



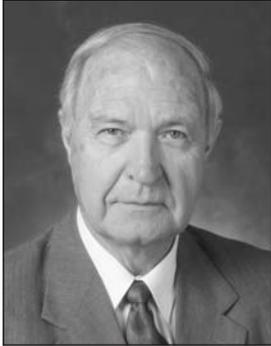
forum

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

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Progress and Achievement
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President's Message

On Collegiality



Robert C. Moffatt, MD

During my first meeting as a member of the North Carolina Medical Board, I participated along with a senior Board member in what the Board terms an "informal interview." We were assigned to talk with two physicians who were having a serious disagreement and had been called to the Board office to discuss the issues. The interview was conducted by the senior member and was skillfully done, while I felt as "green as a gourd." The matter was resolved

with the guidance of the senior board member, who drove home the importance of working together to the contesting physicians. This experience was meaningful to me in several ways. It gave me an insight into how the Board's informal interviews can serve a number of constructive purposes beyond the simple establishing of facts, and it reminded me of the value and purpose of collegiality as a principle of professionalism. It also made me recall the time, years ago, that I received the gift of a textbook that was personally inscribed to me by its author, Dr Jatin P. Shah, Chief of the Head and Neck Service at Memorial-Sloan-Kettering Cancer Center. His note said: "I value our friendship, collegiality and camaraderie." As professionals, we neglect the significance of the concept of collegiality at our peril, and we need to be reminded of its fundamental importance from time to time. It is formally defined as "cooperative interaction between colleagues," but I

simply think of it as "friendly cooperation" and have endeavored in my career to respond to other physicians in keeping with that principle.

On two recent occasions, I have been asked for some advice and guidance on physicians leaving a group practice. There was some discord (what a surprise) as to how to handle certain issues, one of which involved their patients. There was no apparent collegiality—friendly cooperation—reflected in the situation among those involved. In their confrontational state of mind, they lost sight of the basic fact that patients have the right to select their physician. They had to be firmly reminded that several of the Board's position statements are very clear about this matter—and it is also simple common sense. The patient must be given a clear choice and should have 30 days to make that choice. It is in this context that physicians must remember that the patient comes before any personal desires or wishes. It is important to remember our responsibility is first to the patients who have trusted us to care for their health. If the problems among physicians breaking up a practice were dealt with in a collegial manner, that essential concept would certainly not be lost in the maze of dispute.

Aside from such matters as the breaking up of a group, physicians must deal with many other stressful issues: the stress of practice, of finances, of reimbursement decreases, and of rising costs of malpractice insurance. The impact of these can affect our attitudes and our interaction with colleagues and patients. However, they should not cause us to lose sight of the importance of collegiality in every aspect of our professional lives, including dealing with those very stresses. We should remember that al-

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NC MEDICAL BOARD

Raleigh, NC

Vol. XI, No. 3, 2006

The *Forum* of the North Carolina Medical Board is published four times a year. Articles appearing in the *Forum*, including letters and reviews, represent the opinions of the authors and do not necessarily reflect the views of the North Carolina Medical Board, its members or staff, or the institutions or organizations with which the authors are affiliated. Official statements, policies, positions, or reports of the Board are clearly identified.

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

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Editor
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Associate Editor
Dena M. Konkel

E.K. Fretwell, Jr, PhD
Charlotte
Term expires
October 31, 2008

Street Address
1203 Front Street
Raleigh, NC 27609

Robin N. Hunter-Buskey, PA-C
Raleigh
Term expires
October 31, 2006

Mailing Address
PO Box 20007
Raleigh, NC 27619

Donald E. Jablonski, DO
Etowah
Term expires
October 31, 2008

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

Ralph C. Loomis, MD
Asheville
Term expires
October 31, 2008

Fax
(919) 326-0036

Web Site:
www.ncmedboard.org

Michael E. Norins, MD
Greensboro
Term expires
October 31, 2007

E-Mail:
info@ncmedboard.org

though the Oath of Hippocrates has been modified over the centuries, there always remain, in general terms, two fundamental elements: the relationship between physicians and their peers and the relationship between physicians and patients. Those relationships are about collegiality and are essential to the art of medicine.

At the same time, collegiality does not suggest we should overlook difficulties among certain of our peers. There is also a collegial obligation to the profession as a whole and to patients and society. If a physician has a problem that compromises the welfare of the patients, this should be reported to the appropriate and responsible authority (eg, hospital, North Carolina Physicians Health Program, Medical Board) for the good of the physician involved, the profession, and patients. A narrow view of collegiality should never be an excuse for inaction in such cases. Our duty to patient welfare and safety demands we understand that "friendly cooperation" extends not just to individuals but to the broad community of our peers, our patients, and our society. And at times, one can best help a colleague by acting to address his or her problems. The Board has reinforced this element of collegiality in a specific position statement that outlines the obligation to report such matters while protecting patient confidentiality.

With all this in mind, it is my belief that, even in the face of adversity, conflict, or discord, the concept of collegiality should always be a guide for each of us in resolving issues and in fulfilling our duties as professionals.

FSMB Foundation Receives Grant

The Federation of State Medical Boards (FSMB) Research and Education Foundation was recently awarded a \$362,000 grant as part of a national program to educate health care professionals about pharmaceutical industry marketing practices and provide tools for accessing unbiased sources of information about drugs.

The grant is part of a 2004 consumer protection settlement with Warner-Lambert that resolved allegations of deceptive "off-label" marketing of the drug Neurontin®. More than \$9 million will be distributed to grant recipients from the Attorney General Consumer and Prescriber Education Program.

The Foundation will develop the Online Prescriber Education Network (OPEN), a Web-based portal that will provide educational programs to physicians about pharmaceutical industry marketing techniques and their effect on prescribing. The portal will include unbiased sources of information about medications, strategies and tools for evidence-based prescribing, and adverse event assessment and reporting.

James N. Thompson, MD, president and CEO of the FSMB, said the FSMB's 70 member medical boards are positioned with the FSMB to make these resources available to more than 700,000 licensed physicians in the U.S.

Reporting Infectious Diseases: On-Line Training Can Help

Cindi Snider, MHS; Pia MacDonald, PhD, MPH; Martha Salyers, MD, MPH;
Leslie Wolf, PhD, HCLD(ABB); and Jean-Marie Maillard, MD, MSc*

Effective reporting of infectious diseases, including foodborne disease, is crucial to tracking emerging diseases, serving as an early warning for outbreaks or bioterrorism attacks, and determining local and state disease trends.¹

In North Carolina, state law requires physicians to report any diagnosed or suspected cases of nearly 80 different diseases.² Under the supervision of a physician, nurse practitioners (NPs) and physician assistants (PAs) also diagnose and treat ill patients, making them another valuable source of disease reporting. Diseases with bioterrorism potential, such as anthrax and plague, must be reported immediately. Others are reportable within 24 hours (eg, listeriosis) or seven days (eg, lab-confirmed *Chlamydia*). The list of reportable diseases changes as new diseases emerge and old ones reemerge. For example, recent additions include SARS and pediatric influenza deaths.

Foodborne diseases place a significant burden on the U.S. population. An estimated 76 million cases of foodborne disease occur annually in the United States, with approximately 325,000 hospitalizations and 5,200 deaths.³ There are nine foodborne diseases among the currently reportable diseases.⁴ Unlike other reportable diseases, foodborne diseases are listed both as causative agents, such as *Campylobacter* and *E. coli* O157:H7, and as a distinct category.

To improve understanding of foodborne diseases in North Carolina (NC), the NC Division of Public Health (NC DPH) and the NC Center for Public Health Preparedness (NC CPHP) conducted three surveys in 2004 to assess knowledge and practices of testing and reporting of foodborne diseases. These surveys specifically targeted health care providers (HCP) and hospital-based infection control practitioners (ICPs) in western NC as well as laboratorians statewide. ICPs frequently report infectious diseases and laboratory supervisors, like physicians, are required by law to report laboratory confirmed diagnoses of reportable diseases.

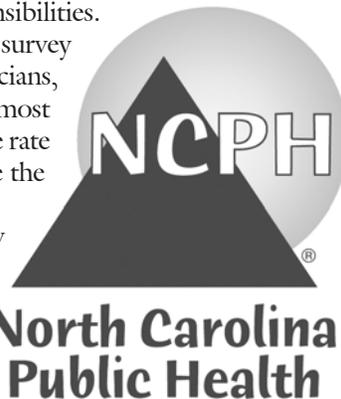
All three surveys indicated a gap in knowledge on

disease reporting responsibilities. The health care practitioner survey was completed by 372 physicians, NPs, and PAs in the westernmost 19 counties of NC (response rate 18%). Key findings include the following.

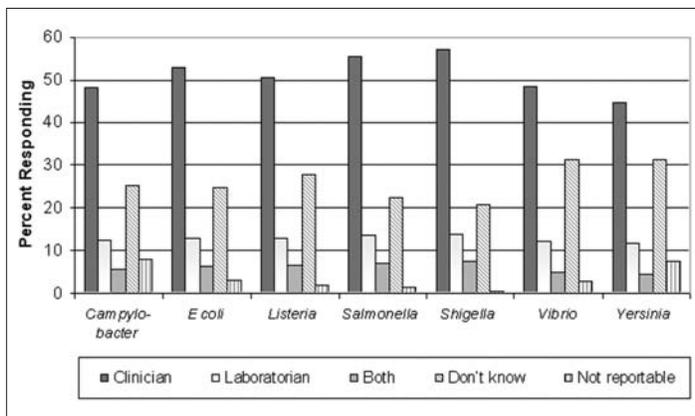
- Only 57% of HCPs knew they were responsible for reporting foodborne disease to the Health Department (see graph).
- As many as 25-30% of HCP participants did not know who should report pathogens such as *Listeria monocytogenes*, *Vibrio*, and *Campylobacter* to the Health Department, or, in fact, that they were reportable at all.
- About 90% of clinicians assumed *Salmonella* and *Shigella* tests were routinely performed on stool samples, when they may not actually be part of the routine screen at their laboratory.
- Nearly a third of study participants reported *not* counseling patients on foodborne disease and prevention when the patient was diagnosed with a foodborne disease.

In response to these findings, NC CPHP created three on-line training modules on disease reporting in NC, in collaboration with the NC Public Health Surveillance Regional Team 6, the NC Division of Public Health General Communicable Disease Control Branch, the NC Division of Public Health State Laboratory of Public Health, and with support from the National Association of City and County Health Officials.

These three 30-minute training modules have been developed specifically for HCPs, ICPs, and laboratorians. These are Web-based lectures with a printable outline and script. Free continuing education units and a certificate of completion are provided to all those who successfully complete the course. The lectures provide a basic introduction to disease report-



"In North Carolina, state law requires physicians to report any diagnosed or suspected cases of nearly 80 different diseases"



Percent of western North Carolina healthcare practitioners who think that clinicians and/or laboratorians are legally responsible for reporting selected foodborne pathogens to the health department.

ing requirements in NC as well as public health surveillance. They have been designed with special emphasis on foodborne disease reporting and include examples of how reporting by HCPs, ICPs, and laboratorians have been integral in protecting the health of all those living in the United States. To participate in the on-line training module, please go to www.sph.unc.edu/nccphp/reporting. For additional information about this educational opportunity, and about the surveys, please contact the NC Center for Public Health Preparedness at nccphp@unc.edu or 919.843.5561.

References

1. Brachman, Philip. "Notifiable Diseases." *Encyclopedia of Public Health*. Ed: Lester Breslow. Thomson Gale, 2002. *eNotes.com*. 2006. 30 Aug, 2006 <http://health.enotes.com/public-health-encyclopedia/notifiable-diseases>
2. North Carolina General Statute (NCGS) §130A-135. NCGS

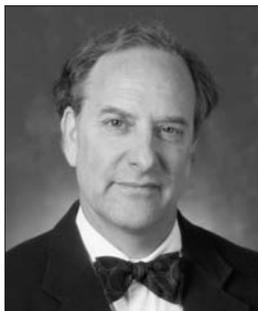
- §130A-136, -138, and -139 require school principals, child care operators, restaurant or other food- and drink-serving establishment owners, and laboratory directors to report. NCGS §130A-137 states that medical facilities, such as hospitals, "may" report.
3. Mead PS, Slutsker L, Dietz V, et al. "Food-related illness and death in the United States." *Emerg Infect Dis* 1999; 5(5):607-625.
 4. "NC Communicable Disease Report Card" (Revised 9/06). Report cards are available from NC DPH in Raleigh and every local health department in NC.

