FORUM
NORTH CAROLINA MEDICAL BOARD
PRIMUM NON NOCERE
FALL 2009
Celebrating 150 Years

Pg. 16 – There's still time: Update your Licensee Info page

FROM THE PRESIDENT

Reflections on my six-year sojourn on the NC Medical Board

In July of 2003, I reported for duty to my first North Carolina Medical Board meeting. I was there to replace John Dees, MD, a family physician from eastern North Carolina who had served as president of the Board until his death earlier that year. Life has come full circle and now, I too leave the Board as president (though thankfully under more fortunate circumstances than Dr. Dees.)

I do not pretend that I was the best candidate for my seat on the Board. I know of others more qualified than me. I was, quite frankly, surprised that my name was put forward as a nominee by the North Carolina Medical Society, and that I was chosen by then-Governor Easley.

I had much to learn. In this, my final President's Message, I would like to share with you some of the things I have learned in my years at 1203 Front Street, and reflect on some of the Board's achievements.

The North Carolina Medical Board is truly one of the best—if not *the* best—in this nation. Your Board serves the citizens of this great state with kindness and care and its licensees with fairness and justice.

NCMB President George Saunders, MD, says "medicine in North Carolina is better for the Board's efforts."

Sometimes when so much is going on, the spectacular seems mundane. Make no mistake—what the Board does here routinely is spectacular.

Let me take you through a few of the changes that have gone forward during my time on the Board.

The Board adopted the first position statement in the nation to sanction discipline of teachers of medicine who abuse their students. The Board has yet to prosecute anyone under this rule, but I have no doubt that the Board's stance on this issue has worked to deter some of the more extreme forms of student mistreatment.

We were nudged, somewhat reluctantly, to provide greater information to the citizens of this great state. This winter, with the public launch of expanded licensee information pages on the Board's website, North Carolina joins the ever-growing number of state medical regulatory bodies that provide a broad range of information about their licensees.

When the very heart of medicine—the preservation of life and alleviation of suffering—was assaulted by state policies that contemplate active physician participation in the death penalty, your Board opposed that position clearly and forcefully. I sat, beaming with pride, as the Board's attorneys took our case to the State's highest court. Our Legal Department was able to convince three of seven justices that doctors should be healers, not harbingers of death. We lost that battle, but I am proud to this day that we fought for the dignity and caring that is the heart of the profession of medicine.

IN THIS ISSUE

Your Board has stood at the forefront of medical regulation, just as doctors in North Carolina have stood in the leadership of medicine and research throughout this country.

Twice during my time on the Board, the Federation of State Medical Boards (the umbrella organization that guides state medical regulators) has selected North Carolina Medical Board members to serve on its Board of Directors. Numerous Board members serve on the many committees of the FSMB, helping to influence policy and scholarship in medical regulation nationally.

Your Board has taken proactive steps to help licensees improve interactions with patients and prevent complaints by recognizing that effective communication is the key to the relationship between doctors and patients. Over the past 12 months, your Board identified homegrown, affordable, convenient courses where physicians who lost, or perhaps never had, good communication skills can learn effective communication. It is my hope and aspiration that these courses will reach beyond the troubled physicians we see here and be used by all physicians who strive to become skilled communicators.

Your Board has done all this, and more, with quiet yet bold leadership. And it has done it all with a modest-sized staff and operating budget that strains under ever-increasing obligations.

Numerous challenges remain before the Board.

The Board needs to streamline its licensing process while maintaining the integrity and high standards of the evaluations. The Board must strive to build a workforce within the Board which looks like the workforce outside the Board. It must find a way of performing clinical evaluations of licensees in their own clinical settings, which would be more relevant and useful than the costly and inefficient practice of sending a physician under review off to some distant place that does not resemble the conditions in which he or she practices.

I know that some of these changes will take members of the staff and Board outside of their comfort zones. Newness is not always a bad thing.

Finally, I personally owe a great deal to the Board's staff and to my colleagues on the Medical Board. The people of this great state, including the Board's licensees, owe them much more. They are the centurions of care and the guardians of good medical practice.

Medicine in North Carolina is better for the Board's efforts. It has been my privilege to be part of those efforts for the past six years.

Send feedback to *forum@ncmedboard.org*.

BE A BETTER COMMUNICATOR

In the last issue of the *Forum*, Dr. Saunders wrote about a Board initiative aimed at improving licensees' communication skills. He wrote of the Board's intention to publicize more information about the specific vendors providing communications training when it was available. The Board is pleased to recommend the programs listed below. Courses are typically scheduled on Saturdays and take a full day.

