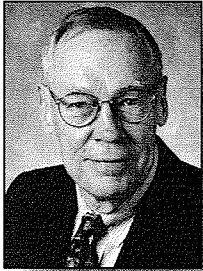


forum

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



President's Message

George C. Barrett, MD

The Good Death: A Necessary Dialogue

Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted life-saving medical treatment; no one is permitted to assist a suicide.... The distinction between assisting suicide and withdrawing life sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational.... The distinction comports with fundamental legal principles of causation and intent.

Vacco, Attorney General of New York, et al v Quill et al, 1997.

Listen with new ears, open your eyes, and look around you at the medicine of our times. Everywhere you will see the patient subservient to medicine and technology, not the reverse.

Eric J. Cassell, MD,
in his book, *Doctoring*

Terminology

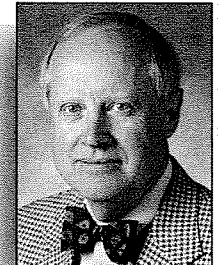
passive euthanasia (letting a patient die): Permitting the disease process to run its course; no intervention when respirations are depressed by medication intended to relieve pain; includes withdrawing life support, food, and hydration.

physician assisted suicide (PAS): Making available the means needed for the patient to commit suicide, eg, an adequate dose of barbiturates.

active or voluntary euthanasia: Making available the means for suicide and, at the request of the patient, administering the agent.

Hippocrates (circa 500-400 BCE) included in his oath the phrase: "to please no one will I prescribe a deadly drug, nor give advice which may cause his death." Dr Robert Weir, a bioethicist at the University of Iowa and editor of the recent book *Physician Assisted Suicide*, notes that the phrase regarding deadly drugs in the Hippocratic Oath was not supported by a majority of the journeymen physicians of Hippocrates' day. It was placed there to garner trust and gain the respect of patients for those physicians who opposed assisted suicide. The recent decisions of the U.S. Supreme Court in *Vacco v Quill* and its companion case, *Washington v Glucksberg*, affirmed that even though a state permits patients to die by refusing treatment (passive euthanasia) it may still prohibit

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From the Executive Director

Bryant D. Paris, Jr

Legislative Alert: Recent Changes in the MPA

In order to give you a concise review of the legislation adopted by the General Assembly in late August amending the Medical Practice Act (MPA), I am devoting my commentary in this number of the *Forum* to that subject. (William Breeze, JD, of the Board's Legal Department, offers a more detailed look at the amendments later on in these pages.) Four substantive changes have been made and should be of interest to all of you.

• *Annual Physician Registration:*

Beginning in 1998, physicians will register within 30 days of their birthdays. Since 1958, all physicians have been required to register in January, putting a strain on the Board and the registrants. That now ends. With the registration of the 23,000 doctors licensed in North Carolina spread throughout a full year, the process should be easier for everyone. Rather than wonder about the time for registration, physicians can now simply recall that their birthday signals the need to register within 30 days. To reinforce that, the Board will send the physician an appropriate form two months prior to the required time of registration. As always, if you have an address change at any time after your last registration, you should notify the Board of the change promptly to assure you receive proper registration notification and other Board information.

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Primum Non Nocere



forum

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

Raleigh, NC

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

North Carolina Medical Board

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•1991: The Omnibus Budget Reconciliation Act requires hospitals to offer "living will" preparation for all patients admitted without such a document.

•1993: The North Carolina General Assembly adopts the Health Care Power of Attorney law.

Death Is Still the Enemy

There are strong differences of opinion within the medical profession regarding the role a physician should assume in the latter days or months of a patient's life. Several national organizations, including the American Medical Association (AMA) and the National Hospice Organization, have taken positions opposing physician assisted suicide (PAS), while many physicians believe failing to provide the means for suicide violates patient autonomy and is not beneficent.

Dr Weir, in *Physician Assisted Suicide*, points out that there are conceptual differences regarding the three roles that are the focus of the controversy: life-abating actions, PAS, and active euthanasia. Some ethicists reject distinctions among the three, while others believe non-intervention cannot be equated with PAS and active euthanasia. Edmund D. Pellegrino, MD, a noted biomedical ethicist at Georgetown University Medical Center, unrelentingly opposes any participation by a physician in PAS and argues that when a patient "opts for euthanasia, he uses his freedom to give up his freedom." On the other hand, Drs Timothy Quill, Christine Cassel, and Diane Meier propose clinical criteria for PAS.

For the physician practicing daily in a modern hospital, however, death is still the enemy. There has been little discussion there of the relationship of suffering to life or of death as a part of life.

The Debate

Even the most reasonable, thoughtful, ethical, caring physicians and philosophers disagree about the morality of PAS and active euthanasia. Dr Pellegrino argues that beneficence does obligate "the physician to help the patient to a good and gentle death. It is also compassionate and morally commendable to help a person to die well." But he contends euthanasia interrupts the last act

President's Message

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assisted suicide and that there is no constitutional right to assisted suicide.

Legislation and Case Law

Quill and *Glucksberg* are the most recent developments in a long process. Over the years, many patients have sought ways to bring about their own deaths when they have found living too burdensome. Physicians and health care institutions have typically resisted such efforts. The following brief sampling of events indicates that several decades of legislation and case law have been necessary to the process of recognizing patient autonomy and focusing physician attention on the complex meaning of beneficence.

"Over the years, many patients have sought ways to bring about their own deaths when they have found living too burdensome."

•1970: A New Jersey court affirms the right of a patient to decline medical treatment (*Quinlan*).

•1973: The U.S. Supreme Court, in *Roe v Wade*, affirms the right of women to choose abortion.

•1977: The North Carolina General Assembly adopts the Right to Natural Death law.

•1983: The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research issues a report on *Deciding to Forego Life-Sustaining Treatment*.

•1986: E. Bouvia is granted permission by a court to refuse food and hydration. ("A precedent was established that when a doctor performs treatment in the absence of informed consent, there is actionable battery.")

•1990: The U.S. Supreme Court recognizes the right of a competent person to decline medical treatment but does not permit withdrawal of a feeding tube in the *Cruzan* case because an accident had rendered her incompetent.

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in the drama of life. In an article in *Physician Assisted Suicide*, Dan W. Brock, PhD, a bio-medical ethicist at Brown University School of Medicine, counters that to deny a patient help is a denial of self-determination and may sometimes be immoral.

Some believe that if PAS and active euthanasia for competent patients become law and common practice, we will have made a choice that will lead us inexorably to widen the circle of those society determines will benefit from an early death. Should the requirement for patient competence be removed, for example, active euthanasia of severely incapacitated incompetents, severely disabled persons, and severely impaired children could become possible—a monstrous corruption of an originally humane intention.

Dr Cassel accuses opponents of PAS of “refusing to deal with their patients at the level of the personal meaning of life and death,” and of not having the intellectual and moral vitality to address ethically complex issues or to confront their own feelings about life and death.

“Myths”

Writing in *The Atlantic Monthly*, Ezekiel Emanuel, MD, associate professor at Harvard Medical School and an oncologist, argues that America should think again before moving ahead with legalizing PAS and euthanasia, that many decisions being made are based on misinterpretations of history and survey data and on simple misinformation. In his view, what he identifies as four “myths” have led to some poor conclusions.

1. *Advances in life-sustaining technology have created the unprecedented interest in PAS and voluntary euthanasia.* Emanuel counters that many of the arguments advanced today were used as far back as 1870, significantly predating the advent of modern medical technology, and rejected.
2. *Legalizing PAS and euthanasia is widely endorsed.* Emanuel interprets these data to reflect endorsement in the abstract when the question is hypothetical.
3. *It is the terminally ill patient with*

uncontrollable pain who is most likely to be interested in PAS and euthanasia. Data from the Netherlands dispute this and other data suggest the most common motivations are depression and psychological distress.

4. *The experience of the Netherlands shows that permitting PAS and euthanasia will not eventually get out of hand.*

The data reveal that 1,000 non-voluntary instances occur each year and that 41 percent of PASs in nursing homes do not follow the guidelines.

The myths. Ay, there’s the rub! How do we address the myths? In 44 years, the medical

profession has moved, or been moved, from not playing God, to accepting abortion, to accepting the autonomy reflected in the living will, to letting the patient die, to debating PAS and active euthanasia. In an article in *Physician Assisted Suicide*, Darrell W. Amundsen, PhD, of Western Washington University, details the circuitous, not necessarily accurate, interpretations of history that led the majority of the Supreme Court to the decision in *Roe v Wade*. In his view, the Court may have misinterpreted the attitude of the ancients about abortion and suicide, mistaking the minority attitude for that of the majority. In *Michigan v Kevorkian*, he says, Judge Kaufman failed to see certain inaccuracies in the Supreme Court’s interpretation of history, thus giving less merit to the prosecutor’s argument regarding the relevance of “history and tradition.”

Facing End-of-Life Issues

Valid differences of opinion surrounding end-of-life issues have placed members of the medical profession and the public in a quandary. Absence of an understanding of the meaning of death and the relationship of death to life has created a void in the physician-patient relationship that must be filled. A partial list of issues to be addressed includes the following.

- How can we educate physicians and the public about end-of-life values?
- What is the role of medical schools and residency training programs in teaching the provision of palliative care and communication techniques about end-of-life decisions?
- Is there a moral difference between letting die and PAS/active euthanasia?
- Will debating these issues as a profession enable physicians to better understand and accept suffering?
- What do the medical profession and the public consider a “good death”?

- Will a discussion of palliative care lead us to understand “good death”?
- How can the medical profession help patients understand and accept the limits of medical technology—and of physicians themselves?

The decisions of the U.S. Supreme Court in *Quill* and *Glucksberg* have presented the medical profession a challenge and an opportunity. The states may let the decisions stand or address the issues of PAS and active euthanasia individually. The myths noted by Emanuel will be cited time and time again, and the historical inaccuracies that have led to some of our laws will not be questioned. The challenge is to be prepared to face these difficult issues intelligently if the North Carolina General Assembly chooses to address PAS and/or active euthanasia. The opportunity is to be an accurate and reliable source of information for the public on these issues.

Educating Professionals

The importance and immediacy of the need for education of professionals and the public is supported by research being conducted at Duke University Medical School by James Tulsy, MD, as reported by Robert Wells in a recent issue of *Duke Medical Perspectives*. A Soros Faculty Scholar working with the Project on Death in America, Dr Tulsy has determined that medical students are not being trained about care at the end of life and that they lack adequate communication skills needed to clearly and empathetically discuss end-of-life issues.

This is shown in a study titled *Support*, also conducted at Duke. This study “documented serious shortcomings in the care of critically ill patients.” It revealed poor physician-patient communication, “with less than half of physicians knowing their patients’ preferences regarding the use of CPR.” According to William J. Fulkerson, Jr, MD, director of the Duke Medical ICU, there is a somewhat anachronistic attitude on the part of patients: they verbalize concern for high tech care, but will ask for aggressive therapy if they believe there is an opportunity for a few more weeks of life. Peter Kussin, MD, also a participant in the *Support* study, characterizes this attitude as the doctor being viewed as “some kind of infallible techno-dietary.”

“Together with our fellow North Carolinians, we must address the difficult questions end-of-life issues present.”

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President's Message

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Dr Tulsy believes "the real problem is that too many people in this country die in pain, with life-sustaining interventions in place that aren't necessarily wanted." The results of the study provide a variety of insights. Of major significance is the need for greater communication between physician and patient, increased time spent ascertaining the patient's values, and assuring adequate information about the impact and problems that may attend aggressive end-of-life care.

A Professional Commitment

Clearly, the task of the North Carolina Medical Board is to enforce current law as it pertains to these issues. However, the North Carolina Medical Society and the North Carolina Hospital Association are uniquely positioned to create an environment for dialogue on all these issues. I have discussed this with Carolyn Ferree, MD, president of the NCMS. She supports the concept of education through dialogue and is committed to establishing a process that will permit free and open discussion. Involving hospital staff members and ethics committee members will help assure broad participation of the physician population. Hospice for the Carolinas and its members can play a valuable role, and faculty from our universities and colleges can provide scholarly insight and resource materials.