*Cindi Snider, MHS: NC Center for Public Health Preparedness; Pia MacDonald, PhD, MPH: Director, NC Center for Public Health Preparedness; Martha Salyers, MD, MPH: Team Leader, Public Health Regional Surveillance Team 6, National Association of County and City Health Officials; Leslie Wolf, PhD, HCLD(ABB): Director, State Public Health Laboratory; and Jean-Marie Maillard, MD, MSc: Head, Epidemiologic Surveillance and Investigation Branch, NC Division of Public Health General Communicable Disease Control Branch.

An Insider's View

The Medical Board at Work: Progress and Achievement

Michael E. Norins, MD
Member, NCMB



Dr Norins

Recently passed legislation (see *Forum* #2, 2006) providing new disciplinary remedies and new legislative authority for the North Carolina Medical Board leads me to reflect on the changes and achievements that have taken place at the Board over the past five years or so. Incremental change, by its very nature, is

subtle and only in retrospect is it apparent that real and dramatic progress has taken place. What follows is a catalogue of these changes, including the composition of the Board, the Board's staff, and the achievements in various areas of Board work. The broadening of statutory authority and expansion of remedies is the most recent step in the evolution of medical regulation in North Carolina based on what has come before.

Members and Staff

All the physician members of the Board are in active practice in a variety of specialties and represent a geographic cross-section of the state. They are actively engaged in the issues and controversies that are part of medicine, giving them a particularly strong sense of their responsibility to the public they are charged to protect and to the professionals whose competence and integrity they must ensure. Our public members and PA member continue to contribute a broad base

of experience and wisdom to the deliberations of the Board. It is this mix of professional and community members of exceptional talent and informed judgment that ensures we make good policy and disciplinary decisions.

Staff leadership at the Board has changed in the past five years. Our current executive director, David Henderson, brings experience and energy to his work. Under his leadership, the Board staff is meeting the demands of complex regulation with dedication, efficiency, and creativity, finding better ways to get the job done.

Gathering accurate and complete information is at the heart of the Board's regulatory work. The Investigations Department, under the leadership of Curtis Ellis, comprises a staff of eight experienced law enforcement professionals. This corps of investigators is respectful of our licensees but firm and determined in how they gather information pertaining to questioned behavior or practice. Investigative reports are thorough and, more importantly, reliable. In a word, the work product created is professional.

Under the direction of Thomas Mansfield, the Legal Department has grown from three to five full-time attorneys, along with a strong support staff. Although there has been some turnover in staff, the Department remains very stable, competent, and productive, with the result being an elimination of a significant backlog of disciplinary cases.

Over the past five years, the Board has enjoyed the benefits of stability and experience in the Licensing

"Incremental change, by its very nature, is subtle and only in retrospect is it apparent that real and dramatic progress has taken place"

Department, under the direction of Joy Cooke, and the Complaint and Malpractice Department, with the leadership of Judie Clark. Dr Jesse Roberts provided outstanding service to the Board as medical director up until his recent retirement. Dr Michael Sheppa, our newly appointed medical director, demonstrated his ability to bring deep knowledge and experience to the office of medical director during his tenure as assistant medical director and then interim medical director. Former Board member and SAS executive Hari Gupta has brought a high level of organization to the Operations Department, further enhancing the function of the Board. Many processes have become significantly paper-free thanks to the excellent service of the Information Technology Department supported by the expertise of its director, Donald Smelcer. Public Affairs, with the guidance and strong editorial skills of Dale Breaden, has taken our message to our licensees with the *Forum* and to the larger community through liaison with print and television media. All Board work moves smoothly under the steady hand of executive assistant Jeff Denton, and the staff of every department serves the Board and the public with outstanding skill.

Improving Tools and Systems

Infrastructure has been improved and expanded enabling better performance in all areas of Board activity. In the spring of 2003, the Board moved into a permanent facility fitted out to provide efficient work and hearing space. Information technology and management are core components that enable the Board's work. Our current systems are up-to-date and secure, allowing for the efficient processing of large amounts of information. For Board members, this means we can manage upwards of 1,000 pages of material each month on a navigable CD ROM. In addition, we now have the opportunity to use multiple large databases in ways that enhance our regulatory function by allowing the analysis of patterns and trends and by standardizing systems and processes.

With the enhanced skills and tools now available to the Board, both staff and infrastructure, we get the work done. Among the most important achievements is the elimination of the backlog of disciplinary cases in the Legal Department. Today we have fewer than a dozen cases older than 12 months, and disciplinary issues move from reporting through investigation to final resolution in a timely fashion. In real terms, we investigate and resolve over a thousand complaints annually. Last year, we took Board actions, both prejudicial and non-prejudicial, relating to 174 individual physicians, compared to 158 in 2004. (See the Board Action Report in this number of the *Forum*.)

The licensing of physicians, physician assistants (PAs), and certified clinical perfusionists (CCPs), and the approval of nurse practitioners (NPs) and clinical pharmacist practitioners (CPPs) have improved in thoroughness and timeliness. Beginning in 2003, by

legislative mandate, all applicants had to have a complete criminal background check, including standard inquiry to the FBI and SBI databases. It should be noted that this important step towards better protecting the public from the very low percentage of miscreant professionals has come at a cost of increased processing time due to factors outside the control of the Board.

A most significant change in the licensing process has been the move from interviewing all license applicants to interviewing applicants on an "as needed" basis. Only after a study of over 100 applications was completed, which established the safety and reliability of the new process, did this change occur. Under this new administrative process, we conserve the resources of the Board and the time and financial resources of the applicants with no diminution in the quality of the screening process.

In order to provide North Carolinians a resource for vetting and selecting a physician or allied health provider for their care, the Board has worked diligently to make public, on our Web site, information about licensees. If a physician or PA has had a public action taken by another state regulatory body, that action is mirrored by the NCMB, eg, taking a similar action, whether punitive or informational, by way of a consent order. When a license is denied for cause, a public record is created so that information is available regarding the applicant's history. These actions are intended to prevent professionals of questionable competence or character from hiding by moving from one part of the country to another.

Allied Professions

Allied health activity includes the licensing of PAs and CCPs and the regulation of the medical practice of NPs and CPPs. Over the past five years, CPPs have evolved as a new group of professional, advanced-level pharmacists empowered to practice limited medical acts involved in the management of well-defined disease states. For all allied health fields, there have been important refinements in the governing rules and regulations of practice developed in concert with the Board of Nursing, the Board of Pharmacy, and the state PA association to improve the quality of services provided to the public. As a part of these refinements and in accord with a focus on quality and safety, a program of audits of PA and NP practice sites has been initiated. These audits ensure the presence of written practice protocols or collaborative practice agreements as required. Furthermore, documentation of required supervisory activity is reviewed. The Board's commitment to fulfilling our responsibilities for quality of care extends beyond audit to our recent disciplinary actions against physicians who fail to carry out their supervisory duties. From a policy perspective, the issue of what constitutes adequate supervision of those licensed or approved by the Board is reviewed on a regular basis as

"Infrastructure has been improved and expanded enabling better performance in all areas of Board activity"

marketplace changes bring new practice models into being.

Handling Issues of Quality

Over the past five years, there has been significantly increased rigor brought to bear in regard to the evaluation of complaints related to medical practice, state medical examiner cases, and professional liability insurance payments (PLIPs). In all cases where there are technical issues that are not encompassed by the pooled expertise of the physician members of the Board, or for complex, controversial cases, outside expert review is increasingly used. Outside expert review has become, in the past several years, a major budgetary item. Efforts continue to establish a pool of expert reviewers who are not only of the highest academic caliber but are also willing to provide opinions in a timely fashion. The recent changes in the Medical Practice Act (MPA) further this effort by offering protections from liability to the reviewers.

In the area of PLIPs, which is an issue of national concern, the Board is developing methods for analyzing the critical elements of malpractice payment and settlement data in an effort to establish a valid, reliable approach to identifying physicians whose practice is of concern.

Over the past two years, the Board has recognized that there is a growing number of physicians and PAs seeking licensure or relicensure after a hiatus from practice. As a part of the Board's commitment to quality and competence, this issue of reentry has generated a process, continuously evolving, that will ensure our licensees have maintained the knowledge and skills necessary to provide care that is up-to-date. We are in the forefront nationally in how this issue is handled and may serve as a model to other boards across the country. The recent change in the MPA provides statutory authority to require proof of competence for applicants with a hiatus of two or more years. In order to develop a set of educational or training options for the reentry candidate, the Board has initiated a meeting to comprise representatives of our state's medical schools, medical liability insurers, and legal community, and experts familiar with this issue on a national level.

An additional set of quality assessment resources is now more available to licensees and the Board. In the past, licensees whose competence was in question have been sent to only a limited number of assessment centers due to a previous requirement that the assessors have a North Carolina license. With the change in the MPA, we can now use any of the growing number of excellent professional assessment centers around the country. As maintenance of competence takes center stage in the improvement of quality of care, the Board will continue to develop an aggressive stance in regard to ordering an assessment of any licensee whose competence comes into question through the processing

of complaints, investigations, or PLIPs.

Several major policies have been developed by the Board over the past five years. Formal guidelines for office-based surgery have been adopted. These guidelines serve to increase patient protection and safety as more procedures are performed outside of regulated facilities. In conjunction with this work, the Board policy statement in regard to perioperative responsibility of the physician has been updated and clarified to meet the needs for patient safety in this changing environment.

In the effort to ensure public safety, the Board has spoken to the issue of various cosmetic procedures that are deemed medical practice. A clear standard for physician involvement and supervision has been articulated. Through disciplinary action, it has been made clear that a physician who is paid to fulfill the role of medical director for such activities will be held responsible for quality of care and for adverse outcomes. In other areas involving the scope of medical practice, the Board has taken a strong stance to protect the public.

New treatments and procedures continuously evolve as part of medicine's quest to improve the medical status of the community. There has been a growing number of innovations and new treatments developed outside academic medical centers. Three major disciplinary cases over the past five years have established a clear precedent that the same standards for patient protection and informed consent used in academic centers will be applied to licensees doing innovative work in the community. The goal is not to stifle new ideas and innovation but to do everything possible to ensure patient protection.

In order to stay vital and pertinent in setting standards that promulgate quality and safety, all the position statements of the Board have been or are in the process of being revisited and revised as appropriate.

Conclusion

Just as medicine is a growing and dynamic field, so is the regulation of medical care. Protecting the people of North Carolina in the area of medical care requires us to enforce the highest standards of scrutiny in licensing and to discipline licensees who have gone astray. It also requires we actively participate in the continuous improvement of medical practice, thereby enhancing the welfare of patients and the skills of practitioners. The Board, in addition to the regular work at hand, is actively reaching out to other regulatory organizations, to hospitals and hospital medical staff leadership, to our rich academic resources, and to the broader health care community to continue to better serve our state and nation. The new powers and remedies provided the Board by the legislature, along with increased financial resources, will enable the continued high level of achievement in quality medical practice regulation that reflects the tradition and history of the Board.

“Protecting the people of North Carolina in the area of medical care requires us to enforce the highest standards of scrutiny in licensing and to discipline licensees who have gone astray”

*From Occupational Health Surveillance
NC Division of Public Health*

New Reporting Rule: Acute Pesticide Illness and Injury

*Sheila A. Higgins, RN, MPH, COHN-S, Manager
Occupational Surveillance, NC Division of Public Health*

Many of us derive considerable benefit from the use of pesticides. Pesticides make our lives safer and more comfortable and help supply us with plentiful food and forest products. Consequently, pesticide use has become commonplace in homes, schools, businesses, and especially agriculture. But while pesticide use has many benefits, it also has risks if products are not used as directed. Exposure can result in acute illness or injury, and there is increasing evidence of chronic health effects.

