Before the appointed lawyer could explain through a translator that the decision would surely be reversed, the girl fled.
- Two pregnant minors treated at a North Carolina hospital asked to be sterilized. The request seems highly inappropriate for a minor, especially given our state's history of coercive ("eugenic") sterilization. These patients, however—still under 18 years of age—had had four and five children, respectively.
- An honor student expecting a college scholarship became pregnant the summer before her senior year. Forced out at home, she came to Greensboro where her father lives. Although he sometimes let her in, she was largely homeless there. A health department nurse tried to help her enroll in school, but failed. The father refused to miss a day's work to sign her up and the school's registrar would not alter her office hours to accommodate him. The girl disappeared when school started.
- A man brought his 17-year-old daughter for a third abortion at the same Raleigh clinic. In private with clinic staff, she revealed that all her pregnancies were her father's. She was only telling, she said, because he was approaching her eight-year-old sister.
- Some participants in Johnston County's adolescent parenting program speak in middle and high schools about their experience. (They can't mention contraception or abortion, though, for fear of jeopardizing federal abstinence funds). They tell about loving their child, but also about losing friends overnight and, in most cases, losing touch with the child's father. Some describe the financial and emotional toll on their parents; others stress how alone they are with overwhelming responsibility. Every speaker's message, the day I observed the presentations, was: "This is very hard. Don't do it."

"A large majority of pregnant minors in North Carolina give birth (4,756 in 2004) and keep the baby"

Aid and Support

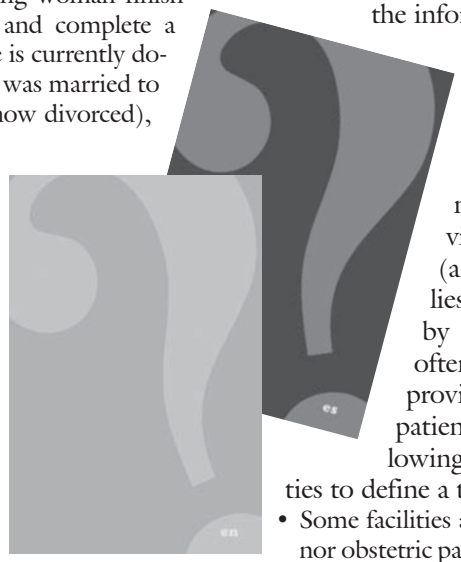
Fortunately, some teens are challenged by pregnancy or parenting rather than crushed. Their families and other adults, including health providers, offer valuable assistance, and the teens rise to the challenge and flourish. Here are several of their true stories.

- A 16-year-old, whose own mother had left the home, lived with her father. The father was involved in the patient's prenatal care and has helped her raise the child. She delivered a baby boy who is now 12 years old and

doing well in school. The young woman, who is a dedicated and proud mother, has had no subsequent pregnancies, has completed two associate degrees and started her own business.

- A young woman had two babies while in high school. Her guidance counselor asked what she wanted to do with her life, and she replied that she wanted to be a pediatrician. The counselor's engaging and affirming response was: "Well, let's explore how you can do that." This attitude helped the young woman finish undergraduate and medical school and complete a master's degree in public health. She is currently doing a residency. For several years she was married to the father of her children (they are now divorced), and she was the primary caretaker of her children while she completed her studies.
- Another 16-year-old and her highly supportive boyfriend had two children and then married. More than a decade later, they are still together, are committed parents, own a house, and both work. The patient is an LPN who loves working at the bedside, especially with hospice patients. While in high school, she loved music, and she continues to engage in solo and choral singing and write songs for herself and others.

"In North Carolina, as in many other states, a minor may consent to prevention, diagnosis, and treatment of several conditions, including pregnancy"



Covers of the English (en) and Spanish (es) versions

Lost Opportunities

Arlene Davis is a nurse, a lawyer, and codirector of the UNC School of Government's Adolescent Pregnancy Project, which publishes the legal guide series, of which *Pregnancy and Parenting* is part. She thinks that pregnant and parenting minors are a paradox and thus inherently confusing to a health provider. Are they pediatric or obstetric patients? "Sometimes," Arlene reflects, "they seem to get the worst of both worlds."

To learn how pregnant minors are cared for, Davis searched 200 medical records from a free-standing women's clinic and a large hospital. The records detailed an individual's health care encounter, but also showed certain patterns. For example, providers were often uncertain about who consents to health care, a girl or her mother? Hospital staff, in particular, recorded only the patient's mother's consent throughout the pregnancy—even consent to anesthesia for labor. Usually, parents *are* the proper parties to consent to minor children's care, but in North Carolina, as in many other states, a minor may consent to prevention, diagnosis, and treatment of several conditions, including pregnancy. Since the patient, her partner, and her parent may disagree about important matters—for instance, continuing or ending the pregnancy—it is crucial that providers know to look to the minor for consent.

Physicians treating minors need to know basic legal facts about minors' pregnancy and parenting, for their own sake and so they can tell patients. For example, North Carolina law lets parents, no matter how young, and no one else *but* parents, place a child for adoption. Yet in two cases among our sample, infants were not placed for adoption because a grandparent objected. Each infant's mother had been raped, surely a compelling reason for not wanting to raise a child. Had the providers known the law, they could have protected the patients—and perhaps the babies, too—by sharing the information.

The Adolescent Pregnancy Project's medical record review and interviews with health providers suggest that pregnant and parenting youth may get short shrift. Several providers said that a few colleagues (and certainly some teens' families) are frustrated, even angered, by the teen's predicament. More often, probably, it's a matter of busy providers choosing to deal with the patient's medical needs only. The following could be seen as lost opportunities to define a teen's "health" more broadly.

- Some facilities and providers do not talk with minor obstetric patients alone in order to take history, identify problems, and secure consent, including consent to discuss health information with family members.
- In a large facility where Arlene Davis reviewed records, the social worker's notes frequently contained vital information about a teen's troubling circumstances, but the notes had usually not been placed in the record, available to other staff, until after the patient's discharge.
- Although record forms in the same facility asked for name and age of father, neither was usually recorded for the 186 very young pregnant teens in our sample. Spaces for data on the patient's age at first intercourse, number of partners, and sexual and other abuse were often blank as well.

An Appreciation

As the vignettes above remind us, teens are vulnerable. The lives of those who face extraordinary tests such as pregnancy and parenting can go either way. Fortunately, numerous North Carolina physicians and other health providers—in private practice, public health departments, hospitals, and clinics—make extra efforts for these young patients and their offspring. The five individuals below must represent the generous, dedicated men and women Arlene Davis and I met in the 10-year course of the project. We thank them all for their help and commend their magnificent work.

- *Annette M. Carrington, MS, CHES*, program manager, Durham County Health Department, has many responsibilities—supervising health educators; teaching at North Carolina Central Univer-

sity; researching, writing and speaking throughout the state on public health issues; securing funding for her and others' work; analyzing public policy; and developing and sustaining local coalitions. Her professional specialties are varied, too: family planning, school health, adolescent suicide, and adolescent pregnancy prevention. No matter what else she is doing, Annette remains the ardent advocate for pregnant and parenting adolescents that they so badly need. For example, as president of the Durham Coalition on Adolescent Pregnancy Prevention, she urged the state Department of Public Instruction to implement State Board of Education policy meant to improve sex education. Her Teen Outreach Program, a project of the Health Department and public schools, enrolls nearly 800 middle and high school students a year. The program's core is showing teens how to work for the community; its goal is to reduce teen pregnancy and school dropout. Annette has just completed an extremely active presidency of the North Carolina chapter of the Society of Public Health Educators.

- *Carol A. Ford, MD*, is director of adolescent medicine at UNC Hospitals. In 1999, she helped expose a significant gap between the health care U.S. teens get and what they think—probably correctly—that they need. "In general," Carol said, "we found that kids who did not go for care were not the 'worried well.' They were kids who engaged in behaviors that put them at significantly increased risk for diverse health problems, from depression to acquiring sexually transmitted diseases. They also were those who had insufficient access to health care mainly as a result of insufficient insurance." She has written about the value of emergency contraception for teens, and the negative effect on use of family planning services and treatment for sexually transmitted infections if teens are not sure that health care will be confidential. She urges physicians, regardless of the medical problem a teen presents with, to look for a hidden agenda, one or more of the broad range of psychosocial issues that concern teens. Recently, Carol was named one of "America's Top Doctors," selected by physicians in her field.
- *Mary Linker, MSW, MPH*, has counseled pregnant teens and their families in the Chatham County Health Department since 1994. Now she manages the Department's Family Outreach and Support Services Division, which she helped to create. Talking with us, Mary expressed concern about how serendipitous a teen's health care can be; that is, the extent to which information—or misinformation—can change a life. For example, a translator told a girl who had been pregnant for only three weeks that abortion was no longer possible for her. Another minor, who had been raped, hoped to use state funds to pay for an abortion. But a man assigned to interview her didn't believe her and denied the request. Linker meets with pregnant teens individually and also establishes new programs for them. "I love working with folks to help them create a better life for themselves," she said in a news interview. In 2005, the North Carolina Public Health Association gave her its annual "Social Work Outstanding Achievement Award." A commentator at the time noted, "Mary embodies social work values. She. . .looks for the strengths of a person or situation."
- *Merry-K Moos, RN, FNP, MPH*, holds appointments at UNC Chapel Hill in the Department of Obstetrics and Gynecology and the Schools of Public Health and Nursing. Her research and writing on maternal and child health are substantial and innovative, focusing on preventing premature births and encouraging women who want to conceive to attend to their health beforehand. She is more than a scholar, though. Her direct contact with pregnant women and teaching of health providers who treat them is also extensive. As director of UNC Hospitals' teen pregnancy clinic, Merry-K has cared for hundreds of pregnant and parenting teens. She has high expectations for young patients and their partners, but is also highly accepting; instills confidence in them; and insists that they plan for the future, particularly education and future conceptions. The work is its own reward. In Merry-K's words, "I have followed many of the young women for more than a decade. Some of their achievements, given their life circumstances, are remarkable and often humbling. While I did not choose to take care of adolescents, I am so glad the 'assignment' came my way. I am richer because they let me be part of their lives." In 2002, Merry-K received an American Academy of Nurse Practitioners' award for excellence in practice, research, education, health policy, and community advocacy.
- *John W. Moses, Jr, MD*, practices pediatrics, specializing in adolescent medicine, at Duke University. Amazingly, his medical practice incorporates art, anthropology, teaching, and an emphasis on social justice. Collaborating with Robert Coles and others, John has helped pioneer the use of documentary photography as "an important component of the medical humanities." Their book, *The Youngest Parents: Teenage Pregnancy as It Shapes Lives*, combines portraiture and narrative so powerfully that viewers are bound to Moses' poignant subjects. Taking a documentary approach to photographing teen parents in North Carolina, he visited them repeatedly over several years. Their mutual trust and respect are evident. John writes, "On the one hand, I found what I thought I was looking for: poor, relatively 'uneducated,' unrestrained, undisciplined, 'sexually active,' 'children having children. . . .' On the other hand, I found the views and notions I brought along on my visits were often confounded, challenged, even derailed by what I saw and heard and felt." "We shouldn't rush to judgment by using the noose of the label 'teenage parent,' but allow them to be as human, unique, and different as anyone."

"'While I did not choose to take care of adolescents, I am so glad the "assignment" came my way. I am richer because they let me be part of their lives'"

These exemplary providers—physicians, a health educator, a social worker, and a nurse—have much in common. Perhaps they began as uncomfortable as most of us remain with adolescent pregnancy. But they moved beyond that point, asking about teen patients' circumstances, caring about them, and acting to improve the situation when possible.

Pregnancy and Parenting: A Legal Guide for Adolescents with Special Information for Their Parents is the last in a series from the School of Government at the University of North Carolina at Chapel Hill. There are three other titles in the series:

Health Care for Pregnant Adolescents: A Legal Guide (2001)

Social Services for Pregnant and Parenting Adolescents: A Legal Guide (2002)

Public Schools and Pregnant and Parenting Adolescents: A Legal Guide (2004)

The series was underwritten by the School of Government, the Z. Smith Reynolds Foundation, the Karl and Anna Ginter Foundation, and the Mary Norris Preyer Fund. Articles describing the earlier guides appeared in previous numbers of the *Forum* (No. 3, 2001; No. 3, 2002; No. 1, 2004).

Health Care for Pregnant Adolescents can be purchased from the School of Government. To order, call (919) 966-4119.