Wishing will not make these issues go away. Although we discussed and rejected PAS and euthanasia in this country over a century ago, our medical successes and the transformation of health care delivery have caused patients over the past several decades to seek relief from our technology through the legal system. We in the medical profession became enamored of technology and failed to fully communicate the advantages and disadvantages of some of our technology. We permitted the techno-diet concept to become part of our patients' value system. We ignored the art for the technology. We believed we could conquer death, the enemy. But death remains a part of life--and the issues remain.

It is incumbent on us in the medical profession to communicate with our patients, listen to them, learn their values, admit the limitations of our technology and ourselves, and accept that death, a "good death," can be a medical success. Together with our fellow North Carolinians, we must address the difficult questions end-of-life issues present

all of us and bring the best we have to this necessary dialogue.

Ultimately, of course, the decisions will rest with the individual patient and the individual physician, both trusting, both informed, both fully aware of the values held by each. ♦

Executive Director's Message

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• Inactive Status:

In the past, physicians who failed or chose not to register their licenses each year had their licenses "suspended," an unpleasant word about which most physicians were understandably unhappy. It required a number of them who applied for hospital privileges, licensure in other states, HMO participation, etc, to answer "yes" when asked if their license had ever been "suspended, revoked, or placed on probation." That has now been changed. Any physician who does not properly register with the Board will now be considered to have an "inactive license." He or she will not be permitted to practice medicine in North Carolina, but the record will not show the license to be suspended.

• Reporting of Hospital Suspension for Failure to Complete Records:

Under the amendments, hospitals will no longer be required to report to the Board the suspension of a physician's privileges for failure to timely complete medical records unless the suspension is the "third within the calendar year." When reporting a third suspension in a calendar year, however, the previous two suspensions must also be reported.

• Continuing Medical Education:

According to the MPA, the Board may discipline physicians for committing certain acts or for certain conduct (NCGS 90-14). A new item has now been added to the grounds for discipline listed in the act: "the failure to complete an amount not to exceed 150 hours of continuing medical education (CME) during any three consecutive calendar years pursuant to rules adopted by the Board." In the normal course of preparing and adopting rules, this new statutory requirement may not be effective for another year. Future numbers of the *Forum* will make you aware of proposed rules and the schedule of hearings. ♦

Record Management in Practice Dissolution*

*Carol Hardman
Risk Management Specialist,
Medical Mutual Group*

When a medical practice is disbanded, provisions must be made for the handling of the medical records. The arrangements will vary depending on whether patients in the practice saw one physician exclusively or were seen in turn by several or all of the physicians.

Physician Custody

If in your practice each patient was seen primarily by only one physician, each physician may take custody of the charts for his or her patients.

- The physician should send a letter to each patient explaining about the practice dissolution, offering to continue the physician-patient relationship, and offering to send a copy of the record elsewhere at the patient's direction (with a signed release).
- If the patient wishes to transfer care to another physician, the record should be retained for 10 years, longer if the patient is a minor.
- The same retention rule applies in the event that the physician does not hear from the patient.

Central Maintenance

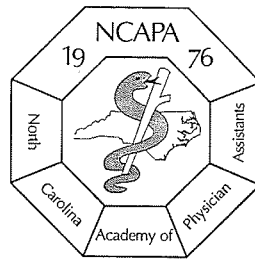
In the alternative, the disbanding practice may make arrangements for the records to be centrally maintained for a period after the dissolution.

- Before the practice is disbanded, a letter should be sent to every patient explaining about the dissolution and offering to send a copy of the patient's record elsewhere.
 - If the physicians desire, the letter may explain where each is going and offer to continue the physician-patient relationship.
 - If the patient and physician continue the relationship, the physician may take custody of the original record.
- Note that the original record should not be sent or given to anyone but the physicians of the disbanding practice. Any records not taken by one of the physicians should be centrally maintained for 10 years, longer for patients who were minors when seen.

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PA-Physician Teamwork: Pursuing Common Goals in the Non-Clinical Setting

Suzanne Reich-Atkins, PA-C
Past President, NCAPA



Physician assistants (PAs) have been an integral part of the delivery of health care in North Carolina since the mid-1960s when the first PA training program began at Duke University. By definition, PAs practice medicine with the supervision of physicians. That unique clinical relationship has reinforced the concept of teamwork in providing health care services in hospitals, clinics, and office settings. Interestingly, this relationship has expanded far beyond the scope of patient care and has served as a model for professional and paraprofessional activities.

Presently, health care is a complex system that involves clinical and multiple non-clinical pursuits, the latter including regulation, reimbursement, ethics, and treatment of impaired providers. In the non-clinical area, PAs work shoulder-to-shoulder with their colleagues from across the spectrum of health care, just as they do in the clinical area.

For the past four years, Wayne VonSeggen, PA-C, has been serving on the North Carolina Medical Board (NCMB). He is the first person to be appointed by the governor to an NCMB seat in the capacity of a PA. He is an active member of the NCMB, chairing the Physician Assistant Committee and serving on several other committees. Other PAs serve in an advisory capacity to the NCMB's Physician Assistant Committee as well. This group is made up of leaders from the North Carolina Academy of Physician Assistants (NCAPA), physician assistant program directors, and other PAs who are in clinical practice throughout the state.

Another group in which PAs are involved along with physicians is the North Carolina Medical Society (NCMS). A Physician Assistant Section of the NCMS has been designated for PAs, and a voting seat in the NCMS House of Delegates will be officially designated in November. The PA section is chaired by Danielle Hogan, PA-C. Debbie Hauser, PA-C, and Barbara Harris, PA-C, share in leadership of the section.

Also through the NCMS, PAs have consulting roles with other committees. Janet Jezsic, PA-C, and Wayne VonSeggen, PA-C, both serve as consultants to the Bioethics Committee. Denise Curtis, PA-C, is a con-

sultant to the Domestic Violence Committee, which has been extremely active on an issue that has turned out to be quite relevant for citizens of North Carolina. Jeffrey Katz, PA-C, serves as a consultant to the Health Care Access Committee, and Barbara Harris, PA-C, is a consultant to a related committee, Third Party Relations. Wade Marion, PA-C, acts as a consultant to the Occupational and Environment Health Committee and has reported to the NCAPA about many issues relevant to clinical practice. Edward Hedrick, PA-C, is a consultant to both the Managed Care and Sports Medicine Committees.

Roger Mitchel, PA-C, who is the NCAPA impairment coordinator, serves on the Physicians Health Committee and on the Board of Directors of the North Carolina Physicians Health Program. This, in particular, has been an area where physicians and PAs have worked closely together, monitoring and initiating treatment for impaired colleagues.

Ron Foster, PA-C, adds his expertise as a consultant to still another committee, STD and AIDS. He is also the current director of the new Physician Assistant Program at Methodist College in Fayetteville. Suzanne Reich-Atkins, PA-C, is serving as a consultant to the Tobacco Control Committee, another active group within the NCMS.

PAs are also involved in non-physician groups. The Allied Health Council is a relatively new organization, active in the past several years, that has created an opportunity for many groups of health professionals to communicate and work together for common goals. Robert Wooten, PA-C, the current NCAPA president, has been serving on this council. Meanwhile, Jeff Crowell, PA, serves by appointment of the governor on the North Carolina EMS Advisory Council.

A high honor was bestowed on Justine Strand, PA-C, who was appointed by Governor Hunt for a five-year term on the Institute of Medicine. This non-partisan group includes many high profile members who gather to advise the North Carolina General Assembly on health care issues.

These are just a few of the PAs that are involved in physician and non-physician interactions in the health care arena in North Carolina. The well-established concept of teamwork in our clinical relationships has provided us with an excellent opportunity to work together in non-clinical settings as

"Our profession can offer unique perspectives and can contribute significant expertise to agencies and organizations involved in or concerned with health care in this state."

well. Because of the numbers of PAs providing clinical care in both primary care and specialties, our profession can offer unique perspectives and can contribute significant expertise to agencies and organizations involved in or concerned with the provision of health care services in this state. ♦

Practice Dissolution

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Other Considerations

Each physician should sign a statement promising to maintain any records of the disbanded practice in his or her possession for 10 years.

It is also a good idea to place a notice in local newspapers announcing that the practice is disbanding and indicating whom patients should call to obtain copies of their records or to receive referrals for future care (with a deadline date).

All provisions made should scrupulously guard the patient's confidentiality and should include arrangements for patients whose conditions will necessitate prompt follow-up.

*Reprinted with permission from the July 1997 number of the *North Carolina Medical Society Bulletin*. For more information, Ms Hardman may be contacted at Medical Mutual in Raleigh at (919) 872-7117. ♦

Key Parts of Recently Amended Sections of the North Carolina Medical Practice Act NCGS Chapter 90: Medicine and Allied Occupations.

As Amended August 1997 by the North Carolina General Assembly

- Substantive changes are in bold italic type ● Changes involving only minor language corrections are not noted

[This material is taken from the North Carolina General Statutes. Though every effort has been made to ensure the accuracy of this material, it is not presented here as a legal reference and the North Carolina Medical Board cannot assume responsibility for any errors contained herein.]

ARTICLE 1.

Practice of Medicine.

§90-2. Medical Board.

(d) . . . Any vacancy in the *public, physician assistant, or nurse practitioner* membership of the Board shall be filled by the Governor for the unexpired term.

§90-11. Qualifications of applicant for license.

Every applicant for a license to practice medicine or to perform medical *acts, tasks, and functions as a physician assistant* in the State shall satisfy the North Carolina Medical Board that the applicant is of good moral character and meets the other qualifications for the issuance of a license before any such license is granted by the Board to the applicant.

§90-12.1. Physician assistant limited volunteer license.

The Board shall issue a limited volunteer license which shall authorize a physician assistant to perform medical acts, tasks, and functions without payment or other compensation if the physician assistant meets one of the following:

- (1) *Holds a current license or registration in another state and submits proof of this status to the Board.*
- (2) *Holds a current license in this State and is not currently employed as a physician assistant.*
- (3) *Is a member of the United States armed services or is employed by the Veterans Administration or another federal agency.*

§90-14. Revocation, suspension annulment or denial of license.

(a) The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or con-

duct, or for any of the following reasons:

.....

- (15) *The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.*

§90-14.13. Reports of disciplinary action by health care institutions; immunity from liability.

The chief administrative officer of every licensed hospital or other health care institution, including Health Maintenance Organizations, as defined in G.S. 58-67-5, preferred providers, as defined in G.S. 58-50-50, and all other provider organizations that issue credentials to physicians who practice medicine in the State, shall, after consultation with the chief of staff of that institution, report to the Board any revocation, suspension, or limitation of a physician's privileges to practice in that institution. *A hospital is not required to report the suspension of a physician's privileges for failure to timely complete medical records unless the suspension is the third within the calendar year for failure to timely complete medical records. Upon reporting the third suspension, the hospital shall also report the previous two suspensions.* The institution shall also report to the Board resignations from practice in that institution by persons licensed under this Article. The Board shall report all violation of this subsection known to it to the licensing agency for the institution involved.

§90-15.1. Registration every year with Board.