The Need for Reporting

Data indicate that many pesticide-related poisonings occur each year in North Carolina. According to Carolinas Poison Center, North Carolina experiences in excess of 2,000 cases a year of pesticide poisoning, with mostly non-occupational cases reported. AAPCC (American Association of Poison Control Centers) data indicate that pesticides are among the substances most frequently involved in adult and pediatric exposures. In North Carolina, farmworkers and their families are most at risk for illness and injury from pesticide exposures. This is related to the fact that most pesticides are used in agriculture and North Carolina is a prominent agricultural state, generating significant income from agriculture and using significant amounts of pesticides compared to other states. Helping tend our crops are large numbers of farmworkers and migrant farmworkers. The size of our farmworker population exceeds that of most other states. Family members of agricultural workers are also at risk of direct or indirect pesticide exposure because many live in close proximity to fields, participate in farming activities, or come in contact with take-home residues. Despite laws regulating agricultural use of pesticides, there is evidence that citizens, especially workers, are still being overexposed and many of these cases go unreported.

Because of concerns regarding potential toxicity, pesticide use, and vulnerable populations, the North Carolina Division of Public Health has determined that a closer monitoring of pesticides is warranted by initiating an acute pesticide illness and injury surveillance program. Surveillance would allow the state to properly track and respond to reports of pesticide illness and injury, and information obtained would be used to develop strategies to prevent overexposure. Reports from physicians are an essential case ascertainment source. Currently, 30 states, including South Carolina, have some form of mandated reporting for physicians.

Reporting Rule

An important first step in evaluating the problem is to ask physicians to report cases. In North Carolina, reporting requirements will also apply to those persons working under the direction of a physician, such as nurse practitioners and physician assistants. A reporting rule was passed by the Commission for Health Services and adopted by the Rules Review Commission effective 4/1/06. Important information about the rule includes the following:

- cases of suspected or confirmed acute pesticide-related illness or injury should be reported within 48 hours, deaths immediately;
- persons reporting may contact Carolinas Poison Center in lieu of Public Health to avoid duplicate reporting and save time;
- the program will start accepting reports *January 1, 2007*;
- go to www.ncdhhs.gov (click P for pesticides under topic index) for more information on reporting requirements, forms, reporting options, clinical consultation, and clinical management resources (*pesticide Web site will be posted by December 2006*);
- the reporting rule, 10A NCAC 41E0101 -.0103, can be viewed at Office of Administrative Hearings at www.oah.state.nc.us (see Rules Division/ Administrative Rules/Administrative Code Online).

“Despite laws regulating agricultural use of pesticides, there is evidence that citizens, especially workers, are still being overexposed and many of these cases go unreported”

Improving Patient Care and Public Health

Data obtained through reporting will contribute to improved patient care and public health by helping public health officials:

- collect better data on how often illness occurs and who are affected most;
- investigate cases to learn why poisonings happen;
- provide advice and resources to reported cases, medical providers, employers, and the general public; and
- share data collected with stakeholders that can impact prevention and best practices.

Questions about this article may be directed to Ms Higgins at (919) 707-5940.

North Carolina Medical Board

Web site:
www.ncmedboard.org
E-mail:
info@ncmedboard.org

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

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

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

Over the past few months, recommendations of the Policy Committee resulting from the Committee's review of seven position statements have moved forward to final approval by the Board and a new statement has been proposed for consideration and comment.

- The following position statements have been formally approved by the Board. They appear with the dates of Board action noted.

COMPETENCE AND REENTRY TO THE ACTIVE PRACTICE OF MEDICINE

The ability to practice medicine results from a complex interaction of knowledge, physical skills, judgment, and character tempered by experience leading to competence. Maintenance of competence requires a commitment to lifelong learning and the continuous practice of medicine, in whatever field one has chosen. Absence from the active practice of medicine leads to the attenuation of the ability to practice competently.

It is the position of the North Carolina Medical Board, in accord with GS 90-6(a), that practitioners seeking licensure, or reactivation of a North Carolina medical license, who have had an interruption, for whatever reason, in the continuous practice of medicine greater than two (2) years must reestablish, to the Board's satisfaction, their competence to practice medicine safely.

Any such applicant must meet all the requirements and complete an application for a regular license. In addition, full-scale assessments, engagement in formal training programs, supervised practice arrangements, formal testing, or other proofs of competence may be required.

The Board will cooperate with appropriate entities in the development of programs and resources that can be used to fulfill the above requirements, including the issuance, when necessary and appropriate, of a time or location limited and/or restricted license (eg, residency training license).

It shall be the responsibility of the applicant to develop a reentry program subject to the approval of the Board.

(Adopted July 2006)

AVAILABILITY OF PHYSICIANS TO THEIR PATIENTS

It is the position of the North Carolina Medical Board that once a physician-patient relationship is created, it is the duty of the physician to provide care whenever it is needed or to assure that proper physician backup is available to take care of the patient during or outside normal office hours.

The physician must clearly communicate to the patient orally

and provide instructions in writing for securing after hours care if the physician is not generally available after hours or if the physician discontinues after hours coverage.

(Adopted July 1993) (Amended May 1996, January 2001, October 2003, July 2006)

REFERRAL FEES AND FEE SPLITTING

Payment by or to a physician solely for the referral of a patient is unethical. A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

It is unethical for physicians to offer financial incentives or other valuable considerations to patients in exchange for recruitment of other patients. Such incentives can distort the information that patients provide to potential patients, thus distorting the expectations of potential patients and compromising the trust that is the foundation of the patient-physician relationship.

Furthermore, referral fees are prohibited by state law pursuant to N.C. Gen. Stat. Section 90-401. Violation of this law may result in disciplinary action by the Board.

Except in instances permitted by law (NC Gen Stat §55B-14(c)), it is the position of the Board that a physician cannot share revenue on a percentage basis with a non-physician. To do so is fee splitting and is grounds for disciplinary action.

(Adopted November 1993) (Amended May 1996, July 2006)

THE RETIRED PHYSICIAN

The retirement of a physician is defined by the North Carolina Medical Board as the total and complete cessation of the practice of medicine and/or surgery by the physician in any form or setting. According to the Board's definition, the retired physician is not required to maintain a currently registered license and SHALL NOT:

- provide patient services;
- order tests or therapies;
- prescribe, dispense, or administer drugs;
- perform any other medical and/or surgical acts; or
- receive income from the provision of medical and/or surgical services performed following retirement.

The North Carolina Medical Board is aware that a number of physicians consider themselves "retired," but still hold a currently registered medical license (full, volunteer, or limited) and provide professional medical and/or surgical services to patients on a regular or occasional basis. Such physicians customarily serve the needs of previous patients, friends, nursing home residents, free clinics, emergency rooms, community health programs, etc. The Board commends those physicians for their willingness to continue service following "retirement," but it recognizes such service is not the "complete cessation of the practice of medicine" and therefore must be joined with an undiminished awareness of professional responsibility. That responsibility means that such physicians SHOULD:

- practice within their areas of professional competence;
- prepare and keep medical records in accord with good pro-

- fessional practice; and
- meet the Board's continuing medical education requirement.

The Board also reminds "retired" physicians with currently registered licenses that all federal and state laws and rules relating to the practice of medicine and/or surgery apply to them, that the position statements of the Board are as relevant to them as to physicians in full and regular practice, and that they continue to be subject to the risks of liability for any medical and/or surgical acts they perform.

(Adopted January 1997) (Amended September 2006)

THE PHYSICIAN-PATIENT RELATIONSHIP

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

Therefore, it is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk. This is true whether such an act is entirely self-determined or the result of the physician's contractual relationship with a health care entity. The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

Elements of the Physician-Patient Relationship

The North Carolina Medical Board licenses physicians as a part of regulating the practice of medicine in this state. Receiving a license to practice medicine grants the physician privileges and imposes great responsibilities. The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to the physician in a vulnerable condition, believing the physician has knowledge and skill that will be used for their benefit.

Patient trust is fundamental to the relationship thus established. It requires that:

- there be adequate communication between the physician and the patient;
- the physician report all significant findings to the patient or the patient's legally designated surrogate/guardian/personal representative;
- there be no conflict of interest between the patient and the physician or third parties;
- personal details of the patient's life shared with the physician be held in confidence;
- the physician maintain professional knowledge and skills;
- there be respect for the patient's autonomy;
- the physician be compassionate;
- the physician respect the patient's right to request further restrictions on medical information disclosure and to request alternative communications;
- the physician be an advocate for needed medical care, even at the expense of the physician's personal interests; and
- the physician provide neither more nor less than the medical problem requires.

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust—communica-

tion, patient primacy, confidentiality, competence, patient autonomy, compassion, selflessness, appropriate care—are foremost in the hearts, minds, and actions of the physicians licensed by the Board. This same fundamental physician-patient relationship also applies to mid-level health care providers such as physician assistants and nurse practitioners in all practice settings.

Termination of the Physician-Patient Relationship

The Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in compliance with the physician's obligation to support continuity of care for the patient.

The decision to terminate the relationship must be made by the physician personally. Further, termination must be accompanied by appropriate written notice given by the physician to the patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other medical care to be secured. A copy of such notification is to be included in the medical record. Should the physician be a member of a group, the notice of termination must state clearly whether the termination involves only the individual physician or includes other members of the group. In the latter case, those members of the group joining in the termination must be designated. It is advisable that the notice of termination also include instructions for transfer of or access to the patient's medical records.

(Adopted July 1995) (Amended July 1998, January 2000, March 2002, August 2003, September 2006)

CARE OF THE PATIENT UNDERGOING SURGERY OR OTHER INVASIVE PROCEDURE*

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

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

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

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

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

(Adopted September 1991) (Amended March 2001, September 2006)

SEXUAL EXPLOITATION OF PATIENTS

It is the position of the North Carolina Medical Board that sexual exploitation of a patient is unprofessional conduct and undermines the public trust in the medical profession. Sexual exploitation encompasses a wide range of behaviors which have in common the intended sexual gratification of the physician. These

behaviors include sexual intercourse with a patient (consensual or non-consensual), touching genitalia with ungloved hands, sexually suggestive comments, asking patients for a date, inappropriate exploration of the patients or physician's sexual phantasias, touching or exposing genitalia, breast, or other parts of the body in ways not dictated by an appropriate and indicated physical examination, exchanging sexual favors for services. Sexual exploitation is grounds for the suspension, revocation, or other action against a physician's license. This position statement is based upon the Federation of State Medical Board's guidelines regarding sexual boundaries.

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

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

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

(Adopted May 1991) (Amended April 1996, January 2001, September 2006)

- The following new position statement is being considered for final action by the Board. Comments on it are invited.

NORTH CAROLINA PHYSICIANS AND CAPITAL PUNISHMENT

The North Carolina Medical Board takes the position that physician participation in capital punishment is a departure from the ethics of the medical profession within the meaning of N.C. Gen. Stat. § 90-14(a)(6). The North Carolina Medical Board adopts and endorses the provisions of AMA Code of Medical Ethics Opinion 2.06 printed below except to the extent that it is inconsistent with North Carolina state law.

The Board recognizes that N.C. Gen. Stat. § 15-190 requires the presence of "the surgeon or physician of the penitentiary" during the execution of condemned inmates. Therefore, the Board will not discipline licensees for merely being "present" during an

execution in conformity with N.C. Gen. Stat. § 15-190. However, any physician who engages in any verbal or physical activity, beyond the requirements of N.C. Gen. Stat. § 15-190, that facilitates the execution may be subject to disciplinary action by this Board.

Relevant Provisions of AMA Code of Medical Ethics Opinion 2.06

An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In cases where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites, starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity; and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

2005 NCMB Board Action Data Report

David Henderson, executive director of the North Carolina Medical Board, reported on the Board's actions for 2005 earlier this year. "The Board's full Annual Report is a rich source of information about the Board and its record for 2005, but this summary of the Board's actions provides a picture of an important facet of the Board's work over the past year," he said.

Mr Henderson pointed out that there is a cycle to the level of any medical board's actions viewed over time—a fairly natural rise and fall of action levels related to the time and resources required to process different types of cases. He also noted that any board's level of activity in each of the various categories of action will vary from year to year. That being said, however, he was pleased by the fact that the overall number of individual physicians concerning whom the Board took action, in prejudicial and non-prejudicial groups

combined, was greater in 2005 than in 2004, as was the total number of Board actions.

