Primum Non Nocere

No. 2, 2007

forum

NC MEDICAL BOARD

Is It Time for a Non-Punitive Medical Liability System? Page 3

President's Message

The Horse Is Out of the Barn
(But We Are Still in Control of the Reins)

H. Arthur McCulloch, MD

Profiling: the term may evoke a sense of distrust and discomfort. To medical boards, profiling is the display of practice-relevant information about physicians and PAs on the board's public Web site. In recent years, demand has increased for information as health care consumers seek to make informed choices about their providers. In fact, the NCMB Web site receives 100,000 inquiries per month. Since Massachusetts passed the first profiling law in 1996, several states have done so, and other medical boards (including North Carolina) have voluntarily provided profile information such as training, specialty, board certification, hospital privileges, public files and public documents, and licensure in other states.

This Board is now considering adding other facts to the physician profile. As we do so, we must insist that the information provided be *accurate* and *relevant*.

The addition of public actions in other states, felony convictions, and discipline by Medicare, Medicaid, FDA, and DEA is valuable information to the public and will not likely be controversial. Two items being considered, however, are controversial and will require significant discussion before decisions are made. These topics are (a) actions taken by a hospital's medical staff resulting in the loss or restriction of a practitioner's privileges and (b) a practitioner's malpractice history.

I believe that a practitioner's reduction or loss of hospital privileges can represent significant information that a patient deserves to know. Every hospital staff office with which I have been associated takes action to reduce a practitioner's ability to practice only after significant concerns have been raised and an arduous discovery process has been completed. Petty personality differences and issues of competition don't typically survive that test. Hospitals must report these actions to the Board. In my opinion, the information is relevant and a pertinent part of the practitioner's professional history.

Turning to the history of "malpractice" payments, we can be confident that the information is accurate (reporting is mandatory). But is it relevant? We all know of anecdotal evidence that the tort system of compensating patients is fraught with shortcomings and misinterpretations. In the December 1996 issue of the *New England Journal of Medicine*, researchers verified what most of us know from experience: 1) neither the presence of an adverse event nor an adverse event due to negligence correlated with payments; 2) cases in which negligence was found were no more likely to result in payment. In fact, the only predictor of payment was the presence of disability. I

In This Issue of the FORUM

Primum Non Nocere

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NC MEDICAL BOARD

Raleigh, NC **Vol. XII, No. 2, 2007**

North Carolina Medical Board

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have believed for years that "malpractice" insurance is an unnecessarily prejudicial term. Rather it should be called "bad outcome" insurance.

The results from that study indicate that liability payments were associated with negligence 11% of the time. More recent studies published in the *Annals of Internal Medicine* and in the *New England Journal of Medicine*, both in 2006, point to a 75% correlation between litigation outcomes and the merits of the claim. If we were presented with a diagnostic test that was correct 11% to 75% of the time, we would not consider the results accurate. Additionally, a special committee convened by the Federation of State Medical Boards found that although malpractice information is in demand, it is not a reliable measure of competence.

There are many possible ways to present payment history, which include:

- reporting of all payments;
- reporting of all payments in excess of an arbitrary amount;
- reporting of all payments after a certain frequency has been exceeded (eg, three in five years);
- reporting of payments as a comparison to others in the same specialty either by number of cases or dollar amounts.

None of these methods addresses the issue of competence. They merely represent a physician's willingness to treat high acuity patients or practice in a high-risk specialty or geographic area. Remember that disability, not negligence, is the predictor of payments. But it is the history of negligence that the public deserves to know.

This Board intends to honor its public trust with valuable information. In demanding "malpractice" information, our patients are really asking about our competence. So how can we serve the public's interest with relevant information? Perhaps a resolution is at hand. All payments are reported to the Board and all cases are reviewed by the Board's medical director, legal director, and Board members. Outside experts are consulted as needed.

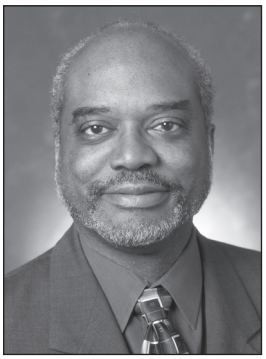
One alternative to the previously mentioned methods of reporting payments would be to report only those cases where a physician's negligence was determined to have contributed to the outcome (payment). In cases where no negligence was found, we could file the information away for what it is worth. The same litmus test of negligence or incompetence could be applied to hospital actions as well.

Perhaps we should keep with the attending's traditional admonition to the intern: "Give me what I want, not what I ask for!" No system will be without its drawbacks, but profiling we create will be more relevant and valuable than that which is initiated elsewhere. The view is better from the saddle.

If You Ask Me

Is It Time for a Non-Punitive Medical Liability System?

George L. Saunders, III, MD
Secretary, NCMB



Dr Saunders

Is it time for a "non-punitive" medical liability system? The very question raises the hackles of the general public, hospital administrators, health care providers, and trial lawyers alike. Possibly the only more controversial subject at this point in American history would be the Iraq war.

What is or should be a non-punitive medical liability system? What elements should it have and, just as importantly, what elements should it not have? It should not be a carte blanche for substandard care, nor a way for wayward practitioners to escape culpability.

A Few Facts and Questions

First a few facts. I will use as a point of reference the experience of a primary care physician because that is the life I know.

The average primary care physician has between 4,000 and 5,000 face-to-face patient encounters per year. (I would estimate another 10 percent or more telephone contacts.) Is there anyone on this planet who can perform 5,500 acts a year, year in and year out, and make not one single error? Those who know me often hear me say: "No one's perfect, except me." Likewise, those who know me know that I will immediately follow up with: "But my wife keeps trying to disabuse me of that idea." I consider myself to be a good practitioner of the medical arts, one with higher than average standards, yet I know that I make mistakes. And, yes, sometimes my patients have been harmed by these mistakes. If there is a physician anywhere who says that he or she has not erred, I say categorically that he or she is a prevaricator (that's a nice way of saying that they are not telling the truth), naive, or both.

If all doctors (and other health care providers) make mistakes, are we therefore to haul them all before the nearest court every year for their yearly legal strap hauling? When put in these terms, the answer, hopefully, would be no. What does happen? Let's talk about that later.

Are people harmed by medicine? Undoubtedly. Is injury avoidable? Sometimes. If the answer is yes in one case, that is one case too many. I went through a decade of training after high school to help people, to end suffering, not to be the cause of suffering. I repeat, if one patient suffers at my hands, despite my best efforts, that is one patient too many.

Are there doctors who need to be weeded out of medicine? Yes. If I did not believe that before, my experience on the North Carolina Medical Board would have shown me that, indeed, this is true. The vast majority of doctors get up every morning and try the best they can to do their very best for their patients, often under trying conditions. There is a small number of physicians who, because of addiction, illness, greed, etc, do not do their best. We physicians owe it to our patients to protect them from impaired physicians.

Still, we all make mistakes. Some of our mistakes have bad outcomes—outcomes where our patients are harmed. Any physician who believes that in the course of thousands of procedures/patient encounters he or she has never made a mistake that has harmed a patient takes a position that defies logic and common sense. To my fellow physicians I would ask: what would you do with a patient who, through no fault of his or her own, was harmed by a procedure /encounter with one of us?

"Is there anyone on this planet who can perform 5,500 acts a year, year in and year out, and make not one single error?"

A Non-Punitive System

What would a non-punitive system look like? It must be transparent, fair, predictable in terms of payouts and total costs. It must lead to meaningful change where preventable error is found. Its ultimate result must be improved outcomes for our patients.

Funding and payouts must be predictable. Patients must have a real opportunity to be heard. When error is present, it needs to be admitted and addressed quickly, openly, effectively, and compassionately. We need to tell patients that we are sorry when we really are sorry for what has happened to them. A year of discovery—where the major impetus of the medical provider is to circle the wagons and cover up, and the major task of the plaintiff's attorney is to find someone with deep pockets to pin the blame on no matter how peripheral that party is to the actual harm—is a waste of valuable resources and time that could and should rightly go to fixing the problem and trying to make a patient whole. We will never be able to fix all the problems with money, but ending the current adversarial system and allowing patients to have frank and open talks with health care providers, in my opinion, will go a long way toward making injured patients whole again. A non-punitive medical liability system would contain the following.

- The method of determining whether a claim is eligible for payment needs to be clear and simple. It needs to have physician and other health care provider input. It needs to have legal input. It

needs public input. Health administrators also need to be part of the process. A panel of diverse interests and groups is essential. There needs to be some discretion, but that discretion needs to be narrowly circumscribed.

- The system must move toward payouts within weeks to months where injury is clear and harm clearly discernible. The current process of taking years to conclude a case cannot continue.
- Appeals must be limited and for clearly determined reasons—eg, a clear conflict of interest in one of the presiding members.
- The payments must be structured to encourage rapid resolution by all parties involved, with reasonable disincentives to delay settlement and to endless appeals.
- Corrective action needs to be quick and effective and must include input by patients.

Will such a system incur more or fewer claims? Probably more. Yes, that's correct, more, because some people who now suffer major injury from a medical procedure get nothing under our current system of medical liability because no one with a deep pocket can be found liable. (Some would say, "Tough luck." Personally, I feel this is unfair.)

"We can encourage a system that creates a climate in which patient safety efforts flourish, where safety issues are removed from legal blackmail"

The benefits would be two-fold. Meaningful change to actually correct the problem rather than hastily considered fixes would go forward. Corrective action could be implemented sooner with proper investigation of root causes leading to fewer injuries—ie, the safer practice of medicine. Also, the large amounts that now go into discovery and legal fees could actually go to the injured patient. I believe that a properly run, non-punitive system will save money.

Another caveat: a high enough bar for injury must be set so that minor, non-life- threatening injury would not be compensated. A one-inch bruise at the site of venipuncture would not be compensated.

Fiscal monitoring of the entire system would have to be constant so that the system remained solvent.

Other Choices

What are the other choices we have? We can allow the medical liability industry to continue as it does now. The result would be the slowing of meaningful corrective action with many more deaths and injuries along the way. Also, patients in many areas would not have access to care by trauma surgeons, neurosurgeons, and obstetricians (among others). We could let medicine make patient safety changes by lawsuit. A slow process of dubious effectiveness, which invites denial and cover-up and which brings cases to light often years after the patient has suffered irreparable but preventable harm.

A second choice is to initiate incremental change of current malpractice law. This course, followed by most physician organizations, would limit non-economic awards, limit plaintiff attorney fees, require certification of litigation, etc. (These changes are primarily economic in nature, understandably, and may, as a secondary effect, change the medical liability climate incrementally toward a very modest increase in safety). The key word here is incremental—ie, slow. Also this method requires offering legislative proposals and educating the public and legislators on often complex micro-issues. This method has met with limited and mixed success at best. The recent twin referendums in Florida show the immense difficulties of trying to reduce complex medical and legal actions to a 30 second television spot. The result was a possible temporary victory for physicians—a cap on non-economic damages. (I say temporary because of constitutional challenges). However, on the same ballot, Florida voters gave a victory to plaintiffs' attorneys in the three-strikes-you're-out rule. Physicians found guilty of three instances of substandard practice will lose their license to practice in Florida forever. In most states, physicians have the threat of large monetary awards and medical board action when faced with a malpractice claim. In Florida, if the proceedings go against him or her, the physician has the added possibility of losing the ability to make a living. This will be a factor, I am certain, in forcing settlements for higher amounts in cases that might not otherwise be settled. Patient safety is not well served under this system

The third choice is to effect a paradigm shift. We can encourage a system that creates a climate in which patient safety efforts flourish, where safety issues are removed from legal blackmail. We can create a system where decisions to root out medical errors are based on the best science available, a system where our decisions for corrective action have the best chance of truly improving the safety of those we work for—our patients.

