Primum Non Nocere

No. 3, 2004

forum

NC MEDICAL BOARD

Electronic Medical Records
Page 4

President's Message

Consistency and Credibility

Stephen M. Herring, MD

Consistency is the steadfast adherence to the same principles, course, or form. It is an important sentinel in medical regulation because without consistency, by definition, regulation cannot be optimal. So important is it that some medical boards have carefully assessed the consistency of their regulatory processes in order to best assure patient protection. They have also presented the resulting data at the annual meetings of the Federation of State Medical Boards of the United States. No two situations are identical in the world of medical regulation, of course, but there are elements of some situations that are generally similar to others. It is these similarities that can be tracked throughout the regulatory process, not to guarantee the same outcomes but to ensure consistency in process itself. Needless to say, consistency simply for the sake of consistency is not desirable, and, as Emerson said, "a foolish consistency is the hobgoblin of little minds." The North Carolina Medical Board has considered the issue of consistency in regulation and has drawn the conclusion that consistency in process is essential to credible public protection and fairness, but seeking consistency in outcomes would be futile due to the many variables, revealed through process, that attend each case coming before it.

Regulation, that is to control or direct by rule, is the sole responsibility and mandate of medical boards. They are, in fact, the "courts of last resort," and ultimately responsible for those they license. However, they also depend on a complex system and a team effort to assist in the process. The list of players is long and includes, but is not limited to, the Federation of State Medical Boards, accreditation organizations, medical schools, graduate training programs, impaired physician programs, general medical societies, specialty societies and boards, hospital oversight systems, and peer review systems. These groups play an important role by assisting medical boards in regulation. If they do not perform their oversight functions effectively, the correction of problems will be delayed, threatening unnecessary harm to patients.

Consistency and credibility throughout the entire system are critical to best ensure meeting our common goals. If any organization has bylaws, rules, policies, resolutions, or codes in place, irrespective of mission statement or mandate, consistency in application must be pursued in order to earn and maintain credibility. One set of standards must be applied at all levels regardless of station or any other factor. As a hypothetical illustration, if a chief of staff of a hospital demands that staff conform to a call schedule, yet does not abide by that same schedule, there is a credibility gap. If a surgery teacher throws instruments in the operating room, but demands that students not throw instruments, there is a credibility gap. To be credible, a professional organization or accreditation body with established standards must act if a member or accredited entity falls outside those standards. Not to do so is not to have standards. Fortunately, lack of consistency in practice settings and in professional and accreditation groups is becoming more the exception than the rule, which significantly enhances their credibility.

In This Issue of the FORUM

Primum Non Nocere

forum

NC MEDICAL BOARD

Raleigh, NC **Vol. IX, No. 3, 2004**

North Carolina Medical Board

Publisher
NC Medical Board

Editor
Dale G Breaden

Assistant Editor
Dena M. Marshall

Street Address
1203 Front Street
Raleigh, NC 27609

Mailing Address
PO Box 20007
Raleigh, NC 27619

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

Fax
(919) 326-0036

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

We are all imperfect. That is inherent in the human condition. In the field of medical licensure, we must face that imperfection and work for consistent and credible regulation in order to advance our quest for the best in medical practice. We are indebted to those medical boards and individuals that recognize the importance of consistency and credibility for initiating and pursuing a national discussion of those fundamental principles. I have no doubt that discussion will remain a significant part of the regulatory agenda for years to come.

During my service on the North Carolina Medical Board over the past six years, it has made many positive changes to improve regulation. Those changes, and the many improvements made over earlier years, were not the result of any one person's effort — they were and are the product of the hard work and personal commitment of each and every past and present Board member and of our dedicated and highly professional staff. Our Board, founded in 1859, is the oldest continuously functioning medical board in the country. It is recognized as a leader in medical regulation and many of its members have provided outstanding national leadership in the field. I am confident the spirit of this distinguished legacy will continue to generate steady advances in the work of the Board because the Board's members, professional and public, and staff will never accept the status quo. The determination to provide effective public protection through consistent and credible processes, ingrained in the Board's culture and tradition, will carry the Board another 150 years and more. It has been a pleasure and an honor for me to be a small part of all this.

DEA Changing Style and Appearance of DEA Controlled Substance Registration Certificate

The Drug Enforcement Administration (DEA) Office of Diversion Control is in the process of changing the style and appearance of the DEA Controlled Substance Registration Certificate. As of October 1, 2004, the revised Certificate of Registration will consist of two parts: one that can be displayed on the wall and one smaller, wallet-size version. The certificate will have an imbedded watermark logo that will provide authentication of the certificate and also deter counterfeiting.

Registrants that are currently allowed to renew their DEA registration via the Diversion Control Program's Web site (ie, retail pharmacies, hospitals, practitioners, mid-level practitioners, and teaching institutions) may print their Certificate of Registration on completion of the registration renewal process as long as no changes have been made to their registration since their last renewal. The Diversion Control Program's Web site may be accessed at *www.DEAdiversion.usdoj.gov*. The DEA will continue to send Certificates of Registration via the U.S. Postal Service to all new registrants and all other DEA registrants renewing their DEA registration.

Examination Notes

USMLE Clinical Skills Examination Underway

Administration of the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination began in June in Philadelphia. There are now five testing centers: Philadelphia, Atlanta, Los Angeles, Chicago, and Houston.

More than 12,000 medical students and graduates of LCME-accredited and international medical schools have applied to take the examination since registration began in January 2004. Of those, more than 7,000 have scheduled to take the examination at one of the test sites.

"We're very pleased with the successful roll-out of the first test centers," said James N. Thompson, MD, president and CEO of the Federation of State Medical Boards (FSMB). "This is a major step toward ensuring that all physicians have the necessary clinical and communication skills to practice medicine safely."

The FSMB and the National Board of Medical Examiners (NBME) are co-sponsors of the USMLE, which is accepted by all allopathic and composite medical boards as meeting their examination requirements for licensure. The new Step 2 CS will assure the public that all MDs who seek licensure in this country have the same set of clinical and communications skills no matter where they have been educated or trained.

The one-day examination mirrors a physician's typical workday in a clinic and other settings. Examinees will examine 11 or 12 "standardized patients"—individuals trained to portray real patients—for 15 minutes each. The "patients" are hired actors, ranging from teen-agers to retirees, who simulate various illnesses that a physician is likely to encounter in common medical practice. After each encounter, examinees record a patient note, including pertinent history and physical examination findings, diagnostic impressions, and plans for further evaluation if necessary.

Examinees are evaluated on their ability to establish rapport with the standardized patient, gather information, perform focused physical examinations, communicate effectively, and document findings and diagnostic impressions.

Scores for the first group of Step 2 CS examinations are expected to be released by mid-November, with subsequent score releases taking place approximately six weeks after test administration. Students who fail the test can try again after 60 days, up to three times a year. Because the actual date for release of scores is uncertain, the FSMB and NBME have written to the directors of all ACGME-accredited residency programs urging them not to require applicants to their programs to complete the Step 2 CS prior to the National Residents Matching Program deadline in March 2005. A copy of that communication and further information on the USMLE Step 2 CS may be found on the USMLE Web site at *www.usmle.org*.

"Debriefing" USMLE Participants Can Lead to Sanctions Against Examinees

The United States Medical Licensing Examination (USMLE) Secretariat has issued a warning to medical school faculty who may be "debriefing" students who have taken the USMLE Step 2 Clinical Skills examination, then sharing information with students who have not yet taken the test. While sponsors of the USMLE Step 2 Clinical Skills examination have no objection to examinees obtaining accurate, practical, and general advice for taking the test, under USMLE rules, providing and/or disseminating information about case material is viewed as "irregular behavior" and examinees run serious risks if they disclose any test material. Sanctions can include permanent annotation of their USMLE records and being barred from taking any Step examination for a period of time.

For more information, contact the Federation of State Medical Board's vice president for Examination and Post-Licensure Assessment Services at (817) 868-4045.

NBOME Begins Clinical Skills Testing at New Pennsylvania Center

The National Board of Osteopathic Medical Examiners (NBOME) began testing at its new National Center for Clinical Skills Testing in Conshoshocken, PA, in September. The center will now conduct COMLEX-USA Level 2-PE (Performance Evaluation) clinical skills examination on a continuous basis throughout the year.

The purpose of the Level 2-PE is to measure doctor-patient communication, history-taking, physical examination, osteopathic principles, manipulative treatment, written communications skills, integrated differential diagnosis, and the formulation of a therapeutic plan in a simulated clinical environment. The DO candidates see 12 patients during the seven-hour examination. The test is similar to the USMLE Step 2 Clinical Skills examination implemented at five sites this year.

Level 2-PE will be required for all DO candidates graduating in 2005 and those who graduated before July 1, 2004, and have not passed Level 2-CE (Cognitive Evaluation) by June 30, 2005. Because Level 2-PE is a separate component from Level 2-CE, the examinations may be taken in any order.

For more information, visit the NBOME Web site at *www.nbome.org*.

Electronic Medical Records and the Development of Electronic Health Records and Electronic Patient Records

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

Ms Satinsky

Electronic medical records (EMRs) are high on most physicians' lists of potential practice enhancements. Currently, there are many more interested physicians than actual users, but I expect the number of purchasers to increase dramatically.

Interest in EMRs is increasing for many compelling reasons. As EMR technology evolves, new vendors are entering the market and lowering their prices. (In fact, as I write this article, EMRs, the current state-of-the-art, are quickly moving toward more advanced technology, such as electronic health records [EHRs] and electronic patient records [EPRs]. I'll say more about this evolution below.) Medical school graduates are very comfortable with information technology and are likely to set up their practices with EMRs, not paper medical records.

Large private and public purchasers already set expectations for health care providers and reward those hospitals and physicians that can demonstrate a high quality of care, practice efficiencies, and lower costs. For example, General Electric, Verizon, IBM, and CISCO, all national companies with North Carolina locations, collaborate with other leading employers to hold providers accountable for what they do.

"NCHICA has passed a resolution endorsing a secure, paperless, person-centered health record by the year 2010"

Like the private sector, the public sector is also interested in promoting the use of information technology. At the federal level, Medicare's e-prescribing initiative is expected to accelerate electronic prescribing for all patients. "Interoperability" in health care information technology is a public priority for President Bush. The Department of Health and Human Services recently appointed its first national coordinator for Health Information Technology to work with the public and private sectors. In late July, that coordinator, David Brailer, MD, PhD, announced federal support for community-based collaborations among providers using IT products that are certified as having a base-level of desirable features.

Here in North Carolina, the North Carolina Healthcare Information and Communications Alliance (NCHICA) has both public and private support. Along with a number of its professional society and association members, NCHICA has passed a resolution endorsing a secure, paperless, person-centered health record by the year 2010. NCHICA is also encouraging North Carolina employers to hold health care providers accountable. I agree with NCHICA and believe that within 10 years, EMRs (or their next manifestations) will be in most physicians' offices. In those communities and practices that are particularly forward-looking, the change will occur even sooner. That said, I encourage you to work thoughtfully rather than quickly so that you purchase systems that suit your needs, that are standards-based, and that are priced within your budget.

I encourage practices that are exploring EMRs to address 10 important questions.

- What's the philosophy behind EMRs?
- How has the technology of EMRs evolved, and what is the future direction?
- What functions/capabilities can most EMRs bring to medical practices?
- What are the potential benefits of EMRs and, equally important, are they measurable?
- What's the cost of introducing EMRs into your practice?
- What steps should you take to get started?
- What are the keys to successful implementation?
- What are recommended resources for information on vendors and their products?
- What questions should you ask vendors?
- What are good sources of additional information?

What's the Philosophy Behind EMRs?