Mr Henderson said, "The Board is dedicated to pursuing the problems that are reported to it or that it identifies from its oversight of medical practice. That effort is the source of these numbers. But it's important to stress that the Board's work includes a number of activities not covered by the annual action figures."

A summary of the Board Action Report follows. [Note that it covers actions concerning physicians, physician assistants, and nurse practitioners.]

NCMB Board Action Summary--2005

[Comparative figures for 2004 appear in brackets and italics.]

PREJUDICIAL ACTIONS:

License Denied: 10 actions (9 physicians, 1 NP)

[2004: 6 actions (5 physicians)]

Annulments: NONE

[2004: None]

Revocations: 16 actions (15 physicians, 1 NP)

[2004: 20 actions (18 physicians, 2 PAs)]

Suspensions: 46 actions [15 stayed in full; 36 by Consent Order] (42 physicians, 4 PAs)

[2004: 63 actions [22 stayed in full; 47 by CO] (55 physicians, 7 PAs)]

Summary Suspensions: 2 actions (2 physicians)

[2004: 4 actions (3 physicians, 1 PA)]

Miscellaneous Board Orders: 1 action (1 physician)

[2004: 1 action (1 physician)]

Denials of Reconsideration/Modification: NONE

[2004: 1 action (1 physician)]

Surrenders: 16 actions [0 by Consent Order] (13 physicians, 3 PAs)

[2004: 27 actions [2 by CO] (24 physicians, 3 PAs)]

Temporary/Dated Licenses Issued (via Consent Order): 11 actions (9 physicians, 2 PAs)

[2004: 11 actions (8 physicians, 3 PAs)]

Temporary/Dated Licenses Allowed to Expire: NONE

[2004: NONE]

Consent Orders: 106 actions—99 persons [6 mod] [4 N-D] (85 physicians, 12 PAs, 2 NPs)

[2004: 96 actions--90 persons [7 mod] (72 physicians, 16 PAs, 2 NPs)]

[Note that COs limit, restrict, reprimand, or otherwise affect the practitioner in some way. In certain cases, they may result in the revocation, suspension, or surrender of a license, the dismissal of charges as a result of other action taken, and/or the issuance of a temporary/dated license, which results are reflected in the appropriate sections of this report. In some instances, a CO may simply modify a previous CO,

and that is indicated by (mod) appearing after the person's name. Non-disciplinary (N-D) COs are included and so noted.]

NON-PREJUDICIAL ACTIONS:

Dismissals: 5 actions (5 physicians)

[2004: 3 action (3 physicians)]

Temporary/Dated Licenses Extended: 46 actions—28 persons (23 physicians, 5 PAs)

[2004: 33 actions--21 persons (16 physicians, 5 PAs)]

Temporary/Dated Licenses Became Full and Unrestricted: 9 actions (7 physicians, 2 PAs)

[2004: 10 actions (9 physicians, 1 PA)]

Consent Orders Lifted: 20 actions (18 physicians, 2 PAs)

[2004: 18 actions (15 physicians, 3 PAs)]

Reentry Agreements/Orders: 15 actions, 14 persons (10 physicians, 4 PAs)

[2004: NONE]

Revocations Reinstated: NONE

[2004: NONE]

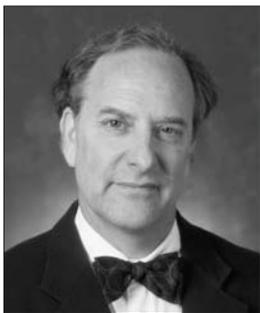
Private Letters of Concern for 2005: 296

[2004: 285]

(A PLOC is sent on a confidential basis to a practitioner when formal action is not warranted but when the Board wishes to call the practitioner's attention to a situation or problem that could lead to more serious consequences. PLOCs are useful educational devices and are part of the Board's effort to prevent problems as well as react to them.)

For a complete listing of all Board Actions see "2005 Board Action Report" on the NC Medical Board's Web site: www.ncmedboard.org.

Dr Norins Elected to Editorial Committee of Federation of State Medical Boards



Dr Norins

At its annual meeting in April 2006, held in Dallas, the Federation of State Medical Boards of the United States, the national association of all state medical boards, elected Michael E. Norins, MD, to its Editorial Committee. Dr Norins, of Greensboro, has been a member of the North Carolina Medical

Board since 2001. He is a member of the Board's Complaints and Reentry Committees and chair of its Licensing Committee.

In commenting on his new role, Dr Norin's said: "It is an honor to have been elected to the Editorial Committee of the FSMB. I sought this position out of a commitment to promulgate the works of this

vital national organization to the health care policy community throughout the country. The FSMB is continuing to grow as a leader in the broad field of quality improvement and its quarterly *Journal of Medical Licensure and Discipline*, for which the Editorial Committee is responsible, provides a dynamic forum of discussion and education around that and significant related issues."

"During my tenure," he continued, "I will work to broaden the base of contributors to the *Journal*, drawing on the best policy centers and the most creative thinkers to address issues of ethics, regulation, and professional discipline. Readership of the *Journal* will spread beyond the regulatory community to both the health policy community and the legislative community through relevant and creative content. Needless to say, I will be looking in particular for ideas and contributions from our North Carolina community."

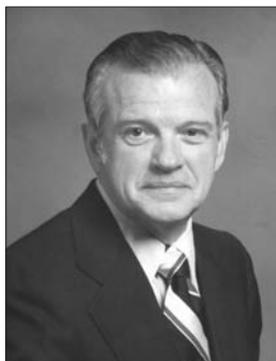
In Recognition of Distinguished Service

Bryant L. Galusha, MD, Honored by North Carolina Medical Board

On May 18, 2006, North Carolina Medical Board members and staff, a large group of invited friends, and special guests gathered at the Board's offices in Raleigh for a reception honoring one of the Board's most distinguished past members: Bryant L. Galusha, MD, of Charlotte. During the reception, R. David Henderson, executive director of the Board, presented Dr Galusha with a Board member lapel pin to commemorate his service on the Board. Dr Robert C. Moffatt, president of the Board, unveiled a signed, sealed, and beautifully framed special resolution adopted by the Board to honor Dr Galusha. Dr Moffatt read out the resolution, which listed the highlights of Dr Galusha's career and dedicated one of the Board's conference rooms to him. The framed resolution, also bearing a portrait of Dr Galusha, has been hung in the new Bryant L. Galusha, MD, Conference Room, and his name appears in cast bronze on a plaque affixed to the door of the room.

Several of Dr Galusha's friends and colleagues, including Barbara S. Schneidman, MD, MPH, vice president for medical education of the American Medical Association; Bryant D. Paris, Jr, former executive director of the North Carolina Medical Board; and Dale G Breaden, a former associate of Dr Galusha's at the Federation of State Medical Boards and now on the staff of the North Carolina Medical Board, spoke about their personal experiences working with Dr Galusha over the years.

Dr Galusha, a native of West Virginia, received his medical degree from Case Western Reserve University School of Medicine. He did a residency in pediatrics at University Hospitals of Cleveland and Cleveland City Hospital and completed his residency at Charlotte Memorial Hospital. He is a diplomate of the American Board of Pediatrics and a fellow of the American Academy of Pediatrics. He served over 22 years as director of medical education at Charlotte Memorial Hospital and was named to what was then the North Carolina Board of Medical Examiners in 1968, serving 12 years on the Board, with one term as its president and five as its secretary. Among his many professional and regulatory activities, he became a strong advocate for steady improvement in the Federation Licensing Examination (FLEX) program of the Federation of State Medical Boards of the United States (FSMB) and was elected to the FSMB's FLEX Board in 1976, leading development of the FLEX I-II program.



Dr Galusha

In 1981, Dr Galusha was elected president of the FSMB, one of the few persons ever to be elected without having served first as an officer or member of the organization's Board of Directors. During the 1980s, he was on the National Board of Examiners and was a member of its Executive Committee for several years. From 1984 to 1989, Dr Galusha served as executive vice president (CEO) of the FSMB, which required him to move to Texas. While there, he was instrumental in making that organization a major player in medical and regulatory affairs. He modernized every aspect of the organization's operations and gave it a strong voice in Washington. He also became the driving force behind the development and implementation of the United States Medical Licensing Examination (USMLE). Retiring from the FSMB after over five years of dynamic

leadership, he returned to Charlotte and spent several years inspecting residency programs across the country for the Accreditation Council for Graduate Medical Education.

Dr Galusha was given the Order of the Long Leaf Pine by Governor Hunt in 1978; Charlotte Memorial Hospital named its medical library in his honor when he went to the FSMB; he received the Distinguished Service Award of the University of North Carolina School of Medicine in 1989; he also received the U.S. DHHS Recognition Award for Dedication and Commitment to the Integrity and Quality of Health Care in 1989; the FSMB named its prestigious Annual Meeting lecture series in his honor in 1990; and the FSMB presented him its Distinguished Service Award in 1993.



Robert C. Moffatt, MD, (l) president of the NCMB, reads resolution honoring Dr Galusha (r) at reception.

“He became the driving force behind the development and implementation of the United States Medical Licensing Examination (USMLE)”

**In Recognition of Dr Bryant L. Galusha's Distinguished Service
to the North Carolina Medical Board, the People of North Carolina, the Federation of
State Medical Boards, and the Profession of Medicine**

NOW, THEREFORE, BE IT RESOLVED that the North Carolina Medical Board publicly and with deep respect and appreciation recognizes and honors the farsighted, effective, and dynamic leadership of Bryant L. Galusha, MD, and expresses its debt to him for his service and dedication to those principles and ideals of professionalism, integrity, and public protection that must characterize the work of the Board, the Federation of State Medical Boards, and the medical profession; and

BE IT FURTHER RESOLVED that a conference room in the North Carolina Medical Board's office building be named in honor of Bryant L. Galusha, MD, on May 18, 2006, and that a copy of this Resolution be on permanent display in the Bryant L. Galusha, MD, Conference Room, that a copy be made a part of the minutes of the Board, and that a copy be presented to Dr Galusha.

New NCMB Officers:

H. Arthur McCulloch, MD, President; Janelle A. Rhyne, MD, President Elect; George L. Saunders, III, MD, Secretary; Ralph C. Loomis, MD, Treasurer

On November 1, 2006, H. Arthur McCulloch, MD, of Charlotte, will take office as president of the North Carolina Medical Board and Janelle A. Rhyne, MD, of Wilmington, will become president elect. George L. Saunders, III, MD, of Shallotte, will assume the office of secretary and Ralph C. Loomis, MD, of Asheville, will become treasurer. Their terms of office will run until October 31, 2007.

H. Arthur McCulloch, MD, President



Dr McCulloch

A native of Ohio, Dr McCulloch, the Board's incoming president, received a BA from Ohio State University and took his MD from the Medical College of Ohio. He did his internship at St Thomas Hospital Medical Center in Akron, Ohio, and his residency in anesthesiology at North Carolina Memorial Hospital.

Following his residency, he was a staff anesthesiologist at Wilford Hall USAF Medical Center. He is a diplomate of the American Board of Anesthesiology and is a clinical assistant professor of anesthesiology at the University of North Carolina. He practices with Southeast Anesthesiology Consultants, in Charlotte, and is vice chief of the Department of Anesthesiology at Carolinas Medical Center.

Dr McCulloch is an active member of the North Carolina Medical Society and, among other things, has served on its MedPAC Board and its Task Force on Of-

fice-Based Surgery. He is also a member of the North Carolina Society of Anesthesiologists, serving on that organization's Executive Committee and as its president. He is a member of the House of Delegates of the American Society of Anesthesiologists. He was appointed to the Board in 2002 and has served as the Board's president elect, secretary, and treasurer. He has served on several Board committees and is chair of its Policy Committee.

Dr McCulloch is coauthor of three journal articles.