All four guides can be read and printed without charge and without providing any information at *http://www.adolescentpregnancy.unc.edu*.

Pregnancy and Parenting: A Legal Guide for Adolescents with Special Information for Their Parents can also be found in English and Spanish at *http://www.teenpregnancy.unc.edu* and at *http://www.teenmother.unc.edu*.

Professor Dellinger is also senior lecturing fellow at Duke University School of Law and co-director of the Adolescent Pregnancy Project.

Important News About Changes to Physician Assistant Rules

Robin Hunter-Buskey, PA-C
North Carolina Medical Board Member

Ms Hunter-Buskey

The North Carolina Rules Commission has approved changes to the Physician Assistant Rules effective June 1, 2006. Many of the changes reflect minor refinements in definitions and grammar. There are a few substantive changes that impact the primary supervising physician-physician assistant practice relationship and the procedures for PA licensure.

Among other criteria for initial licensure in North Carolina, PAs must pass the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA). This new language reflects that the PANCE is now the only certifying examination accepted for licensure in North Carolina.

Other changes to the rules regarding qualification for a PA license are that the Board, as part of the application process, may request written documentation of completion of at least 100 hours of continuing medical education (CME) for a PA if two or more years have passed since graduation. Also, a personal interview may be required.

PAs seeking to reactivate an inactive North Carolina license shall be required to meet specific criteria, including providing CME documentation, providing proof of successful completion of the PANCE, paying appropriate fees, and meeting all other requirements set out for license renewal in the rules. A PA who fails to register after 30 days will automatically become inactive.

The amended definitions now describe the supervisory arrangement: the written description of medical acts, tasks, and functions delegated to the PA by the primary supervising physician. As these rule changes are effective June 1, 2006, please take time to review your working relationship and all documentation regarding your practice. Please visit the North Carolina Medical Board Web site, *www.ncmedboard.org*, for the full text of 21 NCAC 32S.

Changes Proposed in Nurse Practitioner Rules

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NCMB Legal Department

The North Carolina Medical Board and the North Carolina Board of Nursing have jointly proposed changes to rules governing the practice of nurse practitioners. The proposed rules can be found on the two Boards' Web sites: *www.ncbon.org* and *www.ncmedboard.org*. A public hearing on the rules will be held at 1:00 PM on September 20, 2006, at the North Carolina Medical Board. Individuals who do not attend the public hearing may submit written comments on the proposed rule changes to the following: Jean H. Stanley, NC Board of Nursing, P.O. Box 2129, Raleigh, NC 27602 (919-782-3211, ext. 252—fax 919-781-9461) (*jeans@ncbon.com*); or R. David Henderson, NC Medical Board, 1203 Front Street, Raleigh, NC 27609 (919-326-1100—fax 919-326-1131) (*info@ncmedboard.org*). Comments may be sent to the Board of Nursing up to and including September 20, 2006, and the Medical Board up to and including October 2, 2006.

The proposed changes are mostly technical modifications including formatting and organizational changes that are designed to make the rules read more clearly and understandably. Temporary approval for first time nurse practitioner applicants has been removed. These changes do not impact in a substantive manner the qualifications or practice requirements of a nurse practitioner.

What Are You Doing About Health Care Quality in Your Practice? Part II (with Appendices)

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

Ms Satinsky

Designate Someone in Your Practice to Be Responsible for Quality and Quality Improvement

Select one physician within your practice as the leader for your quality and quality improvement efforts. He/she will take a lead role in understanding the state-of-the-art, obtaining standards that are relevant for your practice, and in guiding your entire team to work with those standards to make systematic process improvement.

Take an Objective Look at Your Practice

I get calls all the time about a common state of affairs. Physicians tell me: "My practice is a mess. Can you do an operational audit, tell me what is wrong, and tell me how to fix the problems." Sure I can, and I do. More often than not, however, the physicians know exactly what the problems are but are less clear on how to document the issues, correct what is wrong, and measure the change.

The operational audit that so many of you request has at least three components: analysis of structure, workflow, and outcomes. Let's look at them one at a time. With respect to structure, I regularly see two problems that have a negative impact on quality of care. One is the lack of a competent practice administrator or manager and the second is ambiguous physician responsibility for practice management. Some of you tell me with a straight face that you "sort of have a practice manager." Others tell me that you "love seeing patients, hate practice management, and rotate the physician in charge so that nobody has to spend too much time doing the terrible job of managing the practice." Both of these common structural problems produce the same result: your practice doesn't know what management entails, what steps you need to take, and who is responsible for each task. If you adjust and improve your structure, you'll have a better chance of improving your processes and outcomes.

Workflow process is a second issue, and it's a big one. Many of you haven't changed the way you run your practices in 30 or 40 years. If you introduce EMR into your practice before you improve your workflow, you'll automate your inefficiencies instead of correcting them. Ask yourself about the processes that are currently in place for every aspect of your practice, including but not limited to appointment scheduling, check-in, collection of demographic information, review of systems, moving the patient into and out of the exam room, prescriptions (ordering and refill), check-out, ordering ancillary tests and routing the results to physicians and patients themselves, and billing and collections. Does every process that you now have contribute positively to the delivery of care to your patients in the way in which you would like it to do? I recently asked one of my clients if I could use a stopwatch to look at his practice workflow. He corrected me and suggested I use an hourglass!

"Does every process that you now have contribute positively to the delivery of care to your patients. . . ?"

If your workflow analysis identifies many problems, see if you can measure them, fix them, and measure them again. Here are some examples. How many patients did your practice turn away because you couldn't book a convenient appointment? How many claims denials did you receive because information was incomplete and/or inaccurate? How many more patients could you have seen each day if you weren't saddled with administrative work that could have been done by someone else or electronically? Would your nurse have treated more patients if she had been able to communicate with health plans and pharmacies electronically rather than by phone? How much money did you lose because you filed claims late? How much money do your patients and insurance companies owe you?

Finally, what about outcomes? Can you do a diagnostic test on your practice to see if you can improve a quality gap? Here are practical suggestions.

- Explore reliable national registries to which you can submit information on your patients and from which you can receive comparative information. For example, in January 2006, Medicare implemented its Physician Voluntary Reporting Program enabling physicians to voluntarily report information on 36 evidence-based measures to the Centers for Medicare & Medicaid Services (CMS).
- Select a nationally accepted quality measure and apply it to 20 consecutive patients to see how good a job you are doing. There are excellent evidence-based measures available for diabetes, asthma, congestive heart failure, and preventive care.
- Given the structure and workflow of your practice, extract useful information about the patients for

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whom you care from your practice management, electronic health records, and other systems. Organize the information to tell you about patients as individuals and about subsets of patients. Do you know patients' ages and where they live? If you are a primary care physician, do you know how many of your patients have chronic conditions such as asthma, diabetes, or heart disease? For these chronic patients, do you keep careful track of important measurements, medications, and other indicators? If you are a specialist physician, do you know your most common diagnoses or procedures? If you do, are you sure that the care that you and your partners provide to this group(s) of patients meets the standards that your specialty society promulgates? Do you know how to use evidence-based medicine at the point of care?

Organize Your Findings

If you have done a thorough job of looking at your practice, you are likely to find many areas that need improvement. Make your list of issues and organize it in a way that makes sense to you. Here's an example. One of my clients asked me to do a practice audit and report back on workflow issues. Once that was done, we had a long and overwhelming list of problems that required attention. We then looked at the implications of each problem. Some issues had a direct impact on patient care (eg, communications between front office and clinicians). Other issues had financial implications for the practice (eg, absence of a revenue-cycle management process). Still others were related to compliance. Clearly we couldn't tackle everything at once. Rather than work only on dollars or patient care, we selected several issues from each category, addressing those we knew we could fix sooner rather than later. With a well-organized work plan, we watched our list of tasks shrink. A step-by-step template that takes you through a meaningful improvement effort can be found at *www.clinicalmicrosystem.org*.

"Quality improvement should be an ongoing activity in your practice"

Document Your Quality Efforts

Quality improvement should be an ongoing activity in your practice. Document exactly what you do so that you can determine progress and self-correct your improvement process as you continue to learn. Documentation will also help you with accountability—to yourself, to your practice, to professional organizations, to public and private payers, and to your patients. If you do regular satisfaction surveys for patients and for your colleagues in the medical community, check to see if your quality improvement activities have a positive impact on the results.

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Appendices

Appendix 1: Glossary of Terms (Source: National Quality Measures Clearinghouse Sponsored by Agency for Healthcare Research and Quality and CMS)

Incidence: rate, showing how many new cases of a disease occurred in a population within a specified time interval. It is usually expressed as the number of new cases per time unit per fixed number of people (e.g. number of new cases of cancer per 10,000 persons within a year).

Institute of Medicine: private, not-for-profit institution that provides objective, timely, authoritative information and advice on health and science policy to government, the corporate sector, the professions, and the public under a congressional charter.

Quality Measures

Clinical performance: degree of accomplishment of desired health objectives by a clinician or health care organization.

Clinical performance measure: a subtype of quality measure that is a mechanism for assessing the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient within the optimal time period.

Measure: a mechanism to assign a quantity to an attribute by comparison to a criterion.

Quality measure: a mechanism to assign a quantity to quality of care by comparison to a criterion. A quality measure relies on the definition of clinical performance, clinical performance measure, measure, and quality of care.

Quality of care: the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Rationale for the Measure: a brief statement describing the patients and the specific aspect of health care to which the measure applies. The rationale may also include the evidence basis for the measure and an explanation of how to interpret results.

Reliability: the degree to which the measure is free from random error.

Standard of Comparison:

External comparison at a point in time: comparison using the same measure for multiple comparable entities (e.g. non-teaching hospitals, large health plans, states).

External comparison of time trends: comparison using the same measure for multiple comparable entities tracking change over time.

Internal time comparison: comparison using the same measure in the same organization at two or more points in time to evaluate present or prior performance.

Prescriptive standard: standard set as a goal that ought to be achieved or as a threshold that defines minimum performance. The standard may be derived from studies using different measurement methods.

Validity: the degree to which the measure is associated with what it purports to measure.

Vulnerable populations: groups of persons who may be compromised in their ability to give informed consent, who are frequently subjected to coercion in their decision-making, or whose range of options is severely limited, making them vulnerable to health care quality problems. Examples are: children, disabled, frail elderly, homeless, illiterate/low-literate populations, immigrants, medically uninsured, mentally ill, minority groups, non-English speaking populations, poverty populations, prisoners, rural populations, terminally ill, transients/migrants, urban populations, and women.

Appendix 2: National Quality and Quality Improvements Initiatives

- **Accreditation Council for Graduate Medical Education (ACGME):** this organization now requires all resident physicians to be competent in quality improvement. (*www.acgme.org*)
- **Agency for Healthcare Research and Quality (AHRQ):** this agency is the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. AHRQ supports health services research that will improve the quality of health care and promote evidence-based decisionmaking. (*www.ahrq.gov*)
- **American Board of Medical Specialties (ABMS):** all twenty-four certifying boards now require physician competency in practice based learning and improvement to main-

tain board certification. (*www.abms.org*)

- **American Board of Quality Assurance and Utilization Review Physicians (ABQAURP):** this is the largest organization of interdisciplinary healthcare professionals in the country. The organization's ultimate goal is to improve the quality of care in the US, and it is dedicated to providing healthcare education and certification to physicians, nurses, and other professionals. ABQAURP has an examination that is developed, administered, and evaluated through the National Board of Medical Examiners. (*www.abquaurp.org*)
- **American College of Medical Quality** is the specialty medical association for physicians and other professionals in the fields of clinical quality improvement, quality assessment, and medical quality management. ACMQ publishes the American Journal of Medical Quality. (*www.acmq.org*)
- **Centers for Medicare & Medicaid Services (CMS):** the Physician Focused Quality Initiative includes the Doctor's Office Quality (DOQ) Project, the Doctor's Office Quality Information Technology (DOQ-IT) Project, the Vista-Office E H R, and several Demonstration Projects and Evaluation Reports. Appendix 7 has additional information on these programs. (*www.cms.hhs.gov/quality/pfqi.asp*)
- **California Health Care Foundation's Quality Initiative** coordinates quality measurement and outreach projects in Health Care Quality. (*www.chcf.org*)
- **Hospital Quality Alliance** is a voluntary alliance of the Association of American Medical Colleges (AAMC), the American Hospital Association (AHA), and the Federation of American Hospitals (FAH). Its national effort publicly reports quality performance on ten measures for three conditions, acute myocardial infarction, heart failure, and pneumonia. The data is posted on the Web site. (*www.aamc.org/quality/hospitalalliance/start.htm*)
- **Institute for Healthcare Improvement (IHI)**, founded by Donald Berwick, MD in 1991, is an independent not-for-profit organization located in Boston, MA. Its focus is acceleration of improvement in health care systems in the US, Canada, and Europe through collaboration, not competition. IHI sponsors an annual International Summit on Redesigning the Clinical Office Practice as well as other resources to help individual physicians and larger systems of care make changes toward better quality of care. (*www.ihi.org*)
- **National Association of Healthcare Quality** is dedicated to improving the quality of healthcare and supporting the development of professionals in healthcare quality. (*www.nahq.org*)
- **National Committee for Quality Assurance (NCQA)** is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, including HMOs. NCQA uses HEDIS measures. (*www.ncqa.org*)
- **National Quality Forum for Health Care Quality Measurement and Reporting** is a not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Dr William Roper, chief executive of the University of North Carolina Health Care System, is a new member and chairman-elect of this group. (*www.qualityforum.org*)
- **Professional societies** such as the American College of Physicians (ACP), American Academy of Family Practice (AAFP), and the American Academy of Pediatrics (AAP) offer programs to assist practicing physicians improve the quality of care. See their respective web sites.