The philosophy of EMRs is straightforward. EMRs capture data on the clinical status of individual patients, and they allow users to view in new ways data that have been previously stored. For example, EMRs can capture data from within and outside a physician's practice. Visit notes, rationales for clinical decision making, reports from physicians in other practices, lab and X-ray results, information from hospitals, pharmacies, and other health care institutions, and information from state and national databases are examples of the kinds of data that can be drawn into a single database. Physicians and other users can then view information on both individual patients and groups of patients.

All EMRs have common building blocks (Carter, 2001). First, they have a database management system. Second, they allow data input in a variety of ways, such as pen, voice-based technology, and scan-

ning of paper records. Third, EMRs network through a LAN, Internet, or wireless system. Fourth, they offer security through a combination of one or more mechanisms, including passwords, tokens, biometrics, and/or encryption. Fifth, they allow messaging, and, sixth, they store clinical information in a way that permits movement from one system to another.

Evolution and Future Direction of EMRs: CPRs to EMRs to EHRs and EPRs

As I noted earlier, the technology of EMRs is rapidly evolving. Early work that began in the 1960s at Massachusetts General Hospital, at Duke University Medical Center, and at Indiana University set the stage. By 1970, there was some capability to document clinician-patient interactions and enable clinician alerts. In 1991, the Institute of Medicine (IOM) issued an important report called *The Computer-Based Patient Record: An Essential Technology for Healthcare*. The report grouped 180 features divided into 12 attributes of what was then called computer-based patient records (CPRs). The IOM updated its report in 1997. CPRs were longitudinal records that captured paper-based records for later use.

Further developments saw CPRs move toward the current generation of electronic medical records (EMRs). EMRs capture structured and unstructured data from paper and from disparate computerized systems, including documentary imaging systems, and then manage the information. Users can view the information that has been captured by the EMR in a variety of ways, depending on their needs. EMRs are usually maintained by one organization such as a hospital or medical practice. Although their interactivity and access is superior to that of CPRs, EMRs are limited by both their organization or practice-centered location and their focus on capturing information primarily from a patient encounter.

EMRs are expected to evolve into electronic health records (EHRs) that can capture information from multiple sources and then into electronic patient records (EPRs), lifetime records that patients, not organizations or medical practices, control. EHRs and EPRs will capture information from patients themselves, from a wide variety of demographic and clinical databases, and, with patient authorization, from multiple providers. They will both have great potential for enhanced clinical decision making, since input won't be limited to information obtained at the time of a patient visit. Event-based triggers (eg, blood pressure reaching a particular level) will facilitate clinical decision support, and physicians will be able to customize practice guidelines and protocols to meet the needs of particular patients.

As EMRs evolve into EHRs and EPRs, one of the challenges that must be addressed is standards for interoperability. It's all well and good to talk about bringing data from multiple systems into a single database, but only if different systems and vendors speak a common language. At this year's important annual conference, Toward an Electronic Patient Record (TEPR), several organizations that are working on the continuity of care record, a potential clinical standard, were well-received by vendors that took great interest in the interoperability issue (Featherly, 2004).

Functions and Capabilities of EMRs

As you begin your investigation of EMRs, take an a la carte approach to your decision making. You'll be looking at systems with multiple optional functions, and you can select the features that you want and combine them with other information technology applications in your practice.

Most EMRs allow physicians to perform up to 15 functions (Barrett, 2003) depending on user need. I have listed the common EMR functions in an order that I think makes sense for most physicians. If your vendor allows you to phase-in the implementation of the different functions, pick a sequence that best meets your needs.

"As EMRs evolve into EHRs and EPRs, one of the challenges that must be addressed is standards for interoperability"

EMRs let you:

- **view** problem lists, medications, allergic reactions, test results, and other information that is related to a patient visit;
- **document** what happens during a patient visit and the rationale for clinical decision making;
- **identify** clinical issues using red flags that alert and remind physicians (eg, alerts can remind physicians of drug allergies and reminders can suggest age and sex specific prevention and screening);
- **decide** clinical issues using comprehensive and reliable databases and references (eg, an oncologist might want to check current information from the American Cancer Society);
- **manage prescriptions** by accessing formularies, consulting drug utilization databases, and e-prescribing by routing new scripts and renewals directly to pharmacies;
- **order** lab tests, imaging, and other procedures;
- **communicate** securely with medical colleagues within and outside the practice, with patients in a standard and structured way, and with public health agencies;
- **code** by matching ICD and CPT codes with details in the visit notes, by using an E & M coding tool, and by integrating SNOMED clinical vocabulary;
- **comply** with privacy and security rules;
- **aggregate** data on individual patients into longitudinal records;
- **manage** the chronic conditions and diseases of individual patients;
- **standardize** disease management goals for subgroups of chronic disease patients (eg, pul-

monary physicians with asthma patients could customize this module to include disease-specific goals);
- **query** the system for reports on clinical issues for both individuals and groups;
- **conduct** research, registry, and clinical trial activities;
- **incorporate** information that comes from the patient by direct input and/or by medical devices.

Potential Benefits of EMRs

Practices vary in specialty, size, and operations, so EMRs don't produce the same benefits for all users. Studies of practices that have already implemented EMRs identify three benefits that may result if, and only if, the practice pays attention to factors other than the technology itself. I'll talk about keys to successful implementation a bit later.

"Measuring the quality, financial, and operational improvements from EMRs is challenging"

The three potential benefits of EMRs are improvements in quality of patient care, in financial position, and in practice operations. Let's look at each benefit separately.

Quality of Care:

EMRs can have a positive impact on the quality of care you deliver to your patients. The software eliminates illegible handwriting. It organizes notes from patient visits and test results. You can retrieve lists of patient problems, medications, and preventive protocols more easily than when all information is hand written and placed in paper files in random order. You can also access patient information from locations other than your main office. For example, if you need patient information when you are in a satellite office, the emergency room, or your home, you can easily get what you need. EMRs can facilitate the management of patients with chronic health problems, reduce medication errors, and eliminate duplicate lab tests.

Financial Position:

Financial position depends on revenue and expenses, and EMRs can impact both. With respect to revenue enhancement, EMRs can reduce the percentage and amount of erroneous claims submitted by flagging erroneous codes or data omissions. If you decrease the time spent on chart documentation, you can see more patients per hour and generate more revenue. Coding modules can help you code more accurately and with more confidence. EMRs can also provide information on quality of care that you can use in negotiating managed care contracts.

EMRs can also improve your practice's financial position by reducing operating expenses. For example, practices that embrace EMRs as a replacement for costly transcription can save on that item. Other common cost savings can be the reduction of staff time for chart pulls and prescription renewals and a decrease in dollars spent on paper supplies. Some malpractice carriers offer reduced rates to practices with EMRs because the new systems lower the risk of errors.

Don't expect to see the financial benefits from EMRs right away. Short-term financial gains are offset by significant start-up costs that include not only dollars paid to the vendor, but also the costs of staff time and training. In some practices, physicians reduce their patient loads — and therefore their revenue — while they focus on EMR implementation. In other practices, administrators that are heavily involved in EMR selection and implementation require additional support while they focus on the special project. Still other practices engage an external consultant to manage the EMR project.

Practice Operations:

With respect to practice operations, think about the processes that you now use to enter patient information in a paper record. Your front desk captures demographic information at patient registration. Your nurse interviews the patient and adds clinical information, and then you have a face-to-face visit with the patient. Results from laboratory and other tests, hospital discharge notes, information from other physicians and from public health agencies come from other sources. Requests for prescription renewals come directly from patients. Let's be honest: in most practices, the processes for gathering and organizing all that information may be cumbersome and error-prone, and EMRs can make a big difference.

Measuring the quality, financial, and operational improvements from EMRs is challenging. Practices make many changes over time, and it's hard to isolate those that are a direct result of EMRs. The authors of a 2003 study sponsored by the California HealthCare Foundation found a wide variety of financial benefits ranging from $0 to more than $20,000 a year (Miller, Sim, and Newman, 2003). Quality improvement can be easier to measure, since many practices go from no measurement at all to very careful monitoring of patient care. Physicians like the existence of monitoring although they cannot always place a dollar value on its worth.

What Do EMRs Cost?

I think the cost question is complex. I hesitate to give you a specific dollar figure because you have so many choices, but I am comfortable identifying the cost items that you should consider. I'll also give you a word of advice: you should be making the first of many decisions, not a final decision, so don't assume that once you purchase your first EMR you are finished forever. You should expect to revisit the EMR question repeatedly.

You'll need to know the cost of both the products

and services you are buying from your vendor and your internal start-up. Even when you have this information, the cost can vary widely.

You have a choice between purchasing your own server and selecting an application service provider (ASP). Some practices presume that buying their own server will give them control and reliability. In my experience, these assumptions are not always valid. The purchase approach means higher up-front capital costs. The ASP approach costs less both at the outset and for ongoing maintenance. Just as you might lease a car, you can pay a fixed monthly rate to "rent" the software that is hosted by the vendor or by a third-party Internet provider. The practice also pays for network communications that support data transmission. (Rake Report, July 2002).

For a group of 20 surgical specialists in a single practice with 11 locations that purchased its own server, the typical costs included the following.

- Software licenses: $200,000 — $300,000
- Electronic data interfaces (EDI priced at an hourly rate): $10,000 — $40,000 for consultation, installation, and maintenance
- Conversion from paper to EMR: $5,000 — $15,000
- Hardware, including on-site server and secure virtual private network: $85,000 — $200,000
- Maintenance of EMRs and interfaces: $70,000 — $130,000 a year
- Implementation and training: $70,000 — $220,000 (some vendors include training for the first six months and then make it available as needed at an hourly rate; some vendors vary the costs for these items by the group size)
- Outside consultation to manage vendor selection and implementation: paid on an hourly basis
- Total first year costs: $200,000 — $1 million
- Subsequent years: ongoing maintenance
- Customized programming: variable, at $100 — $125 an hour

Getting Started with EMRs

I recommend you get started with EMRs by taking the following steps in the order listed here.

- Set realistic expectations about your time frame and process. Allow 18 months from the beginning of your investigation to implementation. The process will be long and hard.
- Start with your practice, not with the technology. Set up an internal EMR task force that represents physicians, other clinicians, and administrative staff. Assign task force members to teams that concentrate on particular aspects of EMR implementation, such as capturing demographic and clinical information, patient process, and billing. You want to ensure buy-in for what you are doing, not acceptance of a solution that a handful of people crafted behind closed doors.
- Profile your practice operations. Identify what works well and what needs improvement before you delve into the solutions that EMRs offer.
- Begin your investigation of EMRs so you understand what they can do. Talk with professional organizations, colleagues in other practices, and vendors themselves so you understand what's on the market.
- Achieve consensus on your practice's priorities. You want technology to help you, and you don't want to purchase technology for technology's sake.
- Invite several vendors into your practice to make preliminary presentations.
- Convert a statement of your needs into a formal request for a proposal (RFP) that you send to vendors. At the same time you develop the RFP, list the decision criteria and weighting that you will use to evaluate responses.
- Review the proposals that you receive, shorten your list of potential vendors, and make site visits to those you think can meet your needs.
- Make more site visits — this time to other practices that are using the product. The vendors generally accompany you on these trips, and I encourage you to visit still other users without the presence of vendors. Shadow the physicians as they use the technology and observe how EMRs impact the physician-patient communication.
- Select the vendor.
- Incorporate the terms on which you have agreed in a formal agreement. Be sure to include language on termination and ownership of the data. Include the vendor's proposal as an attachment to the contract.
- Develop an implementation plan that includes the transition to EMR, interconnectivity, evaluation of what you have done, and ongoing maintenance.