Course: Interpersonal and Communication Skills Seminar for Physicians
Offered by: SEAHEC, Charlotte AHEC and MAHEC
Locations: Wilmington, Charlotte, Asheville
Cost: $400-$450
CME Credits: 7 Category 1 Credits
Information/registration: *www.seahec.net*

Course: Strategies for Effective Medical Communication
Offered by: Wake AHEC
Locations: Chapel Hill
Cost: $550
CME Credits: 6.5 Category 1 Credits
Information/registration: *www.wakeahec.org*, 919-350-8547

North Carolina Medical Board Forum Credits

Volume XIV | Fall 2009

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The 'Six Core Competencies': Evaluating Licensee Performance and Conduct

The North Carolina Medical Board has a duty to address misconduct and substandard care. However, its members also consider taking proactive steps to help prevent such problems to be a priority.

To that end, this issue of the *Forum* begins a series of short features on an important tool the Board uses to evaluate possible misconduct: the ACGME's six core competencies.

A decade ago, the Accreditation Council for Graduate Medical Education (ACGME) endorsed six core competencies it expects all medical residents to demonstrate proficiency in. Since then, the core competencies have gained acceptance among numerous healthcare organizations as a useful means of gauging clinical aptitude. For example, the American Board of Medical Specialties uses the six core competencies as part of its Maintenance of Certification programs. Just last year, the Joint Commission began requiring all accredited hospitals to capture physician-specific data that indicate proficiency in the six core competencies.

The Board has used the core competencies as a framework for discussing disciplinary cases for some time. It has observed that licensees under review usually exhibit shortcomings in one or more competency.

This February, during a Board retreat, Board members hit on the idea of educating licensees about the core competencies as a means of preventing problems. In general, the Board believes that a licensee who demonstrates proficiency in the core competencies can reduce his or her chances of patient complaints or disciplinary action.

Licensees who work with resident training programs or who are active members of an accredited hospital staff are likely at least generally familiar with the competencies. However, the Board recognizes that many licensees practice in settings that do not bring them in regular contact with the competencies and may be unfamiliar with them.

Over the next few issues of the *Forum*, the Board will highlight two competencies per issue in detail, and publish a complete list of all six competencies. Detailed definitions for each competency are taken from the ACGME.

In this issue: Patient Care and Medical Knowledge

Read the detailed definitions for information on what behaviors and skills demonstrate proficiency within a particular competency.

Patient Care: "What you do"

Practitioners must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Practitioners are expected to:

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
- Gather essential and accurate information about their patients.
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgment.
- Develop and carry out patient management plans.
- Counsel and educate patients and their families.
- Use information technology to support patient care decisions and patient education.
- Perform competently all medical and invasive procedures considered essential for the area of practice.
- Provide health care services aimed at preventing health problems or maintaining health.
- Work with health care professionals, including those from other disciplines, to provide patient-focused care.

Medical Knowledge: "What you know"

Practitioners must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Practitioners are expected to:

- Demonstrate an investigatory and analytic thinking approach to clinical situations.
- Know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

WHAT ARE THE SIX CORE COMPETENCIES?

A complete list of the six competencies appears below.

- Patient Care
- Medical Knowledge
- Practice-based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-based Practice

SPECIAL FEATURE

Developing a website for your practice

Marjorie A. Satinsky, MBA

Think of the number of times you, your family and friends access the Internet. You use the Web to make travel arrangements, make purchases, download music, share information with friends and relatives and find information on topics that interest you.

Yet many medical practices have yet to establish a presence on the Web. If your patients are online, why aren't you?

Neil Baum, MD, author of *Marketing Your Clinical Practice*, writes, "Your website might be the first impression your patient has of your practice, the way you treat patients, and your attention to detail. If you have built a user-friendly, interactive website, this becomes a way to build trust and enhance the patient-physician relationship."

The purpose of this article is to remove the mystery from website development. It addresses the following topics: types of practice websites, setting goals, selecting a vendor, developing content material, tips for getting noticed and methods for monitoring site traffic.

Practice website basics

Many medical practices regard their websites as a second door to their offices that also offers improvements in efficiency, cost savings, increased visibility and improvements in revenue cycle management.

Depending on the capabilities you choose to offer through a website, you can provide basic information to all users and also give current patients the ability to use the website for both administrative and clinical functions. This interactive feature, called a patient portal, allows patients to request appointments and prescription refills and view lab and other test results. They may download forms and either return them to the practice electronically or bring them to their next appointment. They may pay bills online, receive email reminders about appointments and preventive care, and access health information. Now that payers such as Blue Cross Blue Shield of North Carolina are reimbursing physicians for electronic or "e-visits," physicians may be paid for providing online advice to existing patients, subject to plan-specific requirements.

A 'patient portal' that lets patients request appointments, see lab test results and take care of other business can improve patient satisfaction and reduce overhead.

Prospective patients can use your website to learn about the services that you provide and about your practitioners and administrative staff. Patient testimonials can tell them how other patients perceive your practice. Referring physicians can see what care you provide and what insurance you accept.