<u>Appendix 3:</u> North Carolina Quality and Quality Improvement Initiatives

- **Blue Cross Blue Shield of North Carolina:** Don Bradley, M.D., Executive Medical Director for the company, notes that the concept of quality is embedded in the Blue Cross mission to provide "quality information, services, and products that help members maximize their healthcare." Blue Cross Blue Shield has actually dissolved its Quality Department; the entire organization is responsible for quality improvement.

With respect to meeting patient needs, quality means that the company not only provides covered services to members, but also helps members access services that may not be covered but that may help them get meet their needs. Patients have on-line access to policies so they know the rules on which decisions are based. Blue Cross depends heavily on the use of data to make decisions and to help members make their own decisions. The company tracks HEDIS indicators, and its PPO is the only NCQA-accredited plan in the state. Data also drives Blue Cross' decisions on centers of excellence for bariatric surgery, colon-cancer screening centers, and other programs. Each year, primary care physicians receive report cards that enable them compare their own performance with that of other physicians.

As a former family practitioner in South Boston, VA Dr. Bradley encourages physicians to be proactive about quality within their own practices. He suggests they select key indicators for their own practices and sign up to participate with patient registries. Dr. Bradley is cautious about some of the Pay-for-Performance programs that are receiving so much attention. He believes that measures are valuable to physicians if they are appropriate, actionable, and applicable to a member's well-being. If measures don't meet these criteria, they are not particularly helpful in providing quality care to patients. (Bradley, July 13, 2005).

- **The Carolinas Center for Medical Excellence (CCME), formerly Medical Review of North Carolina, Inc.:** a physician-sponsored, nonprofit health care quality improvement organization, CCME has been designated by the Centers for Medicare and Medicaid (CMS) as the Quality Improvement Organization (QIO) for North Carolina. With input from the medical community, CCME develops cooperative quality improvement projects on clinical topics affecting seniors. Through the DOQ.IT program, the organization provides technical assistance to primary care practices (except pediatrics) that request assistance in selecting and implementing Electronic Medical Records.
- **Center for Children's Healthcare Quality (CCHI):** this center within the University of North Carolina School of Medicine works with medical practices in North Carolina and nationally to do quality improvement projects in office redesign and clinical care.
- **Mid-Carolina Physician Organization/FirstCarolinaCare and FirstHealth of the Carolinas:** Mid-Carolina Physician Organization is the physician component of a community collaborative that includes FirstCarolinaCare and FirstHealth of the Carolinas. The provision of high quality care is one of the organization's major goals. The organization has selected specific HEDIS scores to be in the top 25th percentile for member physicians, and it also provides case management services to help members improve quality and manage the cost of care. MCPO also ensures that its members adopt and commit to nationally recognized guidelines for clinical care with appropriate local modifications (Hendrickson, 2005).
- **North Carolina Business Group on Health (NCBGH):** this not-for-profit employer coalition was founded in 2001 and now includes 41 self-insured employers that are located primarily but not exclusively in the seven-counties of the Raleigh-Durham MSA. The group's sole focus is on health care price and quality, and its goal is to identify lead institutions and physician groups, publicly acknowledge them, and reward them for their commitment.

  Taking its lead from the activities of the National Quality Forum and Leapfrog, NCBGH has asked area hospitals to participate in surveys for Leapfrog and to make the results available on a public Web site. With respect to quality of care in physician practices, the coalition is looking at Bridges to Excellence. IBM and CIGNA are both active in this effort.
- **North Carolina Healthcare Information and Communications Alliance (NCHICA):** NCHICA is a nonprofit collaboration among providers, professional societies and associations, payers, state and federal government agencies, and vendors and consultants. It is dedicated to "improving

healthcare in North Carolina by accelerating the adoption of information technology." NCHICA focuses on safety, quality, effectiveness, and efficiency in the systems and processes that are used in healthcare. It undertakes demonstration projects that meet a defined clinical need and that can be met with standards-based solutions. Past projects include collaboration with the North Carolina Division of Public Health for an Internet-based combined immunization database for children and the collection of emergency room clinical data for public health surveillance and best practice development. NCHICA is currently developing a North Carolina Quality Initiative. Phase I revolves around medications management (i.e. access to medication history, formularies, automation of refills, and electronic prescribing). Phases II and III will focus respectively on electronic lab and radiology orders and reports and electronic health records. (*www.nchica.org*) (Anderson, July 20, 2005)

- **North Carolina Medical Society:** the Quality of Care and Performance Improvement Committee chaired by Clyde Brooks, M.D. has a broad agenda that includes but is not limited to: supporting Ini's 100,000 Lives Campaign and participating as a campaign partner for that initiative to raise physician awareness and facilitate campaign communications to physicians; collaborating with Medical Review of North Carolina on an Enhanced Safety and Performance (or Innovations) Project that seeks to identify, evaluate, and communicate innovative ideas and measures implemented by physician offices across North Carolina that have led to enhanced safety, quality and clinical effectiveness; pursuing an ambitious project to restructure primary care; developing a quality web page that would include resources for clinicians, office staff, and patients; with AHEC, identifying CME opportunities so physicians can earn both I and II CME credit for performance improvement activities; and participating in the AMA Physician Consortium for Performance Improvement (Phelps, July 15, 2005).
- **Orthopaedic and Sports Medicine Associates PLLC:** this private practice in Raleigh has five physicians and three Physician Assistants in one location. The senior Physician Assistant is the Medical Director for the Practice. Since the practice opened in 2000, it has measured quality in four areas: patients, people (i.e. staff), financial management, and facility/environment. In the patient care area, the practice sends out 200 satisfaction surveys each quarter; its goal is 95% satisfaction. The physicians and other clinical staff developed specific protocols for 25 common procedures and conditions; these protocols serve as a guide for clinical care. As in most practices, the physicians were trained in different places, and so each has his/her unique style of practice. In an effort to share knowledge, when time allows, the physicians perform as co-surgeons. The practice also allows and encourages non-physician staff to come into the operating room and watch the surgeons in order to get a better idea of what is going on with patients (Adkins, 2005).
- **Quality Council of North Carolina:** this organization of healthcare professionals in medicine, nursing, research, management, and administration was formed in 2002. Its mission is to improve the quality and value of medical care available to the people of North Carolina, and its vision is to be an integrative force. Three areas of focus are education, collaboration, and action. The Council's annual Innovations in Clinical Practice Symposium is held in April.
- **State chapters of professional societies:** state chapters of the American Academy of Physicians and the American Academy of Family Physicians have sponsored quality improvement efforts.
- **UNC Health Care System:** The UNC Health Care System is a not-for-profit integrated health care system owned by the state of North Carolina. UNC Hospitals in Chapel Hill has 688 licensed beds, 959 attending physicians, and 5,800 FETs. It's big! Brian Goldstein, M.D, the Executive Associate Dean for Clinical Affairs for the UNC School of Medicine and Chief of Staff for the UNC Hospitals is responsible for most although not all of the system's initiatives in quality and quality improvement. Dr. Goldstein heads the Performance Improvement Department for the health care system. Major programs include:

  Support for the Institute for Healthcare Improvement (IHI) 100,000 Lives Campaign. UNC supports six working interventions and has also developed a pediatric rapid response team. Works in process include an adult rapid response team and a program for medication reconciliation.

  Support for unit level clinical and operations improvement projects. Units that approach the Performance Improvement Department receive a pre-formatted spreadsheet that helps them capture and use data.

  Reporting for the CMS Hospital Quality Alliance, JCAHO, and other external agencies.

  The Performance Improvement Department is not the only place within the UNC Health Care System that is concerned about quality and quality improvement. The Department of Hospital Epidemiology, which predates the creation of IHI, has been successful in motivating the entire workforce to support hand hygiene. As a result, UNC's hand-washing rates are consistently excellent. Within the Department of General Internal Medicine, care teams focus on diabetes, congestive heart failure, and chronic pain management. The National Institute for Children's Health Quality focuses on office-based improvement.

  UNC attributes the progress that it has made in quality and quality improvement to several factors, including but not limited to dedication of the caregivers at the bedside, support from top leadership, and an outstanding electronic health record system (Goldstein 2005). As in many organizations, a barrier to progress is resistance to changing processes of care.
- **UnitedHealth Premium Designation Program:** United's Premium designation programs recognize specialty and primary care physicians and cardiac facilities that meet or exceed certain evidence and consensus based quality and efficiency standards. Physicians who are Board Certified or Board Eligible may meet the "quality only" or "quality and efficiency" criteria and see an increase in volume of patients accessing their practice. As part of the program, physicians also have access to evidence based information and peer-to-peer comparison data. Eligible designated physicians who perform at the highest levels may also participate in a limited pilot program called Practice Rewards that provides enhanced reimbursement. (UnitedHealthcare, 2005).
- **WellPath/Coventry Healthcare Plan:** According to Dan Barco, MD, Vice President for Medical Affairs for WellPath Select, Inc., health plans have an obligation to look at the quality of what they themselves do. They need to monitor member complaints and satisfaction, regularly review appeals, and make sure that health plan processes do not have a negative impact on patient care. With respect to the quality of patient care that is delivered within each physician's practice, Dr Barco believes that health plans and other external organizations are not the most appropriate change agents; at best, they can have a limited influence on what goes on behind the closed doors of exam rooms. Having made that important distinction between the internal responsibilities of physicians themselves and that of external organizations, Dr Barco described WellPath/Coventry's two-part quality effort. The plan has a series of programs to evaluate and improve the quality of service and care it provides to members. The focus is on claims payment, utilization review, and the appeals process. It also has a number of small pilot projects to evaluate the potential impact of Pay for Performance programs with larger physician organizations, as opposed to individual practices. WellPath/Coventry's disease management programs have had an impact on care in certain areas. Rather than dealing with the processes of care within physician offices, these programs focus on making sure that patients are aware of the needed preventive services associated with their chronic diseases. (Barco, July 2005).

Appendix 4: Recommended Books and Articles

Audet, M.D., Doty, M.M., Shamasdin, J., et al. (2005). Measure, Learn, and Improve: Physicians' Involvement in Quality Improvement. *Health Affairs*. May/June 24 (3): 843-853.

Berwick, D. (2003). *Escape Fire: Designs for the Future of Health Care*. Washington, D.C. Institute for Healthcare Improvement.

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Agency for Health Care Research and Quality (AHRQ) (2004). *2004 National Healthcare Quality Report*.

Institute for Healthcare Improvement Breakthrough Series Guides:

"Improving Asthma Care in Children and Adults"

"Improving Outcomes and Reducing Costs in Adult Cardiac Surgery"

"Reducing Adverse Drug Events"

"Reducing Cesarean Section Rates While Maintaining Maternal and Infant Outcomes"

"Reducing Costs and Improving Outcomes in Adult Intensive Care"

"Reducing Delays and Waiting Times throughout the Healthcare System"

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Ransom, S.B. and Pinsky, W. Editors (1999). *Clinical Resource and Quality Management*. Tampa, FLA. American College of Physician Executives.

Reinertsen, J. and Schellekens, W. (2005). *10 Powerful Ideas for Improving Patient Care*. Washington, D.C. Institute for Healthcare Improvement.