"Information technology is only half the picture; the success or failure of any technology depends on people"

Keys to Successful Implementation

Information technology is only half the picture; the success or failure of any technology depends on people. EMRs that are a phenomenal success in one practice may be a costly failure in another. Here are keys to successful implementation.

- Identify a *physician champion* who is not only interested in introducing EMRs, but who is able and willing to coach his or her peers through the transition process. The champion will test the software on his or her own patients, work with the EMR and other vendors, and then work with colleagues and other staff to get it right.
- Enlist the *commitment of all physicians* in the practice, including those who are comfortable with technology and those who are not. EMRs should be a practice enhancement, not a tool that

one or two technologically savvy physicians use while others retain their dependence on paper.

- Agree on *timing that suits your practice*. Some vendors permit practices to purchase a comprehensive EMR software package and phase-in the implementation of different modules. Others allow the separate purchase of each module. Still others are inflexible and require all clients to purchase and implement in a way that meets vendor, not purchaser, needs.
- Pay attention to the *relationship between EMRs and other systems*. There are no current standards governing the interconnectivity of EMRs and practice management systems, Web-based communication, lab, and other systems. Smooth working relationships won't be automatic. For example, can the demographic and billing information in your practice management system be imported into your EMR? Can lab results from an external vendor be linked to data that you enter following a patient visit? You need to know what interfaces are possible, who is implementing them, and who will maintain them. Be cautious about vendors that require you to purchase all of their products and that are unwilling to collaborate with other companies.
- Purchase *the level of support* that is suitable for your practice. Even if you have your own information technology specialists, you may need outside help from one or more vendors. Ask about initial installation, availability of the help desk, software fixes and upgrades, and deals on hardware, software, and Internet connectivity.

"EMRs and their expected evolution into EHRs and EPRs have great potential to improve the clinical, financial, and operational aspects of your practice"

Recommended Resources on Vendors and Their Products

The question on EMRs that physicians ask the most frequently is: "Which vendor should I select?" There is no right answer, but there are good sources of information on both vendors and their products. I recommend that you look at the Web sites of the American Academy of Family Physicians (*www.aafp.org*), the California HealthCare Foundation (*www.chcf.org*), Health Data Management (*www.healthdatamanagement.com*), CTS Software Selection (*www.ctsguides.com*), and AC Group, Inc (*www.acgroup.org*), for lists and reviews. The Medical Group Management Association (www.mgma.com) and the North Carolina Healthcare Information and Communications Alliance (*www.nchica.org*) are also good resources.

Questions for Vendors

There are two parts to the vendor question: who do you contact and what questions should you ask? The resources that I've suggested above will give you guidance on the vendors. Here are my suggestions of questions to ask (Barrett, Holmes, and McAulay, 2003 and Rake Report 2002).

- How does each of the functions that the vendor offers work? Request a demonstration for each one and try it out.
- What is the method(s) by which information is put into the system?
- What is the vendor's approach to customization and what are the accompanying costs?
- Do the menus, screens, and categories make sense to you?
- How does the EMR integrate (or not!) with your practice management system, Web-based communication, and other systems?
- How do you access the EMR — remotely, by mobile device, etc?
- How does the product process, exchange, and store graphics and images?
- What customer support is available to the practice during transition from paper records, start-up, implementation, and after that?
- What is the cost?
- What options for financing are available?

Conclusion

I think EMRs and their expected evolution into EHRs and EPRs have great potential to improve the clinical, financial, and operational aspects of your practice. If you agree, approach the challenge with knowledge and foresight, rather than with resistance and fear.

References

American Academy of Family Physicians. Press Release, November 12, 2003.

American Academy of Family Physicians. *AAFP This Week*. January 29, 2003.

Barrett, M.J., with Holmes, B.J., and McAulay, S.E. *Electronic Medical Records: A Buyer's Guide for Small Physician Practices*. California HealthCare Foundation, Oakland, CA. 2003.

Carter, J.H. *Electronic Medical Records. A Guide for Clinicians and Administrators*. American College of Physicians, Philadelphia. 2001.

Healthcare Informatics, Healthcare Information Programs. Electronic Medical Records: Why Their Time Has Come. 2003.

Featherly, K. TEPR '04, A Lot of Singing About Interoperability. *Healthcare Informatics*. July 2004. 10-14.

Miller, R.H., Sim, I., and Newman, J. *Electronic Medical Records: Lessons from Smaller Physician Practices*. California HealthCare Foundation, Oakland, CA. 2003.

Rake Report. *Electronic Medical Record Systems*. July 22, 2002. 10-15.

.....

The author gratefully acknowledges the assistance of W. Holt Anderson, executive director of the North Carolina Healthcare Information and Communications Alliance, Inc, in Research Triangle Park, NC, and Franklin W.

Maddux, MD, chief executive officer of Gamewood, Inc, in Danville, VA.

.....

Ms Satinsky is president of Satinsky Consulting, LLC. She earned her BA in history from Brown University, her MA in political science from the University of Pennsylvania, and her MBA in health care administration from the Wharton School of the University of Pennsylvania. She is the author of two books: *The Foundation of Integrated Care: Facing the Challenges of Change* (American Hospital Publishing, 1997) and *An Executive Guide to Case Management Strategies* (American Hospital Publishing, 1995). The *Forum* has published several articles by Ms Satinsky, including Managing the Implementation of HIPAA and the Privacy Rule, in #4, 2002; How to Determine If Your Practice Could Use a Professional Practice Administrator, in #2, 2003; Using Information Technology to Improve Patient Care and Communication: A Practical Guide - Part 1, in #1, 2004; and Using Information Technology to Improve Patient Care and Communication: A Practical Guide — Part 2, in #2, 2004. An adjunct faculty member at the University of North Carolina School of Public Health, Ms Satinsky is a member of the Medical Group Management Association. She may be reached at (919) 383-5998 or *margie@satinsky consulting.com*.

A Bit of Advice

Warning Signs

Over the years, a number of commentators, medical and non-medical, have advised the public on ways to evaluate and understand the world of medicine, and all health care professionals would benefit from considering their insights from time to time. One of the best efforts of this kind we have seen is by Thomas J. Scully, MD, a former member of the Nevada State Board of Medical Examiners and a former dean of the University of Nevada School of Medicine, and his wife, Celia G. Scully, a distinguished science writer. Their book, *Playing God: The New World of Medical Choices* (Simon and Schuster, 1988), was designed to provide practical advice on how to deal with the increasingly complex choices presented by medicine as the twentieth century neared its end. What appears below is a snippet from the book, a bit of advice for a patient that should be equally valuable for any health care professional open to self-examination.

Clues You're Not Getting the Health Care You Should

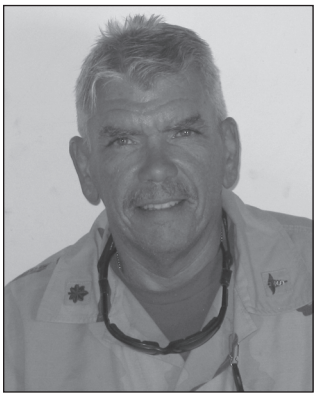
There are 12 warning signs that should raise a red flag in alerting you to the fact that you may not be getting proper health care or may be seeing a doctor who's not right for you.

Your doctor:

1. Doesn't seem to be listening to what you're saying.
2. Doesn't answer your questions or take time to ask if you have any. When there is an answer, it's in words you don't understand.
3. Fails to take an adequate medical history or give you a complete physical examination when it's called for. (Over a period of time, of course, your doctor gets to know your health history, and for certain types of illness, say a cold or "flu bug," may forgo a total-body-system physical and examine only those areas where you have symptoms.)
4. Doesn't help you learn more about your condition and what you can do about it, or explain why the recommended tests, treatment, or medications are necessary.
5. Neglects to inform you of potential risks, benefits, and side effects of prescribed drugs or suggested procedures and tests. (Beware if you've said you're "allergic" to a certain medication and your doctor prescribes it anyway.)
6. Doesn't respect your modesty and makes suggestive remarks while doing a pelvic examination or examining your breasts.
7. Doesn't make a follow-up appointment for you or urge you to call the office to report how you're doing.
8. Seems forgetful, peculiar, or belligerent at times, and may even have alcohol on the breath.
9. Is hard to reach, doesn't return phone calls, and, when away, fails to arrange a replacement.
10. Is not on the staff of any community hospital or medical center.
11. Is rigid, a know-it-all, and insists on an "only" way to treat your condition.
12. Reacts defensively when you suggest a second opinion.

North Carolina National Guard Unit Starts Adopt-a-Clinic Program in Iraq

Major Henry E. Riley, PA-C, NCARNG



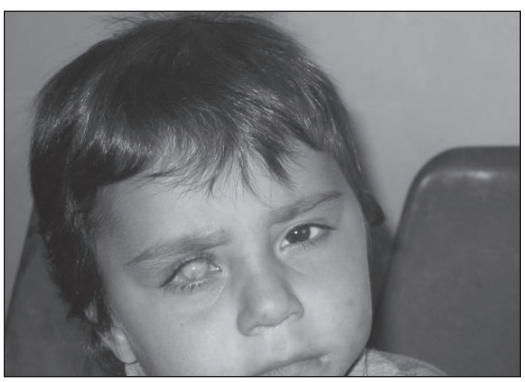
Major Riley

In an effort to strengthen interactions between local Iraqi citizens and North Carolina's Fayetteville-based national guardsmen of the 1/252 Armor Battalion, an Adopt-a-Clinic Program has been established in the Battalion's area of operation. In addition to maintaining a positive relationship between guardsmen and local Iraqi citizens, the program will become a meaningful symbol of that relationship and of a caring commitment to the medically impoverished citizens of Iraq.

Well-baby clinic in A-Sadeya, Iraq.

"We have encountered several local clinics and hospitals that are in dire need of basic medical supplies, equipment, and hospital furnishings"

During several medical assessment missions performed in our area of operation, we have encountered several local clinics and hospitals that are in dire need of basic medical supplies, equipment, and hospital furnishings. Many of these clinics serve not only their expected patients but hundreds of newly displaced refugees from all over Iraq. The patients seen in these facilities present a wide range of illnesses, including thalassemia, typhoid, and leishmoniasis, as well as blast injuries from land mines and old traumatic injuries secondary to torture at the hands of the Saddam regime.



Iraqi girl who developed corneal ulceration and subsequent opacification following chemotherapy for non-Hodgkins lymphoma in October 2003 in Baghdad. Her family fled Baghdad for Jabarra in November 2000.

The only equipment in the emergency room in the clinic in Jabarra.

The 1/252 Armor Battalion, an element of the North Carolina National Guard's 30th Heavy Separate Brigade, has been activated in support of Operation Iraqi Freedom since October 2003 and has been serving in Iraq since February 2004. Our area of operation is in Diyala province and is approximately 100 miles due east of Baghdad. It is the size of Delaware. There are three clinics and two hospitals that are in the most serious need. The people in the Diyala province are a mixture of Khurdish, Arabic, and Turcoman. While relatively quiet in terms of anticoalition activity, the potential for discontent is quite high and occasionally manifests itself by rocket attacks, improvised explosive devices, and attacks against Iraqis assisting coalition forces. Hopefully, a functional Iraqi health care system will provide a sense of confidence and well-being to the local Iraqi populace and assuage any smoldering discontent and unrest.

The Adopt-a-Clinic Program's ambition is to wed a donating hospital, clinic, physician, or group with one of the clinics in our area. The contributing party can observe and nurture the growth and improvement of the recipient Iraqi facility over time, long after the 1/252 Battalion's mission has been completed. The legacy of this relationship between the communities of North Carolina and the Iraqi citizens can only foster a greater understanding between the two countries and provide long lasting stability and freedom from strife for the newly liberated country of Iraq.

