

forum

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

*When the Patient Is a Pregnant Teen:
A New Legal Guide for Physicians - Page 4*



President's Message

Elizabeth P. Kanof, MD

A Parting Tribute

In selecting a theme for my final "President's Message," I reflected on the many facets of Medical Board activities and asked myself which of them was the most productive and gratifying for me personally. The North Carolina Physicians Health Program (NCPHP) came to the fore without hesitation. The NCPHP is now an independent 501c3 organization, working closely with the North Carolina Medical Board to monitor and rehabilitate impaired licensees. It has been highly fulfilling for me to participate in its activities and to experience firsthand the evolution and increasing effectiveness of this program.

The NCPHP actually began in the 1970s

as the Physician's Health and Effectiveness Committee of the North Carolina Medical Society, chaired by Dr Theodore R. Clark of Southern Pines. Ted and his wife, Gail, an active NCMS Alliance member, were pioneers in this field, committed to helping impaired physicians salvage their professional and personal lives. For a decade, local physicians served as volunteers, visiting their impaired colleagues and providing personal intervention. One committee member from the same geographic area as the impaired physician was also assigned to the case.

"The NCPHP has the status of a model program, studied and adopted by other health professions and other states"

By 1986, the need for a more comprehensive, professional program with a full-time medical director became apparent. When this concept was presented to the House of Delegates of the North Carolina Medical Society, there were many who did not support it — colleagues who felt that impaired physicians should resolve their own personal problems and be punished rather

than those consequences could be devastating. You may think as you read this story that there must be more, something that I haven't explained, something else that caused the painful experience that my community and I were about to face.

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Learning a Hard and Costly Lesson: Failing to Register My License

Alison Chadwick VanFrank, MD

As a physician practicing medicine in the State of North Carolina, you should be aware of the potential consequences of failing to comply with changes in the requirements for license registration implemented by the North Carolina Medical Board in January 1998. As I was about to learn,

"I was facing jail time, the end of my medical career, and my community was facing the closure of its only hospital"

those consequences could be devastating. You may think as you read this story that there must be more, something that I haven't explained, something else that caused the painful experience that my community and I were about to face. There isn't anything else. I failed to complete and submit my annual license registration form, along with the annual \$100 registration fee, to the Medical Board on or about my birthday in early 2000 as required by law. Clearly, I had correctly registered in 1998 and 1999. But I made a mistake in 2000. And, but for an estimated \$12,000 in attorney fees and lost time from work, an incalculable amount of heartache and gut-wrenching fear, and the Medical Board's apparent mercy for my own personal situation, I was facing jail time, the end of my medical career, and my community was facing the closure of its only hospital. Read on. This could happen to you if you don't pay attention to the Board's registration process.

It Begins

It was a typical early morning in late November 2000 — dark and brisk. Preliminary preparations were underway for the family Thanksgiving feast later in the week when the phone rang. Early. Too early for regular, run-of-the-mill communication.

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Primum Non Nocere



forum

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

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

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A Parting Tribute

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than assisted in recovery. Medical Society leaders, such as Drs Philip Nelson, Robert Gibson, and Jonnie H. MacLeod, along with others, supported by North Carolina Medical Board leaders Drs Harold L. Godwin, Nicholas E. Stratas, and Charles H. Duckett, argued forcefully for rehabilitation. Dr John W. Foust, president of the Medical Society (and today a member of the North Carolina Medical Board), left the podium in order to voice his strong support for the program. When the speaker of the House ruled that the "nays" had prevailed in a voice vote, Dr MacLeod rose to insist on a hand count. That vote clearly reversed the earlier tally and the NCPHP was on its way.

In 2001, the NCPHP is manned by seven full-time staff members and one part-time staff member. Over the past 14 years, it has assisted over 1,000 physicians and physician assistants and can boast of a long-term recovery rate of 90%. It has the status of a model program, studied and adopted by other health professions and other states. Major financial support is provided by the

North Carolina Medical Board, with other contributions coming from the North Carolina Medical Society, hospital members of the North Carolina Hospital Association, professional liability companies, notably the North Carolina Medical Mutual Insurance Company, and others.

Designated members of the Medical Board meet regularly with the NCPHP to follow the progress of licensees undergoing rehabilitation and to assist in determining when recovery has progressed sufficiently to safely permit a licensee to return to active practice. Those licensees who self-report early in impairment are often allowed to remain anonymous. In their cases, total confidentiality is provided, with no public record or notification to the Federation of State Medical Board's Board Action Data Bank or the National Practitioners Data Bank. However, in cases involving sexual boundary violations or instances in which a licensee is a danger to

"It is considered a professional duty to report an impaired colleague in this state"

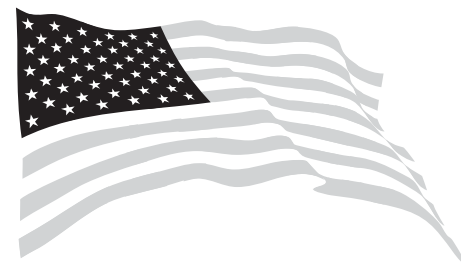
himself or herself or to the public, surrender, suspension, or revocation of the license is more likely to occur. Subcommittees of the Medical Board follow the progress of these individuals and recommend to the full Board when and if a temporary or full and unrestricted license can be reinstated.

It is considered a professional duty to report an impaired colleague in this state. The law protects the reporter from liability when the action is taken in good faith (NCGS 90-21.22). Most impaired individuals deny or have limited insight regarding their problem. We urge you to approach an impaired colleague, stressing the potential advantages of moving into recovery anonymously. The NCPHP would welcome a call, which will be accepted anonymously, to assist a concerned colleague, friend, or family member with guidelines on how to proceed in dealing with an impaired licensee. It also welcomes calls from impaired licensees seeking assistance.

The history and evolution of the NCPHP provides many thoughtful lessons. It is an example of what a small group of dedicated individuals who have a just cause can achieve. It reflects the fact that longstanding beliefs and prejudices can be changed for the better. The saga of the Medical Society vote provides the delightful story of a quiet, unassuming female physician with considerable political acumen and drive. And note particularly the benefits to be derived when circumstances permit the North Carolina Medical Board and the North Carolina Medical Society to work together for the public good.

We enlist your help to identify and steer in the right direction a troubled colleague before his or her professional life is shattered"

We enlist your help to identify and steer in the right direction a troubled colleague before his or her professional life is shattered. The effort merits the support of each one of us. ♦



Hard and Costly Lesson

continued from page 1

With a bit of trepidation, I answered the phone, already somewhat anxious about what might be on the other end of the line.

It was a nurse from the hospital where I work as a staff physician and as assistant medical director of the Emergency Department. She was calling to tell me that one of the paramedics, surfing the Internet the previous night, had stumbled on information that my medical license was deemed inactive by the North Carolina Medical Board. Indeed, she said, my license had been deemed inactive for a full five months prior to this discovery, during which time I had continued to practice medicine completely unaware of any potential problem.

Quite certain that this was just an administrative mix-up that could be fixed in a couple of telephone calls, I was on the phone again as soon as office hours began that morning. I called the North Carolina Medical Board to determine the exact nature of the difficulty. What I learned was that in buying a new house and moving to a new county, I had failed to notify the Board of my change of address. As a result, I had failed to receive the Board's annual registration reminder, as well as several follow-up mailings from the Board, including one by certified mail. I had, therefore, failed to complete my annual registration with the Board some nine months previously. None of the Board's communications actually reached me, nor were any but the final certified letter returned to the Board as undeliverable. Failing to hear from me, the Board had had no choice but to render my license inactive five months earlier.

It is not possible to mend this situation with a simple administrative decision to grant reactivation of one's license. An application process, complete with a face-to-face interview with a current Board member, was required. But this was not to be a retroactive reactivation. Instead, I was left with a glaring, garish five month gap in my licensed status, during which time I had continued to practice medicine without an active license to do so. To obtain activation back to the date of my license being deemed inactive was an entirely separate matter that would have to be brought before the Board in a public hearing, should they even choose to consider an appeal of their denial of my initial request.

The Impact and Cost

I immediately took myself out of the current work schedule. My next phone calls

were to the medical director of the Emergency Department, the hospital administrator, my malpractice carrier, and, of course, with increasing dismay, to retain legal counsel. Slowly, the full impact of my situation began to dawn on me. As we all should know, failure to register annually with the North Carolina Medical Board as is required by law is tantamount to surrender-

"Practicing medicine without a license opens a Pandora's box of difficulty for anyone even remotely connected to the situation"

ing one's privilege to practice medicine in this state. While it took only two weeks to successfully negotiate the current licensure reactivation process, I was still left with this five month gap, a gap that the Medical Board was unwilling

to close. Thus, my inattentiveness to the essential registration process had left me in the position of having unwittingly practiced medicine without a license. Practicing medicine without a license opens a Pandora's box of difficulty for anyone even remotely connected to the situation. The implications are staggering. Even catastrophic. Personally, it means a loss of hospital privileges, perhaps a permanent loss. It means a breach of malpractice insurance policy requirements that forfeits one's policy immediately. It means a complete inability to purchase malpractice coverage for that gap. No amount of money can buy that coverage because no insurance carrier will underwrite work performed by an unlicensed physician. It means a potential uninsurability for malpractice coverage in the future, a step which would effectively terminate one's medical career. It means repayment of all of the third-party billing funds that have been paid in one's name during that period. One is now not only facing potential bankruptcy but also criminal charges of insurance fraud, not to mention criminal charges of practicing medicine without a license to do so. Vulnerability to malpractice claims, bankruptcy, the end of one's medical career, and the potential loss of personal freedom with jail time. These are the personal costs.

The costs to my local county hospital could be just as devastating. Potentially open to charges of insurance fraud for billing in the name of an unlicensed physician, the hospital could face criminal charges as well as being required to repay all of the monies received in my name during that time. The hospital could be open as well to JCAHO

violations. These consequences could effectively close our county hospital's doors: several hundred people now unemployed; the loss of an invaluable community resource; the inconceivable loss of medical services for the entire county. Notwithstanding the devastating personal consequences, the thought of the greater community catastrophe was unbearable. This was not the legacy I had envisioned when I graduated from medical school and residency. My mistake had resulted in this Kafkaesque nightmare. Inconceivable, yet cold, hard reality.

And it could happen to any one of us if we don't pay careful attention to this essential registration process. Although an intricate system of checks and balances exists to remind and prompt a physician to comply with the simple and straightforward requirement of annual registration, it is ultimately the responsibility of each of us to remember and comply with that regulation. I have learned an invaluable lesson from the consequences of my mistake, including the formal and public reprimand that I received from the Board — I have ceased to rely on anyone but myself to remind me of this and other similarly essential obligations.

Conclusion

I am grateful that the Medical Board eventually saw fit to grant me an appeal hearing of their initial refusal to grant retroactive reactivation of my license. I am grateful to my (expensive) attorney for the personal pleading he made of my case to the Medical Board in that appeal hearing. And I am so thankful to the Medical Board for ultimately finding just cause to grant retroactive reactivation of my license, thereby closing that glaring five-month gap.

The hospital administration and medical staff with whom I work were similarly sympathetic. The ordeal now hopefully behind me, I offer my story as a vivid warning to my colleagues. Remember: the North Carolina Medical Board wants to hear from you.

On your birthday.
Every year!

Dr VanFrank practices emergency medicine, with an active license, in Columbus, North Carolina. She is a native of Utah and a 1990 graduate of the University of Utah School of Medicine. ♦

A Précis and Commentary

When the Patient Is a Pregnant Teen: A New Legal Guide for Physicians

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Professor Dellinger

Falling teen pregnancy rates are welcome news, but they obscure how many young lives are still affected. In North Carolina, more than 8,000 girls aged 9 to 17 become pregnant each year and a large majority of them (5,628 in 1999) give birth. A pregnant adolescent is a highly challenging patient. The fact that she is underage means providers must consider more than medical issues in caring for her.

What's a physician to do, for instance, when:

- the mother of a 13-year-old telephones about her daughter's pregnancy test result?
- a preteen says her pregnancy results from rape, but her mother denies it?
- a girl whose parents don't know she's pregnant shows signs of pre-eclampsia?
- the physician is not comfortable explaining that abortion is a pregnancy option?
- a 16-year-old mother brings in an infant who needs surgery?

Every day, North Carolina physicians confront such questions. As national medical associations recognize, responsibility for these patients is greater than normal because of their special needs. In a book now in press, Arlene Davis, JD, RN, and I explain physicians' and other health providers' legal obligations to these patients. This article describes the book's contents and sources — and offers suggestions about the situations above.

I

Health Care for Pregnant Adolescents: A Legal Guide is the first of five books explaining the law to pregnant and parenting ado-

lescents, their parents, and three types of professionals who care for families. While the issues discussed in the first book are relevant to any minor (a person under 18 years of age), the book draws particular attention to the youngest girls, those under age 15, because they present the legal issues most starkly and, arguably, are the most needy. In 1999 in our state, 574 pregnancies occurred in girls under 15, and 353 babies were born to 10-to-14-year-old mothers.

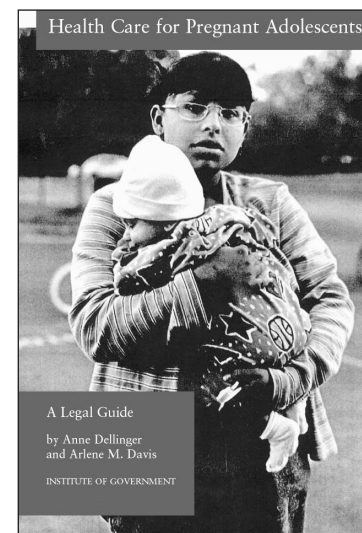
The *Guide* sets out legal requirements that are reasonably clear, but also offers an interpretation of less-clear issues, and sometimes

“The book draws particular attention to the youngest girls, those under age 15, because they present the legal issues most starkly and, arguably, are the most needy”

ventures predictions about unresolved questions. It cites the literature on adolescent pregnancy and relays advice on practice from medical organizations, treatises, and some North Carolina practitioners. An associated Web site (www.adolescent-pregnancy.unc.edu) lists resources for providers.