Appendix 5: Continuing Education and Training on Quality and Quality Improvement

American Academy of Family Physicians
American College of Physician Executives
Institute for Healthcare Improvement
American College of Physicians
North Carolina Medical Review
North Carolina Quality Council

Appendix 6: On-Line Publications Promoting Quality Health Care (from AAFP list)

HealthWeb
National Guideline Clearinghouse
PubMed
Quality in Health Care (e.QHC)
QualityIndicator.com
United States National Library of Medicine

Appendix 7: Information on Centers for Medicare & Medicaid Services (CMS) Physician Focused Quality Initiative

The Doctors Office Quality (DOQ) project is designed to develop and test a comprehensive integrated approach to measuring the quality of care for chronic disease and preventive services in physicians' offices.

The Doctors' Office Quality – Information Technology (DOQ-IT) project supports the adoption and effective use of information technology by physicians' offices to improve quality and safety for Medicare beneficiaries and all Americans. With DOQ-IT funding, the Quality Improvement Organizations (QIOs) in each state will provide assistance to practices that provide care for Medicare patients.

VistA Office E H R: CMS is working with the Veterans Health Affairs (VHA) to transfer health information technology to the private sector. CMS and other federal agencies have funded the development of a VistA-Office E H R version of the VHAs hospital VistA system for use in clinics and physician offices.

Demonstration Projects: One important CMS funded demonstration project for Medicare is testing a combined fee-for-service and a bonus payment derived from savings achieved through improvements in the management of care and services. Another project features a pay-for-performance program to physician groups for promoting the adoption and use of health information technology to improve quality and reduce avoidable hospitalizations.

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

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

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

ACTIONS

The Board's statement on "The Retired Physician" was reviewed in May 2006 and no revision was proposed or adopted.

The following three statements are being considered by the Board for revision, as noted, in the near future. [The opening paragraph in the first ("The Physician-Patient Relationship") is the only section being considered for revision. Therefore, the rest of the statement is not being reprinted here.]

The Physician-Patient Relationship

~~The North Carolina Medical Board recognizes the movement toward restructuring the delivery of health care and the significant needs that motivate that movement. The resulting changes are providing a wider range and variety of health care delivery options to the public. Notwithstanding these developments in health care delivery, the duty of the physician remains the same: to provide competent, compassionate, and economically prudent care to all his or her patients. Whatever the health care setting, the Board holds that the physician's fundamental relationship is always with the patient, just as the Board's relationship is always with the individual physician. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care.~~

The duty of the physician is to provide competent, compassionate, and economically prudent care to all his or her patients. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care.

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(Adopted July 1995)
(Amended July 1998, January 2000; March 2002, August 2003)
(Under revision)

Care of the Patient Undergoing Surgery or Other Invasive Procedure*
~~Care of Surgical Patients*~~

The evaluation, diagnosis, and care of the surgical patient is primarily the responsibility of the surgeon. He or she alone bears responsibility for ensuring the patient undergoes a preoperative assessment appropriate to the procedure. The assessment shall include a review of the patient's data and an independent diagnosis by the operating surgeon of the condition requiring surgery. The operating surgeon shall have a detailed discussion with each patient regarding the diagnosis and the nature of the surgery, advising the patient fully of the risks involved. It is also the responsibility of the operating surgeon to reevaluate the

patient immediately prior to the procedure.

It is the responsibility of the operating surgeon to assure safe and readily available postoperative care for each patient on whom he or she performs surgery. It is not improper to involve other licensed health care practitioners in postoperative care so long as the operating surgeon maintains responsibility for such care. The postoperative note must reflect the findings encountered in the individual patient and the procedure performed.

When identical procedures are done on a number of patients, individual notes should be done for each patient that reflect the specific findings and procedures of that operation.

("Invasive procedure" includes, but is not limited to, endoscopies, cardiac catheterizations, interventional radiology procedures, etc. "Surgeon" refers to the provider performing the procedure)

**This position statement was formerly titled, "Care of Surgical Patients."*

~~**This position statement was formerly titled, "Ophthalmologists: Care of Cataract Patients."*~~

(Adopted September 1991)
(Amended March 2001) (Under revision)

Sexual Exploitation of Patients

It is the position of the North Carolina Medical Board that sexual exploitation of a patient is unprofessional conduct and undermines the public trust in the medical profession. Sexual exploitation encompasses a wide range of behaviors which have in common the intended sexual gratification of the physician. These behaviors include sexual intercourse with a patient (consensual or non-consensual), touching genitalia with ungloved hands, sexually suggestive comments, asking patients for a date, inappropriate exploration of the patients or physician's sexual phantasias, touching or exposing genitalia, breast, or other parts of the body in ways not dictated by an appropriate and indicated physical examination, exchanging sexual favors for services. Sexual exploitation is grounds for the suspension, revocation, or other action against a physician's license. This position statement is based upon the Federation of State Medical Board's guidelines regarding sexual boundaries. ~~Such conduct is not tolerated. As a guide in defining sexual exploitation of a patient by a licensee, the Board will use the language of the North Carolina General Statutes, Chapter 90, Article 1F (Psychotherapy Patient/Client Sexual Exploitation Act), §90-21.41.~~

Sexual misconduct by physicians and other health care practitioners is a form of behavior that adversely affects the public welfare and harms patients individually and collectively. Physician sexual misconduct exploits the physician-patient relationship, is a violation of the public trust, and is often known to cause harm, both mentally and physically, to the patient.

Regardless of whether sexual misconduct is viewed as emanating from an underlying form of impairment, it is unarguably a violation of the public's trust.

As with other disciplinary actions taken by the Board, Board action against a medical licensee for sexual exploitation of a patient ~~or patients~~ is published by the Board, the nature of the offense being clearly specified. It is also released to the news media, to state and federal government, and to medical and professional organizations.

(Adopted May 1991)
(Amended April 1996, January 2001) (Under revision)

Update: "NC Consensus Guideline for Management of Suspected CA-MRSA Skin and Soft Tissue Infections" Revised March 2006

In March 2006, the December 2005 version of the "North Carolina Guideline for Management of Suspected Community-Acquired Staphylococcus aureus (SA-MRSA) Skin and Soft Tissue Infections (SSTIs)," which appeared on pages six and seven of the *Forum*, No. 1, 2006, was revised in order to modify the recommended adult dose of TMP-SMX DS. The revised section of the "Guideline" appears below. The full March 2006 "Guideline" document appears on the Board's Web site at *www.ncmedboard.org* and the Web site of the Statewide Program for Infection Control and Epidemiology (SPICE) at *www.unc.edu/depts/spice/CA-MRSA.html*. More information is available at *www.epi.state.nc.us/epi/gcdc/ca_mrsa/ca_mrsa.html.*

Selection of empiric therapy should be guided by local S. aureus susceptibility and modified based on results of culture and susceptibility testing. The duration of therapy for most SSTI is 7-10 days, but may vary depending on severity of infection and clinical response. ***NOTE: Before treating, clinicians should consult complete drug prescribing information in the manufacturer's package insert or the PDR.***

Antimicrobial	Adult Dose	Pediatric Dose
Trimethoprim-sulfamethoxazole (TMP-SMX) DS	1 to 2 DS tablets (160 mg TMP/800 mg SMX) PO bid; use lower dose with impaired renal function.	Base dose on TMP: 8-12 mg TMP (& 40-60 mg SMX) per kg/day in 2 doses; not to exceed adult dose
Minocycline or doxycycline	100 mg PO bid	***Not recommended for pediatric use - suggest consultation with infectious disease specialist before use.***
Clindamycin	300-450 mg PO qid	10-20 mg/kg/day in 3-4 doses; not to exceed adult dose

NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
February–March–April 2006

DEFINITIONS:

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

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

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

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

Dismissal:
Board action dismissing a contested case.

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

NA:
Information not available or not applicable.

NCPHP:
North Carolina Physicians Health Program.

Reentry Agreement:
Arrangement between the Board and a practitioner in good standing who is "inactive" and has been out of clinical practice for two years or more. Permits the practitioner to resume active practice through a reentry program approved by the Board to assure the practitioner's competence.

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

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

Stay:
The full or partial stopping or halting of a legal action, such as a suspension, on certain stipulated grounds.

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

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

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

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

[For the full text version of each summary and for public documents, please visit the Board's Web site at *www.ncmedboard.org*]

ANNULMENTS
NONE

REVOCATIONS

DIXON, Randall Keith, Physician Assistant
Location: Philipsburg, MT
DOB: 8/23/1951
License #: 0001-01595
PA Education: University of Kentucky (1987)
Cause: Mr Dixon was convicted of theft, a felony, in Montana.
Action: 4/20/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/12/2006: Mr Dixon's North Carolina physician assistant license is revoked.

HAGESITH, Christian Ellis, MD
Location: Cherry Point, NC (Craven Co)
DOB: 2/23/1941
License #: 0000-16280
Specialty: NA
Medical Ed: University of Rochester (1967)
Cause: In 2002, Dr Hagesith entered an agreement with Colorado placing terms on his practice for his failure to meet accepted standards of care, for engaging in a sexual act with a patient, and for mental instability requiring treatment. In March 2004, the North Carolina Board issued Charges against Dr Hagesith based on the Colorado action and, in November 2004, indefinitely suspended his license. In 2005, the Colorado Board issued an Order under which Dr Hagesith surrendered his Colorado license for prescribing over the Internet.
Action: 4/24/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/12/2006: Dr Hagesith's North Carolina medical license is revoked.

KLUTTZ, Brenda Mills, MD
Location: St Louis, MO
DOB: 10/11/1955
License #: 0000-26450
Specialty: FP (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1981)
Cause: Dr Kluttz was convicted of a felony in Missouri. He requested no Board hearing on the matter.
Action: 3/13/2006. Entry of Revocation issued: Dr Kluttz' North Carolina medical license is revoked by operation of law effective 3/07/2006.

SUSPENSIONS

BIZZELL, Aleecia Rich, Nurse Practitioner
Location: Winston-Salem, NC (Forsyth Co)
DOB: 2/23/1973
Approval #: 0002-01269
NP Education: Duke University (1999)
Cause: In 2005, the Board was informed that Ms Bizzell was using cocaine. A Board investigator met with her on November 15 and she provided a saliva sample and a urine sample. A saliva test proved positive for cocaine. Further testing showed the metabolized form of cocaine. The urine sample did not test positive but appeared adulterated. Ms Bizzell said she knew about the coming drug screen and arranged to fake the saliva test. She said she did not adulterate the urine sample. The Board did not find her testimony credible. It found she had used cocaine after November 11 and before November 15 as confirmed by the drug tests.
Action: 3/17/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/15/2006: Ms Bizzell's approval as an NP is terminated and suspended indefinitely. Should she reapply, she must submit herself to and successfully complete a substance abuse program with the NC Board of Nursing, and must secure the advocacy of that program for her reinstatement before the Board will consider it.

BROWN, Frank Joseph, MD
Location: Eatonton, GA
DOB: 11/05/1932
License #: 0000-18854
Specialty: NA
Medical Ed: Medical College of Georgia (1967)
Cause: Georgia summarily suspended Dr Brown on finding his practice posed a threat to the public.
Action: 2/23/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/16/2006: Dr Brown's North Carolina medical license is indefinitely suspended.

DANIEL, Brian Phillip, MD
Location: Nashville, TN
DOB: 9/25/1964
License #: 0094-00771
Specialty: IM (as reported by physician)
Medical Ed: Vanderbilt University School of Medicine (1991)
Cause: In 2004, Illinois and Dr Daniel entered a Consent Order based on information that he committed acts or omissions that constitute gross negligence.
Action: 2/07/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/17/2005: Dr Daniel's North Carolina medical license is suspended for six months, suspension being stayed.

GROSSLING, Sergio Freudenburg, MD
Location: Irving, TX

DOB: 3/18/1929
License #: 0000-34618
Specialty: EM/GS (as reported by physician)
Medical Ed: University of Chile-Santiago (1954)
Cause: In 2004, Dr Grossling surrendered his Minnesota license via a Stipulation Order after he was charged with failing to properly treat two patients who later died. He denied the charges and the Order said he suffered a physical condition that impaired his ability to defend himself.
Action: 2/22/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/16/2006: Dr Grossling's North Carolina medical license is indefinitely suspended.