Setting up and maintaining a website takes time and money. The cost, however, may be less expensive than advertising in the Yellow Pages, which, let's face it, doesn't produce the results it once did now that people have the Internet. These days, patients' fingers are more likely to walk across the computer keyboard than through a cumbersome paper phone book.

Set your goals

If you're interested in establishing a practice website, start by setting goals. Look at the sites of other practices in your specialty and in your community. Some provide information only. Other websites function as interactive patient portals, but are significantly more costly to establish. Decide what's right for your practice before you make decisions about budget, vendors and site content.

If you are happy with your existing practice logo and printed brochures, they may be a good jumping off point for your website's look and feel.

When I opened Satinsky Consulting in 2002, I started with my logo and print materials and created a website that was consistent with them. I wanted to reinforce a clear and simple message with repetition. Three different people collaborated on the design, content editing and programming of my corporate website.

Some experts argue that the Web is a totally different medium and recommend starting fresh with the help of an experienced Web developer. "Some of the advantages of starting with Web design include selecting colors that reproduce well both on the Web and in print," said Alice Saunders of Finishing Software. "The implications of vertical and horizontal logos and taglines on the masthead of a website differ from print material, since space may be more limited." Information that has been specifically written and organized for the Web sometimes produces better copy for print material as well, Saunders said.

Who will build the site?

Some practices may have the in-house expertise to create and maintain a website, but most medical practices prefer to outsource the job to one or more vendors with proven

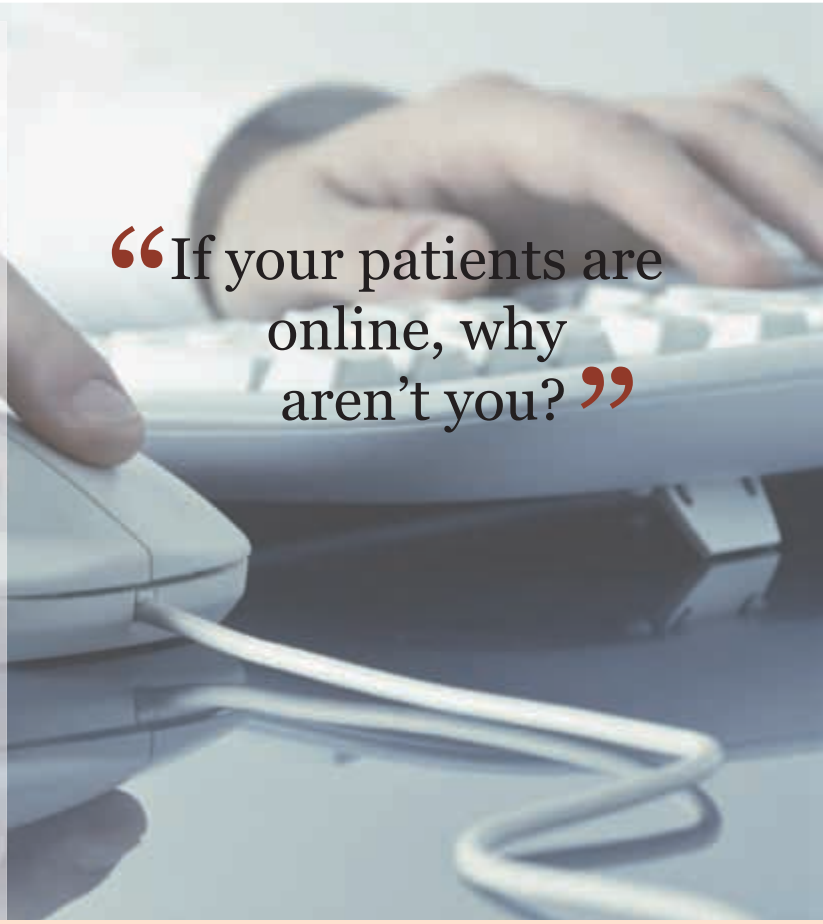
skills and track records of developing attractive, functional sites for their clients.

If your practice uses a marketing consultant, he or she can likely recommend a Web developer and help you with decisions about how to proceed. If you want to go directly to Web vendors, go with the knowledge of what you need and communicate your requirements clearly.

Whatever your preference, you need website design, content editing and programming – three different skills. Some Web design companies do everything, but others do not. In such cases you will need a team of people with complementary skills. Vendors who do not provide the full range of services you require should be able to recommend additional expertise to get the job done. Experienced vendors likely will have established partners who work with them.