Among the questions physicians face are the following: who consents to treatment for a minor patient? who is responsible for payment? must social services or law enforcement authorities be involved? what are the patient's rights? To the extent they can, many health providers also interest themselves in the young patient's living situation and the effect that pregnancy or parenting will have on her future.

The broadest area of concern for health professionals, and the subject the book covers in greatest detail, is the law of consent to treatment. In bare outline, it can be stated briefly: parents usually control the medical care of minors — and if not parents, then custodians, guardians, or other adults in authority. Minors do not need adult consent in several circumstances: in an emergency; when the minor is seeking treatment for certain medical conditions, including pregnan-



Cover: Health Care for Pregnant Adolescents: A Legal Guide

cy; when she is consenting to treatment for her own child; or when she is emancipated. A health facility or practice group would do well to adopt a policy on minors' consent

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and note the basis for accepting consent in each minor's medical record. Let me expand somewhat on that summary. It is more difficult for physicians to accept consent from someone besides a minor's parent, but sometimes they must. A guardian can consent as fully as a parent can. However, only a court can designate a person as a guardian. A physician accepting consent from an adult as a minor's guardian should ask to see the person's court appointment and should place a copy of it in the minor's medical record.

If a local department of social services (DSS) has custody of a minor, but is not the minor's guardian, the DSS director can consent to “routine or emergency medical or surgical care or treatment.” But, unless a

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court has terminated parents' rights, a DSS cannot consent to elective care. Sometimes, a DSS director delegates to foster parents the authority to consent to a minor's routine health care. Before treating a minor brought in by a foster parent, a provider should verify that the foster parent has that authority, and, again, should document it in the minor's medical record. (State law does not define routine, emergency, or elective care.)

An adult may tell a physician that she or he, in effect, is the minor's parent; that is, that she or he stands *in loco parentis*. (The term describes someone who intends, albeit informally, to take on the rights and duties of parenthood, especially the duty of support.) The problem is that providers can rarely know who supports a minor or whether a particular adult intends to act as a parent — and, if so, how fully or for how long. If physicians accept consent on this basis, the American Academy of Pediatrics advises that they “document the situation in the medical record including attempts to obtain verbal or written consent from a parent.”

Other substituted-consent situations are less problematic. For example, a recent North Carolina statute lets a parent transfer the power to consent to a child's treatment when “the parent is unavailable for a period of time by reason of travel or otherwise.” The parent must have sole or joint custody and transfer authority in writing. No parent, though, may authorize another person to withhold or withdraw life-sustaining procedures for a child.

This slightly expanded summary still makes the law seem more straightforward than it is. Most situations have legal nuances. For example, although the statute allowing minors to consent in some cases reads: “[a]ny minor may give effective consent,” a provider should not take *any* literally. In order to give valid consent, a minor, like anyone else, must understand her condition, the alternatives for treating it, and the risks and benefits of treatment or non-treatment. That is, she must be capable of giving *informed* consent.

There is no specific age at which adolescents understand such matters, and selecting an age arbitrarily would seem especially inappropriate for pregnancy, by definition an adult medical condition. Legal commentators, psychologists, and judges are divided on whether girls under 15 should be able to consent to abortion or childbirth — and a number of state legislatures, including ours, will not let a minor of any age consent to

abortion by herself. A national commission on consent to treatment wrote that “there is an age, below about 14 years old, at which the traditional presumption of incompetence remains sensible.” Still, the commission advised against a generally applied rule for age of consent, thinking it “more reasonable to ask — of any person at any age — ‘is *this* person capable of making *this* decision?’”

The commission described *decisional capacity* as having “sufficient ability to understand a situation and to make a choice in the light of that understanding.” Another definition is the ability to understand the situation, weigh the risks and benefits of the

“In the case of adolescent patients, it is extremely important that their options be explained to them as soon as pregnancy is diagnosed”

choices, compare choices, incorporate the patient's own values in the final decision, and make a decision that is not overly affected by the opinions of others. One North Carolina specialist in adolescent medicine uses practical tasks to help form her judgment about a patient's capacity — for example, whether the patient demonstrates responsibility for her own health by keeping appointments that have been described to her as important. In addition, this provider usually asks a pregnant adolescent to describe in writing what she thinks her life will be like in one year and in five years if she makes one choice or another. Simply talking with a patient about her situation and plans can help a provider form an opinion about the patient's competence to make medical decisions, which may differ from what her parent — or the provider — would choose. If she does not seem competent, the provider should not treat on the patient's request only. But parents should not be told of the request unless the physician thinks notifying them may be essential to the minor's life or health.

If a physician thinks that a minor patient is able to consent, he or she must also assess whether her consent is voluntary. Do peers or adults — family, partner, or advisers, including providers — unduly influence the pregnant girl's decisions? People who have studied adolescents making medical decisions disagree on whether most of them act autonomously. Several staff members in North Carolina institutions (hospitals, clinics, and adoption agencies) told us they often fear that life-altering decisions made by a young adolescent — whether to give

birth, have an abortion, or keep her child — were not truly her own. Naturally, their parents will influence adolescents — especially the youngest. However, if physicians suspect that a minor's consent is coerced, they should, after talking with her alone, tell her that she has a right to decide. If necessary, they should ask the DSS to intervene on her behalf. Treatment should be postponed until the issue is resolved and the minor's consent seems to be freely given.

Before a pregnant patient can give informed consent, she must understand her options. In the case of adolescent patients, it is extremely important that their options be explained to them as soon as pregnancy is diagnosed. Typically, these young women lack sufficient information about pregnancy, the law, and health systems. They come for care near the deadline for obtaining an abortion and past the time when prenatal care should have begun. In one group of 58 teens, for example, 74 percent of the young women realized they were pregnant only after “someone else suggested the possibility, and half of them did not detect it until the second trimester.”

A physician should always spend some time counseling a pregnant adolescent in private, even if someone comes with her to the appointment and joins the discussion later. Most pregnant girls, especially the youngest, come with a parent. Of those under fifteen, 90 percent report that one parent knows about the pregnancy; 43 percent, that both parents know. Unless a provider tells them, however, many young patients will not real-

“A physician should always spend some time counseling a pregnant adolescent in private, even if someone comes with her to the appointment”

ize the extent to which they can make health care decisions. They may not know, for example, that a minor can consent to prenatal care and the child's care — or that abortion requires their written consent, plus that of a parent or specified other adult, unless a judge waives the adult consent requirement. Few adolescents who want to consider an abortion without parental involvement know how to seek a judicial waiver. Physicians and their staff can help by explaining these points; having some knowledge of the law on adoption, marriage, and child support; facilitating a patient's return to school after childbirth; and referring young parents to resources.

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II

With this information as background, let's return to the situations briefly described at the beginning.

A mother calling about a child's pregnancy test

State law letting minors consent to pregnancy care leaves it to the physician whether to breach a minor's confidentiality if her parents seek information. The physician could tell the mother the test result. However, national medical organizations advise giving a pregnancy diagnosis to an adolescent alone and talking with her in private about treatment options. Except in rare instances, a physician would then urge a teen to talk with her parents. Some providers offer to do so instead of or with the teen.

The preteen who says she was raped

The mention of rape deserves attention, especially since research indicates that intercourse involving very young girls is often coercive. Talking to mother and daughter separately may help a physician form (or not) a suspicion of child abuse or neglect. A physician, like all other adults, must report a reasonable suspicion to the DSS. A parent's failure to supervise a child is a form of neglect.

In addition, if the girl was raped, a crime was committed. Physicians are required by statute to report several crimes, but not rape in most cases. A report that is not required by law breaches the confidentiality of the doctor-patient relationship and may expose a physician to liability. However, the physician could talk with the patient and her mother about their reporting the crime.

The teen with pre-eclampsia who wants confidential care

Under state law, if parents do not ask, a physician should not tell them that a minor has sought pregnancy care "unless the situation...indicates that notification is essential to the life or health of the minor." The physician must make clinical judgments about whether the pre-eclampsia is such a situation and whether it can be handled safely without involving a parent.

In deciding when to notify a parent against a patient's wishes, a physician should consider her physical and emotional health — hints that she may be

suicidal, for instance, or her refusal to seek treatment for a serious condition. For example, a health director informed a parent when a young patient took no action for months after receiving a troubling PAP test result. His action seems to me a reasonable application of the statute.

The physician who does not want to mention abortion as a treatment option

State and federal law lets a health provider with ethical or moral objections avoid participating in abortion. However, a provider's withdrawal must not limit a patient's options. To satisfy state law on informed consent and, if applicable, the federal family planning regulations, the physician must refer the patient to another provider who will counsel her on all options.

A minor parent seeking care for her child

A parent of any age is responsible for meeting her child's basic needs, which include medical care. Although no statute, regulation, or judicial decision addresses this question, we conclude that a minor parent must be able to consent to her child's treatment because no one else has the duty or the authority to do so.

III

Besides the legal aspects of consent and treatment of pregnancy, *Health Care for Pregnant Adolescents* discusses control of minors' records, providers' liability, and financial responsibility for minors' care. Additional considerations for these patients include extra care in taking history; counseling about contraception and sexually transmitted disease; special legal requirements for sterilizing a minor; reporting abuse, neglect, dependency, and sexual assault; and adolescents' needs for confidentiality, reassurance, and health education. The book describes the latest actions of the General Assembly; for example, the adoption laws and the marriage laws for minors changed this session and health providers were given new responsibilities for newborns surrendered by a parent.

The choice of topics covered emerged from several types of research. First, Arlene Davis and I were fortunate to be able to review 186 medical records of girls pregnant when less than 15 years of age, and 15 medical records, which we selected at random, of infants born to them. Most of these patients had delivered at a large hospital in North Carolina after receiving prenatal care else-

where, usually at local health departments. A smaller number had abortions performed at the hospital or, in more cases, at a private urban clinic in the state. These reviews told us about the medical and social problems affecting patients, both during pregnancy and sometimes for years to come; suggested the nature of their interactions with family members and health care providers; and gave an idea of what legal questions providers most want answered.

Second, we conducted legal research and identified the recommendations of national medical organizations on the care of pregnant adolescents. (With one exception, we found no nursing guidelines, although nurses probably provide more care for pregnant adolescents than any other type of health professional.)

Third, we interviewed more than 100 North Carolinians with some knowledge of adolescent pregnancy. They included nurses,

“Besides the legal aspects of consent and treatment of pregnancy, Health Care for Pregnant Adolescents discusses control of minors' records, providers' liability, and financial responsibility for minors' care”

nurse practitioners, physicians, and social workers in hospitals, health departments, medical faculties, community outreach programs, non-profit agencies, and private practice settings; maternity care coordinators; an owner,

directors, and staff members of two abortion clinics; a counselor in a pregnancy support center; domestic violence and adoption specialists; judges, attorneys, and prosecutors; several parents of girls who became pregnant as young teens; two court-appointed guardians for such girls; and several adult women who had given birth as minors. To protect their privacy, we made no effort to contact pregnant girls or their partners. However, Arlene Davis, a nurse as well as a lawyer, observed sessions at a teen prenatal clinic, and we listened for 15 hours to telephone operators as they staffed a national abortion referral line.

Fourth, we gathered data on facilities, programs, individuals to contact, written material, and other types of assistance available to adolescents and those who care for them.

Finally, we asked a variety of North Carolina providers to use the *Guide* for six months and suggest improvements. The

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pilot sites were Buncombe, Catawba, Chatham, Guilford, and Warren County health departments; the Pediatrics Department of Pitt Memorial Hospital in Greenville and the Department of Adolescent Medicine of UNC Hospitals in Chapel Hill; Planned Parenthood of Orange and Durham Counties; Raleigh Women's Health Organization; Teen Health Connection in Charlotte and Wilmington Health Access for Teens.

The result is a book whose 'authors' number in the hundreds — one that we hope will be used by thousands of North Carolina health professionals who serve children. This fall, many physicians will receive a copy of the *Guide* without charge, as a result of the generosity of the Z. Smith Reynolds Foundation and the Institute of Government, University of North Carolina at Chapel Hill. In addition, the entire book or any portion, as well as a resource list for health providers, can be printed from our Web site:

www.adolescentpregnancy.unc.edu. ♦

Nota Bene

About the Authors of *Health Care for Pregnant Adolescents: A Legal Guide*

Anne M. Dellinger, JD, has been a faculty member at the Institute of Government, University of North Carolina at Chapel Hill, since 1974. She was formerly of counsel with Hogan & Hartson, Washington, DC, and is author of numerous publications on health and hospital law, including an article, How We Die in North Carolina, in *Forum* #2, 1999.

Arlene M. Davis, JD, RN, is a research assistant professor of social medicine in the University of North Carolina at Chapel Hill School of Medicine. Her current work is on law and ethics in health care and research; her prior work as a nurse involved children and adolescents, as well as public health.

About the Series

Health Care for Pregnant Adolescents: A Legal Guide will be published by the Institute of Government, University of North Carolina at Chapel Hill, in fall 2001. The second title in the series will be *Social Services for Pregnant and Parenting Adolescents: A Legal Guide*. A third guide will follow for public school employees; a fourth for parents of pregnant and parenting teens and preteens; and a fifth for adolescents themselves.

Comments About the *Guide*

"I think this document should be in the office of every provider of adolescent care in North Carolina."