Janelle A. Rhyne, MD, President Elect



Dr Rhyne

Dr Rhyne, the Board's incoming president elect, earned a BA degree in anthropology from the University of North Carolina at Chapel Hill and continued her education at Arizona State University, where she took an MA degree in physical anthropology. Following graduation, she returned to UNC Chapel Hill

where she completed additional studies and worked in neuropathology research. She earned her MD at Wake Forest University School of Medicine. She did her internship in internal medicine, her residency training, and a fellowship in infectious diseases at Wake Forest University Baptist Medical Center.

Dr Rhyne currently serves as clinical associate professor in the Department of Medicine at the University of North Carolina School of Medicine and has served

Wilmington's New Hanover Regional Medical Center in many capacities, including chair of numerous medical staff committees, chief of staff, and member of the Board of Trustees. She also practices at Wilmington Health Associates, PLLC, and is medical consultant for New Hanover County Health Department.

Following the completion of her medical education, Dr Rhyne began teaching responsibilities, some of which she still performs today, including giving conferences and precepting medical students and residents. She is certified by the American Board of Internal Medicine in the specialty of internal medicine and subspecialty of infectious diseases.

Dr Rhyne is a member of numerous professional societies, including, among others, the American College of Physicians, of which she is a fellow, the Infectious Disease Society of America, the New Hanover-Pender County Medical Society, and the North Carolina Medical Society, where she chairs the Ethical and Judicial Affairs Committee and is a New Hanover-Pender County delegate. She has been the recipient of numerous honors and awards. In 1998, she was named Physician Scholar for the North Carolina Medical Society Foundation Leadership Symposium. In 1995, she was Professor of the Year at New Hanover Regional Medical Center, and in 1994, Physician of the Year at Wilmington Health Associates. In 2004, she was presented the Ralph E. Snyder, MD, Award of Excellence in Healthcare Quality Improvement from Medical Review of North Carolina, Inc.

In the past, Dr Rhyne has served as president of the North Carolina Chapter of the American College of Physicians, president of the North Carolina Society of Internal Medicine, chief of staff at New Hanover Regional Medical Center, president of the New Hanover-Pender County Medical Society, and governor of the North Carolina Chapter for the American College of Physicians. She has also coauthored scientific publications and given scientific presentations. She was appointed to the Board in 2003, has served on several Board committees and chairs the Investigative Committee. She has served as the Board's secretary and treasurer.

George L. Saunders, III, MD, Secretary



Dr Saunders

Dr Saunders graduated from Loyola University of Los Angeles and earned his MD from the University of California at San Diego School of Medicine. He completed his residency training in family medicine at St Joseph's Medical Center in Yonkers, NY, where he then served as a preceptor. He also served on the faculty at New York Medical College as a clinical instructor in the Department of Medicine.

Following the completion of his medical education,

Dr Saunders became the first medical director of the Urgent Care Network at Jackson Memorial-University of Miami Medical Center, and later was appointed associate clinical professor in the Department of Family and Community Medicine. He joined Landmark Learning Center, in Miami, where he served as medical executive director and quality assurance officer at the 360-bed facility for the developmentally disabled. During his tenure at the Learning Center, his department received a state award for quality and efficiency of service.

Since 1992, Dr Saunders has been in private practice in Brunswick County where he has been a trustee for Brunswick Community College. At Brunswick Hospital, Dr Saunders has served as chief of the medical staff and is a former hospital trustee.

In the past, Dr Saunders has held numerous appointments, including president, vice president, and recording secretary of the Dade County, Florida, Chapter of the National Medical Association. He also served as president of the Brunswick County Medical Society and as president and convention chair of the Old North State Medical Society, by which group he was named Physician of the Year in 1998 and 1999.

He is currently an adjunct clinical instructor at the University of North Carolina School of Medicine and a preceptor for medical students, nurse practitioner students, and family practice residents.

Dr Saunders is a member of the American Geriatrics Society, the American Academy of Family Physicians, the National Medical Association, and other professional organizations. He is certified by the American Board of Family Practice and the American Board of Geriatric Medicine. Dr Saunders is the medical director of Autumn Care Shallotte.

He was appointed to the Board in 2003 and has served on its Policy, Complaints, and Executive Committees.

Ralph C. Loomis, MD, Treasurer



Dr Loomis

A native of Kentucky, Dr Loomis took his undergraduate degree, cum laude, at Vanderbilt University, and his MD degree from Indiana University, where he received the Senior Honors Program Award. He did his internship at Indiana and his residency in neurosurgery at the same institution, during which he received the Willis Gatch General Surgery Award. He also took the Theodore Gildred Microsurgical Course and was coauthor of an article in the *Annals of Surgery*.

Dr Loomis is certified by the American Board of Neurological Surgery and is a fellow of the American College of Surgeons. He is a member of the Congress of Neurological Surgery and the American Association of Neurological Surgery, an officer in the North Caro-

lina Neurosurgical Society, and the North Carolina delegate to the national Council of State Neurosurgical Societies. Dr Loomis represents the neurosurgery section of Mission Hospitals in the level II trauma section of the western region of North Carolina and is past chief

of surgery for Mission Hospitals. He was appointed to the Board in 2005 and has served on its Reentry, Complaint, Licensing, and CPP Committees.

He practices at the Mountain Neurological Center in Asheville.

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

Non-Medical Use and Abuse of Prescription Drugs

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



Dr McEwen



Dr Lohr

Abuse of controlled prescription drugs by both adults and adolescents is at an alarming level in the U.S. According to a 2005 report from the National Center on Addiction and Substance Abuse at Columbia University (CASA), the number of Americans who abuse controlled prescription drugs nearly doubled from 7.8 million to 15.1 million between 1992 and 2003, and abuse among teens more than tripled during that time. This includes the non-medical use of opioid analgesics, sedatives/tranquilizers, and stimulant medications. Abuse of controlled prescription drugs now exceeds the combined abuse of cocaine

(4.0 million), inhalants (2.1 million), and heroin (0.3 million).

Since pain management was established as a distinct medical specialty approximately 20 years ago, a number of new analgesics have come to the pharmaceutical market and there has been a steady increase in the supply and demand of these agents. Because a number of patients require the use of opioids for analgesia, the challenge is to balance efforts to reduce abuse and diversion without compromising access for legitimate users (Smith and Woody, 2005). This is particularly challenging when treating chronic pain patients who are at known risk for diversion, abuse, or dependence (Smith and Woody, 2005). The North Carolina Medical Board (NCMB) issued an updated policy statement in 2005 that provides some guidance. "Policy for the Use of Controlled Substances for the Treatment of Pain" is available on the NCMB's website ([\[medboard.org\]\(http://medboard.org\)\).](http://www.nc-</p>
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Oxycodone and hydrocodone are more likely than other prescription opioids (eg, methadone, morphine, fentanyl, buprenorphine) to be abused. Unlike the pattern of abuse seen with illicit drugs, which is localized mainly to large metropolitan areas, OxyContin® abuse is most prevalent in rural, suburban, and small urban areas (Cicero, 2005). The average age of individuals afflicted is 34; men outnumber women (65% v 35%); and Caucasians outnumber other ethnicities (over 90%).

Purdue Pharma's OxyContin® was approved by the FDA in 1995 as a sustained-release preparation of oxycodone hydrochloride. Because it was sustained-release, it was thought to have lower abuse potential than immediate release opioid preparations. Beginning in 2000, however, reports of regional OxyContin® abuse started arriving at the FDA. The abuse was generally confined to specific, circumscribed areas (eg, southern Maine, the Appalachian region). Although there was an overall increase in the use of opioid analgesics, the growth was most dramatic for OxyContin®. Several federally funded surveys and reports documented the surge in opioid misuse and suggested that the following factors played important roles: (1) ease of obtaining prescription drugs; (2) less close monitoring by law enforcement than for street drugs; (3) the use/abuse of prescription drugs was more socially acceptable than use of street drugs; and (4) the dose and purity of prescription drugs were more predictable (Cicero, 2005).

Once the media brought attention to the problem, Purdue Pharma took a number of steps, including issuing a "black box" warning on the label, educational efforts, sales force retraining, and the establishment of a surveillance program to monitor the abuse and diversion of OxyContin® and a number of other abused opioids.

Prescription drugs may be diverted from their intended use in a number of ways. Seventy percent of OxyContin® abusers listed a physician's prescription as

"Abuse of controlled prescription drugs now exceeds the combined abuse of cocaine, hallucinogens, inhalants, and heroin"

their major source of the drug (Cicero, 2005). The drugs are readily acquired either through a personal prescription or by having access to drugs prescribed to others (eg, parents, roommates, friends). Some of the prescription drugs being abused come from Internet pharmacies and there is a large-scale black market for these drugs, rivaling or exceeding those for cocaine and heroine (Compton and Volkow, 2006). Patients with chronic pain who have legitimate prescriptions may sell a portion of their medication. A 2003 survey and anecdotal evidence indicate that college students largely obtain abusable prescription drugs from their peers.

Despite the fact that teen alcohol use and cigarette smoking are at historic lows (M the F, 2005; Friedman, 2006) and illicit drug use is on the decline in older teens, many teens continue to abuse prescription drugs. According to the National Household Survey on Drug Abuse, young adults aged 18 to 25 years reported the highest prevalence of illicit use of prescription drugs (OAS, 2002; McCabe and Boyd, 2005). Approximately 10% of high school seniors report taking hydrocodone in the past year and 5.5% report taking oxycodone in the past year (Johnston, 2005).

The problem is not confined to opioids, however. Non-medical use of prescription drugs may involve stimulant medication, sedative/anxiety medication, and sleeping medication as well as pain medication, and such use has been on the rise in high-school and college students for over a decade (McCabe and Boyd, 2005). Approximately 7% of high-school seniors reported non-medical use of sedatives in 2005 (Friedman 2006; Johnston, 2005).

At present, immediate-release stimulant medication abuse and diversion is rampant among high-school and college students, but it is uncommon in the absence of co-morbid disorders. It is important, therefore, to monitor medication use in individuals with ADHD and co-occurring conduct disorder and/or substance use disorders and to select extended-release therapeutic agents that have a low likelihood of diversion or abuse (Wilens, 2006).

Teenagers report that while they use illicit drugs for recreation, they often use prescription drugs for their "practical" effects: hypnotic drugs for sleep, stimulants to enhance school performance, tranquilizers to decrease stress (Friedman, 2006). Prescription drugs with a calming effect have become more popular (Johnston, 2005). Many adolescents consider prescription drugs to be safer and more socially acceptable than illicit drugs. Direct-to-consumer advertising by the pharmaceutical companies may play a role by presenting prescription drugs as a safe, routine part of everyday life, with undesirable consequences confined to the fine print (Friedman, 2006).

Adolescents and young adults who misuse prescription medication also report significantly higher rates of alcohol and other drug use than peers who do not use

prescription drugs illicitly (McCabe and Boyd, 2005). Compared to their non-using peers, teens who abuse controlled prescription drugs are twice as likely to use alcohol, five times likelier to use marijuana, 12 times likelier to use heroin, 15 times likelier to use ecstasy and 21 times likelier to use cocaine (CASA, 2005).

In general, doses associated with abuse are higher than doses used therapeutically. For some drugs, however, this is not the case. The dose of opioid analgesic used for pain control might be identical to the dose used by drug abusers, and there are individual differences in sensitivity to the reinforcing effects of these drugs (Compton and Volkow, 2006). Because the re-inforcement of a given drug is inversely related to the rate of onset of action, the route of administration is an important variable. Therefore, the addictive potential for orally administered drugs is lower than drugs administered by injection, inhalation, or smoking. Multiple substances may be used concurrently, altering the addiction, side effect, and reinforcement potential.

What Physicians Can Do

Physicians should assess their patients for substance use and psychiatric issues before issuing prescriptions for stimulants, sedatives, anxiolytics, and narcotic analgesics. In addition, physicians should manage prescriptions for controlled substances in a way that minimizes opportunities for diversion. Physicians are urged to be alert for potential prescription drug diversion and should counsel patients about the risks of theft and diversion. Patients should be warned to destroy leftover pills and physicians should be careful about prescribing to patients when a special vulnerability to addiction is known.

Physicians should take advantage of opportunities for further education about substance use issues. Behavioral health problems (including mental health and substance use disorders) are increasingly being handled in the general medical setting and physicians need to be knowledgeable about screening, brief intervention, and referral for substance abuse and dependence. Specialized substance abuse treatment resources need to be determined ahead of time, so that referral and/or consultation can occur when needed.