With the assistance of the state surgeon of the North

Carolina National Guard, COL/MC Morton Meltzer, and the North Carolina Air Guard and its state surgeon, LTC Jill Hendra, MD, we are attempting to arrange transport of donated materials and supplies

Baby getting out-patient antibiotics for tonsillitis at a better hospital in Kifri, Iraq.

from Raleigh, North Carolina, to Forward Operating Base Cobra, our Battalion's home here in Iraq. After arriving in country, the supplies will be recorded and a receipt will be issued to the donating group. At that time, the supplies will be distributed to the clinics that are in the greatest need. Specific donors will be assigned a particular clinic so that, over time, a dialogue can be established between the donors and the clinics through e-mail, pictures, and correspondence. This will enable both parties to share in the rewards inherent in a project such as this.

Generally, the Iraqi medical facilities in our area are in deplorable condition. The previous regime neglected this area and left the health care system in disrepair. Most of the clinics have no suitable furniture, there are few examination tables, beds, and chairs. Windows and doors are absent or broken from years of war and neglect, as well as from looting that occurred immediately after the previous regime's collapse. What few medical supplies are issued from a central government agency in Baquba are quickly exhausted and are woefully inadequate to meet the needs of the families that the clinics serve. In addition, the Iraqi Ministry of Health was a Baathist party (Saddam Hussein's political party) affiliate and, according to several Iraqi physicians I have talked to, issued supplies to those areas that were politically like-minded and neglected the more rural clinics that reside in our area of operation. Minor surgical instruments are rarely adequately sterilized, dressings are in short supply, and relatively advanced equipment, such as aerosol nebulization machines, is rare and generally damaged. Tubing is reused multiple times if available at all. Patients often wait for hours and are examined on the floor. Well-baby clinics and immunizations are available, but storage of vaccines, particularly in the smaller clinics, is inadequate.

"Patients often wait for hours and are examined on the floor"

Although funds from the Coalition Provisional Authority, the Iraqi government, and non-governmental organizations such as the Admiral Nash Fund have been used to refurbish health care facilities in Iraq, they have been generally limited to larger facilities and have rarely "trickled down" to the smaller rural clinics. Virtually any item that is used in a hospital or clinic in the United States would be gratefully appreciated here.

The Adopt-a-Clinic Program is in its infancy and, as of this writing, we are awaiting our first shipment of

Patients waiting outside clinic in Sheik-Baba, Iraq.

donated supplies from Arlington Surgical Group, an oral surgery group in Akron, Ohio. The 1/252 Armor Battalion maintains a Web site with further details and a link to initiate a donation. It also features information on an Adopt-a-School Program that is similar in form. If you, your group or clinic or hospital, would like to help, please visit us at: *www.tf252armor.com*.

North Carolina's Allied Health Care Professionals: A Clarification

In the fifth paragraph of my article, North Carolina's Allied Health Care Professionals, in *Forum* #2, 2004, I gave the impression that the granting of the physician assistant's license depends on (1) completing appropriate PA education, (2) passing the NCCPA examination, (3) receiving acknowledgement of an intent to practice agreement with a supervising physician, and (4) having a practice location approved by the Board. In fact, while all four of those elements are required to receive permission to practice as a PA in North Carolina, only the first two are basic to the actual granting of the PA license.

Robin Hunter-Buskey, PA-C, NCMB Member

Nurse Practitioner Notes

Preparing for an Atypical Day: Are You Ready, Doctor?

Gale Adcock, FNP

Ms Adcock

3:00 PM: A typically busy Friday in the office; the waiting room is half full but things are beginning to wind down. A well-dressed man approaches the receptionist's window and quietly announces: "I'm John Brown, a staff member at the North Carolina Medical Board. I'd like to see Doctor Smith and Nurse Practitioner Jones, please."

It's crunch time. Are you prepared, Doctor, for this unannounced visit?

What You're Required to Know

North Carolina Administrative Code 32M defines the role and responsibilities of a physician working with a nurse practitioner (NP) when designated as the "primary supervising physician." Commonly referred to as NP "rules," NCAC 32M establishes minimum components for a physician/NP collaborative practice agreement as well as a QA procedure referred to as the "quality improvement process."

The collaborative practice agreement (CPA) is the signed and dated document summarizing mutual understanding of the framework for your supervision of the "medical acts" performed by an NP. The CPA is not an employment contract, nor does it describe an employer/employee or other business arrangement. Rather, it contains details about an NP's scope of duties in your practice setting, a drug and device agreement listing the categories of legend and controlled drugs that you and the NP have agreed will be prescribed for commonly encountered health problems in your patient population, a procedure for emergency care of patients, arrangements for ongoing physician/NP communication, and specification of treatment protocols to be used in patient management.

"The NP, the primary supervising physician, and any back-up supervising physician(s) are equally accountable for reading, understanding, and following all requirements"

The NP, the primary supervising physician, and any back-up supervising physician(s) are equally accountable for reading, understanding, and following all requirements for collaborative practice as specified in the NP rules.

What You're Required to Have

Decrease your chances of a last-minute panic attack when Board staff request to see documentation specified in NCAC 32M. The following items must be maintained in the office and easily retrievable by you and the NP.

- Proof of RN licensure.
- A copy of the NP's approval to practice specifying you as the NP's primary supervising physician.
- A copy of the NP's current certificate of registration issued annually by the North Carolina Medical Board.
- A copy of the collaborative practice agreement. A signature page must be attached, including documentation of an annual review of the CPA itself and the protocols identified in it.
- Quality improvement process plan as well as documentation of every six-month "quality improvement process" meeting with the NP for the previous five years.
- A list of all back-up supervising physicians providing consultation to the NP in your absence.
- CE documentation.
- DEA Registration and Pharmacy Permit, if held.

While not mandated in the rules, it is prudent to have a current copy of the NP rules in the office to use as a reference.

What About Medical Records?

After the first six months of your formal collaborative relationship with the NP, there is no *regulatory* requirement for routine review and co-signature of the NP's patient visits. It is generally accepted practice that when you and the NP consult on a patient, this consultation should be documented in the patient record. NP rules require that whenever the NP wishes to prescribe a drug or device not included in the drug and device agreement, the results of a consultation with you must be documented in the patient record.

Anything Else?

Make the office staff aware that unscheduled visits by a representative of the North Carolina Medical Board or the North Carolina Board of Nursing are possible (as authorized in NCAC 32M). You and the NP will be expected to be available to meet with the Board representative as quickly as possible; other staff members are expected to cooperate with requests to see medical records, make copies of documents, etc. While some visits result from a complaint filed with

either Board, the contents of this article pertain to routine visits at randomly chosen practices intended to ensure regulatory compliance.

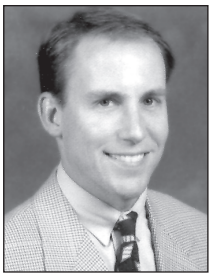
PS: The nurse practitioner must wear a name tag identifying her or him as an NP, whether the title is spelled out or the initials "NP" are used.

If you've addressed all the issues above, relax. You're ready.

Gale Adcock is an elected member of the North Carolina Board of Nursing and a member of the Joint Subcommittee and the Midwifery Joint Committee.

A Dance with Technology

Hayes Woollen, Jr, MD
President, Mecklenburg County Medical Society



Dr Woollen

"Sometimes we don't recognize the most significant events of our lives when they are happening. . . ."

Dr Moonlight Graham
in "Field of Dreams"

We are changing. The health-care industry, as we know it, is reluctantly evolving, crawling into the age of technology. We are transitioning to electronic medical records, computerized physician order entry, pharmaceutical bar coding, electronic prescriptions, PDAs, and e-mails. The impact of technology is upon us, and for some, it is overwhelming. Everyone — from patients and administrators to legislators — is calling for an overhaul of the health-care system, encouraging us to embrace the world of computers. The premise is that digitalization will help us reduce medical errors and improve quality of care.

Some would say that to keep pace with the complexities of medicine and continue to improve quality of care, we will have to make wise investments in new technologies. The Institute of Medicine's 2001 report put this flatly: ". . .information technology must play a central role in the redesign of the health-care system if a substantial improvement in quality is to be achieved over the coming decade." In March 2003, the U.S. House of Representatives' Ways and Means Committee passed the Patient Safety Improvement Act. This legislation proposed to develop voluntary national standards for the interoperability of health-care information systems, specify medical terminology, and evaluate technologies such as computerized physician order entry and medication bar coding. The ultimate goal was to reduce the medical error rate.

While we take apart every process, every communication, and every interaction in health care and put it back together using digitalization and automation, we have to ask ourselves fundamental questions: Will this technology improve the quality of care for my patient? Will it increase efficiencies in our medical system? And most important, will this new technology reduce medical errors? . . . Will it? . . . I don't know. . . . Maybe.

Because of our reluctance to change, the average hospital or doctor's office still uses paper records and documentation that would have seemed familiar even to Dr Moonlight Graham. But, with the increasing complexity of medicine, it is becoming nearly impossible to practice medicine without using electronic systems. In many instances, technology available today can significantly reduce the incidence of adverse events and enhance health care.

However, we must realize that adverse events are most often system errors. More often than not, it's not about hardware or software; it's about people and processes. To capture the full benefits that the system has to offer, health-care organizations need to redesign many core processes. Otherwise, they will simply automate inefficiencies.

Medical errors are a problem. They are a major cause of preventable death in the U.S. Unfortunately, a lot of denial about them exists in the medical industry. A landmark study on medical errors indicated that 70 percent of adverse events were preventable. But most medical errors are systems-related and not attributable to individual negligence or misconduct. The key to reducing medical errors is to improve the systems of delivering care. We have to realize that technology, by itself, is not going to solve medication errors, nor will throwing more money at the problem. It will require a combination of approaches and implementing a system of checks and balances. The airline industry is a good example for health-care professionals to follow. A plane does not fly until its safety has been checked and rechecked.

Most of you are aware of the report released July 28, 2003, from the U.S. General Accounting Office that substantiates the fact that increasing malpractice awards are driving the current medical-liability insurance crisis. We need to continue lobbying for tort reform. We must continue to move away from the culture of blame that surrounds medical errors to create new, proactive systems that spot and prevent potential errors before they occur. Because of its extraordinary complexity, the health-care system is inherently risky, and mistakes will occur. The most common response has been to blame individuals for errors in health care. And, consequently, we some-

"We must continue to move away from the culture of blame that surrounds medical errors to create new, proactive systems that spot and prevent potential errors"

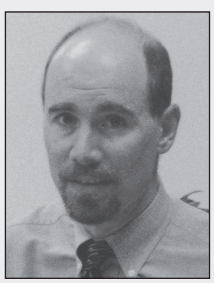
times keep bad outcomes quiet. This deterrent model isn't working.

The U.S. health-care system must move beyond blame to investigate why accidents happen and how the risks of future accidents can be identified. The culture of blame surrounding medical error must be converted into a culture of safety that flushes out information and enables us to prevent or quickly recover from mistakes before they become patient injuries. We must work consistently to monitor ourselves and the way we practice medicine. We need physician-run peer review, and we need to be willing to open ourselves up to criticism and self-evaluation.

Patient safety and reducing medical error should always be our No. 1 concern. We need to enhance our systems to reduce medical mistakes. We need to provide better education for our health-care workers-physicians, nurses, staff, and administrators to avoid the same mistakes in the future. Technology can help us. But it cannot take the place of good decision-making. Dr Jay R. Jackson said it best in the *2004 Handbook of Technology Management in Public Administration:* "What continually vanishes in our quickening dance with technology is often the wisdom of appropriate care, time spent listening to patients and much that really can be called the human interactions, that which is the best of the art of medicine."