Selecting a vendor

Before you select outside help, look at other websites. What look do you like? Do you want videos, case studies, a before/after photo gallery or other enhancements? Try navigating around websites you like to see how informa-



HARNESSING THE POWER OF THE WEB: WHAT OTHERS HAVE DONE

IMPACT ORTHOPAEDICS

Dr. Rob Jones opened Impact Orthopaedics in Raleigh in mid-2008. His website, *www.impactorthopaedics.com*, contains comprehensive information about the services that he provides and about the background and experience of both clinical and administrative staff. Right now, patients can download financial policies, a Notice of Privacy Practices and forms to fill out prior to their appointments. The patient portal aspect of the site gives Dr. Jones the flexibility to add additional interactive features at a later date should he decide to do so.

NC DERMATOLOGY ASSOCIATES

Dr. Vikas Patel opened his new dermatology practice in March 2009. His website, *www.ncdaskin.com*, offers basic information and downloads. Dr. Patel plans to add a patient portal that will integrate into his EHR system. With the portal, patients will be able to pre-register prior to their visit, thus eliminating paper registration. Dr. Patel used a freelance Web designer to help with design. Two features are built into Dr. Patel's site. One is Search Engine Optimization (defined in RFP box Pg. 6) and the second is a Web analytic tool that provides information to help the practice understand user behavior.

AVANCE CARE

Avance Care is a paperless primary care practice with one site in Morrisville and plans to expand to two other locations. Information technology has been a priority since day one. Patients can go to *www.avancecare.com* and click on quick links that take them to new patient registration and appointment requests, established patient appointments and an online patient satisfaction survey. Other sections of the home page offer health information and a live (i.e. on-line) chat with the receptionist to discuss appointments, walk-in policies and waiting time. The results of the patient satisfaction survey, which are very positive, are posted right on the site. Avance Care believes the features on its website help the practice keep its overhead low and manage more efficiently.

BLUE RIDGE FAMILY PHYSICIANS

Blue Ridge Family Physicians in Raleigh had a dilemma. Patients were calling on the phone and waiting on hold for as long as thirty minutes to make appointments, request prescription refills and take care of other administrative matters. With ten providers, the practice struggled with an inefficient front office and with billing and clinical processes that had a negative impact on patient communication. Patient complaints skyrocketed, and the practice realized it needed to address all of these problems.

The practice was already well on its way to becoming a paperless practice. In 2002, it had implemented an electronic medical record system (EHR), and it had a practice website that was up and running. It sought a solution that would blend well with its other investments. Working with Medfusion in Raleigh, the practice added a patient portal to its existing website. Once patients had the ability to request appointments, pay bills, pre-register, submit health forms and renew and refill prescriptions, the telephone problem abated. The practice saved money on postage, paper and printing. Patients and staff love the new features. In fact, the practice involved both groups in contests to come up with ideas to market the new website to patients.

> “There are good reasons to select a vendor that specializes in creating websites for medical practices”

tion is organized and displayed. In some cases you can find the name of the Web developer on the bottom of the home page. Contact colleagues and professional associations whose sites you admire and ask for their suggestions.

In my experience, there are good reasons to select a vendor that specializes in creating websites for medical practices. Examples are Medfusion, Early Design Group and Mednet Technologies . These companies know the medical practice industry and the unique requirements of certain specialties. Partnership arrangements often give them the capability to integrate their patient portal right into other products such as practice management systems (PMS) or electronic health records (EHR).

An effective way to get comparable bids is to develop a concise but thorough Request for Proposal (RFP). Please see the accompanying box (below) for a list of the areas that a good RFP should cover.

Developing content material

Presumably you have looked at other websites before you began your own project and have some idea of the topics that you want to cover on your own site. At the very least, you will want visitors to your website to learn:

- Who you are (name, mission, goals)
- How to contact your office (phone, fax, email)
- How to find your office (driving directions, map, parking)
- Hours when your office is open
- Availability of appointments and walk-ins
- Who provides clinical and administrative services (pictures and biographical information on physicians, other clinical staff, key administrative staff)
- What services you provide (names and brief descriptions)
- What insurance plans you accept
- Information on medical conditions that you frequently treat
- Link to your practice newsletter if you have one
- Current news on you and your practice
- How you comply with HIPAA (download Notice of Privacy Practices)

Tips for getting noticed

Setting up your website is only half the challenge. Once it’s up and running, you want to make sure that people access it. Here are suggestions for maximizing Web traffic:

Finding the right Web vendor(s): A good RFP can help

A thorough Request for Proposal can help a practice clearly state its goals for a website and help select a vendor capable of delivering the results you want. Thanks to the Foundation of the Lucy Daniels Center for Early Childhood in Cary, which shared the basic framework it used for its RFP.