--Harold C. Pollard, MD, Chair, North Carolina Section, American College of OB/GYN

"As program manager of the Women's Health Project and a registered nurse with the Health Department for 29 years, I find this book to be the clearest reading of law related to adolescents I have ever used. It will be a great tool for staff serving teens and parents dealing with teens seeking services independent of their consent."

--Jerry Chance, RN, Guilford County Health Department

"An extraordinarily impressive job of finding and analyzing the complex body of law that is relevant to the health care of pregnant minors in North Carolina. . . . Although I have worked for more than two decades on legal issues in adolescent health care, I learned a lot from the document."

--Abigail English, JD, Center for Adolescent Health and the Law

"Congratulations on your wonderful efforts to take on a very difficult topic. . . . It is important work."

--Carol A. Ford, MD, assistant professor, internal medicine and pediatrics, and director, Adolescent Medicine Program, University of North Carolina at Chapel Hill

"Fascinating. . . . It's an exciting piece of work."

--Merry K. Moos, BSN, FNP, MPH, research associate professor, obstetrics and gynecology, University of North Carolina at Chapel Hill; director, UNC Hospitals' Prenatal Clinic for Teens ♦

North Carolina Medical Schools Educate 27.5% of Physicians Practicing in the State

David Williamson

University of North Carolina News Services

Ask people on the street what percentage of North Carolina's doctors attended medical school in the state and, researchers say, most would guess half or more.

But they would be wrong says a new University of North Carolina at Chapel Hill study. The real figure is 27.5%.

"If we are going to influence the number of physicians who practice in North Carolina, we have to know whether we're training a substantial percentage of them and, if we're not, where the others are coming from," said Dr Thomas C. Ricketts. "Some people have talked about building another medical school, but that's probably not feasible for several reasons. We really need to depend on the rest of the United States and to compete successfully in a national market for physicians from out of state."

Dr Ricketts is professor of health policy at the UNC School of Public Health and deputy director of UNC's Cecil G. Sheps Center for Health Services Research. He oversaw the new study, which focused on 1999 data and was conducted by assistant director Erin Fraher and the NC Health Professions Data System staff.

The study showed that among active, licensed NC physicians that year, 12.2% attended medical school at UNC, 7.1% Wake Forest University, 5.2% Duke University, and 3% East Carolina University. Medical schools in New York, Virginia, Pennsylvania, Ohio, and South Carolina furnished 5.5%, 5%, 4.9%, 3.8%, and 3.1% respectively. One in 10 doctors practicing here graduated from a foreign medical school, and more than a quarter of those studied in India.

"We found that NC physicians who trained in foreign medical schools were more likely to practice in primary health care shortage areas and in rural counties than those trained in the United States or Canada," Ricketts said. "Almost 30% of foreign medical graduates practiced in non-metropolitan areas compared with about 21% of those who went to medical school in the U.S. or Canada."

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From the Executive Director

Andrew W. Watry

Hold The Onions!

Sometimes, applicants for a medical license approach a medical board as if they were buying a hamburger. Waiting in line is a nuisance, they are in a hurry, and they would like to have the hamburger yesterday if possible. Several years ago, there was a catchy advertising slogan for a hamburger chain: "Hold the onions, hold the lettuce—special orders don't upset us, have it your way. . . ." Sometimes, we are asked to hold the onions by an applicant or an applicant's advocate.

Why Licensure Takes Time

We are committed to providing customer service to each applicant. However, the North Carolina General Statutes (NCGS § 90-2(a)) provide that the Board is established "to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. . . ." To that extent, then, when the interests of an applicant conflict with the law or the rules of the Board, the applicant's interests must be secondary. Take, for example, a real case: an applicant who indicated to Medical Board staff that he had a little problem with the law. He had received clemency from a governor, he said, so the Board need not be concerned with the underlying facts. It turned out that, in the state involved, clemency is a routine process to restore voting rights to felons. On closer examination, that "little problem" was a kidnapping for ransom in which he had buried the victim in a box. He had obtained an MD degree at a Caribbean medical school after he served his prison term. He wanted the Board to overlook that "little problem." Hold the onions!

Last year we issued initial licenses to 1,636 individual physicians. On average, initial licensure takes a couple of months. If a person has a problem such as criminal history, discipline in another state, a history of chemical dependency, or any of the myriad other factors that will require extra attention during the licensing process, it can take significantly longer. Yet, we are constantly faced with applicants who want the process expedited. The recruiting of physicians and residents involves high stakes, of course. I

am not belittling that, just offering an explanation of why one needs to give this or any medical board a reasonable period of time to do its job. It is not simply a matter of bureaucratic red tape.

One view is that in a licensing office the squeaky wheels get the grease. There's an impression that there are perhaps several periods of significant dormancy in the application process. There is also a perception that many, if not most, of the documentation requirements are ministerial in nature. It is "bureaucracy." Bureaucracy is a concept that everyone loves to hate, but it is absolutely necessary for any agency that must deal with a significant volume of legally precise work while maintaining effective productivity. The process of screening some 2,000 applicants each year requires structure, documentation, and thoughtful judgment. And sometimes the problems identified through this process are significant enough to even shock Board members.

If We Ask for It, It Is Necessary

In our efforts to provide better services to applicants and the public, we are looking at ways to minimize the documentation burden wherever possible. Core credentials, such as graduation from medical school, should only have to be documented once. But let's examine the process for expendable items.

- (1) Should we discard the check with other states for license history?
- (2) Should we discard our check with the DEA or the Federation of State Medical Boards for disciplinary and board action history?
- (3) Should we take the applicant's word that he or she has had no convictions or other problems in his or her background?

For anyone who thinks we should take applicant information at face value, I have a little anecdote. In Florida, it was legislated that the state medical board do a check on the criminal history of the entire physician population. The board detected that there were a few hundred physicians who, even after getting fingerprinted and filing those finger prints with the board for the purpose of a criminal history check, lied on the form they submitted with respect to prior criminal history! At every meeting of the North Carolina Medical Board, there are physician applications that reflect interesting memory lapses revealed by the Board's background checks. It is a disappointing but not uncommon fact.

All of this is to say that we do examine our application to ensure that we are not overburdening anyone or asking for unnecessary documentation. As a result, you can safely assume that if we ask for it, it is necessary.

Also, the need to go to several different

sources, each of which, in turn, has a backlog of people querying information, causes the application process to take a little time. When it comes to a medical license, it is an unrealistic expectation to walk up to the counter and pick up the hamburger, with or without onions. This being said, we are committed to doing everything in our power to keep the process moving as quickly as possible because we know how critical and important it is to the applicant and to those who will be served by the applicant.

Also, applicants can rest assured that their applications will not be put aside so that someone else's application can be expedited simply because he or she did not allow enough time for the process. However, the inverse is also the case: an applicant cannot expect to be given special consideration at the expense of someone else who allowed enough time for the process to be completed. These policies are designed to give fair treatment to all applicants.

Conclusion

The amount of time it takes to get a medical license in North Carolina compares quite favorably with other states. In coming months, we will continue to work on improvements, such as providing secure, Web-based access for applicants so they can monitor the progress of their applications. This will be an improvement because now, when anxious applicants call the office, every minute spent on the telephone is a minute away from processing an application. So we anticipate being able to provide better service by providing monitoring information through secure, alternate mechanisms.

A dramatic example can be found in the annual registration process now in place. Before, when the process was largely a manual one, it took about a month to receive confirmation of registration from the Board. The process was very labor intensive. Now, with electronic registration, 75 percent of our licensees are registering by spending just a few minutes on our Web site, and they get a confirmation via e-mail within 24 hours. We are working on bringing these efficiencies into our application process to provide better service to our physician applicants.

In closing, the purpose of this article is to ask your help if you are in any way involved in the process of recruiting physicians — as residents, as hospital physicians, or in some other capacity. Things will work much better for you, for the physician, and for the Board if you build in a reasonable time period — at least two months — for the licensing process to run its course. And allow a longer period if there are problems that will require closer examination. Remember, we can't hold the onions or the lettuce. ♦

Selling Goods Within a Medical Practice

James A. Wilson, JD
Former Director, NCMB Legal Department

At its March meeting, the North Carolina Medical Board issued a new position statement on the sale of goods from physician offices. In it, the Board tells physicians they are not at liberty to engage in every form of commerce within their offices. Physicians are expected to sell their services, but when can physicians also sell goods as part of their practices? The position statement concerns both non-health related and health related goods, with different guidance for each.

Non-Health Related Goods

Avoid Selling:

The Board holds that physicians "should not sell any non-health related goods from their offices or other treatment settings." The position statement gives no examples, which would require an almost endless list of possibilities, but suffice to say that physicians should not sell telephone cards, household products, or other consumer items from their practices.

"Girl Scout Cookie" Exception

The Board does allow for what I call the "Girl Scout cookie" exception. Physicians may sell (or permit the sale of) Girl Scout cookies or any item that is (1) low cost and (2) for the benefit of charitable or community organizations; provided the physicians and/or their staffs receive no share of the proceeds, conduct sales only occasionally, and do not pressure patients into buying.

This portion of the position statement is a nearly verbatim restatement of the American Medical Association's Current Opinion 8.062, issued in June 1998. The Board omitted only the AMA's requirement that such sales be "conducted in a dignified manner."

Health Related Goods: Generally Okay to Sell, but with Conditions

The position statement permits the sale of "practice related items," giving as examples of such, "ointments, creams, and lotions by dermatologists; splints and appliances by orthopedists; eyeglasses by ophthalmologists; etc." Physicians may sell these "only after the patient has been told if those items,

or generically similar items, can be obtained locally from another source." The phrase "generically similar items" and the word "locally" are not further defined. Physicians are encouraged not to be exclusive distributors or to personally brand items.

This portion of the Position Statement differs from the AMA's analogous Current Opinion, 8.063. The AMA speaks discouragingly of such sales as "present[ing] a financial conflict of interest, risk[ing] placing undue pressure on the patient, and threaten[ing] to erode patient trust and undermine the primary obligation of physicians to serve the interests of their patients before their own." The AMA would require that physicians:

- sell only products with scientifically valid claims of benefit as judged by "peer-reviewed literature and other unbiased scientific sources";
- sell only products serving an "immediate and pressing need of patients," giving selling crutches to a patient with a broken leg as an example;
- sell at cost or give away all items not meeting the above criteria;
- disclose their financial arrangements regarding such sales;
- disclose the availability of products, or their equivalents, elsewhere; and
- not engage in exclusive distributorships.

Conclusion

Physicians are expected to sell their services. Physicians are permitted to sell prescription drugs, though that requires authorization by the Pharmacy Board and is a topic for another article. Physicians who sell other things should carefully consider the Board's new position statement. Physicians who come to look on their patients as potential customers for the sale of these other things can expect trouble from the Board.

James A. Wilson is a lawyer in private practice in Durham. Formerly director of the Legal Department of the North Carolina Medical Board, he now represents physicians and others in occupational licensing and related matters. This article is provided as general information and should not be construed as legal advice on specific factual scenarios. ♦

See: *Y'all Want Fries or a Pie with That*, page 14.

UNC Information Sessions

October 8 - 18, 2001

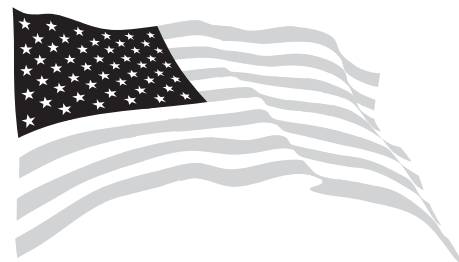
Albemarle, Asheboro, Asheville, Brevard, Burlington, Charlotte, Columbus, Danbury, Eden, Franklin, Hickory, Mocksville, Monroe, Mt. Airy, Murphy, Roxboro, Rutherfordton, Siler City, Thomasville, Troy, Winston-Salem and Yadkinville.

Information sessions for the off-campus Executive Master's Program in Health Care Administration (EMP) are being held in western North Carolina during the month of October. Sponsored by the University of North Carolina Department of Health Policy and Administration (HPAA), the briefings will provide an overview of the entrance requirements, tuition, courses, and distance-learning models used to teach courses in Asheville, Charlotte, Fayetteville, Rocky Mount, Wilmington, and Winston-Salem. This program continues to be ranked by *US News and World Report* as the #2 health services administration program in the country.

Nurses, administrators, educators, physicians, and other health care-related professionals interested in obtaining a Master of Health Care Administration (MHA) or Master of Public Health (MPH) degree are invited to attend a briefing. There is no fee to attend and pre-registration is not required. You are welcome to bring your coffee and/or lunch to the briefing.

A schedule and brochure of EMP Briefings workshops is available at www.ACMNC.com. Contact Mr Fred Sexton at ACMNC@ACMNC.com or call 919-791-0810 if you have questions or wish to host a future EMP briefing workshop.

**Sponsored by the Executive Master's
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A Personal View

A PA's Perspective

Oswald H. Ganley, PhD, PA-C,
Chapel Hill, NC

After a long and tortuous, although successful, career in the periphery of medicine, I finally found my niche: the physician assistant profession. I only regret that the time has been too short.

Early Life and Career

I was born and raised in Amsterdam, Holland, and shortly after World War II my family and I emigrated to the U.S., just as I was ready for college. Being from Holland, and Dutch Reformed by religion, what better place to go than to Hope College, a Dutch Reformed liberal arts college in Holland, Michigan. Hope taught me chemistry and biology, but, more importantly, ingrained in me the importance of staying in touch with a Greater Being, and with the broader world outside of the sciences. After Hope, I went to the University of Michigan and acquired a PhD in medical microbiology and human physiology.