Reprinted with permission from the July/August 2004 number of *Mecklenburg Medicine*, a publication of the Mecklenburg County Medical Society.

Warren Pendergast, MD, New Medical Director of North Carolina Physicians Health Program (NCPHP)



Dr Pendergast

Dr Warren Pendergast has been selected as the new medical director of the North Carolina Physicians Health Program (NCPHP). The Board of Directors of the NCPHP selected Dr Pendergast following a national search. He becomes only the third person to lead the NCPHP since its inception in 1988. He succeeds Dr Mike Wilkerson, who left the NCPHP in April to become medical director of the Talbott Recovery Campus in Atlanta, Georgia.

"Serving the NCPHP as associate medical director has been a privilege. It has been personally rewarding to help physicians, physician assistants, and now veterinarians and veterinarian technicians through periods of difficult change to find the promises of recovery," says Dr Pendergast of his career with the NCPHP.

Dr Pendergast, 44, joined the NCPHP as associate medical director in 1999. Before coming to the NCPHP, he served as director of consultation psychiatry at Carolinas Medical Center in Charlotte, NC, and associate medical director for the Carolinas HealthCare System Department of Psychiatry.

Dr Clark Gaither, chairman of the NCPHP Board of Directors and Search Committee, states: "Dr Pendergast has proven himself to be the caring professional that this position demands. He has the experience, empathy, compassion, and training necessary to propel the NCPHP forward with the same goals and ideals set forth since its inception."

"Warren Pendergast has developed evaluation and treatment resources nationally and has maintained himself on the cutting edge of physician health issues. It is obvious he believes in the recovery process, the recovering physician, and the work of physician health programs. I believe the NCPHP is fortunate to have Dr Pendergast available to step into Dr Wilkerson's shoes. Under his leadership and capable stewardship, I believe the NCPHP will continue to be recognized nationally as a leading program in physician health matters," notes a colleague from the Mississippi Professionals Health Program.

Dr Pendergast is board certified in addiction psychiatry by the American Board of Psychiatry and Neurology. He is also a member of the American Society of Addiction Medicine. He completed his psychiatry residency at the University of North Carolina.

In addition to his varied responsibilities at the NCPHP, Dr Pendergast volunteers at the Mental Health Clinic for Wake County, providing psychiatric care to indigent patients. Dr Pendergast also serves on the Board of Directors of the Federation of State Physicians Health Programs. He is currently serving as chair of the Consortium of Professional Recovery Programs.

The NCPHP originated as a physicians health committee of the North Carolina Medical Society. Established as a formal program by the Medical Society in 1988 and administered by the NCMS Foundation, the program subsequently evolved into a not-for-profit, independent organization. The NCPHP is available to aid any physician, physician assistant, veterinarian or veterinarian technician whose health and/or effectiveness has been significantly impaired by alcohol, chemical dependency, behavior issues, aging, or illness.

Letters from Our Readers

Patient Care Suffers Due to Computers

Dear Ms Satinsky: I write concerning your article (Using Information Technology to Improve Patient Care and Communication: A Practical Guide — Part 2) in the NCMB's *Forum*, No. 2, 2004.

Except for medical students and practitioners to impress themselves and try to impress others with their computers, I submit that "Patient Care and Communication" continue to suffer due to computers!

I practiced for 30 years — general surgery. Retired nine years ago. Everything I hear from patients in today's population is the rush they observe/"suffer" as practitioners look at their computers and use mobile (cell) phones.

Looking a patient in the eyes, listening as the patient talks — telling their story, then examining the patient has gone by the board! No wonder medicine/surgery finds itself in the situation it is in today!

God bless!

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

Ms Satinsky Responds

Dear Dr Nicholson: *I share your opinion that the most important aspect of physician-patient communication is looking a patient in the eyes, listening carefully, and then doing an examination. I suggest, however, that computers, cell phones, and other new technology are not the problem; people are the problem.*

In Part 2 of my two-part series on Using Information Technology to Improve Patient Care and Communication: A Practical Guide, I identify physicians throughout the state who believe that information technology has helped them provide better care. Philip Singer, MD, of Hillsborough Medical Group, PA, demonstrated to me the way in which he looks patients directly in the eye while capturing information that he gathers during a visit. Michael Norins, MD, of LeBauer HealthCare in Greensboro, showed me how he engages his patients in his Web-based searches for information on a particular disease or medication. In other practices, physicians who are less adept at using technology than are Drs Singer and Norins ask a nurse or other assistant to enter the information in their electronic health records so they can maintain eye contact at all times.

There is an art to using information technology in a way that has a positive, not a negative, impact on physician-patient interactions; and for those who lack this skill, there are alternatives.

Sincerely,

Margie Satinsky, President
Satinsky Consulting, Durham, North Carolina

Dr Kevin Yow Named Assistant Medical Director of the NCMB

Kevin B. Yow, MD

Kevin Brewer Yow, MD, has joined the staff of the North Carolina Medical Board on a part-time basis as assistant medical director. He works with Jesse E. Roberts, MD, the Board's medical director, in evaluating the medical records and performance of practitioners about whom questions have been raised. Dr Yow is board certified in family medicine and is in the active practice of family and emergency medicine.

A native of North Carolina, Dr Yow is a graduate of UNC-Chapel Hill School of Medicine. He completed internship at Pitt County Memorial Hospital in Greenville and residency at Duke University Medical Center. Dr Yow also holds degrees in law and public health. Prior to entering medical school, Dr Yow served as general counsel for the North Carolina Hospital Association and as staff attorney for health care issues for the North Carolina General Assembly.

Commenting on his position with the Board, he said: "I look forward to providing clinical input at the staff level to support the Board in its mission to license, educate, and regulate physicians for the betterment of medical care in North Carolina."

THE NORTH CAROLINA MEDICAL BOARD Presents a Caring, On-Line Primer About the Humanity Essential to Medical Practice

Fondly, Carolyn: Letters to a Young Physician

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

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

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

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

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

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

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

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

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

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

[Introductory page for the *Fondly Carolyn* series as it appears on the NCMB Web site]

Fondly, Carolyn: Letters to a Young Physician

Dr Carolyn E. Hart

Carolyn E. Hart, MD, practices neurology in Charlotte, North Carolina. She earned her medical degree from Emory University School of Medicine in Atlanta and did her postgraduate specialty training at the Johns Hopkins University Hospital in Baltimore. In 2002, she served as president of the Mecklenburg County Medical Society and decided to take the opportunity of preparing the monthly president's message for the Society's publication, *Mecklenburg Medicine*, to present a series of letters to a medical student, W, one of whose parents is a physician and both of whom are friends of hers. Her thoughts, so clearly and simply expressed, unfold as a thoughtful and caring primer of sorts, laced with wisdom, a gentle and conversational guide for health care professionals at any point in their careers.

Dr Hart and *Mecklenburg Medicine* were kind enough to allow publication of the letters, slightly revised and titled *Fondly, Carolyn*, in the *Forum*, the quarterly publication of the North Carolina Medical Board, soon after their appearance in *Mecklenburg Medicine*. The series was so well received that the Board's Public Affairs Department asked permission to publish it on line as a permanent part of the Board's Web site, making it available to members of health care professions and students nationwide. Dr Hart and *Mecklenburg Medicine* graciously agreed. What appears here has been further revised by Dr Hart for on-line publication.

We thank Dr Hart and *Mecklenburg Medicine* for the opportunity to offer the *Fondly, Carolyn* series to the widest possible audience.

Letters to a Young Physician:

NCMB 2004

NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
May - June 2004

DEFINITIONS

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

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

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

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

NA:
Information not available.

NCPHP:
North Carolina Physicians Health Program.

RTL:
Resident Training License.

Revocation:
Cancellation of the authorization to practice.

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

Suspension:
Temporary withdrawal of the authorization to practice.

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

Voluntary Dismissal:
Board action dismissing a contested case.

Voluntary Surrender:
The practitioner's relinquishing of the authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.

ANNULMENTS

NONE

REVOCATIONS

AMSELLEM, David, MD
Location: Goldsboro, NC (Wayne Co)
DOB: 6/06/1946
License #: 0000-20869
Specialty: PYM/N
Medical Ed: University Montpellier, France (1973)
Cause: The Board summarily suspended Dr Amsellem's license in March 2004 due to his mental impairment. At a hearing in May 2004, the Board concluded Dr Amsellem was unable to practice with reasonable skill and safety by reason of illness and/or a physical or mental abnormality.
Action: 7/29/2004. Findings of Fact, Conclusions of Law, and Order issued: Dr Amsellem's license is revoked.

HODA, Syed Tanweerul, MD
Location: Inner Grove Heights, MN
DOB: 2/05/1966
License #: 0097-00590
Specialty: IM/FP (as reported by physician)
Medical Ed: Dow Medical College, Karachi, Pakistan (1991)
Cause: In charges filed in March 2004, it was alleged by the Board that Dr Hoda had violated his Consent Order with the Board and had had action taken against his license by Minnesota. He did not appear for the scheduled hearing on these matters on 6/16/2004. The Board found he had violated the Consent Order of January 2002 by which his license was suspended, the suspension being stayed if he complied with conditions, including not prescribing via the Internet for anyone he had not examined unless he had a previous physician-patient relationship with them. This Consent Order was based on his work with Virtual Medical Group. In September 2002, Dr Hoda entered into a Consent Order with the Minnesota Board due to his approving a prescription in March 2002 via the Internet for a person he had not examined. This latter prescription was done within the 60-day stayed suspension period of his North Carolina Consent Order.
Action: 6/22/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Hoda's North Carolina medical license is revoked.

JONES, Miles James, MD
Location: Clayton, GA
DOB: 11/22/1952
License #: 0099-00557
Specialty: PTH (as reported by physician)
Medical Ed: Howard University (1977)
Cause: Dr Jones' license has been revoked or suspended by several states and he has been excluded from participating in Medicare and Medicaid for prescribing via the Internet in an inappropriate manner. He did not examine patients for whom prescriptions were written and to whom medications were sent and he had no physician-patient relationship with them.
Action: 5/28/2004. Final Agency Decision issued: Acting on the Proposal for Decision by Administrative Law Judge A.B. Elkins, who heard the matter and who issued his Proposal in March 2004, and following arguments by Dr Jones and the attorney for the Board, the Board ordered the revocation of Dr Jones' license. He may not apply for reinstatement for two years.

KELL, Michael Jon, MD
Location: Atlanta, GA
DOB: 11/01/1949
License #: 0000-35005
Specialty: OS/ADD (as reported by physician)
Medical Ed: Emory University (1985)
Cause: Dr Kell was convicted in Georgia of one count of felony Conspiracy to Defraud the State, one count of felony Medicaid Fraud, one count of felony False Writings, and three counts of felony Tax Evasion.
Action: 7/02/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Following a hearing on 6/16/2004, the Board revoked Dr Kell's license based on the felony convictions in Georgia.

SUSPENSIONS

MURNANE, John Eugene, III, MD
Location: Phoenix, AZ
DOB: 11/16/1951
License #: 0000-25733
Specialty: AI/EM (as reported by physician)
Medical Ed: Medical College of Virginia (1979)
Cause: Dr Murnane has action taken against his licenses in Arizona and Virginia. In 2000, he entered an agreement with the Arizona Board to abstain from alcohol but in March 2002 a random screening test found him positive for alcohol use. As a result, Arizona suspended his license in May 2002. He surrendered his license in Arizona in December 2002. In June 2002, Virginia suspended his Virginia license due to the action in Arizona. In March 2003, his request for reinstatement of his Virginia license was denied.
Action: 6/30/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Murnane's North Carolina license is indefinitely suspended.