Conclusion

Is medical liability reform the whole answer for medical safety? No. But it plays a much larger part than many of us are willing to admit or recognize. With the institution of a non-punitive system, a major stumbling block for patient safety would be removed.

One of my colleagues told me after I put forward these ideas at a recent North Carolina Medical Society meeting that I should be proud because I was a true leader. He told me that one could always tell a leader because he was the guy standing at the front of the room with all the arrows sticking in his back. This was only the second time I had presented the idea of a non-punitive (no-fault) medical liability system at the NCMS meeting. Though the idea had already received overwhelming approval at the Old North State Medical Society annual convention, had aired favorably among many members of North Carolina Academy of Family Physicians, and had been recommended for action by the leadership of the NCMS meeting I was attending, it was ultimately not adopted by the delegates at large.

It surprised me that these ideas received a 40 percent favorable vote, despite some very vocal opposition. It was at least two years ahead of schedule; I figured it would take five years to pass in that organization. It was, after all, a major change in direction for organized medicine, a totally new paradigm for a nagging and persistent problem.

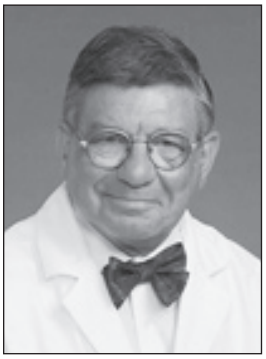
It has been suggested that the safety of American medicine can take a page from the airline industry, an industry that had a horrible reputation for safety at its beginning and which now has a model safety record. One of the airlines' most important steps was to initiate a system of non-punitive reporting. Its past time that physicians institute a similar system.

The opinions expressed here are solely those of George L. Saunders, III, MD. They do not represent the position of the NCMB, nor any organization mentioned in this article.

A Personal View

On the Teaching of Medicine

Walter M. Roufail, MD
Former President, NCMB



Dr Roufail

I was pondering whether to attend, an hour hence, a lecture on euthanasia by one of the nation's leading bioethicists or to take advantage of that sunny afternoon and plant a substantial number of spring bulbs that were definitely overdue. I opted for the latter.

I assume that one of the advantages of partially retiring from the practice of medicine is to have such earthshaking options. I had heard, read about, and tutored students about the subject on multiple occasions and had a slight case of overdose about the matter.

It was rather simple at the beginning: "relieve pain and suffering"; "do no harm to either patients or their families." Since Hippocrates, 23 centuries of observing, bloodletting, leeching, potions, and rudimentary surgery have tried, often unsuccessfully, to fulfill those principles.

I will not dwell on the "Medical Enlightenment" of the 17th to 21st centuries that put medicine on a solid scientific footing. We might reduce it to three words: penicillin, Freud, and DNA. I do not mean to belittle Starling, Pasteur ,Virchow, Charcot, Roentgen, or Madame Currie, but let us face it, penicillin and its offspring have probably doubled the life expectancy of most of the world in the past half-century. With it comes aging, relative prosperity, and the diminishing need to fight for physical survival. Comes AIDS, a runt of a unicellular organism that wipes out millions of multicellular thinking ones—a subtle reminder that we live in an ecosystem in which killing is often synonymous with survival. For millennia, Homo sapiens has killed for food and territory. Now that most bellies are full and survival by reproduction is contained, hunting is limited to supermarkets and reproduction to soap operas and X-rated movies. Our improving Homo sapiens intellect has, however, succeeded in perpetrating the killing of tens-of-millions in the past century, relying on the excuse of improving humanity by way of political and theological theories. I wonder if we will ever find the amino acids sequence for killing in the human genome?

In the meantime, unicellular and multicellular organisms keep on fighting. The hepatitis viruses have now claimed a third of the alphabet. Resistance to Homo sapiens antibiotic weapons is increasing and their long-term consequences are purely theoretical.

DNA, however, is indeed the radical medical revolution of the last half-century. Through thorough understanding of the human genome, we will, possibly in another half-century, remediate all the blind ends of Darwinian "survival of the fittest" and ultimately (why not?) achieve some form of eternity. This indeed will allow us to rejoice in eternal golf, soap operas, and reality shows. I submit to you that in the next half of this century the priority will be to train psychiatrists and psychologists rather than primary care physicians. Comes Freud.

Students in this day and age are encouraged, if not required, to absorb a new medical culture: euthanasia, patient rights, genetic manipulation, animal research, medical economics, alternative medicine, abortion rights, cultural sensitivity, and how to deal with the greed of the "evil" drug and health insurance companies. To expose them to such topics is certainly appropriate and occasionally beneficial. However, one often wonders what belongs to Caesar and what belongs to Hippocrates. At the risk of being blatantly politically incorrect, I think we may be overemphasizing the cultural aspects of medicine.

As a full-time teacher in my waning professional career, I often wonder what we actually need or want to transmit to those aspiring physicians? I admit that I am partial to what I perceive is a recent trend towards returning to the basics of reading and mathematics in our schools, as well as to a return to such basic human values as honesty, civility, and caring for your neigh-

"I think we may be overemphasizing the cultural aspects of medicine"

bors and community. I am told, however, that this is a sure sign of Old Age joining Pregnancy and Menopause on the list of chronic illnesses.

Episodic medicine has been much maligned. Population, preventive, and genetic medicine are certainly not irrelevant buzz words of the day. But I submit to you that a kid with persistent earache or a patient with a Duke D carcinoma of the colon does not give a hoot about their genetic makeup or the "End of History." It seems realistic that the transmission of the basics of episodic medicine should be the primary responsibility of the teacher. Common illnesses, not surprisingly, are common, and the management of acute illnesses has changed marginally in the past few decades. Whether a plain "old cold," chest pain, shortness of breath, abdominal pain, nausea, weakness, or loss of memory is the presenting symptom, our first and most solemn duty is to relieve the pain or suffering, whether by reassurance, medication, or surgery. To ponder whether this is a fleeting episode or the initial symptom of a long-standing illness that will disrupt the patient's life is the second and most important role of the teacher.

"Our first and most solemn duty is to relieve the pain or suffering, whether by reassurance, medication, or surgery"

Today's information about the most innocuous illnesses and the most lethal ones is a forest of unrelenting printed and Web material. To find the pragmatic trees in this dense forest is the role of the teacher.

This brings, of course, the question of mortality and whether the teacher ought to consider it an inevitability or an enemy. This is the fine line between medicine and theology. To cross it is the burden of every generation of physicians. I vote for the relief of physical and mental pain. Mortality at whatever age, I think, is inevitable. Is it the role of the physician to prepare patients, particularly elderly ones, for this inevitable outcome? Philosophers and medical ethicists are often too obscure in their writings and hardly understood by the lay public. Lawyers and hospitals are active in living wills and health powers of attorney. In my experience, it is still individual choices that dictate patients' views of life and death. Some would like to make it into the *Guinness Book* of survival, others (most of them) are grateful to wake up every morning and still be alive. Many have such deep religious faith that it is in nobody's hand when they are going to depart. All are more apt to share their view with their personal physicians than their families. I think it is the duty of the teacher to teach his students to broach the subject. When and how is the art of the individual physician and, in my view, cannot be taught.

To summarize, I think the foremost duty of a teacher is to teach the essentials of scientific clinical medicine, to teach students to listen to the patient's complaints, and to teach them to do a proper physical examination. In the majority of cases, I believe, laboratory, imaging, and endoscopic tests will confirm 90 percent of their original diagnosis, not surfing the Web to find a clue about what is going on.

Dr Roufail is a professor of medicine at Wake Forest University School of Medicine.

REVIEW

Does Hope Make a Difference?

E. K. Fretwell, PhD
Member, NCMB

Dr Fretwell

For a seriously ill person, does hope really make a difference? Basically yes, Dr Jerome Groopman tells us in *The Anatomy of Hope*, provided it is real. In the words of one of his perceptive patients: "For a physician to effectively impart real hope, he (she) has to believe in it him(her)self."

After more than 30 dramatic years of medical practice, Dr Groopman shares with the reader his own clinical experiences, mistakes (viewed in retrospect), and findings based on intensive study, drawing on colleagues and research, and examples of practical application. While his long-term research concentrates on understanding why cancer cells grow and spread, and how viruses like HIV and hepatitis invade and destroy healthy cells, he faces two other demanding questions.

- Why do some people find and hold out a hope while others do not?
- How do the brain and the body biologically talk to each other?

Holder of the Recanati Chair of Medicine at the Harvard Medical School and chief of experimental medicine at Beth Israel Deaconess Medical Center in Boston, Dr Groopman brings to the issue of hope a seeking, actively inquiring mind, and a healthy skepticism about the "vast popular literature" that contends, without much evidence, that positive emotions affect the body in health and disease.

Beginning even before his internship, Dr Groopman faced one of the great uncertainties of a young (and maybe even an older) practitioner: how much does one tell a seriously ill patient when the road ahead is unclear? Starting early in his distinguished career in oncology and hematology, he was often faced with the challenge of how to communicate to patients and their families "a poor prognosis." Not once, he recalls, in schooling, internship, or residency, was he ever instructed in such skills.

In retrospect, it appears that, in his own words, he vacillated over his early years between telling too much (some of it really unpredictable) and not sharing with appropriate candor. Aptly, he quotes from Oliver Wendell Holmes, the nineteenth century physician, poet, and essayist, who cautioned: "Beware how you take away hope from another human being."

The Anatomy of Hope: How People Prevail in the Face of Illness
Jerome Groopman, MD
Random House, New York, 2005
253 pages, $14.95 (paper)
ISBN 0-375-75775-9
[Includes index and reader's guide.]

Coincidentally (and with cross referencing), the *Wall Street Journal* (March 29, 2005) addresses the same issue. How much do you tell the patient who is suffering from what will be known as Lou Gehrig's disease when the patient is Lou Gehrig? Diagnosed at the Mayo Clinic in 1939, this greatest of all New York Yankees first basemen carried on a detailed correspondence with his physician, Dr Paul O'Leary. His curiosity about his faltering future was barely addressed, it appears. "I despise the dark," he wrote to his doctor. "But I also despise equally as much false illusions. . . . I do not want to be a hero but I would also like to know the facts."

With the perspective of 60 years and almost two decades of uncured and terrible debilitating back pain, Dr Groopman draws on his clinical practice and in his own life he came closer to "the middle ground where both truth and hope could survive."

Hope, he observed from research, comes in two varieties: cognition and feeling. They are not separate in the brain but interweave and modify each other.

From among his many patients over the years, Dr Groopman selects examples that illustrate both challenges and possible solutions.

- A former GI who gave up all hope (at first) for his own recovery because he felt his life would mirror that of a deceased wartime buddy.
- An African-American mother and daughter who felt patronized because they were not told the whole truth in a timely manner.
- A distinguished surgeon and cancer patient who went the whole route with surgery and radical chemotherapy and continued (successfully!) to hope when all his doctors saw none.
- A self-described "tough broad" and gambler who was told the odds, sensed "a bad deal," but continued to live.
- A devoutly Jewish woman who would not recognize real options, felt "undeserving of hope" because of a major personal transgression and eliminated all hope because she deserved her disease.
- A retired history teacher whose hope was self-expanded partly because she had made strong commitments to finish some volunteer work.

The most poignant case study was Dr Groopman himself, suffering for some 19 years from a failed spinal surgery. Coming under the influence of an enthusiastic new surgeon, he rekindled his own hope, which gave him courage to embark on what he called an "arduous and contrarian program of treatment." There is an authentic biology of hope. Change in mindset can alter neurochemistry.

"How much does one tell a seriously ill patient when the road ahead is unclear?"

Turning off negative emotions is indeed a challenge, Dr Groopman points out. "The interplay between positive and negative occurs when we set a goal and pursue a path to achieve it. Such behavior," he goes on, "seems to involve the reward circuits—rich in dopamine from the pre-frontal cortex—that runs deeper into lower areas that include the amygdala and the hippocampus."