(a) Every person licensed to practice medicine by the North Carolina Medical Board shall register *annually with the Board within 30 days of the person's birthday.* A person who registers with the Board shall report to the Board the person's name and office and residence address and any other information required by the Board, and shall pay a registration fee fixed by the Board not in excess of one hundred dollars (\$100.00). *A physician who is not actively engaged in the practice of medicine in North Carolina*

and who does not wish to register the license may direct the Board to place the license on inactive status. For purposes of annual registration, the Board shall use a simplified registration form which allows registrants to confirm information on file with the Board. A physician who fails to register as required by this section shall pay an additional fee of twenty dollars (\$20.00) to the Board. The license of any physician who fails to register and *who remains unregistered* for a period of 30 days after certified notice of *the failure* is automatically *inactive.* *A person whose license is inactive shall not practice medicine in North Carolina nor be required to pay the annual registration fee.* Upon payment of all accumulated fees and penalties, the license of the physician may be reinstated, subject to the Board requiring the physician to appear before the Board for an interview and to comply with other licensing requirements. *The penalty may not exceed the maximum fee for a license under G.S. 90-13.*

§90-18. Practicing without license; practicing defined; penalties.

.....

(b) Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. *A person who resides in any state and who, by use of any electronic or other mediums, performs any of the acts described in this subsection shall be regarded as practicing medicine or surgery and shall be subject to the provisions of this Article and appropriate regulation by the North Carolina Medical Board.*

(c) The following shall not *constitute practicing medicine or surgery as defined in subsection (b) of this section:*

-
- (11) The practice of medicine or surgery by any *nonregistered* reputable physician or surgeon *who comes* into this State, *either in person or by use of any electronic or other mediums, on an irregular basis, to consult* with a resident reg-

istered *physician or to consult with personnel at a medical school about educational or medical training.*

This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State.

.....

(13). [Introductory phrase and segments a (limiting physicians to two PAs), b, and c are removed.] *The performance of any medical acts, tasks, and functions by a licensed physician assistant at the*

direction or under the supervision of a physician in accordance with rules adopted by the Board. This subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks, and functions that are otherwise permitted by law or established by custom. The Board shall authorize physician assistants licensed in this State or another state to perform specific medical acts, tasks, and functions during a disaster.

§90-18.1 (c) Physician assistants are authorized to compound and dispense drugs under the following conditions:

.....

(3) *The physician assistant holds a current license issued by the Board.*

§90-21.12A. *Nonresident physicians.*

A patient may bring a medical malpractice claim in the courts of this State against a nonresident physician who practices medicine or surgery by use of any electronic or other media in this state. ♦

Medical Practice Act Amended: Significant Changes Made

William H. Breeze, JD
NCMB Legal Department

The 1997 session of the North Carolina General Assembly came to an end during the last week of August. During that week, three bills amending the Medical Practice Act (MPA) were passed and sent to Governor Hunt for his signature. They will effect the following changes in the MPA.

CME to Be Mandatory

Over half the states now mandate that physicians obtain continuing medical education after being licensed. To achieve this in North Carolina, one amendment gives the North Carolina Medical Board authority to adopt rules to require physicians to obtain up to 150 hours of continuing medical education during any three consecutive years. As the Board considers such rules, input will be needed as to the amount and type of continuing medical education that might be appropriate. The Board will also need to consider reasonable ways to assure compliance with the requirement.

Physicians to Register on Birthdays Starting in 1998

Since 1958, the registration of physicians has taken place in January of the registration year. Beginning in 1998, physicians will register with the Board within 30 days of their birthdays. The Board will send out registration materials in advance to those physicians whose upcoming birthdays will require registration. This new method of registration should prove simpler and easier.

Inactive Status Now Available

For previous registration years, if one failed to register the license, the law established a procedure whereby the license

would be suspended for failure to register. For many physicians, the prospect of such a suspension of the license created real problems. When applying for licenses in other states, privileges in hospitals, or managed care participation, one must answer the question: "Has your license ever been suspended?" A positive answer could be the difference between acceptance and denial. Therefore, many physicians continue to register their licenses each year even when they have no other need to do so. However, the amended law provides that a physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on "inactive status". It also provides that the license of a physician who fails to register and remains unregistered for a period of 30 days after receiving certified notice of that failure is automatically inactive. The term "suspended" will no longer be used to identify the status of those who fail to register.

Hospital Privileges Reporting Modified

Prior to the 1997 legislative session, hospitals were required to report to the Board any limitations of a physician's privilege to practice. As a result, the Board received and reviewed information related to every change in hospital staff privileges in the state. At the request of the NC Hospital Association, a change in the MPA now exempts hospitals from reporting changes caused by a failure to complete medical records in a timely manner unless the physician is suspended on three occasions for this infraction during one calendar year.

However, all other limitations on a physician's hospital privileges, whatever the cause, must still be reported to the Board.

PA Limitation Removed, Volunteer License Authorized

Until now, no more than two physician assistants could be registered for any physician. With the enactment of the amendments, there will be no limit on the number of PAs that may be registered for a physician. This change should be particularly helpful in areas where there are only a few physicians with many patients to care for. The amendments also make provision for the Board to authorize PAs licensed in this or another state to perform specific medical acts, tasks, and functions during a disaster, and to issue a limited volunteer license for PAs who will function without compensation.

Telemedicine, Other Interstate Practice Requires Medical License

There has been a question as to whether someone outside the state who uses electronic or other means to render medical care to patients in the state should have a license to practice medicine in North Carolina. The General Assembly has now made explicit that any person in any state who practices medicine on a patient in North Carolina using electronic or other media must have a North Carolina medical license. The exception to that requirement for the physician who does not regularly practice in the state was left in the MPA and broadened to include a physician who consults with personnel at a medical school about educational or medical training. ♦

NC Medical Society Announces Web Site

Marcy Dion

Assistant Director, NCMS Communications

The North Carolina Medical Society, an association of more than 9,000 physicians, is pleased to announce its new Web site, active as of July 1, 1997. It is located at <http://www.ncmedsoc.org>.

The site consists of links to a page containing the Society's history, the officers of the Society, and pictorial pages introducing members of each department, the department's activities, and biographies of the individuals. Extensive information on membership and its benefits are available through the membership department link.



The Government Affairs Department site contains links to the Legislative Updates, published since the first of the year. This is updated biweekly. Links to other organizations, publications, and societies of interest are also provided on "Our Favorite Links" page. The site will continue to expand and improve, and the staff welcomes comments and suggestions.

The mission of the Society is to unite, serve, and represent physicians, in order to enhance physician advocacy for their patients and improve the health of the people of North Carolina. To that end, the Society seeks to extend medical knowledge and advance medical science, enabling physicians to better prevent and cure diseases and to prolong and add comfort to the lives of the state's citizenry. ♦

Pain and Policy Studies Group Web Site

The University of Wisconsin Pain and Policy Studies Group, which includes its World Health Organization Collaborating Center, now has a Web site for those interested in questions of pain management and public policy. Its address is <http://www.biostat.wisc.edu/painpolicy>.

The purpose of the Web site is to facilitate public access to information about pain relief and public policy, including material published by the Pain and Policy Studies

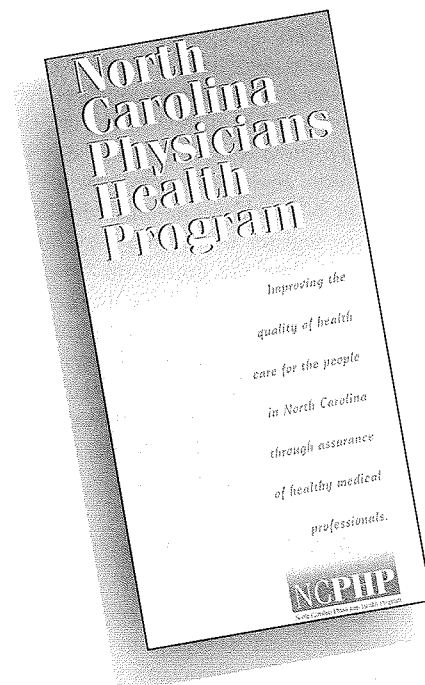
Group, its WHO Collaborating Center, and other authoritative sources.

For example, you can access information about state intractable pain treatment laws, state medical board guidelines, and international policy, including national trends in morphine consumption.

Users are encouraged to read about the PPSG and to browse the information in the site guide, which includes: About the PPSG, Glossary, United States, International, Bibliography, Links, Feedback, Annual Report, and PPSG Home. Those new to the area of pain and policy studies are invited to start with the site's selected readings.

The effort is supported by grants from the Robert Wood Johnson Foundation and the Project on Death in America. The PPSG is part of the University of Wisconsin Comprehensive Cancer Center. ♦

NCPHP Brochure Lists Warning Signs, Impact of Impairment



The informational brochure published by the North Carolina Physicians Health Program (NCPHP) describes the organization's program for working with physicians and physician assistants who have chemical dependency, alcohol, mental illness, physical illness, or aging problems.

Included in the brochure is a list of the "Common Warning Signs of Impairment." It is an important set of indicators, worth reprinting here and reviewing carefully.

ATTITUDE/BEHAVIOR CHANGES

- Rapidly turns from compassionate and caring to abrupt, caustic
- Withdraws from friends and activities
- Becomes mistrusting, anxious, depressed, irritable

PHYSICAL CHANGES

- Loss of appetite or reduced level of exercise
- Looks tired; admits to insomnia
- Personal hygiene deteriorates
- Physical problems and treats himself/herself

PERFORMANCE CHANGES

- Misses appointments
- Makes rounds at unusual hours
- Can't be reached on call
- Sloppy charting
- Smell of alcohol on breath during the day

The impact of impairment on the family is also noted:

- the deterioration of family communication;
- frequent arguments blamed on the spouse, spouse abuse;
- child abuse, poor school performance by children;
- jealousy, infidelity, separation; and
- divorce.

The principles that guide the NCPHP are highlighted:

- humanitarian concern for the public and the impaired physician or physician assistant;
- recognition that alcoholism, drug abuse and mental illness among physicians are too often ignored or untreated;
- recognition alcoholism, drug abuse and mental illness are treatable conditions and that treatment and rehabilitation personnel with skills in these areas have a good success record;
- encouragement of all impaired physicians to seek help and cooperate in treatment at the earliest possible time in order to retain or regain full effectiveness to practice;
- the employment of constructive coercion in order to encourage the impaired individual to obtain necessary assistance when the impairment poses a threat to reasonable delivery of health care;
- the employment of legal coercion when all other efforts have failed.

Copies of the complete brochure may be obtained from the NCPHP, 4700 Six Forks Road, Suite 220, Raleigh, NC 27609. To seek assistance from the NCPHP, please call (919) 881-0585. ♦

The Use of Opioids for the Treatment of Chronic Pain

A consensus statement from the American Academy of Pain Medicine and the American Pain Society

I. The management of pain is becoming a higher priority in the United States.

In the last several years, health-policymakers, health professionals, regulators, and the public have become increasingly interested in the provision of better pain therapies. This is evidenced, in part, by the U.S. Department of Health and Human Services' dissemination of Clinical Practice Guidelines for the management of acute pain and cancer pain. These publications, which have been endorsed by AAPM and APS, state that opioids, sometimes called "narcotic analgesics," are an essential part of a pain management plan. There is currently no nationally accepted consensus for the treatment of chronic pain not due to cancer, yet the economic and social costs of chronic pain are substantial, with estimates ranging in the tens of billions of dollars annually.

II. Current conditions dictate the need for a joint consensus statement of two major national pain organizations.

AAPM and APS believe that the United States is in a critical phase of state-level policy development with respect to the use of opioids in pain treatment. In this regard, there has been recent activity in state legislatures (i.e., intractable pain treatment acts and the establishment of pain commissions) and at the regulatory level (statements of policy from state boards of medical examiners). In response to inquiries from concerned boards, AAPM and APS wish to encourage a dialogue with regulators about the appropriate relation between law and the practice of pain medicine. The purpose of laws that govern controlled substances and professional conduct is to protect the public. Our objective is for state policies to recognize but not interfere with the medical use of opioids for pain relief, while continuing to address the issue of prescribing that may contribute to drug abuse and diversion.