IACONO, Robert Paul, MD
Location: Madison, MS
DOB: 4/07/1952
License #: 0000-25602
Specialty: NS/APN (as reported by physician)
Medical Ed: University of Southern California, Los Angeles (1978)
Cause: In 2004, California charged Dr Iacono with failing to report a suspension of his privileges at Loma Linda University Medical Center in 1999 when he applied for privileges at the Desert Regional Medical Center in 2001. He was also charged with unprofessional conduct for becoming angry with staff members and loudly stating that a nurse was responsible for a patient's brain death. In 2005, he surrendered of his California license.
Action: 4/27/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/12/2006: Dr Iacono's North Carolina medical license is suspended indefinitely.

KHAN, Abdul Rahim, MD
Location: Hudson, FL
DOB: 3/24/1960
License #: 0096-00968
Specialty: CD/IM (as reported by physician)
Medical Ed: Khyber Medical School, Pakistan (1984)
Cause: In 2005, Florida charged Dr Khan with not keeping adequate medical records and not providing his current address. In a Final Order of 10/18/2005, Florida imposed an $8,000 fine on him, issued a letter of concern, and suspended his license. He was required to pay $1,066 in costs.
Action: 4/27/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/12/2006: Dr Khan's North Carolina medical license is suspended indefinitely.

LA GRANGE, Charles Rex, MD
Location: Sun City, CA
DOB: 4/30/1928
License #: 0000-11739
Specialty: FP (as reported by physician)
Medical Ed: Loma Linda University (1956)
Cause: Dr La Grange admitted to engaging in repeated negligent acts in violation of California law in regard to treatment of a single patient. Though not her primary provider, he prescribed excessive amounts of medications and failed to maintain adequate records. He failed to inform her primary provider of his treatment and failed to refer her to a pain specialist. California revoked his license in 2004, the revocation was stayed, and he was placed on three years probation.
Action: 2/21/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/16/2006: Dr La Grange's North Carolina medical license is indefinitely suspended.

MATTHIAS, Weeza, MD
Location: Bangor, ME
DOB: 8/01/1951
License #: 0094-00919
Specialty: FP (as reported by physician)
Medical Ed: University of Vermont (1993)
Cause: In registering her North Carolina license in 2004, Dr Matthias noted her practice in Fort Drum, NY, had been restricted. Several times in 2004 and 2005, the Board requested more information about the restriction of her practice. Dr Matthias never responded to the Board.
Action: 4/29/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/12/2006: Dr Matthias' North Carolina medical license is suspended indefinitely.

MERGENER, Klaus Dieter, MD
Location: Frankfurt, Germany
DOB: 7/30/1963
License #: 0095-01338
Specialty: IM/GE (as reported by physician)
Medical Ed: Heidelberg University, Germany (1989)
Cause: In 2004, Washington entered an Agreed Order with Dr Mergener in which he admitted using greater than reasonable force on a patient during a procedure. He was reprimanded and fined.
Action: 2/13/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/17/2005: Dr Mergener's North Carolina medical license is suspended for six months, suspension stayed.

NWOSU, Okenwa R., MD
Location: Greenbelt, MD
DOB: 6/18/1946
License #: 0097-01836
Specialty: GS/GP (as reported by physician)
Medical Ed: Howard University (1975)
Cause: In 2004, Maryland and Dr Nwosu entered a Consent Order in which Dr Nwosu admitted, among other things, engaging in immoral and unprofessional conduct. His Maryland license was suspended for one year and he was required to complete an ethics course.
Action: 2/13/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/17/2005: Dr Nwosu's North Carolina medical license is suspended indefinitely; may not reapply for one year.

REYNOLDS, Joel Crist, MD
Location: Edenton, NC (Chowan Co)
DOB: 8/06/1960
License #: 0099-00331
Specialty: US/GS (as reported by physician)
Medical Ed: Indiana University (1986)
Cause: Dr Reynolds received office samples of several drugs from drug representatives and used the medications himself. From 2003 to 2005, he diagnosed himself with hypogonadism, prescribed medications for himself, and directed members of his staff to inject him with steroidal drugs. In 2005, after the Board's investigation began, another urologist confirmed his diagnosis and treatment. Further, he treated Patient A with several drugs, including hydrocodone, but did not examine her or keep a chart for her. Also, he did not keep a controlled substance log. In 2003, he was arrested for DWI. He pled guilty to DWI in 2004.
Action: 2/27/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/16/2006: Dr Reynolds' North Carolina medical license is suspended for four months, suspension stayed with Dr Reynolds placed on probation; he shall satisfactorily complete CME courses on prescribing and on proper boundaries, and shall comply with his NCPHP contract.

RITLAND, John Melvin, MD
Location: Flagstaff, AZ
DOB: 7/18/1955
License #: 0000-31631
Specialty: OB/GYN (as reported by physician)
Medical Ed: Loma Linda University (1981)
Cause: In 2004, Arizona issued an Order for Revocation, Stayed with Probation, against Dr Ritland for boundary violations.
Action: 2/07/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/17/2005: Dr Ritland's North Carolina medical license is indefinitely suspended.

TATE, Larry Raymont, MD
Location: Worthington, OH
DOB: 3/28/1946
License #: 0000-23444
Specialty: FOP/ATP (as reported by physician)
Medical Ed: University of Michigan (1971)
Cause: In 2004, Dr Tate was suspended by the Ohio Medical Center and ordered to report to a hospital for residential treatment. Ohio summarily suspended his medical license after finding his practice presented a public danger.
Action: 2/13/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/17/2005: Dr Tate's North Carolina medical license is suspended indefinitely.

WATSON, David Gregory, MD
Location: San Antonio, TX
DOB: 2/23/1963
License #: 0095-00267
Specialty: EM (as reported by physician)
Medical Ed: University of California-Irvine (1993)
Cause: Texas suspended Dr Watson's medical license after he tested positive for cocaine.
Action: 2/13/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/17/2005: Dr Watson's North Carolina medical license is indefinitely suspended.

See Consent Orders:
AUGUSTUS, Carl Trent, MD; BERGER, Jeffrey Allen, MD; CONNINE, Tad Robert, MD;
DERBES, Lawrence Joseph, MD; DERBES, Linda Kaufman, MD; FITZGERALD, Dwight Melvin, MD; JOHNSON, David Wesley, MD; KUNZ, Kenneth Robert, MD; LACEY, Jami Rich, MD;

MOSKOWITZ, Edward James, MD; RICARD, Denis Philip, Physician Assistant

SUMMARY SUSPENSIONS

BASILI, Richard Louis, Jr, MD
Location: Tarboro, NC (Edgecombe Co)
DOB: 10/06/1967
License #: 0097-00464
Specialty: AN (as reported by the physician)
Medical Ed: East Carolina University School of Medicine (1993)
Cause: Dr Basili may possess a mental or physical condition that renders him unable to safely practice medicine.
Action: 4/26/2006. Order of Summary Suspension issued: Dr Basili's North Carolina Medical license is suspended upon service of the Order.

CONSENT ORDERS

AHLAWAT, Ranvir, MD
Location: Toms River, NJ
DOB: 7/21/1964
License #: 2002-01548
Specialty: IM (as reported by physician)
Medical Ed: St George's University (1995)
Cause: In 2003, Dr Ahlawat authorized prescriptions to numerous patients based solely on questionnaires submitted over the Internet. Without admitting wrongdoing, he requested his North Carolina license be made inactive on 2/11/2004.
Action: 3/02/2006. Consent Order executed: Dr Ahlawat surrenders his North Carolina medical license.

AUGUSTUS, Carl Trent, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 1/22/1962
License #: 0096-01218
Specialty: IM (as reported by physician)
Medical Ed: Medical University of South Carolina (1989)
Cause: Dr Augustus began a physician-patient relationship with Patient A in 2004. They then had a romantic, sexual relationship. In 2002, he began a physician-patient relationship with Patient B and indicated a desire to have an inappropriate relationship with Patient B.
Action: 2/26/2006. Consent Order executed: Dr Augustus' North Carolina medical license is suspended for two years beginning 3/2/2006; beginning 4/30/2006, suspension will be stayed and he will be put on probation on terms and conditions related to boundary violations; he shall abide by a contract with the NCPHP and shall permit random inspections of his office by the Board; must comply with other conditions.

BERGER, Jeffrey Allen, MD
Location: Huntersville, NC (Mecklenburg Co)
DOB: 12/29/1969
License #: 0096-01227
Specialty: FP (as reported by physician)
Medical Ed: University of Kentucky (1995)
Cause: Between September 2001 and April 2003, Dr Berger prescribed large amounts of controlled drugs to Patient A. He knew Patient A had a history of narcotic abuse, yet he failed to perform adequate review of his course of treatment or Patient A's compliance. He noted at least once in the chart that he would refer the patient to a pain management specialist, but reversed his treatment plan for no documented reason. Again, he noted he would begin reducing the medication, but again reversed his plan. On one occasion, Patient A told Dr Berger he had given some of his pain medication to friends and on that occasion Dr Berger did not reauthorize Patient A's prescription early. Dr Berger later suspected drugs prescribed to Patient A were being diverted. Dr Berger failed to impose adequate safeguards against diversion. Patient A's pulmonologist told Dr Berger the patient was terminal with COPD, which understanding led Dr Berger to prescribe large amounts to Patient A. By the time Dr Berger realized Patient A was continuing to survive, he was already prescribing large quantities of drugs. Stopping them could cause severe withdrawal. Dr Berger no longer practices chronic pain management. He says this case is an isolated one. He had recently finished residency when he began treating Patient A. Colleagues have written attesting to his professionalism.
Action: 2/16/2006. Consent Order executed: Dr Berger's North Carolina license is suspended for four months, which suspension is stayed on probationary conditions involving a CME course on prescribing and chart review by a colleague; must comply with other conditions.

CONNINE, Tad Robert, MD
Location: Hawkinsville, GA
DOB: 1/19/1964
License #: 0099-00193
Specialty: RO (as reported by physician)
Medical Ed: University of South Florida (1992)
Cause: Dr Connine's Georgia license was suspended in July 2005.
Action: 4/03/2006. Consent Order executed: Dr Connine's North Carolina license is indefinitely suspended.

CREEF, Michael Seldon, MD
Location: Chesapeake, VA
DOB: 4/18/1956
Specialty: FP/EM (as reported by physician)
License #: 0000-39255
Medical Ed: Eastern Virginia (1987)
Cause: In 2003, after a conference with Dr Creef about an allegation he may have violated certain laws, Virginia ordered him to fulfill certain requirements. In 2004, Virginia entered a Consent Order with Dr Creef finding he had not fulfilled the obligations previously imposed and imposing certain restrictions on him. In 2005, Virginia entered an Order modifying the 2004 requirements.
Action: 2/20/2006. Consent Order executed: Dr Creef is reprimanded.

DERBES, Linda Kaufman, MD
Location: Raleigh, NC (Wake Co)
DOB: 1/29/1960
License #: 0095-00112
Specialty: P/CHP (as reported by physician)
Medical Ed: University of South Florida College of Medicine (1990)
Cause: In 2005, Dr Derbes wrote prescriptions for controlled drugs for Patient A, a family member, knowing the patient did not require the drugs. She obtained the drugs for her own use.
Action: 3/13//2006. Consent Order executed: Dr Derbes license is suspended for six months, such suspension being stayed subject to probationary terms and conditions related to self-treatment and drug use; must comply with other conditions.

DURRANCE, Donald William, MD
Location: Tampa, FL
DOB: 2/06/1956
License #: 0097-00535
Specialty: R (as reported by physician)
Medical Ed: University of South Florida (1981)
Cause: In 2004, Florida charged Dr Durrance with practicing below the standard of care in interpreting an X-ray in a report. He neither admitted nor denied the allegations, but he entered a Consent Order with Florida in 2005, agreeing to pay a fine, perform community service, obtain CME. He was issued a letter of concern.
Action: 2/27/2006. Consent Order executed: Dr Durrance is reprimanded.

ELAM, Curtis Jay, MD
Location: Madison, TN
DOB: 8/23/1959
License #: 0000-32492
Specialty: OB/GYN (as reported by physician)
Medical Ed: University of Tennessee (1985)
Cause: In an agreement between Dr Elam and Tennessee, he was found to have practiced below the standard of care on two occasions. His Tennessee license was placed on probation for two years; he was required to complete additional CME and pay a fine of $4,000.
Action: 2/03/2006. Consent Order executed: Dr Elam is reprimanded.