On balance, is this a good read—for highly specialized practitioners? for primary care physicians and nurses? for families and patients for whom the end may be near? and for the answer-seeking general public? Probably yes for all of these. The more sophisticated professional reader will find at least part of this known territory. For some others, reading this book could be a significant breakthrough.

Dr Groopman comes across as an experienced, humane teacher as well as a wise practitioner and researcher. His writing style is clear and straightforward. He avoids the excessively sensational and self-seeking. As he points out in a 20-page note section at the end, he has even more to tell the reader. His editors, he tells us, helped make sure that everything written should resonate as authentic, which it does. An editor riding on "schmaltz patrol" kept him from lapsing, he reports, into the maudlin.

Quite possibly a number of the experiences Dr Groopman describes will not be entirely new to many readers. Still, the clinician or practitioner who reads with an open mind can find *The Anatomy of Hope* a stimulating and long-lasting experience.

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

The Substance-Abusing Impaired Physician

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

Dr McEwen

Impairment: The inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness, including alcoholism or drug dependence. (AMA Council on Mental Health)

"Physicians are ethically obligated to intervene in some way when they recognize or suspect that a colleague has a substance abuse issue that interferes with their ability to practice"

Physicians may become impaired, or unable to perform their professional responsibilities, because of various health problems: medical conditions, psychiatric disorders, and substance abuse and/or dependence (SA). Approximately 15% of physicians will be impaired at some point in their careers (Boisaubin and Levine 2001). Impairment may result in poor occupational functioning and poor patient outcomes. Substance abusing physicians generally do not seek help directly. They may not recognize they have a problem or they may be afraid of the consequences of seeking help (effects on medical license or hospital privileges). More often, concerned friends, colleagues, or hospital administrators take the first step toward addressing a substance abuse problem or potential problem. Physicians are ethically obligated to intervene in some way when they recognize or suspect that a colleague has a substance abuse issue that interferes with their ability to practice medicine. Procedures and programs to identify and rehabilitate impaired physicians in an effort to return them to optimal functioning are readily available in North Carolina and will be discussed in this article. Comprehensive treatment procedures and close monitoring are highly effective in physicians. A recent outcome study showed that 91% of North Carolina physicians in monitored substance abuse treatment had good outcomes (Ganley, et al, 2005).

The Problem

Alcohol is the most common substance of choice and research suggests that physicians are at equivalent risk for alcohol as the general population (Wienecke 2005; O'Connor 2001; Hughes 1999; Mansky 1999). Overall, physicians also have similar incidence of drug abuse and dependence as the general population. This is a result of a lower incidence of addiction to street drugs balancing the higher incidence of addiction to prescription medications by physicians (Mansky 1999). After alcohol, opiates and benzodiazepines are the next most common substances of abuse (Wienecke 2005) and the abuse of these substances does occur at a higher rate than among the general population. Hughes and colleagues found that 11.4% of physicians had used benzodiazepines (unsupervised) and 17.6% reported unsupervised use of opioids in the past year (Hughes 1992). A study of the New York State Physicians' Health Program indicated that 88% of participants used alcohol or prescription drugs as their drug of choice (61% using alcohol and/or sedative drugs; 24% using opioids; 3% using stimulants) and only 12% cited marijuana or cocaine as their drug of choice (Mansky 1999). According to self-report, SA was highest among emergency physicians and psychiatrists. As might be expected, there are also differences in drugs of choice between specialties: ED physicians have higher rates of illicit drug use; psychiatrists have higher rates of benzodiazepine abuse; and anesthesiologists use opiates at a higher rate (Hughes 1999). SA, especially involving the minor opiates or benzodiazepines, may begin during residency. Residency programs, particularly in anesthesiology, have become proactive in identifying and intervening with these residents.

Dr Lohr

In a large survey of 9,600 physicians, physicians were found to be five times as likely as matched controls to take sedatives and minor tranquilizers without medical supervision (O'Connor 2001; Hughes 1999). In Florida, anesthesiologists constitute 5.6% of total licensed physicians, but account for almost 25% of the physicians with drug abuse disorders (Gold 2006). This has generally been attributed to access. Recently, researchers have postulated that unintended secondhand environmental exposure puts physicians working in this setting at increased risk (Gold 2004a; Gold 2005). Researchers have demonstrated the presence of propofol and fentanyl in operating room air after IV administration, with the highest concentrations close

to the patient's mouth where anesthesiologists typically work (Gold 2004b). Anesthesiologists and other physicians exposed to fentanyl in the workplace represent 90% of fentanyl abusers in Florida (Gold 2005). Further studies to determine what role environmental exposure and sensitization play are underway.

Although physicians may not have higher rates of substance abuse than the general population, certain attributes that are advantageous for success in medicine predispose them to substance use disorders. These characteristics include a strong drive for achievement and a strong will, love of challenges exhibited by risk taking behaviors, instrumental use of medications and pharmacological optimism, and a daily need for denial (Mansky 1999). Overall, female physicians appear to have a substance abuse rate equal to that of male physicians (Skipper 1997). Studies suggest, however, that the epidemiology of substance abuse does vary slightly between the genders. Female physicians with substance abuse issues tend to enter treatment out of subjective distress whereas male physicians are more likely to be referred for work-related reasons. At least in part because their SA problems do not usually manifest as problems on the job, women are generally underrepresented in treatment. Female physicians are also more likely than their male counterparts to be dependent upon alcohol and to use alcohol exclusively. Psychiatric comorbidity appears to be equivalent across gender (McGovern 2003).

Identification

Not surprisingly, colleagues and coworkers are often hesitant to confront a physician they suspect has a substance abuse problem. Reporting a colleague to the hospital administration or state medical board also may seem daunting. Hospitals are required to have committees that deal with physician health and referrals to such bodies provide an avenue for concerned colleagues, patients, or administrators to bring the problem the attention it merits. These committees also help to ensure that addicted individuals follow the given treatment protocols (Wienecke 2005).

Common predisposing factors include a family history of addiction, access to mood-altering medications (particularly opioids), domestic upheaval, and unusual work stressors. There are a number of signs that a physician might be experiencing substance abuse or dependence.

Behavioral changes:

- withdraws from friends, colleagues, and activities
- short-tempered, caustic, irritable when previously kind and understanding
- frequent outbursts of anger
- use of large quantities of alcohol, frequent drunkenness
- self-prescribing of sedative-hypnotic, opioid medications
- DUI citations

Physical changes:

- loss of appetite or reduced level of exercise
- frequent medical complaints without specific diagnoses (fatigue, depression, insomnia, indigestion)
- deterioration of personal hygiene
- self-treatment of physical problems

Performance changes:

- misses appointments and rounds
- can't be reached when on call
- deterioration of charting
- smell of alcohol on breath

North Carolina Physicians Health Program (NCPHP)

The North Carolina Medical Board was established by the General Assembly in 1859 "in order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina." The Board has the authority to license, monitor, discipline, educate, and, when indicated, rehabilitate physicians who are deemed incompetent or unsuited to practice.

The North Carolina Physicians Health Program (NCPHP), established by state statute, functions with the support and direct input of the Medical Board. It provides for confidentiality and anonymity for both the reported individual and the reporter. The program is based on concern for both the public and the potentially impaired physician with the goal being that the physician retain or regain full effectiveness. When necessary (to ensure the safety of patients), NCPHP employs various strategies to ensure that the physician avails himself/herself of resources and support necessary for recovery.

"Female physicians are also more likely than their male counterparts to be dependent upon alcohol and to use alcohol exclusively"

The NCPHP coordinates identification, intervention, and treatment for potentially impaired physicians and PAs. Through presentations to physician groups (eg, grand rounds, hospital staff meetings, specialty societies), the NCPHP instructs health care professionals how to identify and intervene. The NCPHP interviews and assesses reported physicians and, when indicated, refers them for treatment. The NCPHP continues to monitor and support these participants as needed to verify and document compliance and continued sobriety. Caduceus and other self-help meeting attendance is normally required as are random urine and other drug screens as well as random home and/or office visits. More information about the NCPHP, including how to make a referral, can be found at *www.ncphp.org*.

Treatment

In general, physicians respond favorably to treatment. Treatment components may include specialty substance abuse treatment, involvement with a physician peer group, an opportunity for inpatient treatment when needed, family involvement, and specialized continuing care and monitoring. Treatment of physicians

as patients can be difficult and expertise is beneficial (Skipper 1997). Physicians generally access medical care less frequently than the general population and often have great difficulty accepting the patient role. In addition, the fear of the impact of disclosure of a substance abuse issue also plays an important role. Firm limits and boundaries are essential so that the patient-physician does not resist the patient role and end up self-directing his/her own care and undermining treatment.

"Firm limits and boundaries are essential so that the patient-physician does not resist the patient role"

A review of 120 impaired physicians shows that long-term (3-4 month) treatment geared specifically to health care professionals was the most effective treatment modality (Skipper 1997; Smith and Smith 1991). To avoid patient harm and the more severe sanctions associated with relapse, it is critical that the initial treatment approach be of sufficient duration and intensity to be effective.

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Sara B. McEwen, MD, MPH, is consultant to the Governor's Institute on Alcohol and Substance Abuse and the Division of Mental Health, Development Disabilities, and Substance Abuse Services. Jacob A. Lohr, MD, is executive director of the Governor's Institute on Alcohol and Substance Abuse. This is the last in a series of articles addressing substance abuse/dependence issues.

"Trust Me, I'm a Doctor"

Mark E. Romanoff, MD
Former President, Mecklenburg County Medical Society

Dr Romanoff

This phrase has gone from beyond cliché to almost being a joke. I have used it myself as a throw-away line when I am being my most sarcastic. It is a shame, because there is a lot of truth contained in that sentence. I think of this because March 30 is Doctors' Day. "Doctors' Day marks the date that Crawford W. Long, MD, of Jefferson, GA, administered the first ether anesthetic for surgery on March 30, 1842."[1]

As an anesthesiologist, I am proud that Doctors' Day commemorates one of the first surgical anesthetics. Not to brag, but the Institute of Medicine has cited anesthesiology for improving operative morbidity and mortality over the past 20 years. Due to our success, life- and limb-saving surgical procedures can be done on patients thought to be "too sick for anesthesia."

"Trust Me, I'm a Doctor," still sounds trite, but shouldn't. "Trust Me, I'm a CEO" just doesn't ring as true. There has been a lot of negative press about Enron and CEOs who engage in mega-mergers with the intent of breaking up these companies in the near future.

Here is the anecdote that convinced me. Two years ago, I attended a dinner at the AMA President's meeting. I had occasion to go downstairs toward the men's room and encountered a group of concerned people hovering aimlessly over a woman lying on the floor. I inquired about the woman and a bystander defensively said that she had "passed out." I then

said that I was a physician. Peter Jackson could not have directed the scene any more efficiently. A path opened up to the "patient" and her friend said, "It will be OK, a doctor is here." I asked a few questions of the woman, who was awake but pale, and determined that she had symptoms of a viral infection and became orthostatic and pre-syncopal after getting up too quickly. I felt her pulse after she gladly offered her wrist. I told her to sit up and she did. I had her stand after a while. She looked fine, and I told her to be cautious as she left. She and her friends thanked me. The incident didn't last 10 minutes. There was never any threat to life or limb, no ACLS needed, but a stranger in a strange situation put all her trust in me, answered all my questions and followed every command I gave her. She didn't know me, so her faith was not in me, it was given to me as a representative of a trusted profession: a doctor. This was not my first time in this situation and I know everyone reading this has his or her own story to tell. This interaction is not uncommon to many clinical encounters we have every day with our own patients. A concerned patient wants information and reassurance about a non-life threatening process. We answer their questions based on our expertise, specialized knowledge and experience, which forms the basis for their belief in us.