- **Project summary**
- **Proposal Guidelines and Requirements** (e.g. open and competitive process, deadline for receipt, fixed price, willingness to incorporate elements of Proposal into final agreement)
- **Length of the Contract Term**
- **Purpose, Description, and Objectives** (what you want to accomplish)
- **Description of website that you want** (e.g. flexibility, informative, easy to maintain, safe and secure, quick loading)
- **Internet Objective** (e.g. create brand identity)
- **Specific Strategies and Required Functionality** (e.g. focus on existing and/or potential patients, resource for referring physicians, provision of downloadable administrative tools/forms, encourage patient communication with practice)
- **Maintenance Strategy** Will you or the vendor provide updates and how extensive and frequent do you expect them to be?
- **Miscellaneous Related Services** How will you acquire a domain name and who will be responsible for this task? How does the vendor handle Web hosting and is the hosting service HIPAA compliant? How will email be sent through the site? Who will provide technical support? What Search Engine Optimization* or Search Engine Marketing** strategy does the vendor propose?
- **Design Preferences** (e.g. look and feel, additional features such as photography or video)
- **Technical Specifications** What software or programming language will the vendor use to create the site? How will site traffic be tracked and analyzed***? Who will host the site ****and who will provide technical support if the site crashes?
- **Timeline for completion**
- **Pricing Terms** Ask the vendor to itemize pricing for various services. (e.g. acquiring domain name, hosting, design, customization, video and other special features, content management if you are not doing it yourself, monthly maintenance, price per click for some items, etc.) If the vendor offers different levels of service, request a pricing range and recommendation for the level appropriate for your organization.
- **Payment Terms** How much money is due up front? How is billing done once the project is underway (weekly or monthly, based on completion of project

- Include your website address on all correspondence, including but not limited to letters, postcards and bills.
- Post signs in your office encouraging patients to use your website.
- Put a computer with access to your website (but not Internet shopping) in your waiting room so patients can explore your website while they are waiting to be seen.
- Involve your patients in website promotion by asking for suggestions and offering prizes for ideas that you select.
- Create and customize listings in online directories and phone books. For example, the Google Maps local business listings appear in Google searches, making them very valuable.
- All links back to your website will improve your search rank, so create listings for your website wherever people look for services online. For example, maintain listings with Yahoo, Superpages, Merchant Circle, HealthGrades and Vitals.
- Encourage patients to write reviews in Google Maps listings and other directories.
- Update your site regularly. Google can determine the last time you updated your site. If your site is "stale," your search ranking will suffer.

Conclusion

So what's the right type of website for your practice? Do you even need one at all? How will you accomplish the project? The decision is up to you!

The author wishes to thank: Robert G. Jones, MD, Impact Orthopaedics; Lynette Mutter, Business Development, Talon for Healthcare; Manish Patel, Avance Care; Vikas Patel, MD, North Carolina Dermatology Associates; Richard Pedersen, Medfusion; Don Rosenblitt, MD, The Lucy Daniels Center for Early Childhood; and Alice Saunders, Finishing Software.

Send feedback to *forum@ncmedboard.org*.

Ms Satinsky is president of Satinsky Consulting, LLC, in Durham, NC. She is a frequent contributor to the *Forum*. Ms. Satinsky may be reached at (919) 383-5998 or *Margie@satinskyconsulting.com*

References

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Brown, P.A. (2008) " Website as Online Patient Service Center – and Strategic Investment." *Group Practice Journal*, October, pages 44-48.

milestones)? If the vendor will provide ongoing maintenance, how will you be billed once the project is done?
- **Asset Ownership** Who owns the assets, such as logos and images, at the initial project completion? In what format will the vendor need these assets? What, if any, proprietary tools and techniques are being used and are essential for further development and maintenance of the site? What are the license fees for these tools and techniques and who is responsible for paying them going forward?
- **Evaluation Criteria** How you will measure the vendor's responsiveness to your needs

Cheat sheet for Web development lingo

*Search Engine Optimization (SEO) is a means of ensuring that the content of your site gets optimal visibility on the Web. For example, if you were a general surgeon practicing in Hickory, you would want to make sure that your practice name comes to the top of the list when people type in Hickory surgeon on Google, Yahoo and other search engines. SEO can make that happen, so ask vendors for examples of ongoing or previous SEO projects so you know how they work.

**Search Engine Marketing (SEM) is related to SEO but extends into the realm of paid advertising in the search engines. Advertising is one way to ensure that your listing appears above others, but it can be costly if there is a lot of competition in your community.

***Tracking and analytics refers to systems that allow you to get as much information as possible about your website users. For example, Google Analytics lets you measure Web traffic, path analysis, visitor trends, page views, entry pages, top pages, exit pages, length of stay per page and what browsers and platforms visitors use. These metrics can help you make changes in both design and content.

****Web hosting is a service that lets individuals and organizations make a website accessible via the World Wide Web. If your vendor provides this service, ask how frequently the server is backed up and how frequently you can expect your site to be down or disrupted because of maintenance. Who will provide technical support and security? Health care practices will want to know if the hosting vendor/company is HIPAA compliant.