EL-DROUBI, Hazem
Location: Rockingham, NC (Richmond Co)
DOB: 1/10/1945
License #: 0000-22392
Specialty: US (as reported by physician)
Medical Ed: University Ein Shams, Egypt (1969)
Cause: Dr El-Droubi began treating Patient B in 1994, and in 1995 he diagnosed Patient B with prostate cancer. In 1997, Dr El-Droubi performed an orchiectomy on Patient B. In 2000, he examined Patient B for follow up. In 2001, during a visit by Patient B, Dr El-Droubi mistakenly scheduled him for an out-patient bilateral orchiectomy. The patient was prepped and sedated. When examined by Dr El-Droubi, the patient was found to have no testes and surgery was canceled without harm.
Action: 3/14/2006. Consent Order executed: Dr El-Droubi is reprimanded for his care of Patient B.

FITZGERALD, Dwight Melvin, MD
Location: Claremont, NC (Catawba Co)
DOB: 11/06/1943
License #: 0000-20792
Specialty: GS/TS (as reported by physician)
Medical Ed: University of Illinois (1969)
Cause: In 2005, Dr Fitzgerald reported to the Board that his privileges at Catawba Valley Medical Center had been suspended from 5/24/2005 to 6/14/2005 following allegations he showed unprofessional and disruptive behavior. He and the Center agreed that if he entered a contract with the NCPHP and took other steps to avoid acting in such a way, his privileges

would be reinstated. He has entered an NCPHP contract and is compliant.
Action: 3/24/2005. Consent Order executed: Dr Fitzgerald's North Carolina license is suspended for two months; suspension is stayed on terms and condition; he shall abide by his NCPHP contract; must comply with other conditions.

GUNNOE, Bryan Andrew, MD
Location: Phoenix, AZ
DOB: 5/19/1958
License #: 0094-00814
Specialty: OSS/ORS (as reported by physician)
Medical Ed: Georgetown University (1989)
Cause: In 2005, Arizona found Dr Gunnoe had deviated from the standard of care, resulting in a patient requiring additional surgery. He was reprimanded by Arizona.
Action: 3/07/2006. Consent Order executed: Dr Gunnoe is reprimanded.

JOHNSON, David Wesley, MD
Location: Wilmington, NC (New Hanover County)
DOB: 11/28/1956
License #: 0000-26547
Specialty: GP (as reported by physician)
Medical Ed: Medical College of Virginia (1981)
Cause: From 10/2003 to 2/2004, Dr Johnson engaged in an intimate personal relationship with Patient A and established a physician-patient relationship with Patient A. From 8/2004 to 10/2004, he engaged in an intimate personal relationship with Patient B and established a physician-patient relationship with her. In 2004, he engaged in an intimate personal relationship with Patient C and established a physician-patient relationship with her.
Action: 4/12/2006. Consent Order executed: Dr Johnson's North Carolina license is suspended for one year, suspension being stayed on probationary terms and conditions relating to boundary violations; must comply with other requirements.

KAISER, Thom Chris, Physician Assistant
Location: Tampa, FL
DOB: 10/21/1947
License #: 0010-00452
PA Education: Emory University (1983)
Cause: On his application for a PA license, Mr Kaiser said he had never been charged with DUI. In fact, he had been so charged on two occasions.
Action: 4/24/2006: Consent Order executed: Mr Kaiser is reprimanded and is granted a PA license; as a condition, he has entered into a contract with the NCPHP; must comply with other conditions.

KELLY, Maureen Agatha, MD
Location: Scottsdale, AZ
DOB: 1/04/1955
License #: 0098-00589
Specialty: IM (as reported by physician)
Medical Ed: Albany Medical College (1996)
Cause: In 2005, Dr Kelly entered into a Consent Agreement for Practice Limitation (non-disciplinary) with Arizona. She agreed not to practice in a busy ambulatory setting because of a medical condition. Her North Carolina license was recently made inactive.
Action: 3/02/2006. Non-Disciplinary Consent Order executed: Dr Kelly's North Carolina license is placed on inactive status; should she ask to reactivate her North Carolina license, she will agree to the same limitations imposed in Arizona at that time,.

KUNZ, Kenneth Robert, MD
Location: Franklin, NC (Macon Co)
DOB: 10/06/1956
License #: 2000-01190
Specialty: ON/IM (as reported by physician)
Medical Ed: University of Manitoba, Canada (1986)
Cause: In 2002, Dr Kunz diverted several controlled drugs to his own or his wife's use. He did this by issuing prescriptions in Patient A's name and purchasing the drugs from Patient A. Dr Kunz denies the Board's findings and allegations but agrees to this Consent Order as being in his best interest.
Action: 3/08/2006. Consent Order executed: Dr Kunz' North Carolina medical license is indefinitely suspended.

LACEY, Jami Rich, MD
Location: Greensboro, NC (Guilford Co)
DOB: 10/15/1969
License #: 2003-00168
Specialty: FP/EM (as reported by physician)
Medical Ed: Medical College of Georgia (1998)
Cause: In 2005, Georgia and Virginia suspended Dr Lacey's licenses in those states.
Action: 2/03/2006. Consent Order executed: Dr Lacey's North Carolina license is suspended indefinitely.

LONGAS, Philip Lee, MD
Location: Atlanta, GA
DOB: 10/19/1964
License #: 2006-00127
Specialty: IM (as reported by physician)
Medical Ed: East Tennessee State University (1995)
Cause: Dr Longas is licensed in Tennessee, but has not practiced since 2002 and requires a reentry program. He has a history of substance abuse dating to 1990 or before and reports a sobriety date of October 2002. Tennessee revoked his license in 2003 and granted him a conditional license in 2004. He has entered and is compliant with a contract with the NCPHP.
Action: 2/02/2006. Consent Order executed: Dr Longas is issued a license to expire on the date shown on the license [6/02/2006]; he shall have a colleague observe and report to the Board on his practice for the first year after resuming practice; terms and conditions are set relating to drug abuse; he shall abide by a contract with the NCPHP; must comply with other conditions.

MARGOLIS, Jeffrey Alan, MD
Location: Richmond, VA
DOB: 10/07/1952
License #: 0000-23861
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1978)
Cause: In 2005, Dr Margolis was reprimanded by Virginia and ordered to complete CME in record keeping, addiction medicine, and pain management.
Action: 3/16/2006. Consent Order executed: Dr Margolis is reprimanded.

MARTONE, Arlene Rae, MD
Location: Venice, FL
DOB: 6/7/1947
License #: 0000-18781
Specialty: GYN (as reported by physician)
Medical Ed: Loma Linda University (1972)
Cause: In 2005, Florida issued an Emergency Suspension of Dr Martone's license. Suspension was lifted several days later and restrictions were placed on her license. She was not to use stabilized botulinum toxin Type A and was limited in use of Botox® for wrinkle reduction. In a Consent Order later in 2005, she was reprimanded, fined $30,000, ordered to complete relevant courses offered by the Florida Medical Association, to perform community service, to attend CME on ethics, and to give lectures on ethics. Her Florida license will be suspended for one year following filing of the Florida's Final Order, with suspension stayed for 11 months. She will be on probation for three years.
Action: 4/26/2006. Consent Order executed: Dr Martone is reprimanded; she shall not use unapproved stabilized botulinum neurotoxin Type A; may only use FDA approved wrinkle reduction treatments.

MATTHEWS, Charles Joseph, MD
Location: Raleigh, NC (Wake Co)
DOB: 2/31/1955
License #: 0000-27245
Specialty: N (as reported by physician)
Medical Ed: University of Virginia (1978)
Cause: To amend Dr Matthews Consent Order of April 14, 2003.
Action: 4/24/2006. Consent Order executed: Reference to "inpatient treatment" is removed from the original Consent Order language.

MENACHEM, Allan Michael, MD
Location: Jackson, TN
DOB: 2/17/1946
License #: 0000-38138
Specialty: IM/GE (as reported by physician)
Medical Ed: University of Bologna, Italy (1972)
Cause: While Dr Menachem was practicing in Raleigh, a patient said he inappropriately embraced her and sat on her legs. His former employer alleged he dismissed Dr Menachem based on the alleged incident and for not reporting a similar claim by a nurse in Columbus County, North Carolina. Dr Menachem denies the charges and says he has a female nurse present when examining females. He claims he gave the patient a brief, reassuring hug because he thought her to be anxious, but admits he did not explain his intentions to her. He contended a nurse was there and would support him. He said this was his first patient complaint in 30 years. He regrets the patient was offended and apologizes to her.
Action: 3/17/2006. Consent Order executed: Dr Menachem agrees that if he returns to North Carolina to practice he will notify the Board and that he will always have a female nurse present when examining female patients; will comply with other conditions.

MOSKOWITZ, Edward James, MD
Location: Marion, VA
DOB: 6/14/1949

License #: 0000-30075
Specialty: US (as reported by physician)
Medical Ed: Tulane University (1975)
Cause: In 2003, Virginia ordered Dr Moskowitz be publicly censured because his care, treatment, documentation, and follow-up of two patients were below the standard of care. He was also ordered to take a course in medical record keeping.
Action: 4/12/2006. Consent Order executed: Dr Moskowitz is suspended for 30 days, stayed on condition he complete the medical record-keeping course.

NIEMEYER, Meindert Albert, MD
Location: Elon, NC (Alamance Co)
DOB: 6/16/1956
License #: 0000-30440
Specialty: FP (as reported by physician)
Medical Ed: Faculty of Medicine, National University of Utrecht (1981)
Cause: To amend the Consent Order of 11/19/2004 by which his license, suspended in May 2004, was reissued on certain conditions. Those conditions included that he enter a contract with the NCPHP, which he did. The NCPHP reports he has been compliant. The contract will end in 7/2006.
Action: 4/12/2006. Consent Order executed: Dr Niemeyer is released from the NCPHP requirement in his Consent Order of 11/19/2004; other terms in that Consent Order remain unchanged.

O'MEARA, James Joseph, III, MD
Location: Gainesville, FL
DOB: 9/08/1961
License 0000-38664
Specialty: IM (as reported by physician)
Medical Ed: University of Virginia (1988)
Cause: Florida charged him with failing to have adequate supplies in an emergency crash cart and with failing to keep adequate surgical logs. While not admitting or denying the charges, he agreed to a Consent Order with Florida in 2005 which included a letter of concern, a fine, and other conditions.
Action: 4/17/2006. Consent Order executed: Dr O'Meara is reprimanded.

PATEL, Aneel Nathoobhai, MD
Location: Hampstead, NC (Pender Co)
DOB: 8/12/1935
License #: 0000-34701
Specialty: N/P (as reported by physician)
Medical Ed: Seth GS Medical College, India (1959)
Cause: Dr Patel's West Virginia license was suspended in 2005, suspension stayed pending his compliance with West Virginia CME requirements. At the same time, he offered documentation that satisfied the requirements. The stayed suspension was dissolved.
Action: 4/17/2006. Consent Order executed: Dr Patel is reprimanded; he must first apply to the Board to activate his inactive North Carolina license before resuming practice in North Carolina.

PRYZANT, Charles Zanwill, MD
Location: Dallas, TX
DOB: 5/29/1964
License #: 0093-00784
Specialty: CHP/P (as reported by physician)
Medical Ed: Baylor College of Medicine (1990)
Cause: In 2005, Texas entered into an Agreed Order with Dr Pryzant. It found a 15- year-old patient complained Dr Pryzant had viewed inappropriate material on his computer while assessing her. As a result, his employer recommended he be let go. He resigned his employment in 2004. Texas ordered him to take ethics training and pay a penalty of $1,000.
Action: 3/17/2006. Consent Order executed: Dr Pryzant is reprimanded.

RICARD, Denis Philip, Physician Assistant
Location: Pembroke, NC (Robeson Co)
DOB: 6/15/1956
License #: 0001-01360
PA Education: Bowman Gray (1990)
Cause: Mr Ricard continued to issue prescriptions to a patient though his supervising physician had directed him to cease as of October 2004. He also failed to make any entry in the patient's records regarding prescriptions written from then to February 2005, when his supervising physician found the medications were still being prescribed.
Action: 2/16/2006. Consent Order executed: Mr Richard's PA license is suspended for six months, stayed on terms and conditions, including an appropriate CME course, chart reviews, prescription log, and other requirements.