Some philosophers (John Locke) suggest that trust implies a contract and this must be consensual. If it is consensual, the person being trusted must act trustworthy.[2] As I have been told numerous times, medicine is a business. It is also an art and a science. My narrative above suggests that it comes close to a deity in some respects. Sometimes we are so inured to the emotional toll surrounding an illness that we forget how it impacts out patients and their families and what patients give up (privacy, humility, control) for us to help them. We must honor this trust with deference. We have an obligation to adjust our priorities toward patient care.

If you listen, you will hear physicians say something like this every now and then, "You don't know what it is like trying to negotiate with (pick a 3rd party payer)" or "I can't believe all the paperwork involved in gaining approval for (pick a treatment option). It is so stressful." Let me go on the record, do not confuse the irritation of negotiating a contract or waiting on hold for an adjuster with the stress of patient care. I can still remember, during my fellowship, trying to keep a pregnant mom and her baby alive during a C-section. She had HELLP syndrome (before it was a named entity) and had developed DIC. She was bleeding profusely from a liver fracture and I had to escort the dad out of the operating room to continue resuscitation of his wife and child. I still remember his face when my attending, the obstetrician and myself, told him his wife had bled to death and his baby was in critical condition in the NICU. We deal with these life and death issues every day. That is stress.

Business is business. Medicine encompasses so much more, a bond, an almost mystical relationship with your patient despite technology. The stress of negotiating is real, but can you compare trying to acquire 130 percent of Medicare rates to keeping someone alive? I am not a Pollyanna. I have seen the consequences of failing practices that cause physicians to change locations to earn a decent wage or retain dignity. I understand that you can't practice medicine without meeting your overhead and making an adequate if not extravagant living, but let us keep our priorities straight. Medicine is a business, but not *just* a business. We cannot confuse saving a few dollars with saving a few lives. We are privileged to be in this position and we have responsibilities beyond the fiduciary, which induce real stress as we try to do our best in every situation. Patients have placed trust and faith in us; we should try always to respect and honor their trust.

"Patients have placed trust and faith in us; we should try always to respect and honor their trust"

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1. American Society of Anesthesiology Web site 2004 *http://www.asahq.org/news/ddnewsrelease.htm.*
2. *The Oxford Companion to Philosophy 2nd Edition*. Edited by Ted Hoderich. Oxford University Press, Oxford, England. 2005, pg. 926.

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Stockpiling Solutions: North Carolina's Ethical Guidelines for an Influenza Pandemic

An Essential New Resource Is Published

In April of this year, the North Carolina Institute of Medicine, in collaboration with the North Carolina Department of Health and Human Services, Division of Public Health, issued *Stockpiling Solutions: North Carolina's Ethical Guidelines for an Influenza Pandemic*. In a letter accompanying the initial distribution of the *Guidelines*, Pam Silberman, JD, DrPH, president and CEO of the NCIM, noted that many experts have warned it is not a question of "if" but "when" the next flu pandemic will arrive. When that occurs, some 40 percent of workers will be out of the workforce due to their own illness or that of a family member. This will

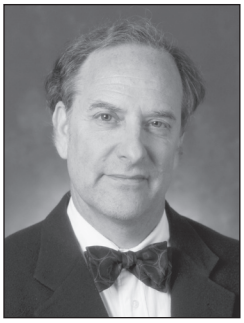
have a dramatic impact on critical industries, including health care, that provide the goods and services basic to the functioning of society.

The *Guidelines* summarizes the conclusions and recommendations of a task force that comprised North Carolinians representing the health, safety, government, business, industry, religious, advocacy, and ethicist communities of the state. The group was convened by the two sponsoring organizations, and the *Guidelines* reflects the results of nearly a year-long examination of the ethical issues the state may face during a flu pandemic and of the rights and responsibilities of private organizations and individuals.

The task force developed a set of 16 recommendations that could help assure government agencies, public and private sectors, and private citizens are acting appropriately in the crisis. Overall, the *Guidelines* represents a timely and extensive analysis of the issues and deserves careful attention. While supplies last, single complimentary copies are available to agencies and programs in North Carolina; and the full text is available on line at: *http://www.nciom.org/projects/flu_pandemic/ethics.html.*

North Carolina Medical Board: A Tradition of National Leadership

Ms Hunter-Buskey



Dr Norins

Dr Rhyne

Over the years, the members of the North Carolina Medical Board have played a major role in leadership of the Federation of State Medical Boards of the United States (FSMB), the national voluntary organization of all the country's medical licensing jurisdictions, which was established in 1912. At present, five members and former members hold key positions in the FSMB, either by election at the FSMB's annual meeting or by appointment by the FSMB's chair and Board of Directors.

Robin N. Hunter-Buskey, PA-C, of Butner, a member of the North Carolina Board from 2000 to 2006, was elected to the FSMB Board of Directors in 2005.

Michael E. Norins, MD, of Greensboro, a member of the North Carolina Board from 2001, was elected a member of the FSMB's Editorial Committee in 2006.

Janelle A. Rhyne, MD, of Wilmington, a member of the North Carolina Board from 2003 and its current president elect, was appointed a member of the FSMB's Finance Committee in 2005, 2006, and again in 2007. She served as a member of the FSMB Sexual Boundary Workgroup, and is currently a member of the FSMB Emergency Preparedness Ad Hoc Committee .

Sarvesh Sathiraju, MD, of Morganton, a member of the North Carolina Board from 2004, was elected to the FSMB's Nominating Committee in 2007.

Dr Sathiraju

Dr Loomis

Ralph C. Loomis, MD, of Asheville, a member of the North Carolina Board from 2005 and its current treasurer, was appointed to the FSMB's Bylaws Committee in 2007.

These distinguished members of the North Carolina Medical Board are maintaining the tradition of service at the national level represented by a number of their predecessors on the Board. Among its presidents, the FSMB had the leadership of North Carolina's Joseph J. Combs, MD, in 1956; Frank L. Edmondson, MD, in 1971; Bryant L. Galusha, MD, in 1981; and George C. Barrett, MD, in 2000. Also, Bryant L. Galusha, MD, served five years as CEO of the FSMB. Also rendering significant service to the FSMB was North Carolina's David S. Citron, MD, who served on the FSMB's Board of Directors from 1986 to 1989. Several of these North Carolinians were instrumental in establishing, first, the Federation Licensing Examination (FLEX) and, then, the United States Medical Licensing Examination (USMLE). A number of other North Carolina Board members also served on various FSMB committees over the years.

All of this represents a national presence that has had a significant impact on the medical licensing system in the United States. That tradition will continue.

For further information about the Federation of State Medical Boards of the United States, go to the FSMB Web site at *www.fsmb.org*.

Curtis Ellis Honored by Administrators in Medicine

Curtis Ellis, director of the North Carolina Medical Board's Investigations Department, recently received the Ronald K. Williamson Memorial Award for Board Investigators from the Administrators in Medicine (AIM).

Mr Ellis received the award at AIM's annual meeting on Wednesday, May 2, 2007, in San Francisco, CA. The award recognizes excellence in the public protection work of board investigators, and is named in memory of Ronald K. Williamson, a former senior investigator at the Vermont Board of Medical Practice. The award is presented in recognition of those who have demonstrated outstanding investigative work and dedication to improving investigative techniques and thus improving complaint-handling services for the public. AIM is the national organization for executive directors of state medical and osteopathic boards.

David Henderson (l), executive director of NCMB, offers congratulations to Curt Ellis after presentation of the AIM award.

In 2006, Mr Ellis coordinated the production of the *North Carolina Medical Board Investigative Proceedures Manual.* The *Manual* sets forth established and consistent methods for conducting investigations initiated by the Medical Board. Mr Ellis said, "We began work on the *Manual* in October 2005. Our whole team in the Investigations Department cooperated in getting it done and we had the help of all the Board's staff in the effort. The *Manual* is proving an invaluable tool and we'll be revising and improving it as time goes on, of course. Speaking for all the folks in the Department and the North Carolina Medical Board, I deeply appreciate AIM's generous recognition."

Mr Ellis also served on the planning committee for the 2007 AIM Inaugural State Medical Board Investigator Certification Training Program. He was a panelist in June for the Program's session on the Investigative Process.

Before joining the staff of the Medical Board in 2003, Mr Ellis served as a special agent for the North Carolina State Bureau of Investigation's Financial Crimes Division, where he assisted local, state, and federal law enforcement agencies on a statewide basis in conducting financial crime investigations, including embezzlement, false pretense, malfeasance of corporate officers, computer crimes, and other business related schemes. He also conducted analysis of financial records to determine possible motives for arson and homicide. He was special agent in charge of the Financial Crimes Division during the last 10 years of his tenure with the SBI. Mr Ellis now leads a staff of 10 investigators and two support staff members in the Medical Board's Investigations Department.

2006 NC Medical Board Data Released: Rate of Disciplinary Actions Continues to Rise

David Henderson, executive director of the North Carolina Medical Board, recently released a Summary Report of the Board's 2006 Board actions. "The Summary Report of Board actions (see next page) provides a clear view of an important facet of the Board's work in 2006 and shows a significant continuation of the rise in actions taken," he said. "The Board's full and detailed Annual Report for 2006 is on the Board's Web site at *www.ncmedboard.org*," he added.

Mr Henderson pointed out the Board took disciplinary actions related to 171 individual physicians in 2006, as compared with 132 in 2005. License revocations were down (7 in 2006 compared to 9 in 2005) while suspensions (55 in 2006 compared to 42 in 2005) and summary suspensions (3 in 2006 compared to 2 in 2005) were up. Consent orders for physicians were up to 121 in 2006 from 85 in 2005. License surrenders by physicians were up to 20 in 2006 from 13 in 2005.

He noted that there were about 20,100 medical licensees in North Carolina in January 2006 and another 8,300 out of state. (During 2006, the Board issued 1,784 medical licenses.)

He added that for all Board actions, both disciplinary actions and non-disciplinary regulatory actions (which are not negative in character), 220 related to individual physicians in 2006 compared to 174 in 2005.

In conclusion, Mr Henderson said, "The Board is dedicated to pursuing the problems that are reported to it and that it identifies from its oversight of medical practice. That effort is the source of these Board action numbers. But it's important to stress that the Board's work in protecting the health and safety of the people of North Carolina includes a number of activities not covered by the action figures we are releasing today."

The Board's report also covers actions concerning physician assistants and nurse practitioners and those numbers are included in the Summary Report.

2006 Summary Report:
Prejudicial/Non-Prejudicial NCMB Board Action List

[Comparative figures for 2005 appear in brackets and italics.]

PREJUDICIAL ACTIONS:

License Denied: 7 actions (6 physicians, 1 PA)
[2005: 10 actions (9 physicians, 1 NP)]
Annulments: NONE
[2005: None]
Revocations: 11 actions (8 physicians, 3 PAs)
[2005: 16 actions (15 physicians,1 NP)]
Suspensions: 66 actions [40 via Consent Order] (55 physicians, 8 PAs, 3 NPs)
[2005: 46 actions [36 via Consent Order] (42 physicians, 4 PAs)]
Summary Suspensions: 3 actions (3 physicians)
[2005: 2 actions (2 physicians)]
Miscellaneous Board Orders: 3 actions (3 physicians)
[2005: 1 action (1 physician)]
Denials of Reconsideration/Modification: NONE
[2005: NONE]
Surrenders: 29 actions [4 via Consent Order] (20 physicians, 7 PAs, 2 NPs)
[2005: 16 actions [0 by CO] (13 physicians, 3 PAs)]
Public Letters of Concern: 2 actions (2 physicians)
[2005: NONE (new action authorized)]
Temporary/Dated Licenses Issued (via Consent Order): 5 actions (5 physicians)
[2005: 11 actions (9 physians,2 PAs)]
Temporary/Dated Licenses Allowed to Expire: NONE
[2005: NONE]
Consent Orders: 141 actions [8 mod, 18 N-D] (121 physicians, 18 PAs, 2 NPs)
[2005: 106 actions--99 persons [6 mod] [4 N-D] (85 physicians, 12 PAs, 2 NPs)]
[Note that COs limit, restrict, reprimand, or otherwise affect the practitioner in some way. In certain cases, they may result in the revocation, suspension, or surrender of a license, the dismissal of charges as a result of other action taken, and/or the issuance of a temporary/dated license, which results are reflected in the appropriate sections of this report. In some instances, a CO may simply modify a previous CO, and that is indicated by (mod) appearing after the person's name. Non-disciplinary (N-D) COs are included and so noted.]