References

- Califano J. (2004). "You've got drugs!" *Prescription drug pushers on the internet: A CASA white paper*. The National Center on Addiction and Substance Abuse. New York, Columbia University.
- CASA. (2005). *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the US*. The National Center on Addiction and Substance Abuse at Columbia University, New York.
- Cicero TJ, Inciardi JA, Munoz A. (2005). "Trends in Abuse of OxyContin and Other Opioid Analgesics in the United States: 2002-2004." *The Journal of Pain*. 6(10): 662-672.
- Compton WM and Volkow ND. (2005). "Developments in the Epidemiology of Drug Use and Drug Use Disorders." *Am J Psychiatry*. 162(8): 1494-1502.

"Physicians should assess their patients for substance use and psychiatric issues before issuing prescriptions for stimulants, sedatives, anxiolytics, and narcotic analgesics"

- Friedman RA. (2006). "The Changing Face of Teenage Drug Abuse – The Trend toward Prescription Drugs." *NEJM* 354(14): 1448-9.
- Johnston LD, O'Malley PM, Bachman, Schulenberg. (2005). *Monitoring the Future: National Survey Results on Drug Use, 1975-2004*. Bethesda, MD: NIDA.
- McCabe SE and Boyd CJ. (2006). "Medical Use, Illicit Use, and Diversion of Abusable Prescription Drugs." *Journal of American College Health*. 54(5): 269-278.
- Office of Applied Studies. (2005). Results from the *2004 National Household Survey on Drug Abuse*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Smith MY and Woody G. (2005). "Non-medical Use and Abuse of Scheduled Medications Prescribed for Pain, Pain-related Symptoms, and Psychiatric Disorders: Patterns, User Characteristics, and Management Options." *Current Psychiatry Reports*. 7:337-343.
- Wilens TE, Gignac M, Swezey A, Monuteaux MC, Biederman J. (2006). "Characteristics of adolescents and young adults with ADHD who divert or misuse their prescription medications." *J Am Acad Child Adolesc Psychiatry*. 45(4): 408-14.
- Sara B. McEwen, MD, MPH, is consultant to the Governor's Institute on Alcohol and Substance Abuse and the Division of Mental Health, Development Disabilities, and Substance Abuse Services. Jacob A. Lohr, MD, is executive director of the Governor's Institute on Alcohol and Substance Abuse. This is the fifth in a series of articles addressing substance abuse/dependence issues.

PA and NP Ownership of Professional Corporations

Marcus B. Jimison, JD
NCMB Legal Department



Mr Jimison

The health professions of physician assistant (PA) and nurse practitioner (NP) have evolved greatly since their inception. This evolution includes PAs or NPs going into practice for themselves and becoming owners of health care practices. The Medical and Nursing Boards are frequently asked about the laws

governing the ownership of medical and nursing practices, and the purpose of this article is to provide answers to a few of the more basic, frequently asked questions.

1. A frequently asked question is, can PAs or NPs own their own practices? The answer is "yes." Under N.C. Gen. Stat. 55B-4, a licensed professional may form a corporation to render professional services. There is nothing in that law prohibiting licensed professionals, such as PAs or NPs, from owning their own practices simply because they must be supervised by another licensed professional. Consequently, PAs or NPs may form their own professional corporations.
2. A corollary to this question is, can PAs or NPs form professional corporations with physicians in which the PAs or NPs own the majority of the stock? Under N.C. Gen. Stat. 55B-14, PAs or NPs and physicians may jointly own stock in professional corporations. There is no requirement that shares of stock be allotted in a certain manner. Given the absence of a required division, PAs or NPs may own a majority of stock in professional corporations that they co-own with physicians.
3. Another question frequently asked is, can PA or NP owned practices hire physicians as employees or independent contractors to practice medi-

cine as part of PA or NP owned practices? The answer to this question is "no."*

Under N.C. Gen. Stat. 55B-4, a licensed professional may form a corporation to render professional services. Chapter 55B further defines the following terms:

"Professional service' means any type of personal or professional service of the public which requires as a condition precedent to the rendering of such service the obtaining of a license from a licensing board..." N.C. Gen. Stat. 55B-2(6).

"Licensee' means any natural person who is duly licensed by the appropriate licensing board to render the **same professional services** which will be **rendered by the professional corporation...**" N.C. Gen. Stat. 55B-2(3) [emphasis added].

Moreover, under N.C. Gen. Stat. 55B-14(a), "a professional corporation shall render only one **specific type** of professional service, and such services as may be ancillary thereto, and **shall not engage in any other business or profession...**" [emphasis added].

N.C. Gen. Stat. 55B-14(c) allows certain combinations of health care providers to form practices. These combinations include different types of nurses (registered nurse, nurse practitioner, nurse midwife, nurse anesthetist) combining to render nursing and related services (N.C. Gen. Stat. 55B-14(c)(2)); a physician and an NP combining to render medical and related services (N.C. Gen. Stat. 55B-14(c)(5)); and a physician and a PA combining to render medical and related services (N.C. Gen. Stat. 55B-14(c)(3)).

When read together, the above statutes require that PA or NP owned practices render only that specific type of professional service PAs or NPs are authorized to provide. In other words, PA owned practices may provide only PA services, while NP owned

"There is nothing in that law prohibiting licensed professionals, such as PAs or NPs, from owning their own practices"

practices may provide only NP services. These PA or NP owned practices cannot provide any other type of professional service they are not authorized to render.

By logical extension, PA or NP owned practices cannot provide physician services. Therefore, practices owned in their entirety by PAs or NPs cannot hire or contract with physicians to practice medicine on behalf of PA or NP owned practices.* Why? Because physicians provide "physician services" and PAs or NPs are not licensed or authorized to provide "physician services." PAs and NPs, by law, may perform medical acts under the supervision of physicians. Physicians, however, practice medicine without supervision. Consequently, the professional services being rendered by physicians are qualitatively different than those rendered by NPs or PAs. N.C. Gen. Stat. 55B-14(a) does allow professional corporations to provide professional services "ancillary thereto" the licensed profession. However, physician services are not ancillary to NP or PA services. The dictionary defines ancillary as being "subordinate" or "auxiliary to." Since physicians practice medicine independently and NPs and PAs practice under the supervision of physicians, it cannot be reasoned that physician services are ancillary to NP or PA services.

"Practices owned solely by PAs or NPs may not hire or contract with physicians to practice medicine on behalf of the PA or NP owned practices"

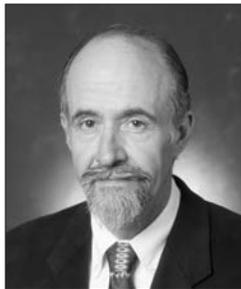
In sum, PAs or NPs may own their own practices for the purpose of providing PA or NP services and nursing and related services as may be ancillary thereto. Practices owned solely by PAs or NPs may not hire or contract with physicians to practice medicine on behalf of the PA or NP owned practices. **

.....
*The analysis of employing a physician by a PA or NP owned practice only applies when the PA or NP owns the practice in its entirety and there is not joint ownership with a physician. Also, nothing in this article should be interpreted as disallowing a PA or NP entirely owned practice from contracting with a physician to provide the legally required supervision of the PA or NP. This is allowed and the supervision services rendered by the physician may be compensated. The prohibition of hiring or contracting with a physician by a PA or NP owned practice refers to the situation wherein the physician is practicing medicine and generating revenue on behalf of the PA or NP owned practice and not simply providing supervision.

**Although this article analyzes the issues of PA and NP ownership under the professional corporation model, the same results occur regardless of the form of ownership of the PA or NP practice, ie, whether it is a sole proprietorship, a partnership, or any form of professional corporation.

The author thanks M. Jackson Nichols, JD, General Counsel, North Carolina Board of Nursing, for his assistance in preparation of this article.

NCMB Names New Medical Director: C. Michael Sheppa, MD



Dr Sheppa

C. Michael Sheppa, MD, was named medical director of the North Carolina Medical Board in September 2006. Dr Sheppa joined the staff of the Board as assistant medical director in February 2006. In August, with the departure of Dr Jesse Roberts, medical director of the Board for some six years, Dr Sheppa became interim medical director.

Dr Sheppa earned his undergraduate degree from Western Reserve University's Adelbert College, where he was elected to Phi Beta Kappa. He graduated from the School of Medicine at Case Western Reserve University and was a member of Alpha Omega Alpha. He completed an internal medicine residency at the University of Virginia Hospital in Charlottesville, and, following his residency, he joined the Department of Medicine faculty at the University of Virginia. While there, he developed an interest in emergency medicine.

He subsequently entered private practice as an emergency medicine physician. Prior to coming to the North Carolina Medical Board as assistant medical director, Dr Sheppa was a partner in and president of Raleigh Emergency Medical Associates in Raleigh. He is board certified in internal medicine and emergency medicine and is a fellow in the American College of Emergency Physicians. He has coauthored articles in the medical literature and has been an invited speaker at local and national scientific assemblies in emergency medicine.

"We were fortunate to have Dr Sheppa join us as assistant medical director earlier this year," said David Henderson, executive director of the North Carolina Medical Board. "Now we are pleased to have him assume the role of medical director, a position he knows well and one for which he is extremely well suited."

The Board's medical director is responsible for assisting the staff and Board in investigating and reviewing matters that may involve quality of care concerns and for making recommendations to the Board regarding those matters.

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

May - June - July 2006

DEFINITIONS:

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

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

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

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

Dismissal:
Board action dismissing a contested case.

Inactive Medical License:
To be "active," a medical license must be registered on or

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

NA:
Information not available or not applicable.

NCPHP:
North Carolina Physicians Health Program.

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

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

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

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

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

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

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

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

ANNULMENTS
NONE

REVOICATIONS

MATTHEW-THOMPSON, Laura Jean, MD

Location: Fayetteville, NC (Cumberland Co)
 DOB: 9/30/1954
 License #: 2001-00736
 Specialty: FP (as reported by physician)
 Medical Ed: Howard University (1980)
 Cause: The Board found that when Employee A, a physician assistant who surrendered his PA license in January 2001, worked for Dr Matthew-Thompson in 2005, his physician assistant license was inactive. Dr Matthew-Thompson knew this to be the case but referred to Employee A as a physician assistant on occasion. She also permitted Employee A to perform medical acts even when he was alone and when she was out of the office. She also left pre-signed prescription blanks for Employee A to use in treating patients and he used them to prescribe and authorize refills for controlled substances.

Action: 5/25/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 4/12/2006: Dr Matthew-Thompson's North Carolina medical license is revoked.

ROHR, Michael Snell, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 4/15/1941
 License #: 0000-38423
 Specialty: GS (as reported by physician)
 Medical Ed: Tulane University (1967)
 Cause: Dr Rohr was convicted of a felony in the General Court of Justice, Superior Court Division for Forsyth County, North Carolina, in December 2005.

Action: 6/29/2006. Entry of Revocation issued revoking Dr Rohr's North Carolina medical license by operation of law on 4/22/2006.

WILLIAMS, Warren Herbert, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 1/03/1951
 License #: 0000-30111
 Specialty: P (as reported by physician)
 Medical Ed: University Autonoma Guadalajara (1980)

Cause: Dr Williams was convicted of a felony in the District Court of the U.S. for the Western Division of North Carolina.
 Action: 6/29/2006. Entry of Revocation issued revoking Dr Williams' North Carolina medical license.

SUSPENSIONS

BASILI, Richard Louis, Jr, MD

Location: Tarboro, NC (Edgecombe Co)
 DOB: 10/06/1967
 License #: 0097-00464
 Specialty: A (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1993)
 Cause: Dr Basili's conduct in filing harassing and abusive documents in various law courts, acting in a disruptive manner, and his diagnosis as suffering from psychosis and having delusional thought patterns constitutes his being unable to practice medicine with reasonable skill and safety. He has also failed to respond in a reasonable time to inquiries from the Board and to obtain evaluation by the NCPHP within the time specified by the Board.

Action: 7/14/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 6/16/2006: Dr Basili's North Carolina medical license is suspended indefinitely; he may not reapply until such time as he has sought evaluation by the NCPHP, complied with resulting recommendations, and obtained support for his reapplication from the NCPHP.