By then, it was the period of the Korean War and I went into the Army. After basic training, I became a medical corpsman, covering some sick call and running the STD clinic at Fort Benning, Georgia, under the general supervision of an MD. This led to a transfer to Walter Reed Army Medical Center in Washington, DC. There, I was put to work on research on gas gangrene and other wound infections, which had been the topic of my doctoral dissertation.

An almost ten-year stint at Merck Research Laboratories followed, where I did research on infectious and immune diseases. I kept hoping to find a way to get into clinical medicine, but this was not possible at the time, for financial and other reasons. At the end of my time at Merck, I was assistant director for international research, and this led to what was to be my career in the international field. A year of mid-career study at Harvard in political economy and foreign affairs included papers written on the politics of birth control and some other health-related subjects. I was given an opportunity to join the Agency for International Development (AID) as special assistant to the science director of the Agency.

Government Service

After a year with the AID, in 1966, I joined the U.S. State Department, where I worked on the political, national security,

and economic aspects of science, technology, and medicine. After tours as counselor for science and technology at the American embassies in Rome and Bucharest, I was recalled to Washington in 1973 to take charge of the implementation of science, technology, atomic energy, and medicine agreements that had just been signed by President Nixon with the Soviet Union and Eastern Europe. To carry out this task, I served as an office director in the State Department, but was also appointed diplomatic advisor to the President's science advisor. These agreements were the cornerstone of a new policy that aimed at "opening" the Soviet Union and Eastern Europe to the West. In 1975, I was appointed deputy assistant secretary of state by Secretary Henry Kissinger. My portfolio as deputy included, in addition to the above issues, work with the World Health Organization

"Notwithstanding I had enjoyed a most interesting and challenging career, I continued to dream of some day getting into clinical medicine"

and other international agencies on health matters. One of the more interesting challenges arose with the swine flu scare of 1976 with all of its diverse ramifications regarding possible pandemic threat, production of vaccine, dealing with shortages, and allocation of limited supply of vaccine.

Although I was a career foreign service officer, in my job as deputy assistant secretary, I was also a political appointee of the Republican Ford administration and Secretary Kissinger. After being held over for a few months by the incoming Democratic Carter administration, in 1978, I was sent into "exile" at Harvard. Here, a temporary stay turned into 16 years of teaching and doing research in the area of foreign affairs and high technology.

A New Life at Age 65

During all this time, clinical medicine had never been far from my mind. Notwithstanding I had enjoyed a most interesting and challenging career, I continued to dream of some day getting into clinical medicine. One day my daughter, Delia, called to

ask me whether I had heard of the PA profession, which I had not. She had been talking with some of her physician friends and they had told her about the contribution this new profession was making to the field of medicine. Further good news was that it would "only" take two years to become a PA!

Once my curiosity was aroused, I checked around and found Roderick Hooker, who was kind enough to send me all sorts of materials. I decided on the spot that "this was for me." I

"With all the hard work I had been accustomed to over the years, I had never experienced anything like the sustained stress and long hours required of a PA student"

started to take evening refresher classes in psychology, physiology, and also EMT training, while I was still fully employed at Harvard. After doing this for about two years, I began sending out applications for PA training. I was 65 at this point, and didn't think there was much chance of being accepted. But, hallelujah! The PA Program at George Washington University Medical School, then under the direction of Lisa Alexander, took me in! I shall always be beholden to her. I retired from Harvard in the summer of 1994 and reported to GW as a first year PA student.

Frankly, with all the hard work I had been accustomed to over the years, I had never experienced anything like the sustained stress and long hours required of a PA student. In fact, after the first year, I felt ashamed that I had not made my Harvard students work harder and had not exposed them to more material. Clinical rotations were great — OB/GYN and emergency medicine were my favorites. Unfortunately, in the social-political climate of the day, my future opportunities as a male PA in OB/GYN seemed limited.

After graduation, my next stop was a real job as a real PA with the Cardiology Associates at Duke University Medical Center. This is a 60-bed inpatient and clinic practice, with 24 attending physicians and

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A PA's Perspective

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10 physician extenders. My principal supervising physician was Dr Robert H. Peter, professor of medicine. In this great tertiary cardiology practice, I learned a great deal of medicine, and perhaps even more about the human spirit and its resiliency, optimism, and capacity for suffering. As a foreign service officer, I had already seen enough of that to last a lifetime. As a PA, I finally got my wish to treat individuals, to help individual people, and to actually see the consequences of my own clinical efforts, for better or worse. Most of my career before had dealt with broad policy issues where the individual was often far in the background.

Unfortunately, after nearly four years of PA practice, a combination of health problems forced me to give up the long days of patient care that were required at Duke. But I enjoyed and give thanks for every minute of my PA experience.

Since leaving the Duke practice in June 2000, I have joined the North Carolina Academy of Physician Assistants Health Committee as a member and monitor, and have acted in an advocacy role in attempts to include impaired PA students under some salvage program similar to that enjoyed by licensed PAs. I also work with UNC Hospice on a part time basis. I am eager to give something back to the PA profession and I am open for assignments on NCAPA committees dealing with areas of my interest. I am also investigating part-time *pro bono* work as a clinician in a medically underserved area.

Reflections on Medicine and the Physician Assistant

As for my view concerning medicine in the U.S. and on PA issues, let me address medicine first. I will skip the general dissatisfaction with managed care, the scandalous situation that leaves 40 million Americans either uninsured or under-insured, and the fact that millions in the advanced stages of disease who are outside the insurance system are using the ER as their primary care source. Rather, I would like to make a special plea for better pain control and for improved palliative care for those at the end of life. This includes not only control of pain, but control of dyspnea, and nausea and

"I would like to make a special plea for better pain control and for improved palliative care for those at the end of life"

vomiting, as well as more and better attention to the family. There have been great strides made in recent years, but physicians and PAs are still too reluctant to deal with death, a vital part of life. Palliative care should be taught in medical and PA schools so all providers are familiar with its practice. It should not become just another board specialty — palliative care is an attitude as well as a skill. Greater awareness of hospice care should be encouraged, and opportunities to earn CME credits in this area should be improved.

An entirely different subject is that of infectious disease as a foreign policy issue as well as a national security issue for the U.S. and other countries. The year 2000 was the first time in the United Nations' 55 years of existence that the Security Council took up a health issue — HIV/AIDS. Here the question is not just one of individuals suffering, but of whole societies disintegrating politically, socially, and economically. This is acknowledged to be happening in parts of Africa, but it is also creating serious problems in Russia, China, and several other countries, although they continue in a state of denial. It is to the credit of the Clinton administration that it made international health, especially HIV/AIDS, a subject of national security importance. Hopefully, it will be treated as an area of priority. This new field within foreign affairs is an area that needs work, and is one where PAs in the future could make a significant contribution.

Another troubling issue is postgraduate PA training. The unwritten assumption of

PA education has been that a rigorous 24-25 months of didactic and clinical training would be followed by one to two years of "apprenticeship" under a supervising physician. With managed care, this model may no longer be realistic. Will this lead to increasingly mandatory "internships" prolonging PA training time? If so, what will be the consequences in terms of recruitment and financial remuneration?

The progress made over the past 35 years by the PA profession, working in tandem with physicians, is close to miraculous. North Carolina and the NCAPA have been in the forefront of this progress. But after we congratulate ourselves, let us keep our guard up. One thing I have learned in my various careers is that as long as you are small and do not "rock the boat," you can get away with a lot. When you become a significant player, be prepared to show your true colors!

Reprinted in edited form from an article appearing in the March-April 2001 number of *Academy*, a publication of the North Carolina Academy of Physician Assistants.

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The author practices as a volunteer PA at the clinics of the Healing Place of Wake County. He is also a volunteer principal investigator of a research project at the North Carolina Physicians Health Program. ♦

Notes for Physician Assistants

*Erin Gough, Physician Extender Coordinator
Licensing Department, NCMB*

Are you a physician assistant working in North Carolina?

If your answer is yes, you are required by law (32S.0102 & .0112) to have a license and to list your primary supervising physician(s) with the North Carolina Medical Board before you may begin to practice. This is accomplished by submitting an Intent to Practice Form, which can be downloaded from the Board's Web site at www.ncmedboard.org. This form must be submitted whenever you add or change a primary supervising physician. No fee is required, only original signatures (no faxes or copies, please).

Medical Board investigators routinely check practice sites to ensure that the appropriate paperwork is on file. You can see a list of required and suggested materials to be kept on file at PA practice sites on the instruction page of the Intent to Practice Form (also on the Web site).

Do you have a temporary physician assistant license?

If so, you are required by law (32S.0103) to notify the Medical Board within 15 days on the receipt of your NCCPA examination scores. This includes passing OR failing scores. This is your responsibility. Do not assume the NCCPA will notify the Board; they typically do not. Temporary licenses expire in one year or after failing the NCCPA examination twice, whichever is sooner. So if you received a temporary license last year and have not submitted your scores or NCCPA certificate, it may be about to expire. The expiration date is listed on your temporary license. ♦

Summary: Management of Occupational Exposures to Hepatitis B, Hepatitis C, and HIV

Kelly T. McKee, Jr, MD, MPH

Head, Communicable Disease Control Branch, North Carolina DHHS Division of Public Health

Recently, the Centers for Disease Control and Prevention (CDC) issued updated guidelines for the management of occupational exposures to bloodborne pathogens (MMWR 50/RR-11, 29 June 2001 *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis*). These guidelines represent a synthesis of recommendations published by CDC (and OSHA) over the past several years in a variety of forums, and reflect the current state of knowledge regarding risks of contracting Hepatitis B, Hepatitis C, and HIV following percutaneous or mucous membrane exposure to blood and body fluids. Additionally, these guidelines summarize current information on, and recommendations for, post-exposure prophylaxis (PEP) for each of these pathogens. Below is a comparison of the changes from previous recommendations. Note that this summary is NOT intended to substitute for a careful review and analysis of the complete CDC document by responsible individuals at the local level. The complete CDC document can be found at: <http://www.cdc.gov/mmwr//preview/mmwr.html/rr5011a1.htm>

Each local health department should ensure that a plan is in place for management of occupational exposures to blood and body fluids. Emphasis must be placed on prompt assessment of incidents by individuals experienced in the management of HIV, familiar with anti-retroviral therapy, and knowledgeable about drug resistance and its impact on choice of post-exposure prophylaxis regimens. It is incumbent on each health department to identify local and/or regional resources capable of responding knowledgeably and in a timely fashion. Telephone consultation on these matters is available through the Statewide Program for Infection Control and Epidemiology (SPICE) at 919-966-3242; however, this should not substitute for local response capability.

UPDATES NEW TO 29 JUNE 01 PHS GUIDELINES

HIV:

- Last guidelines 1998 (15 May 98;

MMWR 47/RR-7).

- Better definition of “less severe” and “more severe” exposure types driving 2 vs. 3 drug PEP regimens.
- New anti-retroviral agents approved by FDA; modified PEP recommendations.
- More info about the use and safety of PEP.
- Potential drugs for post-exposure prophylaxis should not be used if the source patient demonstrates clinical or virological failure
- For all drugs, much more info on tolerability, toxicities, advantages/disadvantages.

OLD: *Basic: 4 weeks (28 days) AZT (600 mg qd-divided doses) PLUS lamivudine (3TC) (150 mg bid); Expanded: Basic regimen PLUS indinavir (800 mg tid) OR nelfinavir (750 mg tid)*

NEW: *Basic: 4 weeks (28 days) AZT (600 mg qd-divided doses) PLUS lamivudine (3TC) (150 mg bid) OR lamivudine (150 mg bid) PLUS stavudine (d4T) (40 mg bid) OR didanosine (ddI) (400 mg qd) PLUS stavudine (40 mg bid); Expanded: Basic regimen PLUS indinavir (800 mg tid) OR Nelfinavir (750 mg tid or 1250 mg bid) OR efavirenz (600 mg qd) OR abacavir (300 mg bid) OR ritonavir OR saquinavir OR amprenavir OR delavirdine OR lopinavir/ritonavir. **Recommended NOT TO USE nevirapine.***

HBV:

- Last comprehensive CDC guidelines 1997 (26 December 1997; MMWR 46/RR-18); included as part of supplement on vaccination of Health Care Professionals (HCPs).

OLD: *No significant differences in management of PEP between OLD and NEW.*

NEW: Consolidates and packages information previously provided into single document. More elaboration of factors to consider in assessing need for PEP and evaluation of exposure source. Emphasis on follow-up and counseling.

HCV:

- Last guidelines 1998 (MMWR 1998 47/RR-17).
- At the present time, the State Laboratory for Public Health is not resourced to support Hepatitis C diagnostic testing; individual arrangements must be made by local health departments for this activity.
- Recently, the General Communicable Disease Control Branch in Raleigh contracted with the Office of Continuing Education at the University of North Carolina-Chapel Hill School of Medicine to provide a series of CME presentations across the state on Hepatitis C Awareness. The schedule for these presentations is under development, and will be distributed soon.

OLD: *Post-exposure follow-up of health-care, emergency medical, and public safety workers for hepatitis C virus (HCV) infection.*

For the source, baseline testing for anti-HCV

For the person exposed to an HCV-positive source, baseline and follow-up testing including baseline testing for anti-HCV and ALT activity; and follow-up testing for anti-HCV (e.g., at 4-6 months) and ALT activity. (If earlier diagnosis of HCV infection is desired, testing for HCV RNA may be performed at 4-6 weeks).

Confirmation by supplemental anti-HCV testing of all anti-HCV results reported as positive by enzyme immunoassay.

NEW: Post-exposure follow-up for HCV

For the source, perform testing for anti-HCV.

For the person exposed to an HCV-infected source: perform baseline testing for anti-HCV and ALT activity; and perform follow-up testing (e.g., at 4-6 months) for anti-HCV and ALT activity (if earlier diagnosis of HCV is desired, testing for HCV

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Occupational Exposures

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RNA may be performed at 4-6 weeks).