NON-PREJUDICIAL ACTIONS:

Dismissals: 10 actions (9 physicians, 1 PA)
[2005: 5 action (5 physicians)]
Temporary/Dated Licenses Extended: 34 actions (27 physicians, 7 PAs)
[2005: 46 actions--28 persons (23 physicians, 5 PAs)]
Temporary/Dated Licenses Became Full and Unrestricted: 12 actions (10 physicians, 2 PAs)
[2005: 9 actions (7 physicians, 2 PAs)]
Consent Orders Lifted: 23 actions (20 physicians, 3 PAs)
[2005: 20 actions (18 physicians, 2 PAs)]
Revocations Reinstated: NONE
[2005: NONE]
Reentry Agreements: 23 actions (14 physicians, 9 PAs)
[2005: 15 actions, 14 persons (10 physicians, 4 PAs)]

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

February-March-April 2007

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.

Public Letter of Concern:
A letter in the public record expressing the Board's concern about a practitioner's behavior or performance. Concern has not risen to the point of requiring a formal proceeding but should be known by the public. If the practitioner requests a formal disciplinary hearing regarding the conduct leading to the letter of concern, the letter will be vacated and a formal complaint and hearing initiated.

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

REESE, Perry, III, MD
Location: Cary, NC (Wake Co) | DOB: 8/17/1958
License #: 0094-00988 | Specialty: FP (as reported by physician)
Medical Ed: Wayne State University (1990)
Cause: Request to amend Order of Discipline of 6/29/2005 to change revocation date from 4/21/2005 to 1/01/2005.
Action: 3/01/2007. Order issued to amend Order of Discipline of 6/29/2005: The date of revocation in the Order of Discipline of 6/29/2005 is changed to 1/01/2005.

SMITH, Tracey, Physician Assistant
Location: Wilmington, NC (New Hanover Co) | DOB: 2/13/1962
License #: 0001-02582
PA Education: University of Washington (1998)
Cause: Mr Smith had a sexual relationship with a patient in 2005 and surrendered his PA license in August 2005.
Action: 3/12/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing of 2/22/2007: Mr Smith's North Carolina PA license is revoked effective August 31, 2005.

SUSPENSIONS

BECK, Jeffrey R., DO
Location: Easton, MD | DOB: 10/21/1953
License #: 0098-00186 | Specialty: EM/PD (as reported by physician)
Medical Ed: College of Osteopathic Medicine, Des Moines (1978)
Cause: Action by the California Board causing immediate suspension of Dr Beck's California osteopathic medical license.
Action: 3/08/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/22/2007: Dr Beck's North Carolina medical license is indefinitely suspended.

GREENWOOD, Denise Rochelle, MD
Location: Huntington, WV | DOB: 6/24/1961
License #: 0000-39149 | Specialty: GS (as reported by physician)
Medical Ed: University of Texas, Galveston (1987)
Cause: Action by the Arkansas Board causing suspension of Dr Greenwood's Arkansas medical license for violation of an Arkansas consent order.
Action: 3/08/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/22/2007: Dr Greenwood's North Carolina medical license is indefinitely suspended, with suspension being stayed conditioned on her compliance with the order of the Arkansas Board.

KABAR, Edward, Physician Assistant
Location: Statesville, NC (Iredell Co) | DOB: 11/11/1948
License #: 0001-02038
PA Education: College of Osteopathic Medicine (1995)
Cause: Violation of multiple domestic violence protective orders.
Action: 3/14/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/22/2007: Mr Kabar's North Carolina PA license is suspended indefinitely; he shall submit to evaluation by the NCPHP and then meet with the Board to determine if a stay of suspension would be possible.

McLIMORE, Perry Glenn, MD
Location: Atlanta, GA | DOB: 2/16/1957
License #: 0000-30208 | Specialty: IM/EM (as reported by physician)

Medical Ed: University of Louisville (1984)
Cause: Action by the Kentucky Board effectively suspending Dr McLimore's Kentucky medical license.
Action: 3/08/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 2/22/2007: Dr McLimore's North Carolina medical license is indefinitely suspended.

See Consent Orders:
ADKINS, Paula Clark, MD
BOYD, William Scott, Physician Assistant
BRAY, Anthony David, MD
CARBONE, Dominick John, Jr, MD
CHAVIS, Robert Michael, Physician Assistant
DOBSON, Richard Carl, MD
HENSLER, Rachel Hurst, Physician Assistant
KELLER, Phillip Arthur, Physician Assistant
MABE, Layla Myers, Nurse Practitioner
McMANUS, Shea Eamonn, MD
RUSSELL, Anthony Otis, MD
SPENCER, John Herbert, Physician Assistant
THRIFT-COTTRELL, Alesia Dawn, MD

SUMMARY SUSPENSIONS

McKEEL, Cameron Roberts, Physician Assistant
Location: Asheville, NC (Buncombe Co) | DOB: 1/09/1968
License #: 0001-03586
PA Education: College of Health Sciences, Virginia (2002)
Cause: Mr McKeel may be unable to practice as a physician assistant with reasonable skill and safety as shown by the Board's Notice of Charges and Allegations, Notice of Hearing dated 2/01/2007.
Action: 2/01/2007. Order of Summary Suspension of License issued: Mr McKeel's license physician assistant license is suspended on service of this Order.

NG, Chun-Ho Patrick, MD
Location: Kannapolis, NC (Cabarrus Co) | DOB: 4/06/1959
License #: 0000-32813 | Specialty: FP (as reported by physician)
Medical Ed: Medical College of Georgia (1985)
Cause: The Board has information that Dr Ng repeatedly committed unprofessional conduct by his departure from or failure to conform to the standards of acceptable and prevailing medical practice or the ethics of the medical profession. His offending conduct is described in the full Order of Summary Suspension and in the Notice of Charges and Allegations dated 2/22/2007.
Action: 2/22/2007. Order of Summary Suspension of License: Dr Ng's North Carolina medical license is suspended on service of this Order.

SHANTON, Gregory Damon, Physician Assistant
Location: Newport, NC (Carteret Co) | DOB: 2/17/1963
License #: 0001-01943
PA Education: Alderson-Broaddus (1992)
Cause: Mr Shanton may be unable to practice with reasonable skill and safety. He has a history of substance abuse as shown in the Notice of Charges and Allegations dated 4/03/2007.
Action: 4/03/2007. Order of Summary Suspension of License issued: Mr Shanton's physician assistant license is suspended upon service of this Order.

CONSENT ORDERS

ADKINS, Paula Clark, MD
Location: South Charleston, WV | DOB: 11/26/1965
License #: 0099-00745 | Specialty: EM (as reported by physician)
Medical Ed: Marshall University School of Medicine (1996)
Cause: Substance abuse and violation of previous Consent Order.
Action: 4/18/2007. Consent Order executed: Dr Adkins' North Carolina medical license is indefinitely suspended.

BOYD, William Scott, Physician Assistant
Location: Eden, NC (Rockingham Co) | DOB: 2/11/1975
License #: 0001-02927
PA Education: NA
Cause: On four occasions in 2006, Mr Boyd improperly obtained controlled substances from a medical supply company. On as many as 50 occasions in 2006 he took controlled substances from the clinic at which he was working. He also prescribed hydrocodone cough syrup for a friend in that same period with the understanding that the friend would give the syrup to him. He surrendered his PA license in October 2006.
Action: 3/22/2007. Consent Order executed: Mr Boyd's North Carolina PA license is suspended indefinitely.

BRAY, Anthony David, MD
Location: Burlington, NC (Alamance CO) | DOB: 11/15/1961
License #: 0094-00023 | Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1992)
Cause: Unprofessional conduct in prescribing controlled substances. He voluntarily surrendered his Schedule II privileges and has entered a Memorandum of Agreement with the DEA.
Action: 4/25/2007. Amended Consent Order executed: license is suspended for 18 months; suspension stayed; probationary elements of the Consent Order of August 2006 are expanded to include required participation in the NCPHP, attendance at a prescribing course at Vanderbilt, and refraining from use of mind- or mood-altering substances.

CARBONE, Dominick John, Jr, MD
Location: Winston-Salem, NC (Forsyth Co) | DOB: 8/09/1965
License #: 0097-00498 | Specialty: US (as reported by physician)
Medical Ed: University of Michigan (1990)
Cause: Dr Carbone engaged in a sexual relationship with one of his patients from approximately December 2005 to March 2006. He voluntarily surrendered his license in January 2007. He has completed an in-depth evaluation at the Professional Renewal Center in Kansas and has entered into a contract with the NCPHP.
Action: 2/21/2007. Consent Order executed: Dr Carbone's North Carolina medical license is indefinitely suspended.

CHAVIS, Robert Michael, Physician Assistant
Location: Raeford, NC (Hoke Co) | DOB: 7/28/1955
License #: 0001-01956
PA Education: Trevecca Nazarene College (1992)
Cause: From 2002 to 2005, Mr Chavis wrote numerous prescriptions for five patients without keeping a patient record. For several of the patients, he wrote multiple prescriptions for controlled substances. Prescriptions for those patients were on blanks for the Hoke County Health Center and several other clinics where there is no record of the patients. Some prescriptions were written on days Mr Chavis was not working. In November 2005, he issued two prescriptions for a single narcotic to one of the patients and they were filled at different pharmacies. Many of the prescriptions in-

volved did not include Mr Chavis' name or the name and phone number of his supervising physician.

Action: 2/21/2007. Consent Order executed: Mr Chavis' PA license is suspended for two years; suspension will be stayed on April 30, 2007, and he shall be placed on probation based on specific requirements; prior to resuming practice he must obtain site approval from the president of the Board; he shall work only at a site where a physician is present on-site when the clinic is open; prior to resuming practice, he must have a plan of reentry into practice that includes having his charts co-signed by his supervising physician within seven days for the first six months; he shall permit random inspections of his office and records by Board investigators; must comply with other requirements.

DOBSON, Richard Carl, MD

Location: Cary, NC (Wake Co) | DOB: 3/18/1944

License #: 2001-00135 | Specialty: PhysMed/Rehab (as reported by physician)

Medical Ed: State University of New York (1976)

Cause: Dr Dobson's New York medical license was suspended for 36 months by a Consent Order with the New York Board in June 2006. The suspension was stayed and Dr Dobson was placed on probation.

Action: 3/23/2007. Consent Order executed: Dr Dobson's North Carolina medical license is suspended for 30 months, suspension being stayed subject to probationary terms; he shall comply with the terms of the New York Consent Order.

FREEMAN, Tyler Ira, MD

Location: Charlotte, NC (Mecklenburg Co) | DOB: 2/01/1934

License #: 0000-25706 | Specialty: IM/OM (as reported by physician)

Medical Ed: Chicago Medical School (1959)

Cause: On application for reinstatement of license. The Board indefinitely suspended Dr Freeman's North Carolina medical license in October 2005 because he had allowed someone not a physician to perform chelation therapy and medical acts and to prescribe medications in his name without his ever examining the patients.