It is imperative that this statement not be misconstrued as advocating the imprudent use of opioids. Rather, if a practitioner decides to treat chronic pain with opioids, this document should serve as a guide for both the practitioner and regulators with regard to the judicious use of these drugs in the course of medical practice.

III. Pain is often managed inadequately, despite the ready availability of safe and effective treatments.

Many strategies and options exist to treat chronic noncancer pain. Since chronic pain is not a single entity but may have myriad

causes and perpetuating factors, these strategies and options vary from behavioral methods and rehabilitation approaches to the use of a number of different medications, including opioids.

Pain is one of the most common reasons people consult a physician, yet it frequently is inadequately treated, leading to enormous social cost in the form of lost productivity, needless suffering, and excessive healthcare expenditures.

Impediments to the use of opioids include concerns about addiction, respiratory depression and other side effects, tolerance, diversion, and fear of regulatory action.

IV. Current information and experience suggest that many commonly held assumptions need modification.

Addiction: Misunderstanding of addiction and mislabeling of patients as addicts result in unnecessary withholding of opioid medications. Addiction is a compulsive disorder in which an individual becomes preoccupied with obtaining and using a substance, the continued use of which results in a decreased quality of life. Studies indicate that the de novo development of addiction when opioids are used for the relief of pain is low. Furthermore, experience has shown that known addicts can benefit from the carefully supervised, judicious use of opioids for the treatment of pain due to cancer, surgery, or recurrent painful illnesses such as sickle cell disease.

Respiratory depression and other side effects: Fear of inducing respiratory depression is often cited as a factor that limits the use of opioids in pain management. It is now accepted by practitioners of the specialty of pain medicine that respiratory depression induced by opioids tends to be a short-lived phenomenon, generally occurs only in the opioid-naïve patient, and is antagonized by pain. Therefore, withholding the appropriate use of opioids from a patient who is experiencing pain on the basis of respiratory concerns is unwarranted. Other side effects, such as constipation, can usually be managed by attention to diet, along with the regular use of stool softeners and laxatives. Sedation and nausea, possible early side effects, usually dissipate with continued use.

Tolerance: It was previously thought that the development of analgesic tolerance limited the ability to use opioids efficaciously on a long-term basis for pain management. Tolerance, or decreasing pain relief with the same dosage over time, has not proven to be a prevalent limitation to long-term opioid

use. Experience with treating cancer pain has shown that what initially appears to be tolerance is usually progression of the disease. Furthermore, for most opioids, there does not appear to be an arbitrary upper dosage limit, as was previously thought.

Diversion: Diversion of controlled substances should be a concern of every health professional, but efforts to stop diversion should not interfere with prescribing opioids for pain management. Attention to patterns of prescription requests and the prescribing of opioids as part of an ongoing relationship between a patient and a healthcare provider can decrease the risk of diversion.

V. Policy is evolving.

State law and policy about opioid use are currently undergoing revision. The trend is to adopt laws or guidelines that specifically recognize the use of opioids to treat intractable pain. These statements serve as indicators of increased public awareness of the sequelae of undertreated pain and help clarify that the use of opioids for the relief of chronic pain is a legitimate medical practice.

VI. Accepted principles of practice for the use of opioids should be promulgated.

Due to concerns about regulatory scrutiny, physicians need guidance as to what principles should generally be followed when prescribing opioids for chronic or recurrent pain states. Regulators have also expressed a need for guidelines to help them to distinguish legitimate medical practice from questionable practices and to allow them to appropriately concentrate investigative, educational, and disciplinary efforts, while not interfering with legitimate medical care.

VII. Principles of good medical practice should guide the prescribing of opioids.

AAPM and APS believe that guidelines for prescribing opioids should be an extension of the basic principles of good professional practice.

Evaluation of the patient: Evaluation should initially include a pain history and assessment of the impact of pain on the patient, a directed physical examination, a review of previous diagnostic studies, a review of previous interventions, a drug history, and an assessment of coexisting diseases or conditions.

Treatment plan: Treatment planning should be tailored to both the individual and

Opioids

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the presenting problem. Consideration should be given to different treatment modalities, such as a formal pain rehabilitation program, the use of behavioral strategies, the use of noninvasive techniques, or the use of medications, depending upon the physical and psychosocial impairment related to the pain. If a trial of opioids is selected, the physician should ensure that the patient or the patient's guardian is informed of the risks and benefits of opioid use and the conditions under which opioids will be prescribed. Some practitioners find a written agreement specifying these conditions to be useful.

An opioid trial should not be done in the absence of a complete assessment of the pain complaint.

Consultation as needed: Consultation with a specialist in pain medicine or with a psychologist may be warranted, depending on the expertise of the practitioner and the complexity of the presenting problem. The management of pain in patients with a history of addiction or a comorbid psychiatric disorder requires special consideration, but does not necessarily contraindicate the use of opioids.

Periodic review of treatment efficacy: Review of treatment efficacy should occur

periodically to assess the functional status of the patient, continued analgesia, opioid side effects, quality of life, and indications of medication misuse. Periodic reexamination is warranted to assess the nature of the pain complaint and to ensure that opioid therapy is still indicated. Attention should be given to the possibility of a decrease in global function or quality of life as a result of opioid use.

Documentation: Documentation is essential for supporting the evaluation, the reason for opioid prescribing, the overall pain management treatment plan, any consultations received, and periodic review of the status of the patient.

VIII. The Mission Statements of AAPM and APS are consistent with this collaborative effort.

The American Academy of Pain Medicine is the AMA-recognized specialty society of physicians who practice pain medicine. The American Pain Society is the national chapter of the International Association for the Study of Pain and is composed of physicians, nurses, psychologists, scientists, and members of other disciplines who have an interest in the study and treatment of pain.

The mission of the American Academy of Pain Medicine is to enhance pain medicine practice in this country by promoting a socioeconomic and political climate con-

ducive to the effective and efficient practice of pain medicine and by ensuring quality medical care by physicians specializing in pain medicine, for patients in need of such services.

The mission of the American Pain Society is to serve people in pain by advancing research, education, treatment, and professional practice.

The undertreatment of pain in today's society is not justified. This joint consensus statement has been produced pursuant to the missions of both organizations, to help foster a practice environment in which opioids may be used appropriately to reduce needless suffering from pain.

The statement was prepared by the following committee members: J. David Haddox, DDS, MD (Chair); David Jovanon, MSSW (Vice Chair); Robert T. Angarola, Esq; Albert Brady, MD; Daniel B. Carr, MD; E. Richard Blonsky, MD; Kim Burchiel, MD; Melvin Gitlin, MD; Matthew Midcap, MD; Richard Payne, MD; Dana Simon, MD; Sridhar Vasudevan, MD; Peter Wilson, MBBS, PhD.

Consultant: Russell K. Portneno, MD.

Approved by the AAPM Board of Directors, June 29, 1996.

Approved by the APS Executive Committee, August 20, 1996

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The North Carolina Board of Nursing's Alternative Program for Chemical Dependency

*Sandy Schaller, RN, MSN
North Carolina Board of Nursing*

The Alternative Program for Chemical Dependency at the North Carolina Board of Nursing is designed to assist nurses with the disease of chemical dependency to return to nursing more quickly than would be possible through the traditional disciplinary method. It also allows them to be more closely monitored once their practice is resumed.

"Some of nursing's brightest and best were being lost to chemical dependency."

The Alternative Program began as a trial project in January 1994 in response to concerns in the nursing community. The North Carolina Nurses Association and the North Carolina Organization of Nursing Executives expressed concern that some of nursing's brightest and best were being lost to chemical dependency. After a successful year as a trial project, the Board adopted the Alternative Program as a continuing effort.

Philosophy, Objectives, Criteria

The Board adopted the following philosophy concerning chemical dependency in nursing.

- Chemical dependency is a disease.
- The effects of chemical dependency can negatively affect one's work performance.
- Without appropriate intervention, chemical dependency is considered a terminal disease.
- The chemically dependent nurse may be a danger to the patient and the public.
- Recovery from chemical dependency is an ongoing, lifelong process.
- The chemically dependent nurse is responsible for accepting responsibility for his/her actions.
- The Board of Nursing supports the opportunity for the chemically dependent nurse to seek treatment and appropriate interventions.

Objectives of the Alternative Program include:

- to ensure the health and safety of the public through a program that closely monitors nurses impaired by alcohol and/or other drugs;
- to achieve earlier intervention with the intent to accomplish:
 - a decrease in the time between the nurse's acknowledgment of chemical dependency and the entry into the recovery process;
 - a means of returning the nurse to safe and effective practice in a more efficient and rapid manner than was achieved through the disciplinary process, while minimizing financial impact;
- to provide a process for nurses to recover from impairment in a therapeutic, nonpunitive, and confidential process.

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Chemical Dependency

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Criteria for participation include the following.

- The licensee attempts to follow the usual disciplinary course of action prior to a Letter of Charges.
- The licensee acknowledges a chemical dependency problem.
- The licensee voluntarily requests to participate in the Alternative Program.
- The licensee has no previous history of disciplinary action by any board of nursing.
- Cases involving previous treatment or previous participation in an alternative program will be evaluated on an individual basis.
- Cases of actual or potential patient harm or injury will be evaluated on an individual basis.
- Felony convictions or pending criminal charges will be evaluated on an individual basis.
- Anyone with charges or convictions of diverting chemicals for the purpose of sale or distribution or dealing or selling of illicit drugs will not be eligible.

Entering the Program

Nurses are referred to the Alternative Program in several ways. The supervisor may make a report or the nurse may call the Board. Also, referral may come through the Disciplinary Section at the Board. Once a referral is made, the nurse is given information regarding the Alternative Program as well as options available through discipline.

If the nurse indicates interest in the Alternative Program and appears to meet the criteria for participation, she/he completes an evaluation at a treatment program associated with the Alternative Program. Currently, there are 22 such programs across the state associated with the Program. The nurse agrees to participate in and complete the recommended treatment. While the nurse is in treatment, the Alternative Program coordinator will meet with her/him and evaluate for participation in the Program.

The nursing license is held in abeyance for a minimum of three (3) months from the date the nurse enters treatment. This time period allows the nurse to enter treatment and begin to lay the foundation for recovery. The nurse re-enters practice after meeting with the Re-entry/ Reinstatement Committee at the Board of Nursing.

The Alternative Program utilizes contracts that state the nurse acknowledges a violation of the North Carolina Nursing Practice Act

and, in lieu of the Board of Nursing pursuing disciplinary action, the nurse agrees to participate in and complete the program.

Monitoring

The nurse is monitored for three (3) years after re-entering nursing practice. Monitoring includes the submission of reports on a designated schedule. The nurse submits a self-report that speaks to the recovery process, including a narrative of events happening in the nurse's life. The nurse also keeps a log of Alcoholics Anonymous and Narcotics Anonymous meetings attended. The AA/NA sponsor also submits a report stating if the nurse is indeed attending meetings and working with the sponsor. The sponsor signs this report with first name only, respecting the anonymity of AA/NA. As long as the nurse is involved in treatment, the counselor also submits a report. Once the nurse returns to practice, the supervisor submits a detailed Work Performance Evaluation.

Each time the nurse is prescribed medication, she/he must submit a Practitioner Report, completed and signed by the individual prescribing the medication. This ensures the practitioner is aware of the history of chemical dependency and the nurse's participation in the Alternative Program. Additionally, nurses must notify the Program coordinator within 72 hours of the first dose of any antihistamine, decongestant, or cough syrup.

Random urine drug screens are completed through the use of an 800 telephone number the nurse calls Monday-Friday. If the nurse's personal identification number comes up, the nurse must be screened before 5:00 PM that day.

Monitoring continues throughout the three (3) years the nurse participates in the Alternative Program. Relapse is evaluated on an individual basis.