MARTINEZ, Fernando Jesus, MD

Location: Baton Rouge, LA
 DOB: 11/12/1952
 License #: 0097-00324
 Specialty: EM/IM (as reported by physician)
 Medical Ed: Tulane School of Medicine (1979)
 Cause: By a Consent Order, the Louisiana Board placed Dr Martinez medical license on probation for a period of three years, prohibited his practicing chronic pain management, required he surrender his DEA permit, and required he enroll in CME, records, and controlled substance prescribing courses.

Action: 5/01/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/12/2006: Dr Martinez' North Carolina medical license is indefinitely suspended.

PANDIT, Ashok Narayan, MD

Location: Panama City, FL
 DOB: 8/30/1948
 License #: 0096-00669
 Specialty: IM/NEP (as reported by physician)
 Medical Ed: Karnatak Medical College, India (1976)
 Cause: The Nevada Board denied Dr Pandit's application for a medical license in 2005 on finding he has a history of substance abuse, had recently relapsed, and had entered a recovery program in Florida. It also held he had been misleading or untruthful in his response to a question regarding the 2002 denial of a license by Nevada.
 Action: 5/01/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/12/2006: Dr Pandit's North Carolina medical license is indefinitely suspended.

SALUJA, Darshan Singh, MD

Location: Baltimore, MD
 DOB: 5/05/1937
 License #: 0000-19178
 Specialty: FP/G (as reported by physician)
 Medical Ed: GSV, Lucknow University, India (1963)
 Cause: In 2005, the Maryland Board found Dr Saluja had failed to conform to the minimal standards of medical practice by failing to order appropriate consultation and diagnostic studies for a cardiac patient. Maryland suspended his license, suspension being immediately stayed on condition he comply with several requirements involving assessment of his competence. Chart reviews or formal peer review will also be done on at least 10 of his charts. He must also submit a plan to the Maryland Board on improving his communication with specialists and consultants.
 Action: 5/01/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/12/2006: Dr Saluja's North Carolina medical license is suspended, suspension being immediately stayed.

See Consent Orders:

CAGGIANO, Christopher John, Physician Assistant
COLLINS, Paul Dwayne, MD
GUARINO, Clinton Toms Andrews, MD
KOCICH, Darlene Christine, Nurse Practitioner
PRESNELL, Tammy Murrelle, Physician Assistant
STARR, Dorothy Elizabeth, Physician Assistant

SUMMARY SUSPENSIONS**BECK, Jeffrey R., DO**

Location: Easton, MD
 DOB: 10/21/1953
 License #: 0098-00186
 Specialty: EM/PD (as reported by physician)
 Medical Ed: College of Osteopathic Medicine, Des Moines (1978)
 Cause: Dr Beck may be unable to practice with reasonable skill and safety as set forth in documents of the California Board and the Notice of Charges and Allegations filed by the North Carolina Medical Board on 7/28/2006.
 Action: 7/28/2006. Order of Summary Suspension of License issued: Dr Beck's North Carolina medical license is suspended.

CONSENT ORDERS**CAGGIANO, Christopher John, Physician Assistant**

Location: Kannapolis, NC (Cabarrus Co)
 DOB: 10/26/1965
 License #: 0001-02355
 PA Education: University of Nebraska (1994)
 Cause: Mr Caggiano's management of three patients, through his ordering of extensive laboratory and diagnostic testing involving significant costs without sufficient clinical indication documented in the patients' records, is unprofessional conduct and failure to conform to standards of acceptable medical practice.
 Action: 7/21/2006. Consent Order executed: Mr Caggiano's PA license is suspended for two years beginning 9/01/2006; suspension will be stayed on 1/01/2007 and he will be placed on probation for the remainder of the suspension period based on certain condi-

tions; he shall divest himself of majority ownership of Cannon Family Medicine and Urgent Care; he shall have his charts assigned by his supervising physician(s) within seven days; must comply with other conditions.

COLLINS, Paul Dwayne, MD

Location: Pembroke, NC (Robeson Co)
 DOB: 2/08/1973
 License #: 2005-00139
 Specialty: FP (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (2001)
 Cause: On 2/13/2006, Dr Collins tested positive for alcohol. This violated the Consent Order of 1/26/2005 that was required prior to his licensure due to his history of alcohol and drug abuse. On 3/13/2006, he surrendered his North Carolina license.
 Action: 7/24/2006. Consent Order executed: Dr Collins' North Carolina medical license is indefinitely suspended.

CRAFT, Patrick Phelps, MD

Location: Norton, VA
 DOB: 8/11/1964
 License #: 0094-01159
 Specialty: EM/FP (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1993)
 Cause: Consent Order with the Virginia Board in which Dr Craft admitted he failed to diagnose, treat, and/or document several patients' illnesses properly. He was reprimanded by the Virginia Board and placed on probation subject to terms and conditions, including required passage of SPEX. He has passed SPEX and is meeting other requirements set by Virginia.
 Action: 6/02/2006. Consent Order executed: Dr Craft is reprimanded; he shall continue to comply with all terms of the Virginia Consent Order; he must ensure copies of all reports from his supervising physician [in Roxboro, NC] be sent to the North Carolina Board as well as the Virginia Board; he must obtain approval from the president of the North Carolina Board before changing his practice site during the period of his Virginia probation; must comply with other conditions.

CROOM, Dorwyn Wayne, II, MD

Location: Valdese, NC (Burke Co)
 DOB: 9/11/1950
 License #: 0000-23371
 Specialty: PTH (as reported by physician)
 Medical Ed: Washington University (1976)
 Cause: In August 2001, Dr Croom interpreted four slides with surgical specimens of breast biopsies from Patients A and B. After initial review, he set the slides and their related documents aside. After reviewing the slides a second time, he inadvertently and mistakenly placed each of the slides with the documentation for the other slide. As a result, Patient A underwent an unnecessary lumpectomy with axillary node dissection. Dr Croom has been licensed in North Carolina since 1979 and has had no other complaints filed against him. This event appears to be an isolated incident. He has settled a malpractice claim with Patient A, the only one he has paid in his career. Patient B has a claim pending against him. His group has added another pathologist to reduce the workload and Dr Croom has a new policy that reports of additional testing, done elsewhere on all cancers, be reviewed along side the original reports by the originating pathologist.
 Action: 5/08/2006. Non-Disciplinary Consent Order executed: The matter is resolved with no disciplinary action imposed; Dr Croom's medical license remains uninterrupted as a full and unrestricted license.

GOLDENTHAL, Nathan David, MD

Location: Phoenix, AZ
 DOB: 9/13/1951
 License #: 0000-38067
 Specialty: OM (as reported by physician)
 Medical Ed: University of Toronto (1975)
 Cause: In a January 2005 Consent Order with the Arizona Medical Board, Dr Godenthal admitted that certain facts alleged by that board, if proven, would constitute unprofessional conduct for failing to keep adequate patient records and charging fees for ser-

vices not rendered. The Arizona Consent Order prohibited him from practicing medicine involving direct patient care and from prescribing medications until the Arizona Board approves such action.

Action: 6/05/2006. Consent Order executed: Dr Goldenthal is reprimanded; must comply with other conditions.

GUARINO, Clinton Toms Andrews, MD

Location: Hickory, NC (Catawba Co)
 DOB: 2/04/1966
 License #: 0099-00062
 Specialty: IM (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (1996)
 Cause: Dr Guarino was stopped in December 2005 and arrested for traffic offenses, including driving while impaired. He was referred by NCPHP for assessment and it was revealed he has a substance abuse/dependency condition. He is undergoing inpatient treatment and, in December 2005, he surrendered his North Carolina medical license.

Action: 5/01/2006. Consent Order executed: Dr Guarino's North Carolina medical license is suspended indefinitely.

HAMMER, Michael, MD

Location: Birmingham, AL
 DOB: 12/02/1954
 License #: 0000-36723
 Specialty: AN/APM (as reported by physician)
 Medical Ed: University Central Del Este, Dominican Republic (1980)
 Cause: In March 2006, Alabama levied a \$15,000 administrative fine against Dr Hammer, reprimanded him, and prohibited him from entering a collaborative practice agreement with a nurse practitioner for two years. These actions resulted from his having a collaborative agreement with a nurse practitioner without approval for a remote site and no approved backup in Dr Hammer's absence. While he was out of the country for several days, the nurse practitioner wrote prescriptions, some for controlled substances. He also failed to maintain quality assurance tracking documentation.

Action: 7/25/2006. Consent Order executed: Dr Hammer is reprimanded.

HUNSAKER, Robert Huson, MD

Location: Key Biscayne, FL
 DOB: 2/04/1956
 License #: 0000-28050
 Specialty: PS (as reported by physician)
 Medical Ed: Ohio State University (1982)
 Cause: In June 2005, Florida filed a complaint alleging Dr Hunsaker failed to practice with the level of care, skill, and treatment recognized as meeting acceptable standards in several ways. In August 2005, he entered into a Consent Order with Florida in which he did not admit or deny the allegations in Florida's complaint, but he agreed to suspension of his Florida license for 12 months, with 11 months stayed, to pay a fine, to perform community service, and to take specified CME.

Action: 6/30/2006. Consent Order executed: Dr Hunsaker is reprimanded; his North Carolina medical license is put on probation for one year from the date of the final Florida action (11/09/2005).

JAMIESON, Brian David, MD

Location: San Diego, CA
 DOB: 12/01/1975
 License #: 2006-00975
 Specialty: AN (as reported by physician)
 Medical Ed: University of Texas Southwestern Medical Center (2001)
 Cause: On application for a license. Dr Jamieson has a history of substance abuse and treatment in California. From April 2004 until the present, he participated in the California Physician's Diversion Program. He has maintained sobriety since that time. He was assessed by the NCPHP in November 2005 and found to be in full remission of his opioid addiction.

Action: 6/27/2006. Consent Order executed: Dr Jamieson is issued a full and unrestricted North Carolina medical license; he shall maintain and abide by a contract with the NCPHP; he shall provide a copy of his North Carolina Consent Order to all current and prospective employers; must comply with other conditions.

KOCICH, Darlene Christine, Nurse Practitioner

Location: Henrico, NC (Northampton Co)
 DOB: 11/16/1952
 Approval #: 0002-00881
 NP Education: NA
 Cause: Ms Kocich prescribed inappropriately to a family member, failed to maintain at her practice proof of earned CME credit, and failed to timely submit documents required to change her supervising physician.

Action: 5/19/2006. Consent Order executed: Ms Kocich's NP approval is suspended; suspension is stayed on terms and conditions; she shall have her supervising physician review her medical charts and prescriptions on a monthly basis until August and thereafter every five weeks for six months; she shall attend a CME course on prescribing within 90 days and submit proof of her attendance to the Board; must comply with other requirements.

KRAYNACK, Barry Joseph, MD

Location: Drums, PA
 DOB: 2/09/1947
 License #: 0000-35401
 Specialty: AN/APN (as reported by physician)
 Medical Ed: University of Pittsburgh (1973)
 Cause: Dr Kraynack entered into a Consent Order with the New York Board in which he did not contest that in December 2001 in Florida he was found guilty on a plea of no contest of Driving Under the Influence, a misdemeanor. He agreed, among other things, to pay a fine of \$2,500.

Action: 6/08/2006. Consent Order executed: Dr Kraynack is reprimanded.

NORMAN, Gayle Marie Johnson, Physician Assistant

Location: East Bend, NC (Forsyth Co)
 DOB: 12/25/1961
 License #: 0001-00937
 PA Education: Bowman Gray (1986)
 Cause: On application for reinstatement of license. Ms Norman has not practiced as a PA since 2000 and her license was made inactive at her request in 2001. She has been teaching science and allied health in Yadkin County and the Department of Public Instruction requires she have an active PA license to teach allied health classes. Reactivation of her license would be for teaching only, not clinical practice.

Action: 5/09/2006. Consent Order executed: Ms Norman's PA license is reactivated; she shall not practice clinical medicine.