Action: 2/23/2007. Consent Order executed: Dr Freeman is issued a full, unrestricted medical license; he shall meet with the Board in May 2007; he shall confirm his CME credits in May 2007; he intends to work for Global Labs as a medical review officer and conduct disability evaluations for the state, but before beginning any other employment he must get site approval from the president of the Board; must comply with other requirements.

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 December 2004, the Minnesota Board and Dr Grossling, whose Minnesota license was inactive, entered a Stipulation in which he agreed not to seek a license in Minnesota and the Minnesota Board agreed to consider his license voluntarily surrendered. The Stipulation also noted he suffered from a physical condition impairing his ability to defend himself against charges the Board had filed. The charges were later dismissed. His North Carolina license is inactive.

Action: 3/21/2007. Consent Order executed: The issue is resolved without the need for specific disciplinary action; Dr Grossling agrees to leave his North Carolina license inactive and not to reapply; he shall comply with the Minnesota Stipulation.

HADDON, Werner Scott, MD

Location: Raleigh, NC (Wake Co) | DOB: 5/27/1959

License #: 0000-35356 | Specialty: GS/EM (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1985)

Cause: In 2005, Dr Haddon entered into an Agreement and Stipulation with the South Carolina Board. He admitted that following a difficult divorce he made certain non-specific threatening statements in recorded phone converations and that his ex-wife filed a complaint against him in June 2004. Law enforcement authorities determined there was a high risk that Dr Haddon would engage in violent or dangerous behavior. In July 2004, he was arrested on a charge of stalking and was incarcerated. In October, the South Carolina Board ordered him to be evaluated. The evaluation stated in part that he did not appear to appreciate the seriousness of his behavior and recommended treatment. In February 2006, the South Carolina Board reprimanded Dr Haddon and ordered he undergo evaluation and treatment within 90 days. In November 2006, Dr Haddon underwent an assessment by the NCPHP, after which it recommended he undergo outpatient therapy.

Action: 2/21/2007. Consent Order executed: Dr Haddon is reprimanded; he shall maintain and abide by a contract with the NCPHP and follow all recommendations made by the NCPHP; must comply with other requirements.

HAMBURGER, David Phillip, MD

Location: Baltimore, MD | DOB: 11/17/1946

License #: 2000-00224 | Specialty: PD/ADM (as reported by physician)

Medical Ed: New York University School of Medicine (1972)

Cause: Dr Hamburger's North Carolina medical license has been inactive since 2004. He has been employed as medical director by several out-of-state organizations since 1997. He has not practiced clinical medicine since that time and does not intend to do so now.

Action: 2/09/2007. Non-Disciplinary Consent Order executed: Dr Hamburger is granted a limited administrative license and shall not engage in clinical practice; prior to resuming clinical practice, he must obtain approval of the Board's president for a practice site and for a plan to update his skills.

HENSLER, Rachel Hurst, Physician Assistant

Location: Wilmington, NC (New Hanover Co) | DOB: 4/01/1978

License #: 0010-00107

PA Education: Nova Southeastern University (2004)

Cause: Ms Hensler has a substance abuse problem and has obtained prescription drugs improperly. She surrendered her PA license in August 2006 and became a participant in the NCPHP. She entered inpatient treatment at the same time and reports she has successfully completed that treatment.

Action: 3/15/2007. Consent Order executed: Ms Hensler's PA license is suspended indefinitely effective August 2006 and may not reapply before February 2007.

JACKSON, Annie Margaret, MD

Location: Rutherfordton, NC (Rutherford Co) | DOB: 8/29/1961

License #: 0098-00575 | Specialty: N/CN (as reported by physician)

Medical Ed: Chicago Medical School (1991)

Cause: Dr Jackson allowed her husband, who is not licensed to

practice medicine in North Carolina, to review several patient charts and sign her initials, creating the false impression she had personally reviewed the charts.
Action: 3/05/2007. Consent Order executed: Dr Jackson is reprimanded.

KELLER, Phillip Arthur, Physician Assistant
Location: Currituck, NC (Currituck Co) | DOB: 7/10/1961
License #: 0001-02305
PA Education: Hahneman University (1985)
Cause: Mr Keller has a history of alcohol dependence. He has been arrested on several occasions for DWI, most recently in October 2006. In late 2006, he admitted being drunk while at work as a PA. He has been a participant in the NCPHP since November 2006 and has completed inpatient treatment for substance abuse, which he reports he completed successfully. He voluntarily surrendered his license in November 2006.
Action: 4/18/2007. Consent Order executed: Mr Keller's PA license is suspended indefinitely effective November 2006.

MATHEWS, Robert Simon, MD
Location: Lancaster, PA | DOB: 8/28/1938
License #: 0000-14253 | Specialty: OAR (as reported by physician)
Medical Ed: Duke University School of Medicine (1964)
Cause: Dr Mathews was reprimanded and assessed a civil penalty by the Pennsylvania Board.
Action: 3/07/2007. Consent Order executed: Dr Mathews is reprimanded.

MABE, Layla Myers, Nurse Practitioner
Location: Hamlet, NC (Richmond Co) | DOB: 10/23/1973
Approval #: 0009-00378
NP Education: University of North Carolina, Greensboro (2002)
Cause: Ms Mabe prescribed to individuals and family members without establishing an NP-patient relationship with them and she failed to document the prescriptions in a patient chart. She also prescribed for a patient in South Carolina when she had no authority to practice in South Carolina.
Action: 4/18/2007. Consent Order executed: Ms Mabe's NP approval is suspended for 12 months, suspension being stayed on terms and conditions requiring her to meet weekly with her supervisor for six months with monthly reports to the Board; she shall have her charts co-signed within seven days for six months; must comply with other requirements.

MERRITT, Benjamin Keith, MD
Location: Sanford, NC (Lee Co) | DOB: 5/15/1953
License #: 0094-00930 | Specialty: OB/GYN/FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1992)
Cause: Dr Merritt prescribed medication for a patient, with whom he had a significant emotional relationship, and her family without preparing or keeping a medical record.
Action: 2/26/2007. Consent Order executed: Dr Merritt is reprimanded; he shall abide by his NCPHP contract; must comply with other requirements.

MOSS, John Simpson, Sr, MD
Location: Roanoke Rapids, NC (Halifax Co) | DOB: 10/03/1952
License #: 2007-00158 | Specialty: OS/SM (as reported by physician)
Medical Ed: Virginia Commonwealth University (1979)
Cause: On application for licensure. Dr Moss has a history of substance abuse. He entered treatment at Farley Center in Virginia in 2003 has maintained sobriety since then. He has a monitoring contract with the Virginia Impaired Physician Program and in under contract with the NCPHP, which specifies he will be monitored for two years when he moves to North Carolina.
Action: 2/09/2007. Non-Disciplinary Consent Order executed: Dr Moss is issued a North Carolina medical license; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other requirements.

NASCIMENTO, Luiz, MD
Location: Hamlet, NC (Richmond Co) | DOB: 6/18/1945
License #: 0000-32811 | Specialty: IM/NEP (as reported by physician)
Medical Ed: Federal Rio de Janeiro (1970)
Cause: Dr Nascimento knew or should have known about the inappropriate prescribing done by Layla M. Mabe, NP, who practiced under his supervision. He failed to adequately supervise Ms Mabe.
Action: 4/18/2007. Consent Order executed: Dr Nascimento is reprimanded.

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: Requested amendment of Consent Order of March 2006.
Action: 3/16/2007. Amended Consent Order executed: Dr Niemeyer is issued a full and unrestricted license subject to terms as noted in the March 2006 Order.

OKOSE, Peter Chukwuemeka, MD
Location: Texas City, TX | DOB: 1/08/1954
License #: 0000-39979 | Specialty: IM/Pharm (as reported by physician)
Medical Ed: University Ibadan, Nigeria (1981)
Cause: In July 2006, the Texas Board summarily suspended Dr Okose's Texas medical license on allegations he failed to conform to minimal standards of medical practice, failed to keep adequate records, and prescribed medications inappropriately. Based on its investigation, the Texas Board found cause to reprimand him, place him on probation for 10 years, prohibit him from practicing chronic pain management, prohibit him from supervising mid-level practitioners, and take other actions against him.
Action: 2/23/2007. Consent Order executed: Dr Okose is reprimanded; he shall comply with all requirements set in the Texas Consent Order.

OWEIDA, Sami Joseph, MD
Location: Charlotte, NC (Mecklenburg Co) | DOB: 4/04/1954
License #: 0000-28788 | Specialty: OSM/ORS (as reported by physician)
Medical Ed: University of Pittsburgh (1979)
Cause: Dr Oweida pre-signed blank prescriptions at the behest of his surgical assistant. The surgical assistant then abused Dr Oweida's trust by writing unauthorized prescriptions for controlled substances for several persons not Dr Oweida's patients.
Action: 4/05/2007. Consent Order executed: Dr Oweida is reprimanded and must submit an article to the *Forum*

on the negative potential in pre-signing prescription blanks.

PAYTON, James Bayard, MD
Location: Asheville, NC (Buncombe Co) | DOB: 1/17/1947
License #: 0000-38406 | Specialty: CP/P (as reported by physician)
Medical Ed: University of Cincinnati (1973)
Cause: Dr Payton wrote several prescriptions for non-controlled substances for himself from 2003 to 2005 and kept a pre-signed prescription pad in his office for use by his secretary on his instructions.
Action: 3/14/2007. Consent Order executed: Dr Payton is reprimanded.

ROBINSON, Lindwood Allen, MD
Location: Raleigh, NC (Wake Co) | DOB: 7/08/1971
License #: 2001-01126 | Specialty: EM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1997)
Cause: On application for reinstatement of his medical license, which he surrendered in October 2006 and which was suspended under a Consent Order of the same month. He has a past record of substance abuse. The NCPHP reports he is now in full compliance with his NCPHP contract.
Action: 4/03/2007. Consent Order executed: Dr Robinson is issued a temporary/dated license to expire on the date shown on the license [8/31/2007]; he shall maintain and abide by an NCPHP contract; he shall undergo a four-day assessment approved by the NCPHP and comply with all recommendations made; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 14 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall attend AA and/or Caduceus meetings as recommended by NCPHP; he shall not work more than 40 hours per week; must comply with other conditions.

SHEPARD, Robert Charles, MD
Location: Chapel Hill (Orange Co) | DOB: 8/02/1952
License #: 2007-00282 | Specialty: HO (as reported by physician)
Medical Ed: Duke University School of Medicine (1978)
Cause: On application for a license. Dr Shepard has not practiced clinical medicine since April 2004. In May 2002, he was reprimanded by the Maryland Board and required to take an ethics course. He entered a Consent Agreement with the Massachusetts Board as a result of the Maryland action. Massachusetts issued an Order of Default in 2005 revoking his ability to renew his license there for failure to respond to the Board and for violation of the Consent Order. Virginia suspended his license in April 2005 based on the Massachusetts action and reinstated his license with conditions in July 2005.
Action: 3/16/2007. Consent Order executed: Dr Shepard is reprimanded; the Board shall issue him a full and unrestricted license; he will have his practice observed by Dr Orlowski for 200 clinical hours and Dr Orlowski shall report to the Board on Dr Shephard's skills within 30 days after the 200 hours of practice.