Confirm all anti-HCV results reported positive by enzyme immunoassay using supplemental anti-HCV testing (e.g., recombinant immunoblot assay [RIBA]).

Health care personnel who provide care to persons exposed to HCV in the occupational setting should be knowledgeable regarding risks for HCV infection and appropriate counseling, testing, and medical follow-up.

IG and antiviral agents not recommended.

No guidelines exist for administration of therapy during the acute phase of HCV infection. When HCV identified, prompt referral is appropriate (because antiviral therapy might be beneficial when started early in course of HCV infection).

BOTH HBV and HCV:

No modifications to an exposed person's patient-care responsibilities are necessary to prevent transmission to patients based solely on exposure to HBV or HCV-positive blood. If an exposed person becomes acutely infected with HBV, the person should be evaluated according to published recommendations. No recommendations exist regarding restriction of activities of HCPs with HCV infection. All chronically-infected HCPs (with HBV or HCV) should follow recommended infection control practices (published).

[July 18, 2001] ♦

For additional information contact:

General Communicable
Disease Control
Epidemiology Section
NC Division of Public Health
1902 Mail Service Center
225 N. McDowell Street
Raleigh, NC 27699-1902
Phone: (919)733-3419
Fax: (919)733-0490

North Carolina's Three Forms of Volunteer Medical License

Joy D. Cooke, Director, NCMB Licensing Department

Special Volunteer License

[Created by Board Rules .0900, .0902]

Requirements:

- The physician who has never been licensed in North Carolina must meet all the state's requirements for a full and unrestricted license. The application fee is \$100.
- If the physician holds an active North Carolina license, that license may be converted to a Special Volunteer License by submitting a \$50 conversion fee and signing a Statement of Application.
- If the physician has an inactive North Carolina license, that license may be reactivated or reinstated to Volunteer status. Reactivation (for licenses inactive for less than one year) requires completion of the Application form, payment of the \$120 fee, and a personal interview. Reinstatement (for licenses inactive for more than one year) requires more in-depth credentialing.

Restrictions:

- The Special Volunteer License allows the physician to practice only at a location approved by the Board, eg, a summer camp, without receiving compensation.
- It requires annual registration with the Board (\$10) and CME as required by law and the rules of the Board.

Limited Volunteer License

(Military Personnel)

[Created by NCGS 90-12(d)]

Requirements:

- The physician must be licensed to practice medicine in a U.S. state other than North Carolina, and that state must submit a letter verifying the license is in good standing or complete the North Carolina Medical Board's License Biography form.
- The physician must produce proof of authorization to treat personnel of the U.S. armed forces or veterans. This requirement can be satisfied by the physi-

cian having a letter of verification submitted by the hospital or clinic administrator.

- No application fee is required.

Restrictions:

- The Limited Volunteer License allows the physician to practice only at clinics that specialize in the treatment of indigent patients and only without receiving compensation.
- It requires annual registration with the Board (no registration fee is required) and CME as required by law and the rules of the Board.

Limited Volunteer License

(Retired Physicians)

[Created by NCGS 90-12(d)]

Requirements:

- The physician with an inactive North Carolina license must complete the Application form and a Statement of Application form. No application fee is required.
- The physician with an active North Carolina license wishing to convert to the Limited Volunteer License must submit a Statement of Application form. No application fee is required.
- The physician who has never held a North Carolina license must complete the Application form, provide verification of active or inactive license in another state, and submit a Statement of Application. No application fee is required.

Restrictions:

- The Limited Volunteer License allows the physician to practice only at clinics that specialize in the treatment of indigent patients and only without receiving compensation.
- It requires annual registration with the Board (no registration fee is required) and CME as required by law and the rules of the Board. ♦



Y'all Want Fries or a Pie with That?

William D. Daniel, MD, Executive Director
American Society of Forensic Obstetricians and Gynecologists

Back when I was just a pimply-faced teenage clerk working Saturdays and Christmas holidays in the local dry-goods store's menswear, boyswear, and shoe departments, I had quite a knack for increasing my sales with suggestions. Somebody would come in for a tie and I'd suggest a matching pair of socks. Need a new dress shirt? Take a look at these new suits we just got in. Simple, appreciated if done properly, and guaranteed to ring the register.

Over the years I've seen many physician colleagues use their offices as local retail outlets for any number of pseudomedical products, such as herbal remedies, nutritional supplements, and weight loss aids, even such things as (let's avoid trouble and make up some names here) "Happy House Products" and "SuperMegaDietDrink." Add to this the countless television ads and infomercials featuring what are represented as legitimate physicians urging you not to miss this extraordinary limited-time offer and you've got a real problem. This always troubled me because I knew, first of all, these products were heavily marked up, and, secondly, were probably touted by the occupants of the offices, perhaps even for unproven health claims.

Don't get me wrong. I've got nothing against someone making a decent profit or comfortable living in the proper circumstances, but it seemed to prostitute our fiduciary patient-physician relationship to suggest patients buy from us probably worthless nostrums at inflated prices, at least presenting the possibility of an unnecessary conflict of interest. It only became worse when we recruited our patients for pyramid and Ponzi schemes such as chain letters and other scams.

For hundreds of years, prescribing physicians were also compounding physicians, mixing up various individualized medicines in their offices as patients waited to pay their bills. One of the last to do so lived and practiced until about 15 years ago in an isolated West Virginia coal mining town approximately 30 miles from where I currently live. While physician ownership of retail pharmacies, especially locating a retail pharmacy in one's office building, has been verboten by the American Medical Association for years, we all have maintained an office inventory of injectable medications and difficult to find specialty devices, such as pessaries and IUDs, that were recommended or pre-

scribed to patients when appropriate and added to their bills. And there was a reasonable markup. Never was anything wrong with that and there still isn't, but you should carefully read, for example, the *ACOG Committee Opinion No. 254, April 2001*, entitled *Commercial Enterprises in Medical Practice: Selling and Promoting Products*.

Sale or promotion of products by physicians to their patients is unethical, with some exceptions, in either clinical sites or other places. . . whether conducted in person, by telephone, or by written solicitation. The following activities are considered unethical:

- sale of prescription drugs to be used at home;
- sale or promotion of nonprescription drugs;
- sale or promotion of presumptive therapeutic agents that generally are not accepted as part of standard medical practice;
- sale of non-health-related items, such as household supplies.

There are some others, but you need to read the whole *Opinion*. There are also exceptions, such as those noted above and Girl Scout Cookies.

The North Carolina Medical Board thought the subject serious enough to issue a new Position Statement in its publication, the *Forum*, Volume VI, No. 1, 2001, including the following advice:

The physician-patient relationship constitutes a fiduciary relationship between the physician and the patient in the strictest sense of the word "fiduciary." In this fiduciary capacity, physicians have a duty to place the interests of their patients above their own financial or other interests. Inherent in the in-office sale of products is a perceived conflict of interest with regard to physicians' fiduciary duty. Further, the for profit sale of goods by physicians to patients raises ethical questions that should not intrude on the physician-patient relationship, as does the sale of products that can easily be purchased by patients locally.

There's also a warning against having exclusive distributorships and your own

name branded products, such as "Dr Daniel's Magic Elixir of Youth, Mammary Enhancer, and Sexual Performance Turbo Boost." Something tells me you could make millions at \$25 a pint by bottling water out of the Buckhannon River and labeling it as such. Licensees are also warned not to sell any non-health-related goods out of their offices or other treatment facilities, with the above exception for Girl Scout Cookies and such.

So if you're one of Happy House Products' Gold Club Sales Leaders, make a choice between selling Pap smears or laundry detergent to your patients and throw out that SuperMegaDietDrink display. It may be a nice way to make each month's payment on the Lincoln, but you're using your patients for unethical personal financial gain.

Reprinted in modified form from *The Medicolegal OB/GYN Newsletter* (Vol 9, #3, May 2001), which is a publication of the American Society of Forensic Obstetricians and Gynecologists, Post Office Box 536, Buckhannon, WV 26201-0536. Telephone (304)472-8594. Web Site: www.ASFOG.com. ♦

NC Medical Schools Educate Physicians

continued from page 7

Some 35% of NC doctors completed their residencies in the state, he said. Almost 10% served residencies at Duke, almost 9% at UNC, and 7% at Wake Forest. Percentages for New York, Virginia, Pennsylvania, Ohio, and Texas were 6.5, 5.3, 4.7, 3.7, and 3.3 respectively.

About one in five licensed doctors here in 1999 were women.

The average age of NC physicians was just over 46. Regardless of where they attended medical school, they averaged 41 hours in clinical care per week. Almost 43% of doctors who completed their residencies in NC reported a primary-care specialty, compared with just under 40% of those who trained out of state.

"One thing that's clear from this study is that we can't solve our physician shortage problem with just North Carolina resources," Ricketts said. "We do have to depend on the rest of the nation and be competitive in attracting physicians here."

An electronic copy of the report can be found at www.shepscenter.unc.edu/lbp. ♦



REVIEW



It's Not the Destination, but Who Your Shipmates Are

Dale G Breaden

Director, Public Affairs Department, NCMB

Full disclosure requires I tell you I have known the author of the memoir reviewed here for over 20 years. Harold E. Jerve, Jr, MD, a native of South Carolina, served twice as chief executive officer of the Federation of State Medical Boards of the United States (FSMB) — from 1961 to 1962 and 1977 to 1984. During the last half of that second period, I served with him as his associate and then continued as associate to his successor, Bryant L. Galusha, MD, of Charlotte, NC. In all the time I have known him, I have sel-



Harold E. Jerve, Jr, MD

dom heard Harold talk about his Navy career. It is good, now, to have him record his experiences after more than 50 years; to have him share, in the recently published *Tin Can Sailor*, some of what made him the man his many friends know and care for.

The book concludes with Harold entering the Medical University of South Carolina in October 1945. For perspective, though, I should mention a few details about his later career. He finished his internship in 1950 and began practice in Columbia, SC. By 1952, he was a member of the South Carolina Board of Medical Examiners, where he continued to serve for two decades. In 1955, he took an interest in the FSMB and became active in its affairs, being chosen its president in 1960. He was also to serve as treasurer of the organization and, briefly, as editor of its *Bulletin*. His leadership in the FSMB and in the field of medical licensure led to three terms as president of the Educational Commission for Foreign Medical Graduates and to 10 years as a representative to the American Board of Medical Specialties. He also served as a consultant to the National Board of Medical Examiners and had an active voice in the many medical groups and associations with which the FSMB interacted. In 2000, Harold was presented the FSMB's Lifetime Achievement Award in honor of his long years of dedicated service to the organization, medicine, medical licensing, and the public interest.

It was 0600 on the morning of Friday, August 3, 1945, north of Timor in the Banda Sea just south of the equator, when Lieutenant Harold E. Jerve, Jr, executive officer of the destroyer USS Connor, barked out the order: "Visit and search parties, stand by the whale boats."

The Connor and its sister ship, the USS Charrette, were about to order the Tachibana Maru, a Japanese hospital ship of 249 feet by 40 feet, to lie to. At 0637, a shot was fired across the bow of the Japanese vessel and in a few minutes she was dead in the water. The Tachibana Maru bore large red crosses on her sides and top, indicating her status. But it was known that the Japanese were transporting healthy troops in their hospital ships, removing them from the islands the Allied campaign in the Pacific had bypassed as it moved toward Japan.

At 0705, a visit and search party from the Charrette, under command of Lieutenant Commander Ernest R. Peterson, climbed aboard the Tachibana Maru without opposition. It was followed by Lieutenant Jerve's party from the Connor at 0759. Jerve was to be assistant prizemaster and second in command of the captured vessel as it was sailed under escort to the American base on Molotai in the Moluccas. The Tachibana Maru had a crew of 76, with 1,562 "patients" and a cargo of "medical" supplies. In fact, the patients were healthy combat troops, and many of the crates marked with red crosses were found to hold 77mm shells. Later searches unearthed 30 tons of assorted ammunition, 400 rifles, 15 light machine guns, 45 knee mortars, and four field howitzers. A sweep of the bunks and pallets produced stacks of pistols, bayonets, and grenades.

Tin Can Sailor: One Man's Account of Navy Life in World War II

Captain Harold E. Jerve, Jr, MC USNR
Press-TIGE Publishing Company, Catskill,
NY, 2000

338 pages (notes, bibliography, photos,
maps), \$16.95 paper
(ISBN #1-57532-1718)

Now, 80 men from the Charrette and the Connor were in charge of the only Japanese ship and the largest contingent of armed

Japanese combat troops ever captured by the Navy during the war. And no casualties. What an unprecedented story! And then, on Monday morning, August 6, almost exactly as the Charrette and the Connor escorted the Tachibana Maru into Molotai Harbor, the bombardier of the Enola Gay called out, "Bomb away." Within 15 minutes,



Lt Harold E. Jerve, Jr

Lieutenant Jerve and his men aboard the Tachibana Maru received the following signal: "Super bomb of immense power dropped on Hiroshima. May result in peace talks. Don't tell the prisoners." With that news, the remarkable work of the men of the Charrette and the Connor was destined to become little more than a footnote to the dawning of a new age. Reporters and photographers swarmed the harbor area to interview the members of the boarding parties, but the resulting stories were drowned back home and around the world in the coverage of Hiroshima. No bold headlines, no widespread acclaim, and no medals for the men of the Connor.