During the first year the nurse is back in practice, certain restrictions on that practice are in place. The nurse:

- shall not work from 11:00 PM to 7:00 AM or be scheduled to work more than 40 hours per week;
- shall not have access to controlled substances, Nubain® or Stadol®;
- shall not work critical care specialty areas or the ER;
- shall work under the direction of an on-site RN or, with approval, under the

direction of an on-site work monitor who is a licensed health care provider.

Outcome and Data as of June 1997

As of June 1, 1997, 69 nurses had been evaluated for participation in the Alternative Program. Thirty-six remain active participants. Ages range from 26 to 66 years, with a mean age of 38. The mean for years in nursing is 9.3. The mean for years of using drugs/alcohol is 7.7.

Demerol® is the drug of choice, followed by Percocet and alcohol. The primary reasons given for drug use are emotional pain and "liked the feeling." The length of time of violation of the Nursing Practice Act was 1.4 years in 1996. The largest percentage of nurses were employed in medical/surgical settings, followed by long-term care.

One goal of the Alternative Program is to decrease the time from confrontation until the nurse enters treatment. A pre-trial group indicated this time was 74 days. This time has decreased to 10.5 days for nurses in the Program.

For 1994/96, the total length of time out of nursing employment was 10.4 months. That compares to 30 months out of work for a pre-trial group of nurses involved in the disciplinary process.

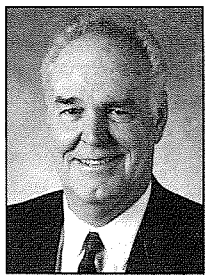
The Alternative Program is also interested in what happens to nurses in their employment once chemical dependency is discovered. Of the 69 nurses evaluated, 32 had been terminated from employment, 26 were placed on medical leave of absence, 3 resigned, 1 was suspended, and 3 were transferred to unlicensed positions. These data seem to reveal a continuing need for education aimed at employers regarding chemical dependency.

The 1996 Alternative Program Evaluation is completed. Employers of Program participants, treatment centers, and participants are surveyed on a pre-determined schedule to elicit responses regarding the Program. The majority of questions are answered on a 5-point scale, with 1 signifying "disagree or poor" and 5 signifying "agree or excellent." Treatment centers rated the Program at 4.8 and the success of the Program at 4.0. Participants rated the Program on therapeutic value (4.8), nonpunitive character (4.9), and confidentiality (4.9).

The first nurses who entered the Alternative Program in 1994 are now graduating. To date, three (3) have completed the Program.

Additional information about the Alternative Program for Chemical Dependency may be obtained from Sandy Schaller, RN, MSN, at the Board of Nursing office (919.782-3211). ♦

Reviews



Dr Trado

No Time to Say Goodbye: Surviving the Suicide of a Loved One

Charles E. Trado, MD
Vice President, NCMB

Suicide is the eighth leading cause of death in the United States and the third leading cause of death among young people ages 15 to 34.

"People who lose a loved one to suicide feel more guilty, more often search for an understanding of the death and appear to experience less social support than those who lose a loved one to other causes." The author of the book *No Time to Say Goodbye*, Carla Fine, dramatically and compellingly explores this assertion through her own tragic experience. Her husband, a prominent New York physician, took his own life in December 1989 at the age of 44.

*No Time to Say Goodbye:
Surviving the Suicide of a Loved One*
Carla Fine.

Doubleday, New York, 1997.
252 pp, \$21.95 cloth (ISBN 0-385-48018-0).

Fine is the author of two earlier books, *Married to Medicine: An Intimate Portrait of Doctors' Wives* and *Barron's Guide to Foreign Medical Schools*, and numerous magazine articles. She walks the reader through her own attempts to deal with stigma, denial, self-blame, guilt, anger, and helplessness, as well as a host of other emotions experienced by survivors.

The importance of survivor support groups to the healing process is revealed in the interviews Fine conducts with many other survivors. Their stories are honest, touching, and painfully revealing.

To the physician and to the survivor, this book offers an exceptional learning experience overlooked far too long. Physicians

need the insights and can utilize the how-to aspects of the book in their practice experience.

Hardly any physician escapes the need to deal with the suicide of a patient, a family member of a patient, a friend, or a member of his or her own family. This book will go a long way toward preparing you for that unenviable but important task.

The book includes a list of organizations and resource materials related to suicide, a state-by-state guide to groups for suicide survivors, and a bibliography.

Living with Spina Bifida: A Guide for Families and Professionals

Staff Review

This book, recently published by the University of North Carolina Press, deals with the most common complex birth defect, spina bifida, a condition that affects approximately one of every 1,000 children born in the United States. The author, Adrian Sandler, MD, is medical director of the Olson Huff Center for Child Development at Thoms Rehabilitation Hospital in Asheville and clinical professor of pediatrics at the University of North Carolina. He took his medical degree at the University of Cambridge, England, in 1982, and did his pediatric residency at Duke University. He then completed a three-year fellowship in behavioral and developmental pediatrics at the University of North Carolina.

*Living with Spina Bifida:
A Guide for Families and Professionals*
Adrian Sandler, MD.

The University of North Carolina Press, Chapel Hill & London, 1997.

292 pp, \$45 cloth (ISBN 0-8078-2352-X),
\$19.95 paper (ISBN 0-8078-4657-0).

Sandler presents comprehensive information on the medical, developmental, and psychological aspects of spina bifida for families, physicians, and others who care for children, adolescents, and adults with the condition. The book begins with a clearly written clinical overview and then offers a series of chapters arranged according to the developmental stages of childhood, discussing the relevant medical, health, and emotional aspects of spina bifida.

The book offers positive and practical advice on daily living, family relationships, building strong parent-professional partnerships, education, and work. Sandler's approach is reinforced by his compassion, understanding, and concern. His book is intended to be a resource for a variety of professionals, including teachers, clinicians, nurses, physical therapists, occupational therapists, speech and language therapists, nutritionists, child psychologists, psychologists, and social workers.

Living with Spina Bifida also includes a state-by-state list of spina bifida associations, topic-based suggestions for further reading, an extensive glossary of useful terms, a thorough index, and special parent-to-parent sections written by parents of children with spina bifida.

Among those who have recommended the book are W. Jerry Oakes, MD, of the Children's Hospital of Alabama; Joanne Mackey, RN, coordinator of the Duke University Myelodysplasia Clinic; and Judy Woodruff, a CNN commentator and the parent of a teenager with spina bifida. ♦

BOOK RECEIVED (Review in preparation.)

Physician-Assisted Suicide. Robert F. Weir, MD, editor. Indiana University Press, 1997. 304 pages, \$29.95 cloth (ISBN 0-253-33282-6). Part of the Indiana University Press Medical Ethics series. The editor is director of the Program in Biomedical Ethics and Medical Humanities at the University of Iowa College of Medicine. The most comprehensive book on the subject of physician assisted suicide now available, this volume serves as a debate in print, presenting historical precedents, contemporary examples, and a wide range of ethical issues from a variety of viewpoints. Contributors include 15 physicians, ethicists, attorneys, and historians who offer thoughtful chapters on ethical and historical perspectives, medical practice, and public policy. Appendices include three key court cases relating to the issue.

Letters to the Editor

Dr Citron, an Asset to Mankind

To the Editor: I read with interest [Mr Paris'] article entitled David S. Citron, MD: The Physician's Physician. [Forum #2, 1997]

I had the pleasure of working with David Citron when he was director of medical education at Carolinas Medical Center. This was one of the most delightful relationships I have had in my 25 years of medicine. [Mr Paris'] kind comments regarding Dr Citron are certainly extremely well deserved and I agree with everything [he] wrote.

Dr Citron has not only been a tremendous asset to his patients, to the physicians with whom he worked, but with his supportive, understanding, and unusually kind demeanor, he is a tremendous asset to mankind in general. I therefore appreciate

[Mr Paris] writing about one of the physicians whom I most admire and respect.

Lowell H. Gill, MD
Charlotte, NC

An Open Mind on Complementary Therapies

To the Editor: I very much enjoyed Dr Barrett's review of *Fundamentals of Complementary and Alternative Medicine*. [Forum #1, 1997]. The tone of this review gives gentle encouragement for our peers to investigate these therapies with an open mind.

As physicians, we tend to bring our own scientific yardstick to the job when, in many cases, double-blind proof may be impossible

to obtain. On the other hand, anecdotal tales are difficult to assess. These mysteries will resolve themselves in time, and I believe physicians must be quick to examine and sort through these methods and lead patients in the proper direction: to better health and peace of mind.

You may be interested to hear that our integrative medical practice is now six years old. I can't begin to tell you how rewarding it is to treat difficult patient problems successfully that were unapproachable using allopathic methods. The fact that our small-town practice has been successful stands for itself.

The attitude that Dr Barrett has displayed is a true credit to our profession and I congratulate him on his insight.

Richard J. House, MD, LAc
Goldsboro, NC

North Carolina Medical Board Meeting Calendar, Application Deadlines, Examinations October 1997 -- September 1998

Board Meetings are open to the public, though some portions are closed under state law:

North Carolina Medical Board November Meeting Deadlines:	November 19-22, 1997
Nurse Practitioner Approval Applications	September 29, 1997
Physician Assistant Applications	September 30, 1997
Physician Licensure Applications	November 4, 1997
North Carolina Medical Board January Meeting Deadlines:	January 21-24, 1998
Nurse Practitioner Approval Applications	December 9, 1997
Physician Assistant Applications	December 2, 1997
Physician Licensure Applications	January 6, 1998
North Carolina Medical Board March Meeting Deadlines:	March 18-21, 1998
Nurse Practitioner Approval Applications	February 2, 1998
Physician Assistant Applications	February 3, 1998
Physician Licensure Applications	March 3, 1998
North Carolina Medical Board May Meeting Deadlines:	May 13-16, 1998
Nurse Practitioner Approval Applications	March 30, 1998
Physician Assistant Applications	March 31, 1998
Physician Licensure Applications	April 28, 1998
North Carolina Medical Board July Meeting Deadlines:	July 15-18, 1998
Nurse Practitioner Approval Applications	June 1, 1998
Physician Assistant Applications	June 2, 1998
Physician Licensure Applications	July 30, 1998

North Carolina Medical Board September Meeting Deadlines:	September 16-19, 1998
Nurse Practitioner Approval Applications	August 3, 1998
Physician Assistant Applications	August 4, 1998
Physician Licensure Applications	September 1, 1998

☛ Residents Please Note USMLE Schedule

Examinations Schedule

United States Medical Licensing Examination (USMLE) Step 3

May 12-13, 1998 Sitting

Deadline for receipt of application: February 11, 1998

December 1-2, 1998 Sitting

Deadline for receipt of application: September 2, 1998

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 400 Fuller Wiser Road, Suite 300, Euless, TX 76039 or telephone (817) 868-4000.

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

May, June, July 1997

DEFINITIONS

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

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

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

Denial: Final decision denying an application for practice authorization or a motion/request for

reconsideration/modification of a previous Board action.

NA: Information not available.

NCPHP: North Carolina Physicians Health Program.

RTL: Resident Training License.

Revocation: Cancellation of the authorization to practice.

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

Suspension: Temporary withdrawal of the authorization to practice.

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

Voluntary Dismissal: Board action dismissing a contested case.

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

SUSPENSIONS

LOWE, James Edward, Jr, MD

Location: Briarcliff Manor, NY

DOB: 12/05/50

License #: 00-37887

Specialty: PS/GS (as reported by physician)

Medical Ed: Meharry Medical College (1975)

Cause: The Administrative Review Board for Professional Medical Conduct of New York entered an order dated 11/27/95 that determined Dr Lowe engaged in fraud in the practice of medicine, submitted false reports, failed to maintain adequate records, and was guilty of moral unfitness in the practice of medicine. That Board revoked Dr Lowe's New York license and imposed a penalty of \$120,000, effective 1/29/96. He ceased practice in New York on 1/03/96 and has not practiced in North Carolina since that time. The actions by the New York Board are grounds for the North Carolina Board to discipline Dr Lowe.