Understanding the NCMB's disciplinary case review process

In the last issue of the *Forum* I reviewed the actions the North Carolina Medical Board takes in response to the complaint, malpractice, medical examiner and investigative case information that comes to its attention. In 2008, the Board took public action in approximately 10 percent of cases closed that year, private action 30 percent of the time and no action (internally referred to as 'Accept as Information') 60 percent of the time. In this commentary I will discuss the process used by the Board and its staff to evaluate each case and explain how that process ultimately results in the final actions taken by the Board.

Michael Sheppa, MD

From the Office of the Medical Director

Initial staff review

The Board opens cases involving its licensees in response to information provided by patients and other private citizens, Board licensees and other health care workers, the North Carolina Medical Examiner's Office, hospitals and other health care institutions, malpractice and other insurance companies, the National Practitioner Data Bank, other regulatory bodies and, occasionally, the media.

The first review of such cases is always conducted by Board staff (as you may know, the majority of Board members are working professionals who meet approximately every two months to do official Board business.) Once the staff reviews the initial information, the first step is to identify the licensee or licensees who appear most involved and ask them to respond. The licensee may be sent information received by the Board and asked to provide a written response, or he or she may be interviewed by a Board investigator. The Board expects licensees to provide a timely, complete and accurate account of their involvement in a case under review. The licensee's response should include pertinent information from the medical record or from other sources that help clarify and support their explanation of the conduct or care at issue.

The licensee response is an important opportunity for the licensee to explain his or her perspective, and to bring any mitigating factors that may have bearing on the case to the Board's attention. After reviewing the licensee's response, Board staff may request additional information, including office and hospital medical records, photographs, North Carolina Controlled Substance Reporting System reports, pharmacy records, information from others associated with the case, copies of advertisements and brochures, evidence of licensee certification and continuing education, billing and coding records and police and court reports. In some instances, a Board investigator may visit a licensee's office, a hospital, laboratory or other site in order to obtain whatever other information is necessary to adequately evaluate the circumstances of a particular case.

Office of Medical Director review

Once a licensee response is received by the Board, all complaints, malpractice and medical examiner information, and those investigations that deal with quality of care issues, are forwarded to me or my colleague, Dr. Scott Kirby, the Board's assistant medical director. If we believe additional information is needed, it is requested. If it is impossible to obtain information needed to adequately assess a particular case, it is noted. When Dr. Kirby or I do not have the expertise to assess a quality of care issue, an opinion from an independent reviewer is requested. (The independent reviewer is a practitioner whose area of practice is similar to that of the licensee whose conduct or care is the subject of the case.) Once we have all the information we need to form an opinion, Dr. Kirby or I then summarize each case and make an initial recommendation for Board action. All the case information, along with the Office of the Medical Director summary and recommendation, is then sent to a panel of senior Board staff for further discussion and review.

Legal Department review

For investigations that do not involve a quality of care issue (such as boundary violations, substance abuse, felony or misdemeanor arrests and convictions, etc.) case information, including licensee responses, are reviewed by a Board staff attorney. The staff attorney makes an initial recommendation for Board action and forwards the case to the senior staff panel.

Occasionally, quality of care cases may also involve potential violations of law. When this occurs, cases are jointly reviewed by the Office of the Medical Director and the Legal Department, which work together to reach a recommendation for Board action.

Senior Staff Review Committee

Each case and its accompanying preliminary recommendation for Board action is then evaluated by the Board's Senior Staff Review Committee. This committee includes Dr. Kirby and me; a Board staff attorney and Thomas Mansfield,

the director of the Board's Legal Department; Curt Ellis, the director of the Investigative Department; and Judie Clark, the director of the Complaint Department. As a group, this committee revisits each case and comes up with its own recommendation for Board action. The committee's discussion and recommendation for action take place in the context of the six core competencies. (If you are unfamiliar with the ACGME's core competencies, see the article on Pg. 3 of this issue of the *Forum*.) Consideration is also given to the licensee's past Board history and to any mitigating factors that may have influenced a licensee's behavior. In cases involving a quality of care issue, attention is focused on whether accepted standards of care have been met. The committee looks at patient outcome, the licensee's level of experience, the presence or absence of patterns of poor performance or behavior, and any previously failed attempts to remediate the licensee. Gross negligence, failure on the part of the licensee to address a fundamental component of good medical practice, a licensee's unwillingness to accept responsibility for clearly substandard care, a dishonest or misleading licensee response, or failure to cooperate with the Board inquiry all influence the committee's recommendation

The Senior Staff Review Committee's recommendation for Board action is one of consensus agreement. It may or may not differ from the initial recommendation of the Office of the Medical Director or Legal Department. If senior staff cannot reach a consensus recommendation, an explanation is provided to the Board.