PITTMAN, John Carl, MD

Location: Raleigh, NC (Wake Co)
 DOB: 1/15/1959
 License #: 0000-31614
 Specialty: GPM/NTR (as reported by physician)
 Medical Ed: Mercer (1986)
 Cause: To amend Dr Pittman's Consent Order of 9/07/2002 in order to lift all but one condition/restriction.

Action: 7/26/2006. Amended Consent Order executed: The Stayed Indefinite Suspension in of Dr Pittman's license is lifted; he will not use IV ozone or hydrogen peroxide therapy in his practice until the Board explicitly orders otherwise.

PRESNELL, Tammy Murrelle, Physician Assistant

Location: Reidsville, NC (Rockingham Co)
 DOB: 7/18/1960
 License #: 0001-03613
 PA Education: East Carolina University (2002)
 Cause: Ms Presnell surrendered her PA license on 2/15/2006. She has a history of substance abuse and was a anonymous participant in the NCPHP. On 7/26/2005, she tested positive for Ultram® and admitted to the NCPHP she had self-administered the drug for headache without first or later telling the NCPHP. On 8/12/2005, she again tested positive for a controlled substance that she said was prescribed by her dentist, but she again failed to tell the NCPHP. She further admitted treating herself for back pain using medication left over from the dental prescription. The Board has no evidence Ms Presnell was ever impaired while working as a PA. She was diagnosed with chronic fibromyalgia syn-

drome in June 2006
 Action: 7/21/2006. Consent Order executed: Ms Presnell's PA license is indefinitely suspended effective 2/15/2006.

STARR, Dorothy Elizabeth, Physician Assistant

Location: Belmont, NC (Gaston Co)
 DOB: 11/10/1967
 License #: 0001-03481
 PA Education: Nova SE University (1996)
 Cause: On four occasions in 2005 and 2006, Ms Starr improperly obtained a controlled substance by calling a pharmacy and authorizing prescriptions using another PA's name. She surrendered her PA license on 5/10/2006.
 Action: 7/26/2006. Consent Order executed: Ms Starr's PA license is suspended indefinitely; she may not petition for reinstatement for at least 90 days.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

NONE

SURRENDERS

BOTWRIGHT, Gene Robert, Jr, MD

Location: Wagram, NC (Scotland Co)
 DOB: 8/23/1955
 License #: 0000-36462
 Specialty: FP (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1990)
 Action: 6/09/2006. Voluntary surrender of North Carolina medical license.

EATON, Hubert Arthur, Jr, MD

Location: Wilmington, NC (New Hanover Co)
 DOB: 5/25/1943
 License #: 0000-17858
 Specialty: IM (as reported by physician)
 Medical Ed: Meharry Medical College School of Medicine (1969)
 Action: 7/21/2006. Voluntary surrender of NC medical license.

GRAVATT, Steven James, Physician Assistant

Location: High Point, NC (Guilford Co)
 DOB: 8/27/1960
 License #: 0001-01713
 PA Education: Duke University (1993)
 Action: 5/31/2006. Voluntary surrender of North Carolina PA license.

JONES, Robert Glen, MD

Location: Raleigh, NC (Wake Co)
 DOB: 4/06/1959
 License #: 0094-00536
 Specialty: OSM/SM (as reported by physician)
 Medical Ed: Emory University (1988)
 Action: 6/19/2006. Voluntary surrender of North Carolina medical license.

MILLER, Shelly Ann, MD

Location: Raleigh, NC (Wake Co)
 DOB: 7/13/1965
 License #: 0095-01008
 Specialty: FP (as reported by physician)
 Medical Ed: University of Connecticut (1991)
 Actions: 6/13/2006. Voluntary surrender of North Carolina medical license.

ROBERTSON, Elisabeth M., MD

Location: Statesville, NC (Iredell Co)
 DOB: 9/20/1957
 License #: 0000-34107
 Specialty: APN/EM (as reported by physician)
 Medical Ed: University of Michigan (1981)
 Action: 5/26/2006. Voluntary surrender of North Carolina medical license.

RUSSELL, Anthony Otis, MD

Location: High Point, NC (Guilford Co)
 DOB: 5/07/1961
 License #: 0000-35491
 Specialty: AN/APN (as reported by physician)
 Medical Ed: New York University (1987)
 Action: 7/05/2006. Voluntary surrender of NC medical license.

STARR, Dorothy Elizabeth, Physician Assistant

Location: Belmont, NC (Gaston Co)
 DOB: 11/10/1967
 License #: 0001-03481
 PA Education: Nova S. E. University (1996)
 Action: 5/10/2006. Voluntary surrender of North Carolina medical license.

COURT APPEALS/STAYS

NONE

TEMPORARY/DATED LICENSES:

ISSUED, EXPIRED, OR REPLACED BY FULL LICENSES

BARBER, Robert Anthony, DO

Location: Morehead City, NC (Carteret Co)
 DOB: 9/30/1954
 License #: 2003-00222
 Specialty: FP (as reported by physician)
 Medical Ed: University of Health Science College of Osteopathic Medicine, Kansas City (1989)
 Action: 5/18/2006. Temporary/dated license issued to expire 11/30/2006.

CRUMP, Carolyn Faydene, MD

Location: Lexington, NC (Davidson Co)
 DOB: 1/27/1950
 License #: 2005-01115
 Specialty: GP (as reported by physician)
 Medical Ed: George Washington University School of Medicine (1976)
 Action: 7/20/2006. Temporary/dated license extended to expire 1/31/2007.

DeVIRGILIIS, Juan Carlos, MD

Location: Boone, NC (Watauga Co)
 DOB: 8/29/1957
 License #: 0000-28719
 Specialty: FP/P (as reported by physician)
 Medical Ed: Faculty of Medical Science, National University of La Plata, Argentina (1982)
 Action: 5/31/2006. Temporary/dated license issued to expire 5/31/2007.

FOLKERTS, AnnaMaria, Physician Assistant

Location: Elon, NC (Alamance Co)
 DOB: 8/24/1961
 License #: 0001-02206
 PA Education: College of West Virginia (1996)
 Action: 5/18/2006. Full and unrestricted PA license issued.

HARRIS, John Joel, MD

Location: Bladenboro, NC (Bladen Co)
 DOB: 6/30/1958
 License #: 0000-32114
 Specialty: AN (as reported by physician)
 Medical Ed: University of Tennessee, Memphis, College of Medicine (1984)
 Action: 5/18/2006. Temporary/dated license issued to expire 11/30/2006.

LONGAS, Philip Lee, MD

Location: Lenoir, NC (Caldwell Co)
 DOB: 10/19/1964
 License #: 2006-00127
 Specialty: IM (as reported by physician)
 Medical Ed: East Tennessee State University (1995)
 Action: 5/31/2006. Temporary/dated license issued to expire 11/30/2006.

MASSENBURG, O'Laf Sorento, Physician Assistant

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 2/10/1960

License #: 0001-01117
 PA Education: Bowman Gray (1988)
 Action: 5/19/2006. Full and unrestricted North Carolina PA license issued.

MUNCHING, Aaron Albert, Physician Assistant

Location: Durham, NC (Durham Co)
 DOB: 1/10/1961
 License #: 0010-00016
 PA Education: Alderson-Broaddus (1990)
 Action: 5/18/2006. Temporary/dated PA license issued to expire 5/31/2007.

NGUYEN, Tuong Dai, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 4/11/1967
 License #: 2000-00566
 Specialty: IM (as reported by physician)
 Medical Ed: Temple University School of Medicine (1996)
 Action: 5/18/2006. Temporary/dated license issued to expire 9/30/2006.

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: 7/20/2006. Full and unrestricted medical license issued.

SMITH, David Lewis, Physician Assistant

Location: Raleigh, NC (Wake Co)
 DOB: 9/19/1951
 License #: 0001-01503
 PA Education: Alderson Broaddus College (1992)
 Action: 7/20/2006. Temporary/dated license extended to expire 7/31/2007.

WHITE, Steven William, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)
 DOB: 12/19/1962
 License #: 0001-02116
 PA Education: Midwestern University (1996)
 Action: 7/20/2006. Temporary/dated license extended to expire 1/31/2007.

CONSENT ORDERS LIFTED

DYER, G. David, MD

Location: Wrightsville Beach, NC (New Hanover Co)
 DOB: 5/03/1944
 License #: 0000-22562
 Specialty: IM/FP (as reported by physician)
 Medical Ed: University of Kentucky (1977)
 Action: 6/06/2006. Order issued lifting Consent Order of 7/12/2001.

FOLKERTS, AnnaMaria, Physician Assistant

Location: Elon, NC (Alamance Co)
 DOB: 8/24/1961
 License #: 0001-02206
 PA Education: College of West Virginia (1996)
 Action: 6/30/2006. Order issued lifting Consent Orders of 5/20/2004 and 12/22/2004.

LEGGETT, Jerry Curtis, Physician Assistant

Location: Greenville, NC (Pitt Co)
 DOB: 7/4/1955
 License #: 0001-00674
 PA Education: Wake Forest University PA Program (1983)
 Action: 6/28/2006. Order issued lifting the Reentry Agreement and Order of 8/24/2005.

MASSENBURG, O'Laf Sorento, Physician Assistant

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 2/10/1960
 License #: 0001-01117
 PA Education: Bowman Gray (1988)
 Action: 7/06/2006. Order issued lifting Consent Order of 8/01/2004.

MILES, Martha Cope, MD

Location: Cary, NC (Wake Co)

DOB: 8/12/1953
 License #: 0000-35989
 Specialty: N (as reported by physician)
 Medical Ed: University of Oklahoma (1988)
 Action: 7/13/2006. Order issued lifting Consent Order of 1/15/2004.

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)
 Action: 6/29/2006. Order issued lifting Consent Order of 5/20/2004.

DISMISSALS

GREER, Michael Edward, MD

Location: Seattle, WA
 DOB: 9/21/1950
 License #: 0000-24970
 Specialty: ??????
 Medical Ed: Hahnemann (1976)
 Action: 5/22/2006. Notice of Dismissal issued: The case against Dr Greer initiated by the Notice of Charges and Allegations dated 2/17/2006 is dismissed without prejudice.

PERDIKIS, George C., MD

Location: Lancaster, PA
 DOB: 11/20/1951
 License #: 0095-00484
 Specialty: Not Reported
 Medical Ed: University of California, Irvine (1985)
 Action: 7/17/2006. Notice of Dismissal Without Prejudice of Charges and Allegations of 8/30/2005.

WOODS, Kristy Freeman, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 1/05/1956
 License #: 2003-00913
 Specialty: IM (as reported by physician)
 Medical Ed: Tulane University School of Medicine (1981)
 Action: 5/31/2006. Notice of Dismissal issued: The case against Dr Woods initiated by the Notice of Charges and Allegations dated 7/14/2005 is dismissed without prejudice.

REENTRY AGREEMENTS

BRANSTETTER, Annie Laura, Physician Assistant

Location: Raleigh, NC (Wake Co)
 DOB: 8/17/1978
 License #: 0010-00489
 PA Education: University of Kentucky (2004)
 Cause: Ms Branstetter has not practiced since she received her PA degree in August 2004. Her CME is current.
 Action: 6/13/2006. Reentry Agreement and Order executed: Ms Branstetter is issued a PA license; she shall arrange to have her supervising physician observe her practice for a year and report to the Board on her performance quarterly; if requested, she shall meet with members of the Board at such times as directed.

McPHEE, Gerard Michael, MD

Location: Pollocksville, NC (Jones Co)
 DOB: 12/30/1945
 License #: 2006-00976
 Specialty: RO (as reported by physician)
 Medical Ed: State University of New York, Buffalo (1976)
 Cause: Dr McPhee has not practiced medicine since June 2003.
 Action: 6/27/2006. Reentry Agreement and Order executed: Dr McPhee is issued a full and unrestricted North Carolina medical license; he shall have a physician colleague observe his practice for the first year and report quarterly to the Board on Dr McPhee's level of clinical skill, if requested, he shall meet with the Board at such times as directed.

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



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North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: November 15-17, 2006; December 16, 2006; January 17-19, 2007;
February 21-22, 2007; March 21-23, 2007

Residents Please Note USMLE Information

United States Medical Licensing Examination

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

Special Purpose Examination (SPEX)

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

North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609