Action: 6/11/97. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Lowe's license is suspended indefinitely; suspension is stayed and he is issued a license to expire 6/11/98; he may practice only in plastic surgery or in a residency program approved by the president of the Board or in another area approved by the Board; the Board is under no obligation to approve any area of practice; the limited license may not be converted to a resident training license; he shall complete and document at least 50 hours of CME, 30 of which shall be Category I, within one year; must comply with other conditions.

See Consent Orders:

NATHAN, Paul Eli, MD

SUMMARY SUSPENSIONS

MARSHALL, John Everett, MD

Location: Lincolnton, NC (Lincoln Co)

DOB: 7/13/54

License #: 00-39646

Specialty: OBG (as reported by physician)

Medical Ed: Universidad Del Noreste, Mexico (1981)

Cause: Dr Marshall may have committed acts of unprofessional conduct.

Action: 6/19/97. Order of Summary Suspension of License executed (effective 6/25/97).

PRESSLY, Margaret Rose, MD

Location: Sylva, NC (Jackson Co)

DOB: 5/05/56

License #: 00-34548

Specialty: FP (as reported by physician)

Medical Ed: University of North Carolina, Chapel Hill (1990)

Cause: Dr Pressly may be unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of a physical or mental abnormality.

Action: 6/26/97. Order of Summary Suspension of License executed (effective 7/8/97).

ROBERTS, Ifor John Wynn, MD

Location: Durham, NC (Durham Co)

DOB: 8/18/40

License #: 95-00202

Specialty: GP (as reported by physician)

Medical Ed: Edinburgh University, Scotland (1966)

Cause: Dr Roberts may be unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of a physical or mental abnormality.

Action: 6/02/97. Order of Summary Suspension of License executed (effective 7/10/97).

CONSENT ORDERS

AUSLEY, Mett Bagley, Jr, MD

Location: Whiteville, NC (Columbus Co)

DOB: 8/06/57

License #: 00-38004

Specialty: PTH (as reported by physician)

Medical Ed: University of North Carolina, Chapel Hill (1984)

Cause: Dr Ausley's license was summarily suspended by an order dated 2/21/97 and a case against him was begun by a Notice of Charges of the same date because of concern about his mental health and its impact on his ability to practice safely; he has been in treatment since then with a psychiatrist; he has provided the Board reports from an independent psychologist and psychiatrist indicating his condition has improved and opining he should be able to practice pathology safely; he has waived his right to any hearing.

Action: 7/10/97. Consent Order executed: the Summary Suspension of Dr Ausley's license is lifted; the Notice of Charges is dismissed; he shall continue in therapy with his psychiatrist and cause his psychiatrist to report to the Board quarterly, beginning August 1; he shall obtain and document 50 hours of CME each year, including at least 30 hours of Category I CME; must comply with other conditions.

BERLINER, Stephen Harvey, MD

Location: Elon College, NC (Alamance Co)

DOB: 9/07/53

License #: 94-00721

Specialty: OBG (as reported by physician)

Medical Ed: State University of New York (1978)

Cause: Request by Dr Berliner to amend his Consent Order of 12/10/96.

Action: 5/02/97. Consent Order executed. Dr Berliner is issued a license to expire on the date shown on the license; he shall maintain and abide by a contract with the NCPHP; unless lawfully prescribed for him by someone else, he shall refrain from use of all mind or mood altering substances and controlled substances

Board Orders/Consent Orders/Other Board Actions...(cont.)

and from the use of alcohol; he shall notify the Board in writing of his use of such medication or alcohol within two weeks of doing so and shall identify the prescriber and the dispensing pharmacy; on request of the Board, he shall make available bodily fluids and tissues for analysis to determine if he has consumed any of the substances noted; must comply with other conditions.

BUNN, David Glenn, Jr, MD

Location: Wilmington, NC (New Hanover Co)

DOB: 4/03/50

License #: 00-20771

Specialty: OBG (as reported by physician)

Medical Ed: University of North Carolina, Chapel Hill (1975)

Cause: Dr Bunn admits he has a history of alcoholism; he obtained numerous pain medications from 8/95 through 10/96 by prescribing them for himself and by having prescriptions for himself called in to a pharmacy under authorization of an associate's name. He has renewed his contract with NCPHP and continues to participate in that program; he had met with the Board to discuss his possible addiction to pain medications; he attends Alcoholics Anonymous and Caduceus meetings regularly.

Action: 5/13/97. Consent Order executed: unless lawfully prescribed by someone else, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and from the use of alcohol; he shall notify the Board in writing within two weeks of his use of such medication or alcohol and identify the prescriber and the pharmacy filling the prescription; he shall supply bodily fluids and/or tissues on request of the Board for screening; he shall maintain and abide by his contract with NCPHP; he shall maintain a log of all controlled drugs he dispenses, orders, or administers and submit a copy to the Board on request; must comply with other conditions.

COLLINS, Natalear Rolline, MD

Location: Franklinton, NC (Franklin Co)

DOB: 10/22/55

License #: 00-27108

Specialty: GP/OM (as reported by physician)

Medical Ed: East Carolina University (1981)

Cause: Modification of Consent Order of 2/07/97; she reports she has complied with earlier Consent Orders in completing a three month treatment program for impaired physicians, is involved in an active recovery program with AA and Caduceus, regularly meets with her NCPHP monitor, and has tested negative on all random drug screens.

Action: 7/10/97. Consent Order executed: Dr Collins is issued a dated license to expire on the date shown on the license (11/30/97); unless lawfully prescribed by someone else, she shall refrain from use of all mind or mood altering substances and controlled substances and from the use of alcohol; she shall notify the Board within two weeks of her use of such medication or alcohol, identifying the prescriber and the dispensing pharmacy; she shall cooperate with drug/alcohol screens requested by the Board; she shall maintain and abide by an NCPHP contract; she shall not prescribe for herself; she shall obtain and document 50 hours of CME per year, at least 30 of which must be Category I; must comply with other conditions.

GLENN, Robert Alan, Physician Assistant

Location: Asheville, NC (Buncombe Co)

DOB: 3/13/59

License #: 1-01972

Education: George Washington University (1989)

Cause: Application for reissuance of the license he surrendered 11/21/96 following a report he had obtained a controlled substance for his personal use by forging prescriptions; he admits he has had a problem with substance abuse. From 11/26/96 to 2/20/97, he attended and successfully completed inpatient treatment at Pine Grove Next Step in Hattiesburg, Mississippi; he currently participates in several recovery programs and is active in NCPHP.

Action: 7/01/97. Consent Order executed: Mr Glenn is issued a dated license to expire on the date shown on the license (7/31/97); he shall maintain and abide by a contract with NCPHP; unless lawfully prescribed by someone else, he shall refrain from the use of mind or mood altering substances and all controlled substances and from the use of alcohol; he shall notify the Board within two

weeks of his use of such medications or alcohol, identifying the prescriber and dispensing pharmacy; he shall cooperate with drug/alcohol screens requested by the Board; he shall not prescribe any drug for his own use; he shall not purchase, administer, prescribe, dispense, or order any controlled substances; he shall not apply to the DEA for any registration; a copy of this Consent Order shall be provided to his primary supervising physician(s) and they shall confirm this fact in writing to the Board; he shall not practice except in a setting approved by the Board; all requests for provisional approval of an Intent to Practice application shall be considered by the president of the Board, though the president is under no obligation to approve such applications; must comply with other conditions.

HAINES, Richard Littleton, MD

Location: Wilmington, NC (New Hanover Co)

DOB: 8/10/22

License #: 00-23932

Specialty: IM/GER (as reported by physician)

Medical Ed: University of Virginia (1947)

Cause: License suspended under a Consent Order of 2/17/97; Dr Haines acknowledges he has a problem with alcohol abuse. He has undergone complete neurological and psychological evaluations and is an active participant in the NCPHP.

Action: 6/18/97. Consent Order executed: Dr Haines is issued a license to expire on the date shown on the license (11/30/97); he shall practice only under specific conditions and with restrictions approved by the president of the Board in writing; in October 1997, he shall obtain and have submitted to the Board an update of his psychological evaluation; he shall maintain and abide by his NCPHP contract; he shall obtain 50 hours of CME in his field each year; must comply with other conditions.

HOLTKAMP, John Harry, MD

Location: Raleigh, NC (Wake Co)

DOB: 11/20/54

License #: 00-28045

Specialty: CHN/PD (as reported by physician)

Medical Ed: New York University (1980)

Cause: Application for reinstatement of his license, which was surrendered 1/17/97 by a letter in which he acknowledged a relapse in his alcoholism. Dr Holtkamp has completed a three-month inpatient treatment program for alcoholism; he has entered a new contract with NCPHP and attends AA meetings; he reports he has been clean and sober for over six months.

Action: 7/23/97. Consent Order executed: Dr Holtkamp is issued a dated license to expire on the date shown on the license (9/30/97); unless lawfully prescribed by someone else, he shall refrain from the use of mind or mood altering substances and controlled substances and from the use of alcohol; he shall cooperate with random drug/alcohol screens requested by the Board; he shall maintain and abide by an NCPHP contract and continue attendance at AA; he shall not practice more than 25 hours per week; must comply with other conditions.

HUNSAKER, Robert Huson, MD

Location: Key Biscayne, FL

DOB: 2/04/56

License #: 00-28050

Specialty: PS/GS (as reported by physician)

Medical Ed: Ohio State University (1982)

Cause: Dr Hunsaker's medical license in Florida was summarily suspended on December 23, 1996; an Administrative Complaint in the matter of the suspension was issued by Florida on January 10, 1997. Dr Hunsaker denies the allegations in the Order of Emergency Suspension and the Administrative Complaint and a hearing is pending; Dr Hunsaker has said he will not attempt to practice in North Carolina until the situation in Florida is resolved.

Action: 5/22/97. Consent Order executed: Dr Hunsaker shall not practice medicine or surgery in North Carolina until a final agency decision is reached concerning his license in Florida; prior to recommencing practice in North Carolina, he shall meet with the Board to discuss his practice plans and obtain a written order releasing him from this Consent Order; must comply with other conditions.

Board Orders/Consent Orders/Other Board Actions...(cont.)

MINARD, John Lawrence, MD

Location: Raleigh, NC (Wake Co)

DOB: 1/12/35

License #: 00-29347

Specialty: P/CHP (as reported by physician)

Medical Ed: University of Pittsburgh (1961)

Cause: Application for reinstatement of license surrendered 2/03/97. Dr Minard has been diagnosed with bipolar disorder and alcohol and benzodiazepine dependence. He has successfully completed three months of chemical dependency treatment, has been active since that time in AA and Caduceus meetings, and has signed a contract with NCPHP.

Action: 7/31/97. Consent Order executed: Dr Minard is issued a dated license to expire on the date shown on the license (1/31/98); he shall not practice except in a setting first approved in writing by the Board through its president; unless lawfully prescribed for him by someone else, he shall refrain from the use of all mind or mood altering substances and shall refrain from the use of alcohol; he shall notify the Board within two weeks of his use of such medication or alcohol, including identification of the prescriber and the pharmacy; on the Board's request, he shall supply bodily fluids or tissue for drug/alcohol screening; he shall maintain and abide by his NCPHP contract; must comply with other conditions.

MITCHELL, Greg Steven, Physician Assistant

Location: Waynesville, MO

DOB: 4/07/48

License #: 1-02309

Education: Fort Sam Houston, TX (1984)

Cause: Application for a PA license; the Board has concerns about Mr Mitchell's health and the effect his health could have on his ability to practice safely.