Board committee review and Board action

Each case and corresponding senior staff recommendation is then sent to either the Board's Disciplinary or Review committee, depending upon what Board action has been recommended by senior staff (In general, the Disciplinary Committee reviews cases of a more serious nature and the Review Committee looks at cases that involve misconduct of a lesser degree.) There are two exceptions: in complaint and investigative cases where the Senior Staff Review Committee's recommendation is for no Board action, the complaint or investigative case is closed and retained in the licensee's confidential permanent file.

Cases sent to the Board's Disciplinary or Review committee are assigned to individual Board members who serve on that committee. The Board member is responsible for familiarizing him- or herself with the facts of the assigned cases and with the accompanying Board staff recommendations. The Review and Disciplinary committees have the opportunity to review and discuss each case assigned to their committee members. The committee will either agree with the senior staff recommendation for Board action or offer an explanation for alternative action. When a Board committee reaches a recommendation for action, the case and recommendation are then sent to the full Board for review and discussion.

During the full Board discussion, the staff recommendation or suggested alternative action may be discussed at length. Following the discussion, the full Board may vote to take action, or it may defer action until more information can be obtained. For example, the full Board may order a licensee to undergo a physical or mental health examination, a substance abuse evaluation, a competency assessment or ask the staff to gather additional information. At times, the Board may obtain additional information directly from a licensee by requesting that the licensee attend a confidential interview with members of the Board. The Board votes to take disciplinary action only when Board members are satisfied they have received all the information needed to thoroughly evaluate a case.

Conclusion

At each step in the review process, opportunity exists to further clarify or amplify the information and recommendations associated with a particular case. The entire review process receives input from numerous individuals and involves checks and balances.

The full Board's final action reflects the collective wisdom, expertise and experience of the Board's 12 individual members, as well as that of the staff. This rigorous process helps the Board regulate medicine and surgery for the benefit and protection of the people of North Carolina, as mandated by state law. It also helps the Board avoid taking inappropriate action against licensees who, despite the circumstances that may have brought them to Board attention, practice medicine safely and professionally.

Send feedback to *forum@ncmedboard.org*

NCMB SEEKS PHYSICIAN ASSISTANT FOR NEW FULL-TIME STAFF POSITION

The North Carolina Medical Board is expanding its Office of the Medical Director (OMD) to include a full-time physician assistant. The OMD, which currently employs two full-time physicians, helps review quality of care issues associated with the complaint, investigative and licensing work of the Board.

The Board seeks employment applications from physician assistants who hold an active North Carolina license and have no history of disciplinary actions. Candidates for the position must be certified and have at least 15 years of experience in broad-based areas of practice including in-hospital and outpatient clinical work. The position also requires excellent written and oral communication skills.

Interested applicants should send curriculum vitae, the names of three professional references and contact information for each and a 250 word statement of interest to: HR Director, NCMB, PO Box 20007, Raleigh, NC, 27619.

Policy Committee offers new position statement on telemedicine

The Policy Committee of the North Carolina Medical Board has drafted a proposed position statement on telemedicine for consideration and possible adoption by the full Board. The Policy Committee discusses position statements in public sessions during regularly scheduled Board meetings. In addition, proposed statements are published on the Board's website and in the *Forum* before they are considered by the full Board. This allows licensees and other interested parties the opportunity to provide written comments that may influence the final version presented for Board action.

The full text of the proposed position statement on telemedicine appears below. Comments may be submitted to the Policy Committee via email at *info@ncmedboard.org* or post (PO Box 20007, Raleigh, NC 27619).

Telemedicine

"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a physician in one location and a patient in another location with or without an intervening health care provider.

The Board recognizes that technological advances have made it possible for physicians to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care.

The Board cautions, however, that physicians practicing via telemedicine will be held to the same standard of care as physicians employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the physician to potential discipline by this Board.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff— Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

Examinations — Physicians using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate examination prior to diagnosing and/or treating the patient. However, this examination need not be in-person if the technology is sufficient to provide the same information to the physician as if the exam had been performed face-to-face.

Other examinations may also be considered appropriate if the physician is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the physician needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate examination may be a violation of law and/or subject the physician to discipline by the Board.

Informed Consent — The physician using telemedicine should obtain the patient's informed consent before providing care via telemedicine services. In addition to information relative to treatment, the patient should be informed of the risks and benefits of being treated via telemedicine, including how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure. The patient retains the right to withdraw his or her consent at any time.

Physician-Patient Relationship — The physician using telemedicine should have some means of verifying that the person seeking treatment is in fact who he or she claims to be. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status examination, physical examination and appropriate diagnostic and laboratory testing. Physicians using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

Medical Records — The physician treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate evaluation of the patient's presenting symptoms, and relevant components of the electronic professional interaction must be documented as with any other encounter.

The physician must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary physician and a telemedicine physician for the same ailment, then the primary physician's medical record and the telemedicine physician's record constitute one complete patient record.