See Consent Orders:
AARON, Maureen Margaret, MD
CROSS, Harry Giles, Jr, Physician Assistant
HAMBLETON, Scott Lewis, MD
HOOPER, Jeffrey Curtis, MD
JOHNSON, Welburne Dewitt, II, MD
MILTON, Bernard Gerald, MD
NIEMEYER, Meindert, MD
PATEL, Rakesh Dahyabhai, MD
POLLACK, Sheldon Victor, MD
SKIPPER, Michelle Taylor, Nurse Practitioner

SUMMARY SUSPENSIONS

ECHOLS, Everett Raphael, II, MD
Location: Rockingham, NC (Richmond Co)
DOB: 6/12/1954
License #: 0095-00562
Specialty: FP/P (as reported by physician)
Medical Ed: Meharry Medical School (1981)
Cause: The Board has information that Dr Echols is prescribing dangerous drugs to individuals over the Internet without first examining those individuals to determine if the drugs are medically indicated and are safe for use by the individuals. Dr Echols' offending conduct is described in detail in the Notice of Charges and Allegations filed by the Board on 6/16/2004.
Action: 6/16/2004. Order of Summary Suspension of License issued: Dr Echols' North Carolina medical license is summarily suspended effective on service of the Board's Order.

CONSENT ORDERS

AARON, Maureen Margaret, MD
Location: Martinsville, VA
DOB: 6/11/1945
License #: 0000-25685
Specialty: FP (as reported by physician)
Medical Ed: University of Saskatchewan (1968)
Cause: In January 2004, the Virginia Board of Medicine placed Dr Aaron's medical license on indefinite probation subject to conditions, including her completion of a comprehensive course of medical record keeping within six months, her keeping of complete and accurate medical records, and unannounced review of her controlled substance records by the Board.
Action: 7/02/2004. Consent Order executed: Dr Aaron's North Carolina license is indefinitely suspended, said suspension being stayed on condition she comply with the Virginia Order and other requirements.

ALLEN, Aaron Russell, MD
Location: Anaheim, CA
DOB: 1/22/1942
License #: 0000-35576
Specialty: N/CN (as reported by physician)
Medical Ed: University of Southern California, Los Angeles (1971)
Cause: In April 2001, while working in Lumberton, NC, and Myrtle Beach, SC, Dr Allen pre-signed three prescription pads that were delivered to the Myrtle Beach Medical Center to allow two physicians there who did not have valid DEA registrations to issue prescriptions. He mistakenly believed it was lawful to do this after being erroneously advised by the MBMC facility manager that the DEA had approved the pre-signing. Approximately 13 patients and two employees were issued Dr Allen's pre-signed prescriptions by two physicians at MBMC. Dr Allen never completed a physical on these persons to determine a diagnosis and treatment prior to pre-signing the prescription blanks. Dr Allen says he checked by telephone with the physicians before they issued the prescriptions and later reviewed and co-signed the records. Dr Allen cooperated with the Board's investigation. In late 2002, Dr Allen relocated to California and does not plan to return to North Carolina to practice.
Action: 5/21/2004. Consent Order executed: Dr Allen is reprimanded, must comply with other conditions.

BOVELLE, Renee Claudia, MD
Location: Bowie, MD
DOB: 12/30/1963
License #: 2001-01177
Specialty: OPH (as reported by physician)
Medical Ed: UCLA Drew School of Medicine (1992)
Cause: Dr Bovelle was reprimanded by the Nevada Board of Medicine for engaging in medical practice in Nevada with an inactive license on three occasions.
Action: 7/01/2004. Consent Order executed: Dr Bovelle is reprimanded.

BOX, James Brent, MD
Location: Calhoun, GA
DOB: 7/24/1959
License #: 0000-33622
Specialty: IM (as reported by physician)
Medical Ed: Mercer University (1986)
Cause: In October 2003, Dr Box was fined $1,000 by the Georgia Board for employing a physician assistant for a period of three years during which the physician assistant has allowed her license to lapse.
Action: 7/02/2004. Consent Order executed: Dr Box is reprimanded.

CIRILLO, Robert L. Jr, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 1/25/1967
License #: 0099-00187
Specialty: VIR/DR (as reported by physician)
Medical Ed: Georgetown University (1994)
Cause: In submitting his license application to the North Carolina Medical Board in January 1999, Dr Cirillo failed to reveal on the application form that he had attempted to withdraw his application for a Florida license in September 1998 following an interview with the Florida Credentials Committee, and that, in November 1998, the Florida Board filed notice of its intent to deny his application. The North Carolina application form asked specifically for such information.
Action: 6/16/2004. Consent Order executed: Dr Cirillo is reprimanded.

CROSS, Harry Giles, Jr, Physician Assistant
Location: Southern Pines, NC (Moore Co)
DOB: 3/11/1960
License #: 0001-01139
Specialty: IM/GER (as reported by physician)
PA Education: Wake Forest University School of Medicine PA Program (1989)
Cause: In May 2001, Mr Cross pled guilty to one count of conspiracy to submit false claims and two counts of making false claims. All of these were felonies. He was sentenced to 27 months imprisonment and three years of supervised probation by the U.S. District Court for the Middle District of North Carolina. He was also assessed a fine of $200,000. In December 2001, he surrendered his PA license. He has now completed his term of imprisonment and paid all fines and restitution.
Action: 6/17/2004. Consent Order executed: Mr Cross' PA license was suspended from December 1, 200l, until the date of issuance shown on the license issued pursuant to this Consent Order [6/17/2004]; his license is reissued to expire on the date shown on the license [12/17/2004]; he shall practice only in a setting first approved by the president of the Board; must comply with other requirements.

EDGE, Kendra Dian, Physician Assistant
Location: Winston-Salem, NC (Forsyth Co)
DOB: 10/15/1975
License #: 0001-02842
PA Education: NA
Cause: Ms Edge practiced under the supervision of Dr James Spencer from October 1999 through November 2003 without submitting the required Intent to Practice form with the Board. She then practiced from December 2003 to February 2004 under the supervision of Dr David Smull prior to submitting the required Intent to Practice form. On 2/19/2004, she submitted the proper Intent to Practice form.
Action: 6/18/2004. Consent Order executed: Ms Edge is reprimanded.

ENGLISH, Thaddeus David, Physician Assistant
Location: Elizabeth City, NC (Pasquotank Co)
DOB: 8/01/1972
License #: 0001-03217
PA Education: University of Pennsylvania, Lock Haven, PA Program (2000)
Cause: Between January 2002 and February 2004, Mr English prescribed controlled substances to a physician co-worker suffering from back pain. He failed to document the prescriptions, failed to keep a chart on the co-worker, and failed to inform his supervising physician of his action.
Action: 5/20/2004. Consent Order executed: Mr English is reprimanded; he must provide a copy of the Consent Order to all current and prospective employers; must abide by all laws, rules, and regulations in future.

FOLKERTS, AnnaMaria, Physician Assistant
Location: Elon, NC (Alamance Co)
DOB: 8/24/1961
License #: 0001-02206
PA Education: College of West Virginia (1996)
Cause: In December 2002, the Board issued a finding that Ms Folkerts engaged in unprofessional conduct by providing false and mislead-

ing responses on her application for a PA license by not disclosing she has been disciplined by the New Jersey Board of Medical Examiners. The Board suspended her license indefinitely, holding Ms Folkerts could not reapply for reinstatement until December 2003. She applied for reinstatement in April 2004.
Action: 5/20/2004. Consent Order executed: Ms Folkerts is issued a PA license to expire on the date shown on the license [12/31/2004]; she shall meet with Board members in November 2004; before that meeting, she shall obtain 20 hours of Category 1 CME and she shall provide an evaluation of her performance by her supervising physician; must comply with other conditions.

GEORGE, Pazhayidathe K., MD
Location: Zebulon, NC (Wake Co)
DOB: 5/16/1939
License #: 0000-27457
Specialty: IM/GE (as reported by physician)
Medical Ed: Trivandrum, India (1964)
Cause: Relative to testimony given at the time, Charges and Allegations that Dr George committed boundary violations with three female patients were dismissed in October 2003. Dr George testified at the hearing that, from 1992 to 2003, he did breast examinations on female patients outside their bra or outer clothing and these examinations were below the minimum standard of care. He further testified he had recorded these examinations in the medical record without noting how they were conducted. He admitted any physician reviewing these records would assume an appropriate breast examination had been conducted. Those actions of Dr George constitute unprofessional conduct. He has agreed to stop performing breast examinations and to complete 10 hour of CME about breast examination so he may better recognize symptoms that require referral for a proper breast examination.
Action: 5/04/2004. Consent Order executed: Dr George is reprimanded; he shall obtain 10 hours of Category I CME on breast examinations; must comply with other conditions.

GOODWIN, William Pierce, MD
Location: Jacksonville, NC (Onslow Co)
DOB: 9/18/1949
License #: 0099-00849
Specialty: FP (as reported by physician)
Medical Ed: Meharry Medical College (1976)
Cause: Relative to the Charges and Allegations dated 5/19/2004. In November 2002, the Georgia State Board of Medical Examiners and Dr Goodwin entered a Consent Order in which Dr Goodwin agreed to attend and successfully complete a mini-residency in appropriate prescribing. In July, 2002, the Georgia Board reprimanded and fined him for failing to complete the required mini-residency. He was also ordered to attend the program as originally required. Dr Goodwin completed the program, however, only after the deadline to which he agreed in his second Consent Order with the Georgia Board. In September 2003, he was reprimanded and fined again by the Georgia Board.
Action: 7/27/2004. Consent Order executed: Dr Goodwin is reprimanded.

GRAU, Gerard Dean, MD
Location: Fort Lauderdale, FL
DOB: 12/15/1945
License #: 0000-25299
Specialty: PS (as reported by physician)
Medical Ed: University of Virginia (1971)
Cause: In 2001, Dr Grau entered into a Consent Agreement with the Florida Board that assessed a $5,000 fine against him based on allegations involving deficiencies relating to paperwork required in managing the stock of office medications at his plastic surgery center. He neither admitted nor denied the allegations.
Action: 5/07/2004. Consent Order executed: Dr Grau is reprimanded.

HALL, Bruce Parker, MD
Location: Orchard, NY
DOB: 6/10/1953
License #: 0094-00516
Specialty: DR (as reported by physician)
Medical Ed: University of Rochester (1981)
Cause: Dr Hall was placed on probation for two years by the New York Board to resolve allegations he practiced below the standard of care. He was required to practice under supervision and to complete a specific CME course.
Action: 6/09/2004. Consent Order executed: Dr Hall is reprimanded and must submit a complete application for a license before resuming practice in North Carolina.

HAMBLETON, Scott Lewis, MD
Location: Shelby, NC (Cleveland Co)
DOB: 4/15/1963
License #: 2000-00444
Specialty: FP/EM (as reported by physician)
Medical Ed: University of Tennessee (1994)
Cause: Dr Hambleton has a history of substance abuse. In December 2002, he signed a Consent Order with the Board admitting his attempt in February 2002 to obtain controlled substances for his own use in by writing a prescription to a fictitious name. He surrendered his license in February 2002. He was then reissued a license under the December 2002 Consent Order, which required he refrain from all use of mind- or mood-altering substances or alcohol unless lawfully prescribed. In March 2004, a bodily fluid sample was collected from Dr Hambleton by an NCMB investigator and Dr Hambleton subsequently admitted he had been ingesting hydrocodone for at least two months in violation of his Consent Order. He surrendered his license on 3/18/2004.
Action: 6/02/2004. Consent Order executed: Dr Hambleton's license is suspended indefinitely.