ROARK, Steven Forest, MD
Location: Gainesville, FL
DOB: 11/03/1952
License #: 0000-24941
Specialty: C/IM (as reported by physician)
Medical Ed: Duke University School of Medicine (1978)
Cause: Florida charged him with failing to have adequate supplies in an emergency crash cart and with failing to keep adequate surgical logs. While not admitting or denying the charges, he agreed to a Consent Order with Florida in 2005 which included a letter of concern, a fine, and other conditions.
Action: 4/17/2006. Consent Order executed: Dr Roark is reprimanded.

ROSSI, Paul Christopher, DO
Location: Raleigh, NC (Wake Co)
DOB: 3/15/1953
License #: 2006-00123
Specialty: EM/OM (as reported by physician)
Medical Ed: Des Moines University College of Osteopathic Medicine (1978)
Cause: Dr Rossi appeared before the Board in 2006 to discuss his plans to practice in North Carolina. His job responsibilities since 1999 have not included clinical practice. He will practice only in an administrative setting.
Action: 3/17/2006. Non-Disciplinary Consent Order executed: Dr Rossi is granted an administrative license that limits his practice to administrative medicine; clinical practice will require approval from the Board president of a plan to update his medical skills and of his practice site .

RUFF, Ron Harry, MD
Location: Rancho Santa Fe, CA
DOB: 3/25/1957
License #: 0000-29386
Specialty: AN (as reported by physician)
Medical Ed: University of California- San Diego (1982)
Cause: Dr Ruff's North Carolina license expired in 1988. He maintained an Oregon license. In 2004, Oregon reprimanded him for discrepancies with billing practices in 2002.
Action: 4/03/2006. Consent Order executed: Dr Ruff is reprimanded.

SAPPINGTON, John Shannon, MD
Location: Linville, NC (Avery Co)
DOB: 1/30/1962
License #: 0094-00628
Specialty: P/CHP (as reported by physician)
Medical Ed: University of Texas-Houston (1989)
Cause: Dr Sappington has a history of drug abuse. His North Carolina license was suspended in 2002. In 2003, he inappropriately obtained Ritalin® by altering a prescription for Prozac® issued by another physician. Later, he successfully completed long-term residential treatment and is now receiving treatment for ADHD. He continues to be suspended.
Action: 2/17/2006. Consent Order executed: Dr Sappington is reprimanded; must comply with conditions related to his history of drug abuse; he shall strictly adhere to the Board's position statement on self-treatment.

SWEET, Amanda Jayne, Physician Assistant
Location: Raleigh, NC (Wake Co)
DOB: 11/17/1975
License #: 0010-00409
PA Education: James Madison University (2005)
Cause: Ms Sweet pled no contest to a misdemeanor charge of uttering a forged prescription in California in 2001. She received a three-year sentence of probation. On completion of the probationary period, the conviction was set aside, she pled not guilty, and the original complaint was dismissed.
Action: 2/22/2006. Consent Order executed: Ms Sweet is reprimanded.

TAUB, Harry Evan, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 11/24/1970
License #: 2006-00491
Specialty: P/CHP (as reported by physician)
Medical Ed: Dartmouth Medical College (2001)
Cause: To amend Dr Taub's Consent Order of 2004 by moving from an RTL to a full license.
Action: 4/28/2006. Amended Consent Order executed: Dr Taub is issued a full and unrestricted license; terms and conditions in his previous Consent Order remain in effect.

TAYLOR, Jeffrey Scott, MD
Location: Raleigh, NC (Wake Co)
DOB: 3/31/1946
License #: 0000-27322
Specialty: NA
Medical Ed: University of Illinois (1977)
Cause: In 2003 and 2004, Dr Taylor prescribed for a close friend, for two family members, and for himself. He denies, and the Board has no evidence, that he was diverting any of the prescriptions for Patients A, B, C, or himself. He was not aware of the Board's position statement on self-prescribing or treating and prescribing for family members or those with whom significant emotional relationships exist.
Action: 2/17/2006. Consent Order executed: Dr Taylor is reprimanded; he shall

DENIALS OF LICENSE/APPROVAL

FINEBERG, David Aaron, MD
Location: Raleigh, NC (Wake Co)
DOB: 10/16/1962
License #: NA
Specialty: NA
Medical Ed: Sackler School of Medicine, Tel Aviv University (1988)
Cause: Dr Fineberg has not practiced since 1999, his license was suspended by New York in 1999, he surrendered his New York license in 2004, and he admitted multiple instances of unprofessional conduct.
Action: 3/10/2006. Letter issued denying Dr Fineberg's application for a North Carolina license.

HAMBLETON, Scott Lewis, MD
Location: Atlanta, GA
DOB: 4/15/1963
License #: 2000-00444
Specialty: FP/EM (as reported by physician)
Medical Ed: University of Tennessee (1994)
Cause: Dr Hambleton failed to satisfy the Board of his qualifications. Action is also based on his previous acts of unprofessional conduct and substance abuse as noted in his 2002 and 2004 Consent Orders with the Board.
Action: 4/25/2006. Letter issued denying Dr Hambleton's application for reinstatement of his North Carolina license.

POLITI, Barry Joseph, MD
Location: Jackson, MS
DOB: 6/13/1968
License #: None
Specialty: OM (as reported by physician)
Medical Ed: St George's University (1998)
Cause: Dr Politi failed to satisfy the Board of his qualifications for a North Carolina medical license. The state of Ohio took action against him and denied his license there.
Action: 2/28/2006. Letter issued denying Dr Politi's application for a North Carolina license. [He requested a hearing on 3/08/2006.]

UEDA, Robert Kazuo, MD
Location: North Canton, OH
DOB: 12/26/1961
License #: NA
Specialty: DR (as reported by physician)
Medical Ed: Creighton University School of Medicine (1993)
Cause: Dr Ueda was found by Florida to have failed to disclose on his application for a license the fact he repeated medical school classes and was placed on probation while in PG training. His application was ultimately granted, but he was ordered to pay a fine of $1,000 and correct his application. He was also placed on probation in medical school and took the USMLE Step 3 multiple times before passing.
Action: 4/28/2006. Letter issued denying Dr Ueda's application for a North Carolina license.

WALTER, Steven Wayne, MD
Location: Cary, NC (Wake Co)
DOB: 12/19/1957
License #: NA
Specialty: IM (as reported by physician)
Medical Ed: Medical College of Ohio (1983)
Cause: Dr Walter requested a hearing on the Board's denial of his application for a license in November 2005. At hearing, it was stipulated that Dr Walter was convicted of DUI in North Carolina and in Ohio in 1995, that he self-reported to the West Virginia Board that he was alcohol dependent and had been diagnosed with bipolar disorder, that he entered a voluntary agreement with the West Virginia Board in 1996 related to his alcohol dependency, that he entered an agreement with the Ohio Board that provided probationary terms related to his alcohol dependency, that he voluntarily surrendered his West Virginia license as a result of a relapse in 1999, that he was placed on probation by West Virginia, that he was convicted on DUI in North Carolina in 2001, that he surrendered his West Virginia license in 2001, that he entered a Consent Order with West Virginia reinstating his license but placing a stayed revocation and a probation on his license, that his West Virginia license became inactive in 2003, that reinstatement in West Virginia will require him to pass SPEX, that he has an active Virginia license, that he has practiced since January 2001 and that he has been sober since that time.
Action: 4/29/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/15/2006: Denial of Dr Walter's application for a North Carolina medical license was proper and shall remain in effect.

SURRENDERS

BASAMANIA, Beth P., MD
Location: Chapel Hill, NC (Orange Co)
attend a course on prescribing within six months

THURMAN, Roger Zalon, MD
Location: Wilson, NC (Wilson Co)
DOB: 9/14/1939
License #: 0000-18151
Specialty: GS/VS (as reported by physician)
Medical Ed: Medical College of Virginia (1965)
Cause: In August 2005, having information regarding Dr Thurman's practice that prompted a review of his practice, the Board contacted him. He responded that his practice had conformed with the standards of practice and that he had retired as of August 2005, not renewing his license.
Action: 3/17/2006. Non-Disciplinary Consent Order executed: Dr Thurman has retired and his license is placed on inactive status; should he seek reactivation of his license, it is understood the Board will reinstate its review of his practice; the Board now makes no findings regarding his practice.

TRIANA, Rudolph Joseph, Jr, MD
Location: Raleigh, NC (Wake Co)
DOB: 2/24/1962
License #: 0000-39704
Specialty: OTO/FPS (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1989)
Cause: Florida issued a Notice of Intent to Approve Licensure with Conditions for Dr Triana. Florida found he failed to correctly answer two questions on his application. It ordered his application be approved once he corrected those questions. He had failed to disclose he took a leave of absence from medical school and his privileges at Methodist Hospital were terminated.
Action: 3/03/2006. Consent Order executed: Dr Triana is reprimanded.

WADDELL, Roger Dale, MD
Location: Aberdeen, NC (Moore Co)
DOB: 11/17/1954
License #: 0000-30105
Specialty: GP (as reported by physician)
Medical Ed: University of Colorado School of Medicine (1981)
Cause: Amendment of previous Consent Orders. Dr Waddell's Consent Order of 2004 limited him to 20 hours of practice per week. This was raised later to 30 hours per week. He has requested 40 per week. He appears to be complying with previous Consent Orders.
Action: 3/02/2006. Consent Order executed: Dr Waddell may practice up to 40 hours per week.

WITTICH, Arthur Clifford, DO
Location: Ft. Belvoir, VA
DOB: 10/25/1938
License #: 0000-36077
Specialty: OB/GYN (as reported by physician)
Medical Ed: Iowa College of Osteopathic Medicine (1971)
Cause: In 2005, Colorado issued a letter of admonition, without a hearing, on Dr Wittich's management of delivery of a newborn who later died. Dr Wittich says he gave adequate care.
Action: 2/13/2006. Consent Order executed: Dr Wittich is reprimanded as a result of the Colorado letter.

MISCELLANEOUS ACTIONS

BUFFONG, Eric Arnold, MD
Location: Columbus, GA
DOB: 5/11/1951
License #: 0000-27894
Specialty: GYN/REN (as reported by physician)
Medical Ed: Howard University (1977)
Cause: In 2004, Dr Buffong's Georgia license was summarily suspended on allegations of criminal or other misconduct involving patients under his care. On November 9, 2004, Georgia and Dr Buffong agreed that his Georgia license be suspended. It was also agreed no other action would be taken until criminal matters pending against him were resolved or until further order from Georgia's Board. In November 2004, based on Georgia's action, the North Carolina Board summarily suspended Dr Buffong's North Carolina license and issued charges. Dr Buffong waives his right to a hearing on the North Carolina charges until completion of Georgia's case. He shall be entitled to a hearing on the North Carolina Board's charges should the Board decide to conduct proceedings after Georgia's final decision.
Action: 4/28/2006. Tolling Agreement and Order: Dr Buffong shall not practice in North Carolina until the Board issues a final decision in the case against him on the charges of November 2004; the Board shall not conduct further proceedings until the Georgia Board issues its final decision; should the Board decide to conduct further proceedings, Dr Buffong will be entitled to a hearing.

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DOB: 3/31/1963
License #: 0099-00323
Specialty: FP (as reported by physician)
Medical Ed: George Washington University Medical School (1990)
Action: 2/17/2006. Voluntary surrender of North Carolina medical license.

BEDINGTON, William David, Physician Assistant
Location: Hickory, NC (Catawba Co)
DOB: 11/14/1959
License #: 0001-02534
PA Education: Butler University (1998)
Action: 4/20/2006. Voluntary surrender of North Carolina medical license.

COLLINS, Paul Dwayne, MD
Location: Pembroke, NC (Robeson Co)
DOB: 2/08/1973
License #: 2005-00139
Specialty: FP (as reported by physician)
Medical Ed: Wake Forest University School of Medicine (2001)
Action: 3/13/2006. Voluntary surrender of North Carolina medical license.

De GREGORIO, Peter Anthony, MD
Location: Sneads Ferry, NC (Onslow Co)
DOB: 6/01/1943
License #: 0000-38755
Specialty: IM (as reported by physician)
Medical Ed: Columbia University (1969)
Action: 2/28/2006. Voluntary surrender of North Carolina medical license.

LONG, Joseph Watson, Nurse Practitioner
Location: Concord, NC (Cabarrus Co)
DOB: 8/29/1961
Approval #: 0002-01774
NP Education: University of North Carolina, Charlotte (2002)
Action: 4/20/2006. Voluntary surrender of North Carolina NP approval.

PRESNELL, Tammy Murrelle, Physician Assistant
Location: Reidsville, NC (Rockingham Co)
DOB: 7/18/1960
License #: 0001-03613
PA Education: East Carolina University (2002)
Action: 2/15/2006. Voluntary surrender of North Carolina PA license.