These events of August 1945, painted with a vivid but matter-of-fact clarity in his recently published memoir, *Tin Can Sailor: One Man's Account of Navy Life in World War II*, marked the end, or almost the end, of the war for Lieutenant Jerve, who was soon on his way stateside to home and to the woman he loved, Lil Hair. He arrived back in South Carolina on October 5 and received his detachment orders several days later, with promotion to lieutenant commander. He was formally released from the Navy as of

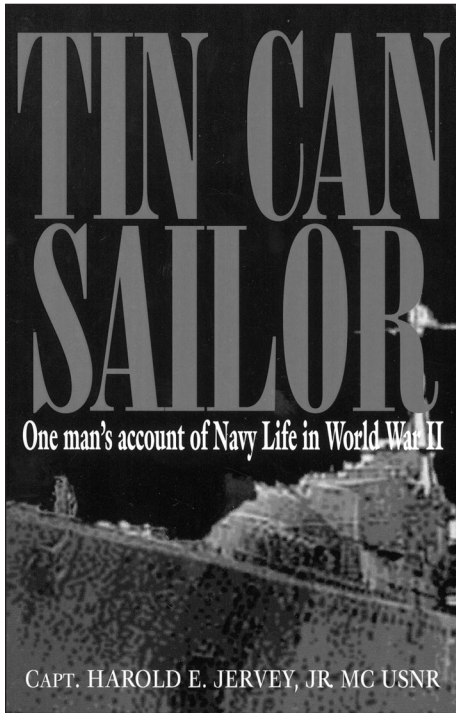
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Review

continued from page 15

December 6, almost exactly four years to the day from the attack on Pearl Harbor. But for him, the story had begun two years before Pearl Harbor.

In 1939, at the age of 18, a junior at the University of South Carolina, he joined the



National Guard as the sound of war became clear in Europe. After a chilling encampment of the Guard in December at the Sesquicentennial State Park in Columbia, SC, he resolved: "Fighting a war is one thing, but I'll be damned if I'm going to fight it on the ground freezing my butt off. I'm going to join the Navy. I may get seasick, but at least I'll be warm." Signing on for the Navy, he continued his college work, and reported to Norfolk, VA, for the beginning of training on the USS Quincy on November 1, 1940. Midshipman School was to begin June 16, 1941, which required he miss a final examination in one course, costing him a letter grade and eligibility for Phi Beta Kappa.

From that point on, *Tin Can Sailor* provides the reader a detailed and very human look at the day to day of the war at sea. Training, leave, sea duty, combat, and the endless reaches of time. Jervey saw his first fighting with the British Home Fleet at Scapa Flow in the Orkneys in February 1942 and his last with the Australian Navy at

Borneo. He provides an eye-witness account of the first D-Day landing on August 7, 1942, at Guadalcanal, and the last one on July 1, 1945, at Balikpapan, Borneo. He vividly describes the battles at Savo Island, the third of which Admiral Nimitz called the turning point in the battle of the Solomon Islands. In that fight, his ship, the destroyer USS Sterett, received a Presidential Unit Citation for heroism. He was present for most of the naval battles in the Pacific, including the Battle of Leyte Gulf, the largest naval battle ever fought — and he struggled through the fleet's bruising encounter with Typhoon Cobra.

Tin Can Sailor is an active duty book, a fighting man's book, a rich and enriching look at World War II at sea. It is also a love story, complete with extended quotes from letters Jervey wrote home to Lil Hair. And he adds depth to his story by connecting what was happening to and around him and his mates at sea with the wider war, both in the Pacific and Europe. This provides a

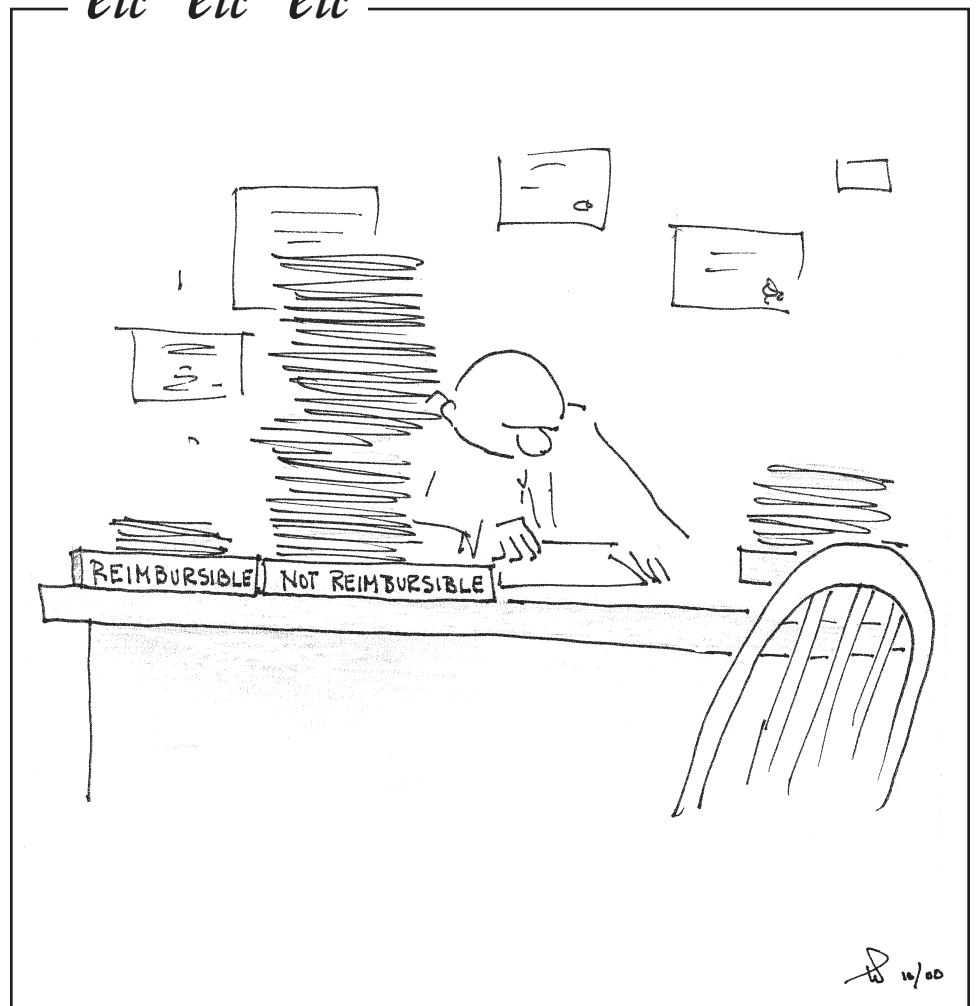
frame of context for his personal adventure.

Though the book has excellent illustrations, delightfully informative notes, and a bibliography, it suffers from lack of an index. It also shows the need for better proofreading, eg, one chapter ends in the middle of a sentence. Many of the scores of reconstructed conversations in the book, often appearing in quotes, are certainly drawn from the mist of memory, the memoirist's privilege, and cannot be assumed to be more than approximations of what was said, but they effectively capture the essence of time, place, and emotion.

Looking back today with the perspective of over half a century, Dr Jervey sums up his experience at sea in World War II by saying: "I learned in the Tin Can Navy that it's not the destination, but who your shipmates are." And as to that, he and Lil have been married for over 50 years.

Taken all in all, *Tin Can Sailor* is a book worth having and reading. Trust me on this, I'm unbiased. ♦

Etc Etc Etc



LETTERS TO THE EDITOR

About That Panda

To the Editor: I'm writing in reference to [Dr Pories'] recent article (To Kill a Panda) in the NCMB [*Forum*, #2, 2001]. The analogy between pandas and physician assisted suicide was, I thought, a bit of a stretch, but I understand and very much agree with [his] point. There was a fairly slippery slope somewhere between what we all agree on, "keeping the patient comfortable," and physician assisted deaths.

Unfortunately, [Dr Pories] includes both advisable and inadvisable treatments in [his] same, second to last paragraph. When our patients hurt, we should certainly give them medication to relieve pain. When they are dry, we do not necessarily want to give them fluids. When patients are truly terminal, placing them on intravenous hydration can have a number of untoward consequences. These include artificially prolonging the dying process. When an individual can no longer take hydration orally, placing them on an IV is in every sense of the word "artificial."

- More fluid in means more fluid going out. The patient may be incontinent, wetting the bed, require a catheter, etc.
- More fluid going in may mean more pulmonary secretions, more gurgling respirations, and more discomfort.

Adequate nursing interventions do exist to keep mouth and mucus membranes moist, and hospice nurses have gotten very skilled at doing this.

The reason I am bringing this up is because of [Dr Pories'] position as vice president of the North Carolina Medical Board. The comments in [his] article could be misconstrued as representing a basal form of medical care which cannot be violated under the Medical Practice Act. I recognize this was not [his] intent; the comments were given through a speech that was reproduced for the [*Forum*]. Perhaps a clarification might be in order?

Tim Carey, MD, MPH
Professor of Medicine, University
of North Carolina at Chapel Hill
Director, Cecil G. Sheps Center
for Health Services Research

Response:

I appreciate Professor Carey's thoughtful comments. I agree fully with his reluctance to give IV fluids to the terminally ill. That is why I wrote, "When they are dry, give them fluids," and made no reference to intravenous adminis-

tration. His emphasis is important.

There are, however, exceptions. During my years as the medical director of two hospices, one in Cleveland and another in Greenville, I had several patients who benefited from intravenous solutions. One was a woman who was mortally ill from hypercalcemia due to massive bone involvement from cancer of the breast. She responded miraculously to fluids and endocrine intervention. In fact, within a week, she went home and survived a full year. Another was a patient dying of bowel obstruction who could no longer talk because her mucous membranes were so dry. The little swabs just didn't do the job. adding the IV gave her a voice. Similarly, a patient treated expectantly with severe burns may be comforted by assuaging the severe thirst of fluid translocation.

Even so, Professor Carey is right on target. Treasuring life does not translate to prolonging death. Doing too much can be just as cruel as not doing enough. It is a message that cannot be repeated too often.

Walter J. Pories, MD, FACS
Vice President, NCMB

About License Portability

To the Editor: I enjoyed [Mr Watry's] column (A Trip to Useless) in the recent *Forum* (#2, 2001). I enclose an article (Is It Time to Rethink the 10-Year Rule?) found in the July 2001 issue of *Imaging Economics* that relates well to [his] message [about the problem of license portability], and also relates to the current shortage of radiologists in the United States.

I am 66 years of age and practice only part-time in small hospitals, but each week I get more telephone calls from radiologists in need of help than I could ever imagine. Licensure obstacles are definitely a problem, particularly for senior radiologists who have taken their certifying examinations more than 10 years ago. The "10-year rule" may be theoretically correct, but is impractical in reality.

I'm not lobbying for any change; I am only informing you that some licensing rules are detrimental to the delivery of needed health care. Examining the realities of medical practice and the medical delivery system I happily leave to [Mr Watry] and [his] fellow state medical board administrators.

Keep on writing. You're doing a better job of communication than many other state boards.

James A. Walsh, MD
Hilton Head Island, South Carolina

About the Forum

To the Editor: I wanted to tell you several things about the *Forum*. The articles are both interesting and informative. In the current issue (#2, 2001), Dr Kanof's editorial on the Slippery Slope and Mr Watry's empathic Trip to Useless were superb. I enjoyed reading both. Dr Klimas' doctor-patient issues were current, especially DTC advertising. The update on West Nile virus was especially relevant since it has been found in Ohio. Your list of MDs/Board Action is so complete, one needn't "guess" as to the reasons for sanctions or the outcomes, including restorations.

Overall, I wish to commend you for the fine publication you edit!

William H. Beute, MD
Grand Rapids, Michigan

Response:

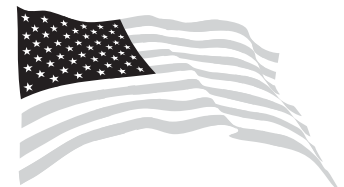
Thank you for your kind letter. I should say that we owe a great debt to the many people, physicians and non-physicians, who give of themselves and their time to write for the Forum. I hope they take your letter as evidence of the importance of what they do so generously for the people and profession in this (and other) states. We will do all we can to continue offering you something of value.

Dale G. Broaden, Editor
Director, Public Affairs, NCMB

About Retirement

To the Editor: I knew [Dr Kanof] as "Liz" when I served on the Council as councilor for the district in which Carteret County is assigned. In my opinion, every point on which [she] wrote [in her article on physician retirement in the *Forum*, #1, 2001] is applicable! Each one was a factor in leading my wife and me to retire from general surgery after 30 years at 62 years of age. We have not regretted for one second our decision. As I understand from friends who remain in practice, things have only gotten worse!

Charles P. Nicholson, Jr, MD
Concord, North Carolina ♦



NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

May/June/July 2001

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

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

Consent Order:

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

Denial:

Final decision denying an application for practice

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

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program.

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

Immediate temporary withdrawal of the authorization to practice pending prompt commencement and determination of further proceedings. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

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

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

The practitioner's relinquishing of the authorization to practice pending an investigation or in lieu of disciplinary action.

ANNULMENTS

NONE

REVOICATIONS

WHITENER, Betty Lou, MD

Location: Oak Ridge, LA
 DOB: 1/20/1930
 License #: 0000-20085
 Specialty: FP (as reported by physician)
 Medical Ed: University of Oklahoma (1959)
 Cause: Hearing on charges dated 2/22/2001. Pursuant to a Consent Order of 5/24/2000, the Louisiana Board of Medical Examiners suspended Dr Whitener's license for one year, staying all but the first three months on certain conditions, as a result of her pleading no contest to one count of Medicaid fraud.
 Action: 7/09/2001. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Whitener's license to practice medicine in North Carolina is revoked.

SUSPENSIONS

ROBERTS, Ifor John Wynn, MD

Location: Caversham Reading, UK
 DOB: 8/18/1940
 License #: 0095-00202
 Specialty: FPG (as reported by physician)
 Medical Ed: Edinburgh University, UK (1966)
 Cause: Hearing held on 7/20/2001 on charges filed on 4/05/2000 alleging violation of his Consent Order with the Board of 10/16/1997, in which he agreed to obtain a mentor acceptable to the president of the Board. Based on the evidence before it, the Board found the charges were true.
 Action: 7/26/2001. Findings of Fact, Conclusions of Law, and Order issued: Dr Roberts' license is suspended indefinitely.