HATCHER, James Jackson, MD
Location: Virginia Beach, VA
DOB: 3/02/1951
License #: 0000-21961
Specialty: IM/PCC (as reported by physician)
Medical Ed: University of Virginia (1976)
Cause: In June 2003, Dr Hatcher was formally reprimanded by the Virginia Board of Medicine for improper prescribing.
Action: 5/26/2004. Consent Order executed: Dr Hatcher is reprimanded.

HOOPER, Jeffrey Curtis, MD
Location: Greensboro, NC (Guilford Co)
DOB: 9/21/1964
License #: 0097-00286
Specialty: FP (as reported by physician)
Medical Ed: Vanderbilt School of Medicine (1995)
Cause: Dr Hooper has been an anonymous participant in the NCPHP since 1997 due to alcohol abuse. In early 2004, he tested positive for alcohol and at the direction of the NCPHP he entered a treatment program. At this point, the Board gave Dr Hooper the choice of surrendering his license or having it summarily suspended. He surrendered his license in March 2004 and remains in a residential treatment program.
Action: 5/27/2004. Consent Order executed: Dr Hooper's license is indefinitely suspended from this date.

HOWARD, Jerome, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 3/01/1944
License #: 0000-18523
Specialty: FP (as reported by physician)
Medical Ed: State University of New York Upstate, Syracuse (1970)
Cause: From October 2001 to July 2002, Dr Howard wrote prescriptions for several controlled substances for a close relative. He has acted as the primary care physician for that relative for over 20 years and prescribed numerous medications, including controlled substances, to that person. In November 2002, Dr Howard prescribed Ritalin(r) to another close relative, for whom he has also acted as the primary treating physician. He admits this is unprofessional conduct.
Action: 5/06/2004. Consent Order executed: Dr Howard is reprimanded; he shall comply with the Board's Position Statements on prescribing and on treating family members.

JOHNSON, Welburne Dewitt, II, MD
Location: Cookeville, TN
DOB: 5/18/1956
License #: 0000-29126
Specialty: EM/FP (as reported by physician)
Medical Ed: Northwestern University (1980)
Cause: In November 2003, following previous action on Dr Johnson's case, the Tennessee Board of Medical Examiners suspended Dr Johnson's license for three years by Consent Order based on allegations that he engaged in inappropriate behavior with patients and staff and was diagnosed with sexual addiction and narcissistic personality disorder. Dr Johnson neither admitted nor denied the allegations but agreed to the Consent Order. In October 2003, he surrendered his Kentucky license in lieu of revocation based on actions of the Tennessee Board.
Action: 6/16/2004. Consent Order executed: Dr Johnson's license is suspended indefinitely and he shall not be eligible to reapply for at least two years; he shall comply with the orders of both Tennessee and Kentucky; must comply with other conditions.

MacCARTHY, Justin Daniel, MD
Location: Jacksonville, NC (Onslow Co)

DOB: 4/10/1942
License #: 0094-00908
Specialty: OTO (as reported by physician)
Medical Ed: National University of Ireland (1966)
Cause: On 8/26/2002, Dr MacCarthy pled guilty to four counts of failure to pay/file income tax and was sentenced to 36 months of supervised probation, including supervised community service, and to pay restitution of $2,679. This conduct occurred when Dr MacCarthy was experiencing significant personal and financial problems.
Action: 6/02/2004. Consent Order executed: Dr MacCarthy is reprimanded.

MARTIN, Wayne Robert, MD
Location: Newland, NC (Avery Co)
DOB: 7/08/1940
License #: 0000-18277
Specialty: FSM/OS (as reported by physician)
Medical Ed: University of Colorado (1968)
Cause: When practicing in Montana in 2003, Dr Martin was censured by the Montana Board and ordered to pay a fine of $1,000. They found his conduct not to be within the standard of care when he sutured a patient's self-inflicted lacerations without the use of anesthesia in an effort to dissuade the patient from injuring himself in future
Action: 6/16/2004. Consent Order executed: Dr Martin is reprimanded for his conduct in the referenced case and for having his license acted against by Montana.

MILTON, Bernard Gerald, MD
Location: Braidwood, IL
DOB: 11/30/1944
License #: 0000-33098
Specialty: FP (as reported by physician)
Medical Ed: University of Maryland (1973)
Cause: Under a Consent Order dated 3/21/2003, Dr Milton's license in Illinois was suspended indefinitely by the Illinois Board for a minimum of two years based on information he suffers from mental illness, including bipolar disease, that impairs his ability to practice. As a result of his illness, he failed to appear at his office for appointments for some three months, yet he continued to authorize medical treatments and new prescriptions for patients. He failed to keep dispensing logs and he allowed unlicensed persons to work as nurses.
Action: 6/03/2004. Consent Order executed: Dr Milton's North Carolina license is suspended indefinitely and he shall not be eligible to reapply for at least two years.

NIEMEYER, Meindert Albert, MD
Location: Elon, NC (Alamance Co)
DOB: 6/16/1956
License #: 0000-30440
Specialty: FP (as reported by physician)
Medical Ed: Faculty of Medicine, National University of Utrecht (1981)
Cause: Regarding the Charges and Allegations against Dr Niemeyer filed 1/13/2004. Dr Niemeyer has been prosecuted criminally in the District Court of Alamance County on substantially the same allegations as contained in the Board's Charges labeled "Boundary Violation." Dr Niemeyer was convicted of six counts of misdemeanor assault on a female and one count of misdemeanor false imprisonment. He was acquitted of two counts of misdemeanor assault on a female. Dr Niemeyer has also sold Juice Plus+® from his medical office to patients and has encouraged them to become distributors of the product. He surrendered his license in March 2003.
Action: 5/20/2004. Consent Order executed: Dr Niemeyer's license is suspended indefinitely effective March 20, 2003, the date of his license surrender.

PATEL, Rakesh Dahyabhai, MD
Location: Schiller Park, IL
DOB: 9/30/1966
License #: 0095-00177
Specialty: IM/PD (as reported by physician)
Medical Ed: Boston University (1990)
Cause: In 2003, Dr Patel was placed on probation for one year by the Arizona Medical Board for inappropriate sexual intimacies with patients. Arizona found that a patient alleged Dr Patel rubbed her shoulders and back, asked her how her marriage was going, then began to touch and rub her breasts and became aroused; that the patient later sued Dr Patel for malpractice; that Dr Patel denied the allegations and settled the lawsuit; and that a second patient made similar allegations against Dr Patel. As a result of its investigations and proceedings, Arizona placed Dr Patel on probation and required he obtain 20 hours of approved CME on sexual intimacy/boundary issues.
Action: 5/20/2004. Consent Order executed: Dr Patel's license is suspended for 12 months; suspension is stayed on terms and conditions, including that he obtain 20 hours of CME on sexual intimacy/boundary issues within 90 days (which may be the same CME completed pursuant to his Arizona discipline) and that he obtain practice site approval by the Board's president before resuming practice in North Carolina. [Site approval has been granted under the Consent Order for Dr Patel to practice at the Rocky Mount Family Medical Center in Rocky Mount, NC.]

PEISEL, Francis James, MD
Location: Wilmette, IL
DOB: 7/11/1950
License #: 0000-21096
Specialty: AN (as reported by physician)
Medical Ed: University of Kentucky (1975)
Cause: In 2001, the Kentucky Board of Medicine entered an Order denying Dr Peisel's application for a license due to his providing false information on his application.
Action: 5/06/2004. Consent Order executed: Dr Peisel is reprimanded; must comply with other conditions.

PHILIPS, Sherif Antoun, MD
Location: Greenville, NC (Pitt Co)
DOB: 6/24/1958
License #: 0095-01056
Specialty: NEP/IM (as reported by physician)
Medical Ed: Ain Shams Medical School, Egypt (1981)
Cause: In May 2000, Dr Philips was medical director of Total Renal Care in New Bern, NC. He was not Patient A's attending physician, but was on duty as medical director when Patient A received hemodialysis. The procedure was begun on Patient A and he was left unattended by a technician. Later, an employee noticed a pool of blood under Patient A's chair and, after examination, found Patient A was in cardiac arrest. The employee called for aid and a nurse practitioner began CPR until an EMT arrived. Dr Philips subsequently learned Patient A was in cardio-respiratory arrest and needed help, but he did not attempt to aid the patient in any way prior to the arrival of the EMT. The patient was moved to Craven County Hospital, where he died of blood loss.
Action: 5/21/2004. Consent Order executed: Dr Philips is reprimanded.

POLLACK, Sheldon Victor, MD
Location: Toronto, Canada
DOB: 5/01/1949
License #: 0000-23641
Specialty: D (as reported by physician)
Medical Ed: University of Toronto (1974)
Cause: Dr Pollack was disciplined by the College of Physicians and Surgeons of Ontario for injecting non-approved injectable grade liquid silicone into patients for lip augmentations after informing the Ontario College he would not do so. In September 2003, the Ontario College suspended Dr Pollack's license for six months; placed terms, conditions, and limitations on his license; and fined him $2,500.
Action: 5/21/2004. Consent Order executed: Dr Pollack's license is suspended for six months from the date of the Consent Order; prior to resuming practice in North Carolina, he must demonstrate compliance with the Order of Discipline of the Ontario College and his good standing with the College.

SKIPPER, Michelle Taylor, Nurse Practitioner
Location: Laurinburg, NC (Scotland Co)
DOB: 10/27/1967
Approval #: NP 0002.00849
NP Education: NA
Cause: In a Settlement Agreement with Ms Taylor signed on 2/01/2004, the NC Board of Nursing found that Ms Taylor violated the Nursing Practice Act by prescribing medications for a co-worker without her supervising physician's knowledge. The Nursing Board suspended Ms Taylor's license for three months and will reinstate it thereafter on probationary conditions.
Action: 6/03/2004. Consent Order executed: Ms Taylor's approval as an NP is suspended for three months (2/01/2004-5/01/2004) and she must reapply with the NCMB for approval as an NP after reinstatement by the Nursing Board; she must comply with all the terms of her probation with the Nursing Board.

TAYLOR, David Howarth, MD
Location: Searcy, AR
DOB: 8/31/1953
License #: 0000-28814
Specialty: GE/IM (as reported by physician)
Medical Ed: University of Arkansas (1981)
Cause: In March 2003, Dr Taylor entered into an agreement with the

Texas State Board of Medical Examiners to restrict his license due to complications/adverse outcomes with two patients undergoing endoscopic procedures.
Action: 6/16/2004. Consent Order executed: Dr Taylor is reprimanded.

THOMPSON, Robert Bruce, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 2/29/1956
License #: 0000-40006
Specialty: N/APM (as reported by physician)
Medical Ed: University of Miami School of Medicine (1987)
Cause: Amendment to Consent Order of7/25/2003. The Board voted to allow Dr Thompson to engage in clinical practice under certain terms and conditions.
Action: 6/19/2004. Consent Order Amendment executed: Dr Thompson shall practice with R. L. Follmer, MD, at Carolinas Medical Center for a two-month mini-fellowship; Dr Follmer shall supervise and monitor Dr Thompson's clinical practice; Dr Thompson shall not practice more than 40 hours per week; Dr Follmer must submit a letter to the Board indicating he has read the Consent Order of July 2003 and this Amendment; all other provisions of the July 2003 Consent Order remain in effect.