SPENCER, John Herbert, Physician Assistant
Location: Rocky Mount, NC (Nash Co) | DOB: 1/16/1950
License #: 0001-02279
PA Education: University of Oklahoma (1986)
Cause: In 2004 and 2005, Mr Spencer prescribed medications for two patients he treated for pain but seldom noted in the records the medication name, dose, and other appropriate information. He also failed to perform or order adequate physical examinations for those patients and did not ask during patient visits whether the patients were receiving medications from other sources. He did note that one patient was being treated by another physician and had had surgery and that the other had a history of substance abuse, had attempted suicide, and had obtained controlled substances illegally. Mr Spencer failed to take other appropriate steps required when treating pain.
Action: 2/21/2007. Consent Order executed: Mr Spencer's PA license is suspended for six months; suspension being stayed as of March 31, 2007 based on his complying with requirements set forth in this Consent Order; for one year he shall meet weekly with his supervising physician to have his charts involving controlled substances and a random sample of his other charts reviewed and signed, not including charts of patients seen in the hospital; he shall improve his keeping of records and comply with the related position statements of the Board; he shall keep a log of all controlled substances he prescribes and have it available for inspection for one year, not including prescriptions for his hosptital patients; must comply with other requirements.

THRIFT-COTTRELL, Alesia Dawn, MD
Location: Red Springs, NC (Robeson Co) | DOB: 6/06/1964
License #: 2002-01318 | Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1997)
Cause: Dr Thrift-Cottrell, who had a Consent Order with the Board, tested positive for drug use in September 2006. She was also being monitored by the NCPHP for issues related to mental health. As a result of her drug use and issues related to mental health, the NCPHP withdrew its advocacy of her. On September 8, 2006, she surrendered her North Carolina medical license.
Action: 4/18/2007. Consent Order executed: Dr Thrift-Cottrell's North Carolina medical license is indefinitely suspended.

TICKLE, Dewey Reid, MD
Location: Wilson, NC (Wilson Co) | DOB: 10/18/1929
License #: 0000-9903 | Specialty: R (as reported by physician)
Medical Ed: Duke University School of Medicine (1954)
Cause: Dr Tickle has not practiced in over seven years, though he has an active North Carolina license. In October 2005 the Board determined Dr Tickle has prescribed for himself. He was informed this was against the Board's stated position relating to self-prescribing. He was sent a Private Letter of Concern in January 2006. In April 2006, he was found to be continuing precribing for himself. None of the prescriptions involved controlled substances. His license went inactive in February 2007.
Action: 2/23/2007. Consent Order executed: Dr Tickle is issued a Public Letter of Concern regarding his conduct.

WALKER, Rogers Smith, MD
Location: Calabash, NC (Brunswick Co) | DOB: 1/14/1953
License #: 0000-27331 | Specialty: EM/FP (as reported by physician)
Medical Ed: Medical University of South Carolina (1979)

Cause: Dr Walker was the supervising physician for John Alden Blake, PA, in Shallotte, NC, from October 2004 to January 2006. Mr Blake practiced in an unacceptable manner. Dr Walker failed to take reasonable measures to ensure Mr Blake practiced appropriately, though he developed a comprehensive remediation plan concerning Mr Blake's treatment of certain patients after he became aware of the situation.
Action: 2/22/2007. Consent Order executed: Dr Walker is reprimanded.

MISCELLANEOUS ACTIONS
NONE

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

DENIALS OF LICENSE/APPROVAL

SUTHERLAND, James Michael, DO
Location: Tallahassee, FL | DOB: 6/05/1957
License #: 0096-00376 | Specialty: GS/VS (as reported by physician)
Medical Ed: Philadelphia College of Osteopathic Medicine (1991)
Cause: Dr Sutherland failed to disclose a criminal conviction on his original application for a license in 1996 and failed to disclose a 2005 arrest on his current application for license reinstatement.
Action: 2/08/2007. Letter issued denying Dr Sutherland's application for reinstatement of his North Carolina medical license.

VINCENT, Robert Allen, MD
Location: Fitchburg, WI | DOB: 5/15/1944
License #: NA | Specialty: R (as reported by physician)
Medical Ed: University of Wisconsin Medical School (1970)
Cause: Dr Vincent failed to satisfy the Board of his qualifications for a medical license. The states of California, North Dakota, and Wisconsin has acted against his license.
Action: 2/08/2007. Letter issued denying Dr Vincent's application for a North Carolina license.

SURRENDERS

BRYDON, Kim Marie, MD
Location: Raleigh, NC (Wake Co) | DOB: 11/06/1957
License #: 0000-33795 | Specialty: P (as reported by physician)
Medical Ed: University of Kansas (1987)
Action: 4/25/2007. Voluntary surrender of North Carolina medical license.

CHEMELLI, Marcia Gaddy, Physician Assistant
Location: Durham, NC (Durham Co) | DOB: 10/18/1962
License #: 0001-03967
PA Education: Long Island University PA Program (1994)
Action: 3/10/2007. Voluntary surrender of North Carolina PA license.

ELLIS, Rickie Wade, MD
Location: Greenville, NC (Pitt Co) | DOB: 2/04/1962
License #: 2001-01442 | Specialty: P (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1995)
Action: 3/09/2007. Voluntary surrender of North Carolina medical license.

FIELDS, Jason Baker, MD
Location: Wilmington, NC (New Hanover Co) | DOB: 5/24/1969
License #: 0099-00833 | Specialty: PD (as reported by physician)
Medical Ed: East Tennessee State University College of Medicine (1996)
Action: 4/23/2007. Voluntary surrender of North Carolina medical license.

HEARN, Richard Forrest, MD
Location: Delafield, WI | DOB: 9/11/1934
License #: 0000-31834 | Specialty: ESM/GS (as reported by physician)
Medical Ed: Marquette University (1962)
Action: 3/08/2007. Voluntary surrender of North Carolina medical license.

HOLMBERG, Ricky David, MD
Location: Greensboro, NC (Guilford Co) | DOB: 5/17/1949
License #: 0000-28651 | Specialty: NS (as reported by physician)
Medical Ed: University of Calgary, Canada (1975)
Action: 2/01/2007. Voluntary surrender of North Carolina medical license.

HUCKS-FOLLIS, Anthony George, MD
Location: Pinehurst, NC (Moore Co) | DOB: 5/30/1941
License #: 0000-20290 | Specialty: NS (as reported by physician)
Medical Ed: University of Virginia (1969)
Action: 3/12/2007. Voluntary surrender of North Carolina medical license.

MORTER, Gregory Alan, MD
Location: Wilmington, NC (New Hanover Co) | DOB: 12/03/1959
License #: 0000-36401 | Specialty: PD (as reported by physician)
Medical Ed: University of Pittsburgh (1986)
Action: 4/05/2007. Voluntary surrender of North Carolina medical license.

RIOS, Gustavo Ernesto, MD
Location: Jacksonville, NC (Onslow Co) | DOB: 9/13/1967
License #: 2006-01305 | Specialty: PD (as reported by physician)
Medical Ed: Faculty of Medicine, Autonomous University of Guadalajara (1998)
Action: 2/17/2007. Voluntary surrender of North Carolina medical license.

SQUIRE, Edward Noonan, Jr, MD
Location: West End, NC (Moore Co) | DOB: 11/27/1948
License #: 0098-01509 | Specialty: AI/PD (as reported by physician)
Medical Ed: University of Kentucky (1974)
Action: 2/01/2007. Voluntary surrender of North Carolina medical license.

WHITLOCK, Gary Thomas, III, MD
Location: Jacksonville, NC (Onslow Co) | DOB: 7/15/1948
License #: 0000-24331| Specialty: EM/ADDM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1978)
Action: 2/01/2007. Voluntary surrender of North Carolina medical license.

PUBLIC LETTERS OF CONCERN

ALVARADO, Teresa Lois, MD
Location: Jacksonville, NC (Onslow Co) | DOB: 7/30/1952
License #: 0000-30273 | Specialty: OB/GYN (as reported by physician)
Medical Ed: University of Monterrey, Mexico (1981)
Cause: Payment made on Dr Alvarado's behalf in resolution of a claim arising out of the case of an infant who suffered hypoxic ischemic injury during vaginal delivery.

Board is concerned that treatment was below standard of care. Dr Alvarado indicates she no longer practices obstetrics.

Action: 3/05/2007. Public Letter of Concern issued: Dr Alvarado is admonished and cautioned that any repetition of such an incident may lead to disciplinary proceedings.

BRANTLEY, Julian Chisolm, III, MD

Location: Rocky Mount, NC (Nash Co) | DOB: 5/01/1948

License #: 0000-21455 | Specialty: OB/GYN (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1975)

Cause: Payment was made on Dr Brantley's behalf for a claim arising from his performing a hysterectomy for what he presumed was endometriosis prior to further appropriate diagnostic testing to confirm his opinion. It developed the patient did not have endometriosis. Instead, the patient had a partially herniated disc that caused her pain.

Action: 4/05/2007. Public Letter of Concern issued: Dr Brantley is admonished and cautioned that repetition of such practice may lead to disciplinary proceedings.

COUNCELL, Richard Bruce, MD

Location: Asheville, NC (Buncombe Co) | DOB: 9/12/1952

License #: 0000-33222 | Specialty: OB/GYN (as reported by physician)

Medical Ed: Bowman Gray School of Medicine (1981)

Cause: Payment was made on Dr Councell's behalf for a claim arising from his failure to identify and treat fetal distress in a laboring mother that resulted in a baby being born brain damaged and quadriplegic.

Action: 3/16/2007. Public Letter of Concern issued: Dr Councell is admonished and cautioned that any repetition of such practice may lead to disciplinary proceedings.

GALLUCCI, Richard Pat, MD

Location: Goldsboro, NC (Wayne Co) | DOB: 7/03/1938

License #: 0000-34318 | Specialty: AN/FP (as reported by physician)

Medical Ed: Wayne State University (1964)

Cause: Payment was made on Dr Gallucci's behalf for a claim arising from the fact that after his placement of a right internal jugular central line in a patient, the guide wire for the catheter was retained after post-operative removal of the catheter. The wire migrated to the right femoral vein and was removed surgically without complication.

Action: 4/16/2007. Public Letter of Concern issued: Dr Gallucci is admonished and cautioned that any repetition of such practice may lead to disciplinary proceedings.

KHAWAJA, Usman Anwar, MD

Location: Thomasville, NC (Davidson Co) | DOB:11/25/1965

License #: 2001-01078 | Specialty: Cardiovascular/IM (as reported by physician)

Medical Ed: King Edward Medical College, Pakistan (1990)

Cause: Payment was made on Dr Khawaja's behalf for a claim arising from perforation of a patient's renal artery during a stent procedure for which written informed consent was not obtained.

Action: 3/23/2007. Public Letter of Concern issued: Dr Khawaja is admonished and cautioned that any repetition of such practice may lead to disciplinary proceedings.

KING, Joseph John, MD

Location: Monroe, NC (Union Co) | DOB: 12/27/1946

License #: 0000-22933 | Specialty: OS (as reported by physician)

Medical Ed: Jefferson Medical College (1973)

Cause: Payment of a claim on his behalf arising out of the delayed diagnosis and treatment of a patient's injury that resulted in a worse outcome after subsequent surgery.

Action: 2/27/2007. Public Letter of Concern issued: Dr King is admonished and cautioned that a repetition of such practice may lead to disciplinary proceedings.

McLANAHAN, Gregory Allen, MD

Location: Tallahassee, FL | DOB: 1/04/1971

License #: 0098-01713 | Specialty: AN (as reported by physician)

Medical Ed: University of Florida (1993)

Cause: Action was taken against Dr McLanahan by the Florida Board. On reviewing the issues, the North Carolina Board is concerned his treatment of the patient involved may have been below the standard of care when he gave intravenous anesthetic agents through the right radial arterial line instead of the intravenous line when preparing for open heart surgery.

Action: 4/1/2007. Public Letter of Concern issued: Dr McClanahan is admonished and cautioned that any repetition of such practice may lead to disciplinary proceedings.