Action: 5/09/97. Consent Order executed: Mr Mitchell is issued a PA license to expire on the date shown on the license (9/30/97); he shall obtain and document 50 hours of category I CME relevant to his practice each year with an initial report to the Board on 9/01/97; he shall cause his psychiatrist to send a report of his mental health to the Board for receipt by 9/01/97; he shall provide a copy of this Consent Order to each of his primary supervising physicians and have each one confirm that fact in writing to the Board; the Board shall not approve his practice with any new primary supervising physician until it has received confirmation that that physician has seen this consent order, though such confirmation shall not obligate the Board to issue approval; within four months of his beginning practice, his primary supervising physician shall submit a report to the Board regarding Mr Mitchell's practice; must comply with other conditions.

MORGAN, Roger Eliot, MD

Location: Raleigh, NC (Wake Co)

DOB: 6/06/57

License #: 00-36781

Specialty: GS/TRS (as reported by physician)

Medical Ed: University of Illinois College of Medicine (1983)

Cause: Application for reinstatement of license surrendered 3/12/97 due to depressive illness. Dr Morgan is under the care of a therapist and has progressed in his recovery; he has entered into a contract with NCPHP.

Action: 7/31/97. Consent Order executed: Dr Morgan is issued a dated license to expire on the date shown on the license (7/31/98). Unless lawfully prescribed for him by someone else, he shall refrain from the use of all mind or mood altering substances and shall refrain from the use of alcohol; on the Board's request, he shall supply bodily fluids or tissue for drug/alcohol screening; he shall maintain and abide by his NCPHP contract; he shall continue in therapy and cause his therapist to make quarterly reports to the Board; he shall practice only in settings approved in writing by the president of the board; he shall obtain 50 hours of CME relevant to his practice each year, at least 30 hours of which must be Category I; must comply with other conditions.

MORRIS, Robert Harry, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)

DOB: 11/18/50

License #: 1-00110

Education: Howard University (1975)

Cause: Application for reissuance of PA license, which was surrendered by Consent Order dated 3/22/97. He admits he has had a problem with substance abuse. He is now participating in several substance abuse programs and is an active participant in NCPHP, having completed a 28 day inpatient treatment program at Samaritan Colony.

Action: 6/11/97. Consent Order executed: Mr Morris is issued a PA license to expire on the date shown on the license (9/30/97); he shall maintain and abide by a contract with NCPHP; unless lawfully prescribed by someone else, he shall not use mind or mood altering substances or controlled substances; he shall not use alcohol; he shall notify the Board in writing within two weeks of his use of such medication or alcohol, identifying the prescriber and the pharmacy filling the prescription; he shall supply bodily fluid and tissue samples as requested for drug and alcohol screening; must comply with other conditions.

NATHAN, Paul Eli, MD

Location: New Orleans, LA

DOB: 12/22/60

License #: 00-35712

Specialty: C/IM (as reported by physician)

Medical Ed: St George's, Granada (1987)

Cause: The Louisiana Board charged Dr Nathan with habitual and recurring use of drugs, including alcohol, and charged that his capacity to practice with reasonable skill and safety was compromised as a result of his drug and alcohol abuse and that he made false statements on his application for a Louisiana license; the Louisiana Board found Dr Paul guilty on all three charges and suspended his license for one year, effective October 22, 1995, and imposed a five year period of probation on him.

Action: 5/22/97. Consent Order executed: Dr Nathan's North Carolina medical license is suspended. (Effective 5/22/97.)

POWELL, Eddie Nelson, MD

Location: Roseboro, NC (Sampson Co)

DOB: 8/14/48

License #: 00-23962

Specialty: GP/GER (as reported by physician)

Medical Ed: Hahnemann Medical College (1978)

Cause: To dispose of the case initiated by the Board with a Notice of 7/21/95. Dr Powell was indicted on 19 felony charges related to alleged sexual relations with his stepdaughter, though all but three charges were dismissed prior to trial or before submission to the jury; shortly before and during the trial, the state's principal witness indicated she wished to recant her allegations but testified anyway, later saying she did so under duress; Dr Powell was convicted in the Superior Court of New Hanover County on 2/28/91 of one count of taking indecent liberties with a minor and two counts of incest; following the criminal trial, the principal witness instituted a civil action against Dr Powell for the same acts of sexual misconduct about which she had testified at the criminal trial, then disavowed all her prior testimony. Dr Powell was sentenced to probation and, as a condition of probation, performed 1,000 hours of community service and spent 52 weekends in jail. The Board gave notice of its intention to automatically revoke his license by reason of the felony convictions; Dr Powell requested a hearing, which was conducted, and the Board deferred its decision due to Dr Powell's appeal of his convictions. The North Carolina Court of Appeals affirmed the convictions on 9/27/93 and the Board entered an Order revoking Dr Powell's license; Dr Powell filed a Notice of Appeal of the Board's decision and a motion for a stay in Superior Court of Wake County; his motion for a stay of the Board's decision was granted on 10/15/93. Dr Powell moved in the Superior Court for appropriate relief from his criminal convictions based on the recantation of the principal witness, but the motion was denied and judgment on the motion for appropriate relief is now final. On 5/03/94, the Board withdrew its order of 9/27/93 without prejudice, stating withdrawal was based on the various events that occurred following entry of the 9/93 Order. On 9/18/95, the Board served Dr Powell with notice of its intention to automatically revoke his license based on the felony convictions. Dr Powell requested a hearing but disputed the Board's authority to conduct further hearings. He has practiced since 10/15/93

Board Orders/Consent Orders/Other Board Actions....(cont.)

without incident and the alleged conduct resulting in the convictions occurred outside the scope of his medical practice and did not relate to competence; he recognizes the authority of the Board and its jurisdiction over him and the subject matter of this case and waives his right to any hearing on the issues raised in the Notice dated 7/21/95 and to any judicial review or appeal on those charges.

Action: 6/18/97. Consent Order executed: Dr Powell's license is revoked for the period of time beginning with 9/27/93, the day the Board's Order revoking his license was entered, and ending 10/15/93, the day the stay was entered in the Superior Court of Wake County; his license has remained restored since that time.

ROBERTSON, Charles Gurney, Jr, MD

Location: Mount Airy, NC (Surry Co)

DOB: 5/13/27

License #: 00-9879

Specialty: OBG (as reported by physician)

Medical Ed: University of North Carolina, Chapel Hill (1954)

Cause: Board concerns about record keeping and the health of Dr Robertson; he may not be sufficiently documenting the care given patients and sometimes his findings do not justify his treatments; he sometimes records little if any examination results; the Board is concerned about Dr Robertson's health and that he treats himself for a complex condition.

Action: 5/02/97. Consent Order executed: Dr Robertson shall obtain and document 50 hours of Category I CME relevant to his practice each calendar year beginning with 1997; he shall have a physical examination by his personal physician and cause that physician to report the results to the Board; no later than 1/01/98, he shall resign or otherwise relinquish all his hospital privileges and shall not apply or reapply for such privileges; must comply with other conditions.

SHANKS, David Edward, MD

Location: Charlotte, NC (Mecklenburg Co)

DOB: 6/02/41

License #: 00-20440

Specialty: PUD/HO (as reported by physician)

Medical Ed: Bowman Gray School of Medicine (1966)

Cause: Request to modify Consent Order of 8/02/96 that was issued on his admission he had a romantic relationship with a patient.

Action: 7/16/97. Consent Order executed: Dr Shanks is issued a license to expire on the date shown on the license (11/30/97); will maintain and abide by a contract with NCPHP; will continue counseling with approved psychologist, who shall be directed by Dr Shanks to report his progress to the Board quarterly; must comply with other conditions.

SHIVE, Robert MacGregor, MD

Location: Charlotte, NC (Mecklenburg Co)

DOB: 11/02/33

License #: 00-13226

Specialty: P (as reported by physician)

Medical Ed: University of North Carolina, Chapel Hill (1961)

Cause: To amend the Consent Order between Dr Shive and the Board dated 8/20/96 in view of his statement to the Board that he intends to limit his practice to counseling and supervision of pastoral and other counselors and would have no patients of his own.

Action: 6/18/97. Consent Order executed: Dr Shive is issued a license to expire on the date shown on the license (3/31/98); he shall not administer, prescribe, dispense, or order any drugs; he shall not meet with, interview, examine, treat, or otherwise interact with a female patient unless a chaperon is present in the room during the entire encounter; he shall obtain and document 50 hours of category I CME relevant to his practice each year; must comply with other conditions.

STEWART-CARBALLO, Charles Willy, MD

Location: Fayetteville, NC (Cumberland Co)

DOB: 2/24/57

License #: 00-38215

Specialty: OBG/OS (as reported by physician)

Medical Ed: University of Minnesota (1985)

Cause: To modify the consent order of 6/28/95, which had no provisions relating to substance abuse. In 1996, Dr Stewart-Carbollo pled guilty to and was convicted of driving while impaired.

Action: 7/31/97. Consent Order executed: Dr Stewart-Carbollo shall notify his supervisor of his present health status; he shall maintain and abide by his aftercare contract with the NCPHP; he shall obtain neuropsychological evaluations at intervals of six months and cause reports of those evaluations to be submitted to the Board; these evaluations will be done by a practitioner designated by the Board; he shall obtain and cause to be reported to the Board evaluations of his general health at intervals of six months, again using a practitioner designated by the Board; unless lawfully prescribed for him by someone else, he shall refrain from the use of all mind or mood altering substances and shall refrain from the use of alcohol; on the Board's request, he shall supply bodily fluids or tissue for drug/alcohol screening; must comply with other conditions. Terms and conditions in this Consent Order supersede those in the Consent Order of 1995.

SUVILLAGA, Victor Ivan, MD

Location: Wilmington, NC (New Hanover Co)

DOB: 10/19/48

License #: 00-26877

Specialty: FP/EM (as reported by physician)

Medical Ed: University of El Salvador (1979)

Cause: His license was summarily suspended on 6/07/96 and a Notice of Charges was preferred against him for, among other allegations, violating a Consent Order of 5/08/95. He admits that while the Consent Order was in effect, he prescribed Schedule IV controlled substances while he lacked federal registration to do so and thereby committed unprofessional conduct. He believes his conduct was in part a result of his then poorly controlled obsessive-compulsive disorder. He has undergone treatment for his condition and appears to be doing well.

Action: 6/12/97. Consent Order executed: the Board dismisses with prejudice the Notice of Charges of 6/07/96 and lifts the summary suspension of Dr Suvillaga's license; Dr Suvillaga surrenders his license to practice medicine and is issued a license to practice to expire on the date shown on the license (11/30/97); he shall practice only in a structured setting approved by the Board; he shall practice no more than 32 hours a week; he shall not administer, prescribe, dispense, or order any controlled substance for which federal registration is required and shall not apply to the DEA for registration; he shall continue his therapy and treatment; he shall obtain 50 hours of relevant CME each year, including 30 hours of Category I credit; must comply with other conditions.

SYKES, Larry Justain, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)

DOB: 9/11/46

License #: 1-00388

Education: Fort Sam Houston, TX (1976)

Cause: Application for extension of license. During Mr Sykes military service in 1981, he engaged in a relationship with a PA student in a clinic where he worked. He has completed psychosexual assessment and is participating in individual therapy; is active in NCPHP.

Action: 7/22/97. Consent Order executed: Mr Sykes is issued a dated license to expire on the date shown on the license (1/31/98); shall maintain and abide by a contract with NCPHP; shall continue to participate in individual therapy until released by the Board; shall have his therapist report to the Board quarterly; shall have a chaperon present whenever he examines or treats a female; shall provide a copy of this Consent Order to his primary supervising physician(s); must comply with other conditions.

VAUGHAN, Howell Anderson, Physician Assistant

Location: Hickory, NC (Catawba Co)

DOB: 3/31/58

License #: 1-01513

Education: Wake Forest University (1992)

Board Orders/Consent Orders/Other Board Actions...(cont.)

Cause: Request to amend his Consent Order of 1/18/95.
 Action: 5/07/97. Consent Order executed: Mr Vaughan shall not work more than 50 hours in any calendar week; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions. This Consent Order supersedes that of 1/18/95.