WADDELL, Roger Dale, MD
Location: Apex, NC (Wake Co)
DOB: 11/17/1954
License #: 0000-30105
Specialty: GP (as reported by physician)
Medical Ed: University of Colorado School of Medicine (1981)
Cause: In 1999, Dr Waddell met with the NCPHP after being convicted for the second time of DWI. He admitted he had a history of alcoholism and entered an inpatient treatment program. Between May 2000 and November 2001, he continued to consume alcohol despite his work with the NCPHP and additional treatment. In May 2000, the NCPHP broke Dr Waddell's anonymity and reported his problems to the Board. After several meetings with the Board, he surrendered his license in November 2001. In August 2002, he entered treatment at Metro Atlanta Recovery Residences and stayed in residence there for 15 months. He has continued to maintain and abide by a contract with the NCPHP.
Action: 6/23/2004. Consent Order executed: Dr Waddell's license is reissued to expire on the date shown on the license [10/31/2004]; unless lawfully prescribed by someone else, he shall refrain from the use of all mind- or mood-altering substances, including alcohol; on request, he shall supply bodily fluids or tissues for drug/alcohol screening; he shall maintain and abide by a contract with the NCPHP; he shall practice no more than 20 hours a week; must comply with other conditions.

MISCELLANEOUS ACTIONS

ROSNER, Michael John, MD
Location: Hendersonville, NC (Henderson Co)
DOB: 12/04/1946
License #: 0000-26865
Specialty: NS/NCC (as reported by physician)
Medical Ed: Virginia Commonwealth University School of Medicine (1972)
Cause: The Board summarily suspended Dr Rosner's license in November 2002. Following a hearing in January 2003, at which the Board determined Dr Rosner had performed surgery that was not medically indicated on eight patients, the Board indefinitely suspended his license on 2/05/2003. An initial request for reinstatement of Dr Rosner's license was denied in February 2004. A hearing was requested by Dr Rosner and was held on 6/16-17, 2004. As a result of that hearing, the Board determined Dr Rosner is qualified for a license.
Action: 7/23/2004. Findings of Fact, Conclusions of Law, and Order issued: The Board issues Dr Rosner a license to expire on the date shown on the license [1/31/2005]; whenever Dr Rosner proposes to perform surgery for hypoplastic posterior fossa (HPF), he shall ensure the patient has first obtained a second opinion from another licensed North Carolina neurosurgeon approved by the Board; the second opinion does not have to agree that surgery is indicated for Dr Rosner to operate; Dr Rosner may perform the HPF surgery only when included in a formal research project under the oversight of an institutional review board.

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

DENIALS OF LICENSE/APPROVAL

MACKEY, William Frederick, Jr, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 10/20/1944
License: 0000-19801
Specialty: CHP/P (as reported by physician)
Medical Ed: University of Tennessee, Memphis, College of Medicine (1969)
Cause: At the scheduled hearing on 5/21/2004 on Dr Mackey's request for reinstatement of his license, summarily suspended in March 2000 and indefinitely suspended in April 2000, the Board found Dr Mackey unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, or any other type of material or by reason of a physical or mental abnormality. It also found Dr Mackey did not present sufficient cause in his last minute motion for continuance of the hearing to excuse his absence from the hearing.
Action: 5/28/2004. Order issued: Dr Mackey's appeal is dismissed for lack of prosecution and his application for reinstatement is denied.

STANTON, Eugene Stefan, MD
Location: Cocoa Beach, FL
DOB: 3/04/1922
License #: 0000-34744
Specialty: GS/GYN (as reported by physician)
Medical Ed: Institute of Medicine, Cluj, Romania (1946)
Cause: License has been inactive since March 1998 and Dr Stanton has not satisfied the Board that he has maintained his skills.
Action: 4/13/2004. Application for reinstatement of license denied.

SURRENDERS

AUSTERMEHLE, Paul Edward, Physician Assistant
Location: Asheville, NC (Buncombe Co)
DOB: 8/04/1966
License #: 0001-02541
PA Education: Philadelphia College Textile (1997)
Action: 7/23/2004. Voluntary surrender of North Carolina PA license.

CYNN, Steven Jae, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 11/12/1936
License #: 0000-19592
Specialty: FP/NTR (as reported by physician)
Medical Ed: Yonsei University, Korea (1961)
Action: 6/23/2004. Voluntary surrender of medical license.

GILMER, Vince Donald, MD
Location: Fletcher, NC (Henderson Co)
DOB: 9/05/1962
License #: 2000-01139
Specialty: FP (as reported by physician)
Medical Ed: University of South Alabama (1997)
Action: 7/06/2004. Voluntary surrender of North Carolina medical license.

WHITMER, Gilbert Gomer, Jr, MD
Location: Rocky Mount, NC (Edgecombe Co)
DOB: 9/04/1961
License #: 0000-36854
Specialty: ORS/SOH (as reported by physician)
Medical Ed: The Johns Hopkins University School of Medicine (1987)
Action: 7/08/2004. Voluntary surrender of North Carolina medical license.

CONSENT ORDERS LIFTED

FORD, Angela B., Physician Assistant
Location: Oak Ridge, NC (Guilford Co)
DOB: 9/08/1969
License #: 0001-02891
PA Education: NA
Action: 7/02/2004. Order issued lifting Consent Order of 7/31/2002.

RODINE, Mary Kim, MD
Location: Weaverville, NC (Buncombe Co)
DOB: 11/30/1954
License #: 0000-27295
Specialty: IM (as reported by physician)
Medical Ed: University of Illinois (1980)
Action: 6/14/2004. Order issued lifting Consent Order of 11/14/2003.

TATE, Denny Cook, MD
Location: Graham, NC (Alamance Co)
DOB: 9/07/1958
License #: 0000-29427
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1984)
Action: 5/06/2004. Order issued lifting Consent Order of 8/30/1999.

WODECKI, Tadeusz K., MD
Location: Stone Mountain, GA
DOB: 3/04/1954
License #: 2003-01312
Specialty: IM/GP (as reported by physician)
Medical Ed: Silesian Academy of Medicine, Zabrze, Poland (1979)
Action: 6/30/2004. Order issued lifting Consent Order of 11/25/2003.

WOLEBEN, Martyn Dean, MD
Location: Goldsboro, NC (Wayne Co)
DOB: 11/13/1956
License #: 0097-00428
Specialty: OBG (as reported by physician)
Medical Ed: University of Mississippi School of Medicine (1988)
Action: 5/10/2004. Order issued lifting Consent Order of 11/03/2003.

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

BREWER, Thomas Edmund, Jr, MD
Location: Denton, NC (Davidson Co)
DOB: 11/04/1956
License #: 0000-28141
Specialty: EM/OM (as reported by physician)
Medical Ed: Wake Forest University School of Medicine (1983)
Action: 5/20/2004. Temporary/dated license extended to expire 1/31/2005.

BUZZANELL, Charles Anton, MD
Location: Asheville, NC (Buncombe Co)
DOB: 9/23/1956
License #: 0098-00481
Specialty: AN/APM (as reported by physician)
Medical Ed: Georgetown University School of Medicine (1984)
Action: 5/20/2004. Temporary/dated license extended to expire 1/31/2005.

CARLSON, James Lennart, MD
Location: Cerro Gordo, NC (Columbus Co)
DOB: 11/20/1959
License #: 2002-00010
Specialty: FP (as reported by physician)
Medical Ed: Medical College of Wisconsin (1991)
Action: 7/22/2004. Temporary/dated license extended to expire 11/30/2004.

GOTTSCHALK, Bernard Joseph, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 5/10/1955
License #: 0000-30162
Specialty: IM/ON (as reported by physician)
Medical Ed: University of Pittsburgh School of Medicine (1981)
Action: 722/2004. Temporary/dated license extended to expire 3/31/2005.

HEINER, Daniel Edward, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 7/06/1964
License #: Resident Training License
Specialty: ORS (as reported by physician)
Medical Ed: University of Kansas (1997)
Action: 7/22/2004. Undated RTL issued.

LAVINE, Gary Harold, MD
Location: New Bern, NC (Craven Co)
DOB: 11/04/1964
License #: 2001-00403
Specialty: EM (as reported by physician)
Medical Ed: University of Southern Alabama (1983)
Action: 5/20/2004. Temporary/dated license extended to expire 2/28/2005.

LEMAIRE, Pierre-Arnaud Paul, MD
Location: Wilson, NC (Wilson Co)
DOB: 3/24/1960
License #: 0000-39440
Specialty: GS/VS (as reported by physician)
Medical Ed: University of Medicine and Dentistry of NJ, RW Johnson Medical School (1985)
Action: 7/22/2004. Temporary/dated license extended to expire 11/30/2004.

MATTHEWS, Charles Joseph, MD
Location: Raleigh, NC (Wake Co)
DOB: 2/03/1955
License #: 0000-27245
Specialty: N (as reported by physician)
Medical Ed: University of Virginia (1978)
Action: 5/20/2004. Temporary/dated license extended to expire 11/30/2004.

McClelland, Scott Richard, DO
Location: Wilmington, NC (New Hanover Co)
DOB: 7/19/1948
License #: 0000-29064
Specialty: P (as reported by physician)
Medical Ed: Kirksville Osteopathic (1980)
Action: 7/22/2004. Temporary/dated license extended to expire 1/31/2005.

MOIR, Ronald Jeffrey, MD
Location: Morganton, NC (Burke Co)
DOB: 12/30/1956
License #: 0000-31176
Specialty: AN (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1984)
Action: 5/20/2004. Temporary/dated license extended to expire 9/30/2004.

PRESSLY, Margaret Rose, MD
Location: Boone, NC (Watauga 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: 5/20/2004. Temporary/dated license extended to expire 11/30/2004.

STROUD, Joan Marie, Physician Assistant
Location: Gastonia, NC (Gaston Co)
DOB: 4/24/1956
License #: 0001-01476
PA Education: Pennsylvania State University PA Program (1980)
Action: 7/22/2004. Temporary/dated license extended to expire 1/31/2005.

THOMPSON, Robert Bruce, MD
Loction: Charlotte, NC (Mecklenburg Co)
DOB: 2/29/1956
License #: 0000-40006
Specialty: N/APM (as reported by physician)
Medical Ed: University of Miami School of Medicine (1987)
Action: 5/20/2004. Temporary/dated license extended to expire 7/31/2004.
7/22/2004. Full and unrestricted license issued.

WHITE, Steven William, Physician Assistant
Location: Cameron, NC (Moore Co)
DOB: 12/19/1962
License #: 0001-02116
PA Education: Midwestern University (1996)
Action: 5/20/2004. Temporary/dated license extended to expire 1/31/2005.

WODECKI, Tadeusz Kazimierz, MD
Location: Stone Mountain, GA
DOB: 3/04/1954
License #: 2003-01312
Specialty: IM/GP (as reported by physician)
Medical Ed: Silesian Academy of Medicine, Zabrze, Poland (1979)
Action: 5/20/2004. Full and unrestricted license issued.

See Consent Orders:
CROSS, Harry Giles, Jr, Physician Assistant
FOLKERTS, AnnaMaria, Physician Assistant
WADDELL, Roger Dale, MD

DISMISSALS
NONE

CHANGE OF ADDRESS FORM

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

Please print or type. Date:_____

Full Legal Name of Licensee:_____

Social Security #:_____License/Approval #:_____

(Check preferred mailing address)

❑ Business: _____

_____

_____

Phone:(_____)_____Fax:(_____)_____

❑ Home: _____

_____

_____

Phone:(_____)_____Fax:(_____)_____

The Board requests all licensees maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 60 days of a move.

Prsrt Std
US Postage
PAID
Permit No. 1486
Raleigh, NC

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: September 22-24, 2004; October 20-22, 2004; November 17-19, 2004
January 19-21, 2005; February 16-17, 2005

Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)
Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's web site at *www.fsmb.org*. If you have additional questions, please e-mail Kelli Singleton, the Board's GME Coordinator, at *kelli.singletom@ncmedboard.org* or visit the Board's web site at *http://www.ncmedboard.org*.

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

North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609