PULEO, Joel Gregg, MD

Location: Pinehurst, NC (Moore Co) | DOB: 9/15/1953

License #: 0000-27965 | Specialty: OB/GYN (as reported by physician)

Medical Ed: Duke University School of Medicine (1979)

Cause: Dr Puleo performed an in-office surgical procedure and the patient suffered complications requiring transfer to a hospital. He did not have admitting privileges at the hospital and another physician completed the surgery. Dr Puleo did not directly contact the accepting physician to advise him of the nature of the patient's condition prior to her arrival. The complications could not have been predicted and the Board does not fault him for those.

Action: 2/01/2007. Public Letter of Concern issued: Dr Puleo is cautioned that repetition of similar facts and circumstances may lead to disciplinary proceedings.

SHUGARMAN, Richard Gerald, MD

Location: Atlantis, FL | DOB: 2/06/1940

License #: 0000-16248 | Specialty: OPH (as reported by physician)

Medical Ed: University of Maryland (1964)

Cause: According to a Consent Order/Letter of Concern signed with the Florida Board, Dr Shugarman performed a laser procedure on the incorrect eye of a patient. Because both the patient's eyes required the procedure, she was not harmed by this error and the other eye was later done. The patient did not complain to the Florida Board.

Action: 2/27/2007. Public Letter of Concern issued: Dr Shugarman is cautioned that a repetition of similar facts and circumstances may lead to additional disciplinary proceedings in North Carolina.

TALLAPUREDDY, Sreedhar Reddy, MD

Location: Charlotte, NC (Mecklenburg Co) | DOB: 12/10/1973

License #: RTL | Specialty: OB/GYN (as reported by physician)

Medical Ed: Osmania Medical College, India (1998)

Cause: Dr Tallapureddy accepted a Consent Order with the Texas Board reprimanding his license in that state. Texas acted because he failed to report previous disciplinary action in Oklahoma, where he was placed on probation during residency. Charges were filed and then dismissed by the Oklahoma Board. He states his

failure to report those actions was unintentional.
Action: 2/02/2007. Public Letter of Concern issued: Dr Tallapureddy is admonished and is cautioned to be completely candid when applying for licenses in future. Complaints about any failure in this regard may lead to disciplinary proceedings.

WEISS, Allan Stuart, MD
Location: St. Petersburgh, FL | DOB: 10/25/1957
License #: 0000-34198 | Specialty: N (as reported by physician)
Medical Ed: Hahnemann (1987)
Cause: Action was taken against Dr Weiss by the Florida Board. In reviewing the case involved, the North Carolina Board was concerned that his treatment of the patient involved may have been below the standard of care in that he failed to keep legible records justifying his course of treatment.
Action: 4/16/2007. Public Letter of Concern issued: Dr Weiss is admonished and cautioned that any repetition of such practice may lead to disciplinary proceedings.

YAGER, Howard Sanford, MD
Location: Atlanta, GA | DOB: 4/08/1941
License #: 0099-01493 | Specialty: FP/GP (as reported by physician)
Medical Ed: George Washington University (1966)
Cause: Dr Yager treated and issued prescriptions to employees of his bed and breakfast and the medical records of those employees were then stolen.
Action: 3/09/2007. Public Letter of Concern issued: Dr Yager is admonished for issuing prescriptions to his employees and failing to safeguard their patient records; any repetition of such behavior may lead to disciplinary proceedings.

See Consent Orders:
TICKLE, Dewey Reid, MD

CONSENT ORDERS LIFTED

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)
Action: 4/19/2007. Order issued lifting Consent Order of 2/17/2006.

BLEVINS, Douglas Dane, MD
Location: Durham, NC (Durham Co) | DOB: 8/31/1950
License #: 2005-00141 | Specialty: IM/Inf Dis (as reported by physician)
Medical Ed: University of Virginia School of Medicine (1976)
Action: 2/02/2007. Order issued lifting Consent Order of 2/07/2005.

URETZKY, Ira David, MD
Location: Raleigh, NC (Wake Co) | DOB: 10/21/1966
License #: 0099-00706 | Specialty: OTO/FPS (as reported by physician)
Medical Ed: George Washington University (1992)
Action: 4/16/2007. Order issued lifting Consent Order of 9/08/2005.

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: 3/22/2007. Temporary/dated license extended to expire 9/30/2007.

FARRELL, Edwin Gayle, MD
Location: Greensboro, NC (Guilford Co) | DOB: 3/13/1945
License #: 0000-17345 | Specialty: Ped/AdolMed (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1971)
Action: 3/22/2007. Temporary/dated license extended to expire 3/31/2008.

WESSEL, Richard Fredrick, Jr, MD
Location: Coinjock, NC (Currituck Co) | DOB: 1/24/1959
License #: 0096-00772 | Specialty: Cardio/IM (as reported by physician)
Medical Ed: East Virginia Medical School (1990)
Action: 3/22/2007. Temporary/dated license extended to expire 3/31/2008.

WHITMER, Gilbert Gomer, Jr, MD
Location: Raleigh, NC (Wake Co) | DOB: 9/04/1961
License #: 0000-36854 | Specialty: OS/OHS (as reported by physician)
Medical Ed: The Johns Hopkins University (1987)
Action: 3/22/2007. Temporary/dated license extended to expire 3/31/2008.

WILLIAMS, Dwight Morrison, MD
Location: Roanoke Rapids, NC (Halifax Co) | DOB: 2/15/1952
License #: 0000-33577 | Specialty: OB/GYN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1982)
Action: 3/22/2007. Temporary/dated license extended to expire 9/30/2007.

See Consent Orders:
ROBINSON, Lindwood Allen, MD

DISMISSALS
NONE

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REENTRY AGREEMENTS

BARTLETT-PANDITE, Arundathy Nirmalini, MD
Location: Res. Triangle Prk., NC (Durham Co) | DOB: 11/30/1958
License #: 2007-00280 | Specialty: ON (as reported by physician)
Medical Ed: University of Liverpool (1983)
Cause: Dr Bartlett-Pandite has not practiced clinical medicine since 2000.
Action: 3/07/2007. Reentry Agreement executed: Dr Barlett-Pandite is issued a North Carolina medical license; her practice shall be observed by a physician colleague for six months; she must inform the Board of the hours she will be working and her clinical duties for approval by a Board member; the observing physician shall report to the Board within 30 days after the six-month observation period concerning Dr Bartlett-Pandite's clinical skills; she shall meet with members of the Board as requested.

BLEVINS, Douglas Dane, MD
Location: Durham, NC (Durham Co) | DOB: 8/31/1950
License #: 2005-00141 | Specialty: IM/ID (as reported by physician)
Medical Ed: University of Virginia School of Medicine (1976)
Cause: Dr Blevins has not practiced clinical medicine since September 2003. His CME is current.
Action: 2/12/2007. Reentry Agreement executed: Dr Blevins is issued a North Carolina medical license; his practice shall be observed by a physician colleague for six months and that physician shall report to the Board within 30 days after that period concerning Dr Blevin's clinical skills; he shall meet with members of the Board as requested.

GOSFIELD, Edward, III, MD
Location: Asheville, NC (Buncombe Co) | DOB: 10/30/1948
License #: 2007-00160 | Specialty: PM/Rehab
Medical Ed: University of Pennsylvania School of Medicine (1989)
Cause: Dr Gosfield has not practiced clinical medicine since October 2004. His CME is current.
Action: 2/20/2007. Reentry Agreement executed: Dr Gosfield is issued a North Carolina medical license; his practice shall be observed by a physician colleague for three months and that physician shall report to the Board within 30 days after that period concerning Dr Gosfield's clinical skills; he shall meet with members of the Board as requested.

KROEGER, Christopher Allan, MD
Location: Chapel Hill, NC (Orange Co) | DOB: 3/30/1968
License #: 2007-00162 | Specialty: GS (as reported by physician)
Medical Ed: Stanford University School of Medicine (1996)
Cause: Dr Kroeger has not practiced clinical medicine since July 2003. He agrees his practice will be limited in specified ways.
Action: 2/19/2007. Reentry Agreement executed: Dr Kroeger is issued a North Carolina medical license; his practice shall be observed by a physician colleague for six months and that physician shall report to the Board after the six months concerning Dr Kroeger's clinical skills; he shall practice only as specified; he shall meet with members of the Board as requested.

MacPEEK, David Martin, MD
Location: Collegeville, PA | DOB: 12/11/1952
License #: NA | Specialty: RHU (as reported by physician)
Medical Ed: University of Rome (1981)
Cause: Dr MacPeek has not practiced clinical medicine since 2001. His CME is current.
Action: 3/05/2007. Reentry Agreement executed: Dr MacPeek is issued a North Carolina medical license; his practice shall be observed by a physician colleague for three months and that physician shall report to the Board within 30 days after that period concerning Dr MacPeek's clinical skills; he shall meet with members of the Board as requested.

MORGAN, Perri Anne, Physician Assistant
Location: Chapel Hill, NC (Orange Co) | DOB: 12/27/1958
License #: 0001-01009
PA Education: Emory University (1987)
Cause: Ms Morgan has not practiced since August 2004. Her CME is current.
Action: 2/05/2007. Reentry Agreement executed: Ms Morgan is issued a North Carolina PA license; her practice shall be observed by her supervising physician for six months and that physician shall report to the Board after three months and after six months concerning Ms Morgan's clinical skills; she shall meet with members of the Board as requested.

STUART, Paula Shropshire, Physician Assistant
Location: Winston-Salem, NC (Forsyth Co) | DOB: 11/06/1974
License #: 0010-00811
PA Education: Wake Forest University School of Medicine (2004)
Cause: Ms Stuart has not practiced since completing her education in 2004.
Action: 2/06/2007. Ms Stuart is issued a North Carolina PA license; her practice shall be observed by her supervising physician, working on-site, for six months and that physician shall report to the Board after those six months concerning her clinical skills; she shall meet with members of the Board as requested.

WALKER, Cheryl Lynn, MD
Location: Charlotte, NC (Mecklenburg Co) | DOB: 11/17/1958
License #: 2007-00157 | Specialty: IM/AI (as reported by physician)
Medical Ed: Duke University School of Medicine (1984)
Cause: Dr Walker has not practiced clinical medicine since April 2003. Her CME is current.
Action: 2/09/2007. Reentry Agreement executed: Dr Walker is issued a North Carolina medical license; her practice shall be observed by a physician colleague for 12 months and that physician shall report to the Board quarterly concerning Dr Walker's clinical skills; she shall meet with members of the Board as requested.

A change of address form is now available on the Board's Web site at *www.ncmedboard.org*.

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.

NCMB Panel of Expert Reviewers Being Updated

The North Carolina Medical Board evaluates a large number of quality of care issues each year. To accomplish this, the Board draws on the knowledge and experience of expert reviewers from all fields of medicine. These reviewers analyze medical records and report their opinions and conclusions to the Board for its consideration. On occasion, a reviewer may be asked to offer testimony at a formal hearing of the Board. Generally, these evaluations are confidential and are handled by mail. Because the issues involved must be dealt with in a timely manner, evaluation reports are required to be completed in four weeks. Although the time required to complete an evaluation report varies, a typical review may take two or three hours. Compensation is provided at the rate of $150 per hour.

The Board began developing its panel of expert reviewers six years ago and recognizes the importance of updating its list of experts from time to time. We would like to invite North Carolina licensed physicians and physician assistants and approved nurse practitioners who might be interested in assisting the Board as a part of its panel of experts to contact the Board's medical director by regular mail, and include a detailed CV. Direct correspondence to:

C. Michael Sheppa, MD, Medical Director | North Carolina Medical Board |
P.O. Box 20007 Raleigh, NC 27619

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: August 15-16, 2007; September 19-21, 2007; October 17-18, 2007; November 14-16, 2007

Residents Please Note USMLE Information

United States Medical Licensing Examination

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at *www.fsmb.org*.

Special Purpose Examination (SPEX)

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

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