SABATIER, Richard Edward, MD
Location: New Orleans, LA
DOB: 2/05/1949
License #: 0000-22819
Specialty: PS (as reported by physician)
Medical Ed: Tulane University (1973)
Action: 4/09/2006. Voluntary surrender of North Carolina medical license.

SHIVE, Robert MacGregor, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 11/21/1933
License #: 0000-13226
Specialty: P (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1961)
Action: 3/21/2006. Voluntary surrender of North Carolina medical license.

TROGDON, James Clifford, NP
Location: Chapel Hill, NC (Orange Co)
DOB: 10/19/1957
Approval #: 0002-01033
NP Education: University of North Carolina (1997)
Action: 4/05/2006. Voluntary surrender of North Carolina nurse practitioner approval.

See Consent Orders:
AHLAWAT, Ranvir, MD

COURT APPEALS/STAYS
NONE

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

AARONS, Mark Gold, MD
Location: Southern Pines, NC (Moore Co)
DOB: 5/07/1958
License #: 0000-31233
Specialty: Neph/IM (as reported by physician)
Medical Ed: Baylor College of Medicine (1984)
Action: 3/16/2006. Temporary/dated license extended to expire 9/30/2006.

CRUMP, Carolyn Faydene, MD
Location: Lexington, NC (Davidson Co)
DOB: 1/27/1950
License #: 2005-01115
Specialty: GP (as reported by physician)
Medical Ed: George Washington University School of Medicine (1975)
Action: 3/16/2006. Temporary/dated license extended to expire 7/31/2006.

GOTTSCHALK, Bernard Joseph, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 5/10/1955
License #: 0000-30162
Specialty: IM/ADDM (as reported by physician)
Medical Ed: University of Pittsburgh School of Medicine (1981)
Action: 3/16/2006. Full and unrestricted medical license issued.

HARDY, Stephen Carl, MD
Location: Waxhaw, NC (Union Co)
DOB: 7/11/1957
License #: 0000-35911
Specialty: Neuro (as reported by physician)
Medical Ed: University of Virginia (1985)
Action: 3/16/2006. Temporary/dated license extended to expire 9/30/2006.

NIEMEYER, Meindert Albert, MD
Location: Elon, NC (Alamance Co)
DOB: 6/16/1956
License #: 0000-30440
Specialty: FP (as reported by physician)
Medical Ed: Faculty of Medicine, Utrecht (1981)
Action: 3/16/2006. Temporary/dated license extended to expire 3/31/2007.

MORTER, Gregory Alan, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 12/03/1959
License #: 0000-36401
Specialty: Ped (as reported by physician)
Medical Ed: University of Pittsburgh School of Medicine (1986)
Action: 3/16/2006. Temporary/dated license extended to expire 11/30/2006.

ROGERS, Bruce William, MD
Location: Clayton, NC (Johnston Co)
DOB: 8/11/1947
License #: 0000-32563
Specialty: FP/EM (as reported by physician)
Medical Ed: Medical College of Pennsylvania (1982)
Action: 3/16/2006. Temporary/dated license extended to expire 9/30/2006.

WHITE, Steven William, Physician Assistant
Location: Cameron, NC (Moore Co)
DOB: 12/19/1962
License #: 0001-02116
PA Education: Midwestern University (1996)
Action: 3/16/2006. Temporary/dated license extended to expire 7/31/2006.

WHITMER, Gilbert Gomer, Jr, MD
Location: Raleigh, NC (Wake Co)
DOB: 9/04/1961
License #: 0000-36854
Specialty: OS (as reported by physician)
Medical Ed: The Johns Hopkins University (1987)
Action: 3/16/2006. Temporary/dated license extended to expire 9/30/2006.

CONSENT ORDERS LIFTED

ANDRINGA, Richard Cornell, MD
Location: Greensboro, NC (Guilford Co)
DOB: 12/23/1946
License #: 0000-20463
Specialty: AN/PD (as reported by physician)
Medical Ed: University of Wisconsin (1974)
Action: 4/11/2006. Order issued lifting Consent Orders of 1/08/2001 and 1/31/2001.

GOTTSCHALK, Bernard Joseph, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 5/10/1955
License #: 0000-30162
Specialty: IM/ADDM (as reported by physician)
Medical Ed: University of Pittsburgh School of Medicine (1981)
Action: 4/07/2006. Order issued lifting Consent Orders of 4/07/2000, 4/17/2003, and 4/28/2005.

LANGSTON, Bernard Leroy, MD
Location: Shallotte, NC (Brunswick Co)
DOB: 4/06/1945
License #: 0000-27938
Specialty: FP (as reported by physician)
Medical Ed: Medical University of South Carolina (1972)
Action: 4/26/2006. Order issued lifting Consent Order of 6/09/2003.

LAVINE, Gary Harold, MD
Location: New Bern, NC (Craven Co)
DOB: 11/04/1964
License #: 2001-00403

Specialty: EM (as reported by physician)
Medical Ed: University of South Alabama (1989)
Action: 3/09/2006. Order issued lifting Consent Order of 3/06/2003.

LONG, James Randall, MD
Location: Lexington, NC (Davidson Co)
DOB: 2/05/1960
License #: 0000-33456
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1986)
Action: 3/02/2006. Order issued lifting Consent Order of 10/25/2004.

MATTHEWS, Charles Joseph, MD
Location: Raleigh, NC (Wake Co)
DOB: 2/31/1955
License #: 0000-27245
Specialty: N (as reported by physician)
Medical Ed: University of Virginia (1978)
Action: 4/28/2006. Order issued lifting Consent Orders of 4/14/2003 and 4/26/2006.

McCLELLAND, Scott Richard, DO
Location: Wilmington, NC (New Hanover Co)
DOB: 7/19/1948
License #: 0000-29064
Specialty: P (as reported by physician)
Medical Ed: Kirksville College of Osteopathic Medicine (1980)
Action: 3/02/2006. Order issued lifting Consent Orders of 4/22/2003 and 9/23/2004.

PATTERSON, Ronald Halford, MD
Location: Midlothian, VA
DOB: 7/27/1943
License #: 0000-20747
Specialty: ORS (as reported by physician)
Medical Ed: Medical College of Virginia (1971)
Action: 4/04/2006. Order issued lifting Consent Order of 4/04/1990.

DISMISSALS

AHMAD, Nasiha, MD
Location: Carrollton, TX
DOB: 3/15/1947
License #: 0000-28916
Specialty: OB/GYN (as reported by physician)
Medical Ed: Dacca-Bangladesh (1970)
Cause: Dr Ahmad now has proven she has completed the required CME for 2002, 2003, 2004.
Action: 2/21/2006. Order Dismissing Charges issued: The charges of August 2005 against Dr Ahmad concerning her failure to complete required CME are voluntarily dismissed.

MacGUFFIE, Martha Morgan, MD
Location: New York, NY
DOB: 1/22/1924
License #: 0000-21680
Specialty: PS/GS (as reported by physician)
Medical Ed: Columbia University (1949)
Action: 4/18/2006. Notice of Dismissal issued: the Notice of Charges and Allegations dated 2/27/2006 against Dr MacGuffie is dismissed with prejudice.

SMITH, Forrest Owen, MD
Location: Pleasanton, CA
DOB: 1/27/1939
License #: 0000-19035
Specialty: OB/GYN (as reported by physician)
Medical Ed: Duke University School of Medicine (1970)
Cause: Dr Smith now has proven he has completed the required CME for 2002, 2003, 2004.
Action: 2/21/2006. Order Dismissing Charges issued: The charges of September 2005 against Dr Smith concerning his failure to complete required CME are voluntarily dismissed.

REENTRY AGREEMENTS

BERGER, Mitchell Zachary, MD
Location: Alpharetta, GA
DOB: 10/15/1957
License #: 2001-01312
Specialty: IM/HO (as reported by physician)
Medical Ed: University of Medicine and Dentistry of New Jersey
Cause: Dr Berger has only practiced medicine for several weeks since 1999. His CME is up to date.
Action: 3/24/2006. Reentry Agreement and Order executed: The Board shall issue Dr Berger a license; he shall have a physician colleague observe his practice for the first three months of practice; the physician observing him shall send the Board an evaluation letter at the end of the observation period; Dr Berger shall meet with the Board on request.

ELLIS, Dale Edwin, Physician Assistant
Location: Denver, NC (Lincoln Co)
DOB: 3/31/1954
License #: 0001-00890
PA Education: Alderson-Broaddus (1982)
Cause: Mr Ellis' North Carolina PA license has been inactive since September 2001.
Action: 4/21/2006: Reentry Agreement and Order executed: Mr Ellis is issued a PA license; he shall have his supervising physician observe his practice for the first six months and send the Board an evaluation letter at the end of the observation period; Mr Ellis shall obtain all required CME.

FAULCON, Clarence Lee, MD
Location: Durham, NC (Durham Co)
DOB: 8/02/1951
License #: 0000-30334
Specialty: IM (as reported by physician)
Medical Ed: State University of New York, Downstate (1983)
Cause: Dr Faulcon has not practiced medicine since October 2000 and is not current with CME.
Action: 3/10/2006. Reentry Agreement and Order executed: Dr Faulcon is issued a full license; he shall have a physician colleague observe his practice for the first year and report to the Board on Dr Faulcon's performance at the end of each quarter of the one-year observation period; Dr Faulcon shall meet with the Board on request.

MONDEREWICZ, Kathleen Marie, MD
Location: Ashland, KY
DOB: 3/16/1955
License #: 2006-00340
Specialty: FP (as reported by physician)
Medical Ed: Temple University School of Medicine (1994)
Cause: Dr Monderewicz has not practiced clinical medicine since November 2001. She has practiced occupational medicine since November 2003. CME is up to date.
Action: 4/10/2006. Reentry Agreement and Order executed: Dr Monderewicz is issued a full license; she shall continue to limit her practice to occupational medicine; should she decide to change to a position involving treatment, rather than only diagnosis, she shall notify the Board and not begin clinical practice until she has met with the Board to discuss a plan for her safe resumption of practice.

PETERSEN, Ruth, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 2/07/1961
License #: 2006-00485
Specialty: GPM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1989)
Cause: Dr Petersen has not practiced medicine since 6/2000. Her CME is up to date.
Action: 4/12/2006. Reentry Agreement and Order executed: Dr Petersen is issued a full license; she shall have a physician colleague observe her practice for two years; the observing physician shall meet with her as required by the Consent Order and provide the Board a report on her performance at the end of each quarter; Dr Petersen shall not begin practicing until she has approval of her observer and her reentry plan by the Board's Dr Loomis; must meet with the Board as requested; must pass the specialty board examination in preventive medicine by 3/31/2007; must not supervise midlevel practitioners for at least six months after resuming practice and only after approval by her physician observer.

TINSLEY, Ellis Allan, Sr, MD
Location: Wrightsville Beach, NC (New Hanover Co)
DOB: 1/21/1934
License #: 0000-15373
Specialty: GS/TS (as reported by physician)
Medical Ed: Vanderbilt University School of Medicine (1959)
Cause: Dr Tinsley has not practiced medicine since April 2002. His license became inactive in February 2005.
Action: 2/04/2006. Reentry Agreement and Order executed: The Board shall issue Dr Tinsley a full license; he shall have his practice observed by a physician colleague for the first six months of practice; the observer shall report on Dr Tinsley's performance to the Board at the end of the six-month period; Dr Tinsley shall obtain practice site approval from the president of the Board; he must meet with the Board as requested.

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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Raleigh, NC

North Carolina Medical Board Meeting Calendar

Meeting Dates: August 16-17, 2006; September 20-22, 2006; October 18-19, 2006; November 15-17, 2006, December 16, 2006

NCMB Licenses Perfusionists

On July 1, 2006, the North Carolina Medical Board began licensing and regulating the practice of perfusionists. Typically certified by the American Board of Cardiovascular Perfusion, perfusionists will now be required to apply for a license and register their license biennially with the Board. The NCMB approves license applications and regulates perfusionist practice with the advice of the Perfusionist Advisory Committee, a subcommittee of the Board. For more information on licensure, or to view the PAC's meeting dates, agenda, and minutes from previous meetings, please visit the Board's Web site at *www.ncmedboard.org* or contact Quanta Williams, Perfusionist Coordinator, at *quanta.williams@ncmedboard.org*.

North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609