See Consent Orders:

DYER, G. David, MD
 KOLASKI, Kathleen Mary, MD (stayed)

SUMMARY SUSPENSIONS

CEPEDA, Jaime, Jr, MD

Location: Greenville, NC (Pitt Co)
 DOB: 4/07/1970
 License: Resident Training License
 Specialty: GS (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1997)
 Cause: Dr Cepeda may be unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by

reason of any physical or mental abnormality within the meaning of the law.

Action: 7/26/2001. Order of Summary Suspension of License issued: Dr Cepeda's resident's training license is suspended effective 7/27/2001. [Notice of Charges and Allegations, dated 7/26/2001, available on request.]

JORDAN, Richard Liming, MD

Location: Jacksonville, NC (Onslow Co)
 DOB: 6/14/1946
 License #: 0000-19612
 Specialty: FP (as reported by physician)
 Medical Ed: Vanderbilt University (1971)
 Cause: Dr Jordan may be unable to practice by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality.
 Action: 5/16/2001. Order of Summary Suspension of License issued. Dr Jordan's medical license is suspended effective 5/18/2001. [Notice of Charges and Allegations issued 5/16/2001.]

CONSENT ORDERS

BJORK, Paul Edward, Jr, MD

Location: Laurinburg, NC (Scotland Co)
 DOB: 3/06/1954
 License #: 0000-36146
 Specialty: OBG (as reported by physician)
 Medical Ed: University of South Carolina (1983)
 Cause: To amend Dr Bjork's Consent Order of 10/11/2000. He has a long history of polydrug dependency and alcohol abuse, details of which are set out in that Consent Order. He asked that the restriction on the number of hours he may work each week be eliminated from his Consent Order. It appears he continues to be involved in an active recovery program with AA, NA, and Caduceus.

Action: 5/08/2001. Consent Order executed: Dr Bjork is issued a license to expire on the date shown on the license; he is no longer required to restrict the number of hours he works each week; he shall obtain psychotherapy and shall have his therapist send quarterly reports on his progress to the Board; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use or possession of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall provide a copy of this Consent Order to those colleagues with whom he works or shares call and to all present and future

employers; he shall maintain and abide by a contract with the NCPHP; he shall regularly attend meetings of AA, NA, and Caduceus, must comply with other conditions. The numbered paragraphs of this Consent Order supersede those in any prior consent order except those regarding the public nature of such consent orders.

CLAYTON, Thomas Vann, MD

Location: Andrews, NC (Cherokee Co)

DOB: 9/20/1956

License #: 0000-30895

Specialty: FP/FPG (as reported by physician)

Medical Ed: St George's University, Grenada (1983)

Cause: On Dr Clayton's application for reinstatement of his license, which became inactive in September 1998. Dr Clayton has a history of abuse of and dependence on opiate and benzodiazepine drugs. He admits use of such drugs renders him unable to practice with reasonable skill and safety. He successfully completed a three-month inpatient substance abuse treatment program and reports he has remained clean and sober since his release from that program. He has entered into a five-year contract with the NCPHP, and the NCPHP reports he has been compliant and that all drug screens have been negative.

Action: 6/01/2001. Consent Order executed: Dr Clayton is issued a license to expire on the date shown on the license [9/30/2001]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

COYNE, Mark Dennis, MD

Location: Stoney Creek, NC (Guilford Co)

DOB: 8/12/1949

License #: 0000-33493

Specialty: EM/OS (as reported by physician)

Medical Ed: Chicago Medical School (1983)

Cause: On Dr Coyne's request to amend his Consent Order of 3/21/2000, which was itself amended from a consent order of 2/16/2000. Dr Coyne's consent orders have derived from his problems with alcohol dependency, which are detailed in the Consent Order of 2/16/2000. He has asked that the current Consent Order be amended to eliminate the requirement that his practice setting be approved by the president of the Board. The Board has agreed to this under certain conditions.

Action: 6/25/2001. Consent Order executed: Dr Coyne is issued a license to expire on the date shown on the license; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall attend AA meetings as recommended by the NCPHP; he shall provide a copy of this Consent Order to all prospective employers; he shall obtain and verify to the Board in writing at least 50 hours of relevant Category I CME each year; must comply with other conditions. The numbered paragraphs of this Consent Order supersede those in any prior consent order except those regarding the public nature of such consent orders.

DUBEY, Subu, MD

Location: Jacksonville, NC (Onslow Co)

DOB: 2/21/1961

License #: 0094-01175

Specialty: IM (as reported by physician)

Medical Ed: Northwestern University (1987)

Cause: Due to personal concerns about his ability to provide adequate care to his patients, Dr Dubey voluntarily limited his practice and refers many patients to other physicians at the local ER. He recently obtained an evaluation of his medical skills at the

ECU Medical School and asserts he obtained CME by reading journals and self-study rather than attending conferences. Results of the evaluation of skills indicated significant patterns of mismanagement in his practice and raise questions about his clinical competence. As a result of the evaluation, Dr Dubey has chosen to cease accepting new patients and to transition care of his current patients to other physicians. He is in the process of closing his practice and is obtaining assistance in review of each of his patient encounters by another physician. He has agreed to cease practice on June 30, 2001, so he can focus on improving his cognitive and diagnostic skills. Prior to reapplying for a license in North Carolina, he plans to complete at least a year of residency training and to demonstrate his medical and scientific knowledge by passing an appropriate examination.

Action: 6/25/2001. Consent Order executed: Dr Dubey surrenders his North Carolina medical license effective 6/30/2001.

DYER, G. David, MD

Location: Jackson, TN

DOB: 5/03/1944

License #: 0000-22562

Specialty: IM (as reported by physician)

Medical Ed: University of Kentucky (1977)

Cause: Regarding the Notice of Charges and Allegations of 12/14/2000 against Dr Dyer. He closed his private office in late 1999 to work in emergency medicine on a locum tenens basis. From the middle of 1999 through the middle of 2000, he responded to requests from patients of his private practice that copies of their medical records be provided to them, their attorneys, or other physicians with a standard written policy stating that "before your request can be processed, we must have prepayment in the form of a check, money order, or bank check in the amount of \$50.00 per year for each year requested to cover the costs of research, copying, and postage. Severe hardship for indigent cases will be considered on an individual basis." This policy of charging \$50 per year for each year of the medical record failed to conform to the standards of prevailing medical practice within the meaning of the law. Since the issuance of charges, Dr Dyer has changed policies, providing copies of records from his former practice free of charge and without restriction. He now feels the limits on fees for providing records set in NCGS §90-411 (covering such charges for records in cases of personal injury and Social Security disability claims) are reasonable. Dr Dyer will also no longer retain medical record requests based on a balance due him for copying a record.

Action: 7/12/2001. Consent Order executed: Dr Dyer's license is suspended for 30 days. Suspension is stayed on the following terms and conditions: he shall provide copies of medical records from his former practice to patients, their representatives or designees, at no charge; he shall meet with the Board as requested; he shall notify the Board of any change of residence or practice or of the addition of a new practice site within 10 days of the change or addition; he shall obey all laws and all rules and regulations involving the practice of medicine.

GUALTEROS, Oscar Mauricio, MD

Location: Pinehurst, NC (Moore Co)

DOB: 5/11/1964

License #: 0099-00236

Specialty: IM (as reported by physician)

Medical Ed: University of Navarra, Spain (1991)

Cause: On the request of the Board to amend Dr Gualteros' Consent Order of 11/14/2000. He has had problems with boundary violations and sexually harassing behavior. The details of that behavior are noted in his Consent Order of 11/14/2000. On 3/11/2001, he improperly touched a female nurse with whom he was working by patting her on the buttocks. The Board met with him to discuss this and other concerns regarding compliance with his Consent Order.

Action: 6/06/2001. Consent Order executed: Dr Gualteros is issued a license to expire on the date shown on the license [9/30/2001]; he shall continue to obtain counseling from his current therapist or from such other mental health professionals as may be approved by the president of the Board and he shall comply with all recommendations of the therapist; he shall direct his therapist to report on his progress to the Board on a quarterly

basis; he shall have and document in the patient record the presence of a chaperone during all encounters with female patients; he shall post a copy of the Principles of Medical Practice on his office, exam, and reception room walls and in other places where it can be easily seen by patients; he shall ask three members of his staff who have read this Consent Order to complete a "Staff Surveillance Form" and forward the forms to his therapist for inclusion in the quarterly report to the Board; during one week each quarter, he or his staff will ask all patients he has seen that week to complete a "Patient/Patient's Family Satisfaction Survey," which shall be sent to the therapist for inclusion in the quarterly report; he shall maintain and abide by his contract with the NCPHP; he shall provide a copy of this Consent Order to the principals of all current practice locations and to all future locations prior to beginning employment; must comply with other conditions. The numbered paragraphs of this Consent Order supersede those in any prior order except those regarding the public nature of such consent orders.

HARRIS, Inez Michelle, Emergency Medical Technician-Intermediate

Location: Kinston, NC (Lenoir Co)

Cause: On her application for certification as an EMT-I. Ms Harris currently works for Convalescent Transports of Kinston, NC. On her application for certification as an EMT-I, she advised the Board through the Office of Emergency Medical Services that she had pled guilty to, been convicted of, and served six months probation on a criminal violation committed before she was 21. The director of EM Services for Lenoir County and the manager of Convalescent Transports are aware of her record and have expressed support for her excellent work, ethics, and integrity. The Board is impressed with the honesty and forthrightness with which Ms Harris addresses the issues in her past and is confident she will function ethically and competently. She is willing to subject her practice to monitoring.

Action: 6/08/2001. Consent Order executed: The Board approves Ms Harris to perform medical acts as an EMT-I subject to terms. For the first 60 days of this Consent Order, she shall serve as a third person on any calls in which she takes part; all ambulance reports on calls in which she serves shall be reviewed by her medical director for one year; she shall assure the medical director on her service shall submit a report to the Board concerning her service within 10 days following the first 60 days of that service and again within 10 days of her first year of service; she shall provide a copy of this Consent Order to her medical director; must comply with other conditions.

JORDAN, Richard Liming, MD

Location: Jacksonville, NC (Onslow Co)

DOB: 6/14/1946

License #: 0000-19612

Specialty: FP (as reported by physician)

Medical Ed: Vanderbilt University (1971)

Cause: On Dr Jordan's request that the Board lift the summary suspension of his license and resolve the Notice of Charges and Allegations against him dated 5/16/2001. Dr Jordan admits he has been diagnosed with bipolar disorder, characterized by unpredictable swings from mania to depression; in the past he has responded well to prescribed medication; prior manic episodes resulted in consent orders between him and the Board in 1996 and 1998; the Board released him from the 1998 Consent Order in August 1998, believing he was safe to practice; in December 2000, while driving on Interstate 40, he engaged in certain erratic behavior fully described in the Charges; based on this behavior and his prior manic episodes, the Board issued the 5/16/2001 Summary Suspension and Charges. Dr Jordan has not practiced since 5/18/2001. At the time of the 12/18/2000 incident, Dr Jordan was compliant with his psychiatrist's treatment; however, in August 2000, the psychiatrist had terminated his medication due to certain side effects; by December, Dr Jordan began having symptoms of manic behavior; when the psychiatrist became aware of the driving incident, he immediately renewed Dr Jordan's medication; Dr Jordan is now taking the medication and has had no further episodes. He has a ten-year contract with the NCPHP, which requires quarterly reports from his psychiatrist and a practice monitor; it is his psychiatrist's opinion that Dr Jordan can return to practice without threat to his patients.

Action: 7/19/2001. Consent Order executed: the Board lifts the Order of Summary Suspension and dismisses the Notice of Charges and Allegations of 5/16/2001; Dr Jordan shall surrender his medical license; the Board shall issue him a temporary license to expire on the date shown thereon [10/31/2001]; he shall maintain his relationship with a psychiatrist approved in writing by the president of the Board and he shall direct his psychiatrist to send the Board quarterly reports on his progress, medication levels, and any neuropsychiatric problems; he shall also direct his psychiatrist to immediately inform the Board if Dr Jordan is experiencing neuropsychiatric problems that could jeopardize patient care; he shall direct his psychiatrist to send copies of quarterly reports required by the NCPHP contract to the Board's director of investigations; he shall maintain and abide by his NCPHP contract; must comply with other conditions.