VIRMANI, Ashutosh, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 8/06/53
 License #: 00-38567
 Specialty: OBG (as reported by physician)
 Medical Ed: University of Medicine and Dentistry of New Jersey (1985)
 Cause: Notices of Charges of 9/13/96 and 1/02/97; Board began investigation after Dr Virmani's staff privileges at Presbyterian Hospital in Charlotte were summarily suspended; he contested the suspension of his hospital privileges in court; on 7/19/96, he and his attorney were parties to an informal interview with the Board on matters pertaining to his medical practice; on 8/21/96, Dr Virmani verified a motion authored by his attorney and filed in the court action, which motion alleged the Board had concluded the investigation in question and determined no disciplinary action would be taken against Dr Virmani; he admits that at the time he verified the motion, its statements about the Board's investigation were not true.
 Action: 7/18/97. Consent Order executed: Dr Virmani is reprimanded with regard to the Notice of Charges of 9/13/96; the Board dismisses the Notice of Charges of 1/02/97.

DENIALS OF LICENSE/APPROVAL

GOMEZ, Raul Fernando, MD

Location: Jacksonville, FL
 License #: 00-17680 (surrendered 8/20/93 following Amended Notice of Charges and Allegations preferred against him by the Board on 6/07/93)
 Specialty: P (as reported by physician)
 Medical Ed: University Caldas, Columbia (1967)
 Cause: Immoral, dishonorable, and unprofessional conduct involving, among other things, sexual intercourse with a patient and prescribing controlled substances for the same patient without documented medical need or reason, notwithstanding evidence of controlled substance abuse by the patient. These incidents occurred while he practiced in Fayetteville prior to the surrender of his license.
 Action: 6/11/97. Findings of Fact, Conclusions of Law, and Order issued by the Board: application for a license to practice medicine in North Carolina is denied.

VOLUNTARY SURRENDERS

MEAD, Robert J., MD

Location: Greensboro, NC (Guilford Co)
 Asheboro, NC (Randolph Co)
 DOB: 12/13/45
 License #: 00-32790
 Specialty: AN/PD (as reported by physician)
 Medical Ed: Jefferson Medical College (1978)
 Action: 7/06/97. Voluntary surrender of license.

SIMSEN, Donald Anthony, MD

Location: Manteo, NC (Dare Co)
 DOB: 1/24/30
 License #: 00-18573
 Specialty: OBG/GO (as reported by physician)
 Medical Ed: Georgetown University (1956)
 Action: 4/14/97. Voluntary surrender of license.

WALTMANN, Brian Keith, MD

Location: Atlanta, GA
 DOB: 6/28/55
 License #: 94-00179
 Specialty: AN/APM (as reported by physician)
 Medical Ed: Medical University of South Carolina, Charleston (1979)
 Action: 7/23/97. Voluntary surrender of license.

See Consent Orders:

SUVILLAGA, Victor Ivan, MD

DATED LICENSES:

ISSUED/EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

ADAMS, Beverly Jean S., MD

Location: Durham, NC (Durham Co)
 DOB: 11/11/45
 License #: 00-25974
 Specialty: OTO (as reported by physician)
 Medical Ed: Duke University (1976)
 Action: 7/18/97. Issued temporary license to expire 1/31/98.

BLAKE, Daniel Jackson, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 4/12/48
 License #: 00-23830
 Specialty: P/CD (as reported by physician)
 Medical Ed: University of North Carolina, Chapel Hill (1978)
 Action: 5/23/97. Issued temporary license to expire 5/31/98.

BRANCH, Robert Donald, Jr, Physician Assistant

Location: Kinston, NC (Lenoir Co)
 DOB: 7/07/58
 License #: 1-02026
 Education: University of Texas (1995)
 Action: 5/23/97. Issued temporary license to expire 11/30/97.

BROWN, David Houston, MD

Location: Lillington, NC (Harnett Co)
 DOB: 12/11/45
 License #: 00-28623
 Specialty: IM/EM (as reported by physician)
 Medical Ed: Universidad Autonoma Guadalajara (1976)
 Action: 7/18/97. Issued temporary license to expire 11/30/97.

BROWN, Thomas Walter, MD

Location: Chapel Hill, NC (Orange Co)
 DOB: 8/18/51
 License #: 00-35104
 Specialty: ADP/ADM (as reported by physician)
 Medical Ed: Case Western Reserve University (1978)
 Action: 7/18/97. Return of full and unrestricted license.

COLLINS, Natalear Rolline, MD

Location: Franklinton, NC (Franklin Co)
 DOB: 10/22/55
 License #: 00-27108
 Specialty: GP/OM (as reported by physician)
 Medical Ed: East Carolina School of Medicine (1981)
 Action: 5/23/97. Issued temporary license to expire 11/30/97.

BUNN, David Glenn, Jr, MD

Location: Wilmington, NC (New Hanover Co)
 DOB: 4/03/50
 License #: 00-20771
 Specialty: OBG (as reported by physician)
 Medical Ed: University of North Carolina, Chapel Hill (1975)
 Action: 7/18/97. Issued temporary license to expire 1/31/98.

CARMACK, Keith Keenan Kilauea, MD

Location: Goldsboro, NC (Wayne Co)
 DOB: 1/24/49
 License #: 00-30306
 Specialty: FP (as reported by physician)
 Medical Ed: University of Hawaii (1983)
 Action: 7/18/97. Issued temporary license to expire 1/31/98.

GLENN, Robert Alan, Physician Assistant

Location: Asheville, NC (Buncombe Co)
 DOB: 3/13/59
 License #: 1-01972
 Education: George Washington University (1989)
 Action: 7/18/97. Issued temporary license to expire 11/30/97.

Board Orders/Consent Orders/Other Board Actions...(cont.)

HALE, Phillip Douglas, MD

Location: Danville, VA
 DOB: 2/05/55
 License #: 96-00826
 Specialty: FP (as reported by physician)
 Medical Ed: Uniformed Services University (1982)
 Action: 5/23/97. Issued temporary license to expire 5/31/98.

HARRIS, Donald Philip, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 4/09/34
 License #: 00-13127
 Specialty: M (as reported by physician)
 Medical Ed: University of North Carolina, Chapel Hill (1961)
 Action: 5/23/97. Issued temporary license to expire 7/31/98.
 7/18/97. Issued temporary license to expire 9/30/97.

HAWLEY, John Patrick, Physician Assistant

Location: Hubert, NC (Onslow Co)
 DOB: 4/27/46
 License #: 1-02243
 Education: Duke University (1977)
 Action: 5/23/97. Issued temporary license to expire 9/30/97.

KEEVER, Richard Alan, MD

Location: High Point, NC (Guilford Co)
 DOB: 6/11/41
 License #: 00-16400
 Specialty: OTO (as reported by physician)
 Medical Ed: University of North Carolina, Chapel Hill (1969)
 Action: 7/18/97. Issued temporary license to expire 11/30/97.

LESTER, Allan John, MD

Location: Cary, NC (Wake Co)
 DOB: 9/19/44
 License #: 00-20159
 Specialty: FP/OM (as reported by physician)
 Medical Ed: University of Otago, New Zealand (1970)
 Action: 7/18/97. Issued temporary license to expire 1/31/98.

LUTZ, Robert Paul, MD

Location: Chapel Hill, NC (Orange Co)
 Raleigh, NC (Wake Co)
 DOB: 5/05/48
 License #: 00-27387
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina, Chapel Hill (1982)
 Action: 7/18/97. Issued temporary license to expire 1/31/98.

MARTIN, Gerald Randall, MD

Location: Brevard, NC (Transylvania Co)
 DOB: 6/04/56
 License #: 00-32949
 Specialty: IM (as reported by physician)
 Medical Ed: University of Texas, Galveston (1987)
 Action: 5/23/97. Issued temporary license to expire 5/31/98.

McALLISTER, John David, Jr, MD

Location: Fayetteville, NC (Cumberland Co)
 Raeford, NC (Hoke Co)
 DOB: 3/14/49
 License #: 00-38271
 Specialty: IM (as reported by physician)
 Medical Ed: University of North Carolina, Chapel Hill (1985)
 Action: 5/23/97. Issued temporary license to expire 11/30/97.

NELSON, Mark Theodore, MD

Location: Dunn, NC (Harnett Co)
 Wilmington, NC (New Hanover Co)
 DOB: 11/24/61
 License #: 93-00251
 Specialty: ELY/AN (as reported by physician)
 Medical Ed: University of Kansas (1989)
 Action: 5/23/97. Issued temporary license to expire 11/30/97.

O'DONNELL, Robert William, MD

Location: Shallotte, NC (Brunswick Co)
 Whiteville, NC (Columbus Co)
 DOB: 1/30/42
 License #: 00-29636
 Specialty: P/ADP (as reported by physician)
 Medical Ed: University of Maryland (1974)
 Action: 5/23/97. Issued temporary license to expire 11/30/97.

PAINE, Karen Nicholson, MD

Location: Raleigh, NC (Wake Co)
 DOB: 7/07/46
 License #: 00-20834
 Specialty: FP/EM (as reported by physician)
 Medical Ed: New York University (1971)
 Action: 5/23/97. Issued temporary license to expire 9/30/97.

PULEO, Joel Gregg, MD

Location: Pinhurst, NC (Moore Co)
 DOB: 9/15/53
 License #: 00-27965
 Specialty: OBG (as reported by physician)
 Medical Ed: Duke University (1979)
 Action: 5/23/97. Issued temporary license to expire 5/31/98.

SCHULTZOW, Mark Howard, MD

Location: Matthews, NC (Mecklenburg Co)
 DOB: 8/19/57
 License #: 97-00166
 Specialty: PM (as reported by physician)
 Medical Ed: Ohio State College of Medicine (1993)
 Action: 7/18/97. Issued temporary license to expire 11/30/97.

SHANKS, David Edward, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 6/02/41
 License #: 00-20440
 Specialty: PUD/HO (as reported by physician)
 Medical Ed: Bowman Gray Medical School (1966)
 Action: 5/23/97. Issued temporary license to expire 11/30/97.

THOMPSON, Robert Bruce, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 2/29/56
 License #: 00-40006
 Specialty: N/EM (as reported by physician)
 Medical Ed: University of Miami (1987)
 Action: 5/23/97. Issued temporary license to expire 9/30/97.

WHEELER, James Hastings, III, MD

Location: Marion, NC (McDowell Co)
 DOB: 10/20/50
 License #: 00-33912
 Specialty: ORS (as reported by physician)
 Medical Ed: Medical College of Wisconsin (1977)
 Action: 5/23/97. Issued temporary license to expire 9/30/97.

VOLUNTARY DISMISSALS

See Consent Orders:

AUSLEY, Mett Bagley, Jr, MD
 SUVILLAGA, Victor Ivan, MD
 VIRMANI, Ashutosh, MD

CHANGE OF ADDRESS FORM

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(Check preferred mailing address)

Business: _____

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

Home: _____

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

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

By completing this form when appropriate, all physicians registered with the Board can assure that their registration forms and other Board mailings will be sent to the correct address. In the same way, physician assistants and nurse practitioners can assure their renewal notices and other Board mailings will be sent to the correct address.

1997 ROSTER ORDER FORM

Newly Published Roster of Registered Physicians in the State of North Carolina

The Roster is an alphabetical listing, with addresses and license numbers, of the physicians, physician assistants, nurse practitioners, professional corporations, and limited liability companies registered in North Carolina as of March 1, 1997. It also includes the text of the Medical Practice Act, the sections of the Administrative Code that constitute the North Carolina Medical Board's rules and regulations, and the Position Statements of the Board as of that date. The Roster is printed in an 8 1/2 x 11, three-ring format. To purchase a copy or copies, please complete the form and send it, along with a check for the correct amount made to the North Carolina Medical Board, to:

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