KILE, Paul Edward, MD

Location: Louisburg, NC (Franklin Co)

DOB: 7/05/1950

License #: 0000-29129

Specialty: IM (as reported by physician)

Medical Ed: Tufts University (1982)

Cause: Dr Kile destroyed medical records. In April 1996, he had two patients with the same last name, the first of whom (Patient A) was diagnosed with a mass in his right lung. He was referred for appropriate treatment. The second patient (Patient B) had an automobile accident in April 1996 and, during emergency room treatment, had an x-ray that revealed a right lung mass. A copy of the radiologist's report diagnosing the mass was sent to Dr Kile, who was listed as Patient B's local physician. Dr Kile reviewed Patient B's x-ray report and mistook it for that of Patient A. He signed it and left it to be filed. In January 1998, Patient B came to Dr Kile complaining of dizziness. An MRI revealed cancer in Patient B's brain. In reviewing the file in February 1998, Dr Kile realized he had mistaken Patient B's x-ray for that of Patient A and had, thus, failed to provide appropriate treatment to Patient B in 1996. He became angry at his mistake and destroyed the x-ray report. He then told the patient and his family that someone had failed to correctly read and act on the ER x-ray. He did not reveal he had reviewed the report and mistook it for that of Patient A or that he had destroyed it. This precipitated a malpractice suit against the hospital, the ER physician, and the radiologist. He was not named as a defendant. In a deposition taken September 2000 in connection with the suit, Dr Kile denied he had received or reviewed the x-ray report. Shortly thereafter, he met with legal counsel and revealed the truth and his failure to tell the truth. In November 2000, he informed the parties to the suit of the truth of the situation. He also informed Duke University Health systems, which led to his resignation from his practice. In December 2000, he informed the Board of the facts. In January 2001, Dr Kile voluntarily obtained a psychiatric evaluation, which concluded he destroyed the x-ray report and kept it a secret because of his inability to adjust to the stressors in his professional and personal life and not entirely out of self-interest. It was the psychiatrist's opinion that Dr Kile is a person of considerable conscience and not likely to repeat such an action. He also concluded Dr Kile is not mentally ill and is fit to practice medicine. He recommended Dr Kile use pharmacotherapy and psychotherapy to aid him in overcoming his difficulty in coping with the stressors in his life and added that Dr Kile, if allowed to practice, do so in a setting allowing for greater physician interaction and collegiality than he had in his rather isolated practice in Louisburg. Dr Kile reports he has voluntarily complied with the psychiatrist's recommendations. He has been cooperative with the Board, has acknowledged the wrongful nature of his conduct, is remorseful, has an excellent reputation in his community, and has no disciplinary record with the Board. It is unlikely the Board would have learned of his actions had he not voluntarily disclosed the information.

Action: 6/25/2001. Consent Order executed: Dr Kile is reprimanded; he shall continue his psychotherapy and pharmacotherapy; he shall practice only in a setting where there is collegial interaction as recommended by his psychiatrist; must comply with other conditions.

KOLASKI, Kathleen Mary, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 4/12/1961
 License #: 0095-00121
 Specialty: PM/PD (as reported by physician)
 Medical Ed: Hershey Medical College (1988)
 Cause: Concerning prescribing practices. From January 1995 to September 2000, Dr Kolaski neglected her own medical needs in failing to seek appropriate medical care from a physician other than herself; from August 1997 to November 2000, she issued prescriptions averaging one dose per day of Dexedrine® 15mg spansules, a Schedule II controlled substance, in the name of Patient A, without Patient A's knowledge or consent, when, in fact, the medication was for Dr Kolaski's personal use; she picked up and paid for these prescriptions herself and used them to treat herself; she maintained little, if any, medical record to justify her need for the drug; she has advised the Board she has a previous diagnosis of ADD for which she received treatment as an adolescent and again during medical school. Following health problems that affected her practice in 1997, she began self-prescribing without the assistance or opinion of a treating physician. Colleagues noted an improvement in her ability to meet the heavy demands of her practice in 1997, concurrent with her beginning of self-medication with Dexedrine®. On her own initiative in September 2000, Dr Kolaski sought and obtained the assistance of a treating physician who has confirmed the ADD diagnosis and has continued treatment with the drug; she has been evaluated and does not appear to meet the criteria of one suffering chemical dependence. Her continued practice poses no harm to the public.

Action: 6/08/2001. Consent Order executed: Dr Kolaski's license is suspended for 60 days effective midnight June 4, 2001. Suspension is stayed on the following terms: unless lawfully prescribed by someone other than herself, Dr Kolaski shall refrain from the use of all prescription medications; she shall never purchase medication in any pharmacy in the name of or for any patient; she shall not self-prescribe nor prescribe to family members and others with whom she does not have a formal physician/patient relationship; she shall maintain a relationship with a physician to follow her ADD and be her primary care physician; she shall direct her physicians to provide the Board with updates on her health at the request of the Board; must comply with other conditions.

MARSHALL, Lisa Gayle, MD

Location: Cornelius, NC (Mecklenburg Co)
 DOB: 10/20/1954
 License #: 0000-29771
 Specialty: PD (as reported by physician)
 Medical Ed: Medical University of South Carolina (1983)
 Cause: Dr Marshall failed to register her North Carolina medical license within 30 days after receiving certified notice and the Board, therefore, placed her license on inactive status effective 1/26/2001. She continued to practice until 2/08/2001, when she first learned her license was inactive. She did not resume practice until 2/27/2001, when the Board approved her reinstatement application. She has asked the Board to retroactively reinstate her license to 1/26/2001 so there will be no lapse in her authority to practice. Dr Marshall now appreciates the importance of promptly reviewing and responding to communications from the Board and registering her license in a timely manner.

Action: 6/12/2001. Consent Order executed: Dr Marshall's license is reinstated effective 1/26/2001; she is reprimanded for her failure to timely register; must comply with other conditions.

McINTOSH, Michael Stephen, MD

Location: Parkersburg, WV
 DOB: 1/11/1951
 License #: 0000-39029
 Specialty: FP/EM (as reported by physician)
 Medical Ed: West Virginia University (1979)
 Cause: Dr McIntosh has been disciplined by the medical boards of Ohio and West Virginia. [In an agreement with the Ohio Board, he admitted he had been diagnosed with narcotic dependency and that he had obtained hydrocodone by ordering samples and using those samples himself. He also surren-

dered his DEA certificate when confronted by DEA about his ordering of those samples. He entered treatment in August 2000. At the same time, he placed his West Virginia license on inactive status. In October 2000, his Ohio license was suspended via a Consent Agreement with the understanding his reinstatement would be dependent on strict conditions. In November 2000, West Virginia, via a Consent Order, agreed to reactivate his license under strict conditions.]

Action: 6/25/2001. Consent Order executed: Dr McIntosh shall comply with the terms and conditions of the Ohio Consent Agreement and the West Virginia Consent Order; if he desires to practice in North Carolina prior to successful completion of the terms and conditions of the Ohio and West Virginia actions, he shall refrain from the use of all mind or mood altering substances unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of alcohol, he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription, at the Board's request he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above, he shall obtain evaluation by the NCPHP and comply with any recommended NCPHP contract, and he shall not register with the DEA; he must appear before the Board prior to practicing in North Carolina and at other times requested by the Board; must comply with other conditions.

WHITT, John Alan, MD

Location: Wilson, NC (Wilson Co)
 DOB: 10/21/1958
 License #: 0000-31692
 Specialty: P (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1985)
 Cause: On the request of Dr Whitt to amend the Consent Order dated 3/18/1999 that limited his license to expire on the date shown on the license and subjected the license to certain terms and conditions. Amendment is justified by his actions, his progress, and his compliance with the Consent Order.

Action: 6/25/2001. Consent Order executed: Dr Whitt's license is fully reinstated and shall not be time limited; he shall remain subject to paragraph 2 (a,c,d,e,f,g,h) of the 3/18/1999 Consent Order and shall continue his contract with the NCPHP until 2/23/2002; paragraphs 3 through 8 of that Consent Order shall also remain in effect; must comply with other conditions.

YOUSSEF-AHMED, Maged Zakaria, MD

Location: Rockville Center, NY
 DOB: 5/20/1957
 License #: 0094-01367
 Specialty: PD/CCP (as reported by physician)
 Medical Ed: Ain-Shams University (1980)
 Cause: The New York Board for Professional Medical Conduct suspended Dr Youssef-Ahmed's license by consent order for 24 months, staying all but the first four months and placing him on probation for two years in exchange for his agreement not to contest charges that, intending to mislead, he submitted a fabricated specialty board certificate to a hospital when he had never held board certification, that he falsely told a hospital on a reappointment application that he was board certified, and that he falsely listed on his CV that he was board certified. Dr Youssef-Ahmed has placed his North Carolina license on inactive status.

Action: 6/01/2001. Consent Order executed: Dr Youssef-Ahmed's North Carolina license shall remain on inactive status for 24 months from this date, after which he may apply for reinstatement; he shall comply in all respects with his Consent Order with New York; must comply with other conditions.

MISCELLANEOUS ACTIONS**VAN FRANK, Alison Chadwick, MD**

Location: Columbus, NC (Polk Co)
 DOB: 2/08/1959
 License #: 0000-35063
 Specialty: EM/OS (as reported by physician)
 Medical Ed: University of Utah (1990)
 Cause: Dr Van Frank failed to register in accord with law and the Board placed her license on inactive status effective 6/26/2000.

She continued to practice from that time until late November 2000 when she learned of her inactive status. She did not resume practice until the Board approved her reinstatement application effective 12/05/2000. She then asked the Board to retroactively reinstate her license to 6/26/2000 so there would be no lapse in her authority to practice. A hearing was held on that request.

Action: 5/16/2001. Findings of Fact, Conclusions of Law, and Order issued by the Board following a hearing held on 3/16/2001. Finding cause existed to grant Dr Van Frank's request, the Board reinstated her license effective 6/26/2000. The Board also reprimanded her for her failure to register in a timely manner as required by law and required that she prepare an article for the Forum on the importance of registering in accord with law.

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

DENIALS OF LICENSE/APPROVAL
NONE

SURRENDERS

BRIDGES, Michael Howard, MD

Location: Elkin, NC (Surry Co)
DOB: 6/12/1966
License #: 0096-00463
Specialty: IM/PD (as reported by physician)
Medical Ed: Wright State University (1992)
Action: 5/03/2001. Voluntary surrender of North Carolina medical license.

McINTOSH, John Clarke, MD

Location: Asheville, NC (Buncombe Co)
DOB: 7/16/1956
License #: 0000-36570
Specialty: PD/PDP (as reported by physician)
Medical Ed: Medical University of South Carolina (1981)
Action: 6/04/2001. Voluntary surrender of North Carolina medical license.

STROUD, Joan Marie, Physician Assistant

Location: Gastonia, NC (Gaston Co)
DOB: 4/24/1956
License #: 0001-01476
PA Education: Pennsylvania State University (1980)
Action: 5/24/2001. Voluntary surrender of North Carolina PA license.

WORLAX, Eric, Physician Assistant

Location: Efland, NC (Orange Co)
DOB: 8/25/1960
License #: 0001-01585
PA Education: Duke University (1992)
Action: 6/15/2001. Voluntary surrender of North Carolina PA license.

See Consent Orders:

DUBEY, Subu, MD
JORDAN, Richard Liming, MD

COURT APPEALS
NONE

CONSENT ORDERS LIFTED

GREGORY, Ginger Dobbins, Physician Assistant

[Previously known as: BLEMMINGS, Ginger Dobbins]
Location: Angier, NC (Harnett Co)/Fuquay-Varina, NC (Wake Co)
DOB: 8/30/1963
License #: 0001-01410
PA Education: Bowman Gray (1991)
Action: 6/08/2001. Order issued lifting Consent Order of 4/06/1998.

JACOBS, Kenneth Lee, MD

Location: North Wilkesboro, NC (Wilkes Co)
DOB: 7/26/1959
License #: 0096-00953
Specialty: OBG (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1992)
Action: 5/29/2001. Order issued lifting Consent Order of 9/11/2000.

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

COYNE, Mark Dennis, MD

Location: Stoney Creek, NC (Guilford Co)
DOB: 8/12/1949
License #: 0000-33493
Specialty: EM/OS (as reported by physician)
Medical Ed: Chicago Medical School (1983)
Action: 5/17/2001. Temporary/dated license extended to expire 11/30/2001.

DENTON, Beecher Tate, III, Physician Assistant

Location: Salisbury, NC (Rowan Co)
DOB: 1/03/1955
License #: 0001-00993
PA Education: Bowman Gray (1987)
Action: 7/19/2001. Temporary/dated license extended to expire 1/31/2002.

GREGORY, Ginger Dobbins, Physician Assistant

[Previously known as: BLEMMINGS, Ginger Dobbins]
Location: Angier, NC (Harnett Co)/Fuquay-Varina, NC (Wake Co)
DOB: 8/30/1963
License #: 0001-01410
PA Education: Bowman Gray (1991)
Action: 5/17/2001. Full PA license issued.

JACOBS, Kenneth Lee, MD

Location: North Wilkesboro, NC (Wilkes Co)
DOB: 7/26/1959
License #: 0096-00953
Specialty: OBG (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1992)
Action: 5/17/2001. Full and unrestricted license reinstated.

MEAD, Robert J., MD

Location: Asheboro, NC (Randolph Co)
DOB: 12/13/1945
License #: 0000-32790
Specialty: PD/PDA (as reported by physician)
Medical Ed: Jefferson Medical College (1978)
Action: 5/17/2001. Full and unrestricted license reinstated.

MORRIS, Robert Harry, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)
DOB: 11/18/1950
License #: 0001-00110
PA Education: Howard University (1975)
Action: 5/17/2001. Temporary/dated license extended to expire 7/31/2001.
7/19/2001. Temporary/dated license extended to expire 9/30/2001.

PRESSLY, Margaret Rose, MD

Location: Sylva, NC (Jackson Co)
DOB: 5/05/1956
License #: 0000-34548
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1990)
Action: 5/17/2001. Temporary/dated license extended to expire 11/30/2001.

SAPPINGTON, John Shannon, MD

Location: New Bern, NC (Craven Co)
DOB: 1/30/1962
License #: 0094-00628
Specialty: P (as reported by physician)
Medical Ed: University of Texas (1989)
Action: 5/17/2001. Temporary/dated license extended to expire 11/30/2001.

SHAFTNER, Kimberly K., MD

Location: Princeton, NC (Johnston Co)
DOB: 12/09/1954

CHANGE OF ADDRESS FORM

Mail Completed form to: North Carolina Medical Board
PO Box 20007, Raleigh, NC 27619

Please print or type. Date: _____

Full Legal Name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

Business: _____

Phone: (____) (____) (____) Fax: (____) (____) (____)

Home: _____

Phone: (____) (____) (____) Fax: (____) (____) (____)

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