Licensure — The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any physician using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina. Physicians need not reside in North Carolina, as long as they have a valid, current North Carolina license.

North Carolina physicians intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards website: *www.fsmb.org/directory_smb.html.*

Fees — The Board's licensees should be aware that third-party payors may have differing requirements and definitions of telemedicine for the purpose of reimbursement.

[1]See also the Board's Position Statement entitled "Contact with Patients before Prescribing."

[2]N.C. Gen. Stat. § 90-18(c)(11) exempts from the requirement for licensure: "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 registered 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."

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, "The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone." N.C. Gen. Stat. § 90-1.1(5)f.

NCMB implements changes to investigative and disciplinary processes

A new law that modifies the North Carolina Medical Board's investigative and disciplinary processes took effect October 1. Many of the provisions codify existing policy or interpretation of the Medical Practice Act, while other provisions create entirely new practices.

The brief article below summarizes two significant changes that affect licensees who are under investigation by the Board or who face an imminent public charge of misconduct by the Board.

Written notice of rights, responsibilities

Historically, when the Board received a complaint against a licensee, it provided the licensee with a copy and gave oral answers to any questions about the Board's review process. For investigations initiated on or after October 1, the Board will now mail or deliver in person written notices to licensees under investigation. The notices address the licensee's duty to cooperate with the Board, how the Board will communicate with the licensee and any legal counsel, the amount of time the investigation is expected to take and the licensee's rights should the Board vote to take public disciplinary action.

Pre-charge conference for licensees pending charges

Traditionally, the Board conducted informal conferences with some licensees prior to voting to initiate a public disciplinary proceeding. The new law requires the Board to provide, upon request, the licensee with the opportunity to meet with a designated Board member. Such meetings would occur after the Board votes to charge but before charges are issued and a hearing is scheduled. If a meeting is requested, it will be scheduled soon after the decision to take public action. Prior to the meeting, which may be telephonic or in person, the Board will provide the licensee and/or his or her legal counsel, with information gathered in the investigation. The purpose of the meeting will be to inform the licensee of the basis for the Board's decision to charge and explain the process going forward.

READ MORE ONLINE

The law covers numerous other aspects of the Board's investigative and disciplinary procedures. To read the full text of the new law, visit: *www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S958v6.pdf*

North Carolina Medical Board

Quarterly Disciplinary Report | May – July 2009

Board actions are now published in an abbreviated format. The report no longer includes non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. If you prefer the previous method of reporting Board actions, you may access an expanded disciplinary report by visiting the Board's website at *www.ncmedboard.org* Readers who prefer the more comprehensive version may sign up on the website to be notified when a new report is posted. Go to "Professional Resources" and select "Subscriptions" to sign up for an RSS Feed to be notified. Be sure to select the feed for "Bimonthly Disciplinary Report."

Name/license#/location	Date of action	Cause of action	Board action
REVOCATIONS			
ANDERSON, Eric Andres, PA-C (000102798) Charlotte, NC	07/17/2009	Felony conviction for Medicaid fraud and obtaining controlled substance by fraud.	Notice of revocation
HAQUE, Ehteshamul, MD (009500929) Norfolk, VA	05/20/2009	Felony conviction for trading a controlled substance for sex with patient	Notice of revocation
SMALL, Fairleigh David, MD (000024710) Abingdon, VA	06/04/2009	Felony conviction for malicious wounding	Notice of revocation
SUSPENSIONS			
GREENWOOD, Denise Rochelle, MD (000039149) Huntington, WV	05/29/2009	History of alcohol/substance abuse; multiple disciplinary actions in Ark.	Indefinite suspension of NC medical license
HARRIS-CHIN, Cheryl Jacqueline, MD (200200914) Charlotte, NC	06/18/2009	Disciplinary action by Maryland State Board of Physicians	Indefinite suspension of medical license
(See also Consent Orders)			
SUMMARY SUSPENSIONS			
HENSON, Joseph Bascom, MD (000007500) Greensboro, NC	06/17/2009	Physical and mental impairment	Summary suspension of medical license
CONSENT ORDERS			
ANDERSON, Jeffery Stuart, MD (000039759) Morehead City, NC	07/17/2009	Billing and records issues; prescribing w/o keeping proper records of exams, treatment and prescribing	Reprimand
DACOSTA, Gaston Fitzgerald, MD (200900761) Carthage, NY	05/06/2009	Disciplined by New York medical regulatory authority	Reprimand
DOBYNS, Perrin Thomas, MD (200701865) Fayetteville, NC	07/30/2009	Substance abuse; multiple positive drug screens while under NCPHP contract.	Indefinite suspension of NC medical license
EARLA, Janaki Ram Prasad, MD (200701202) Fayetteville, NC	07/06/2009	Prescribed controlled substances for coworkers and others without first establishing an appropriate physician-patient relationship.	Indefinite suspension of NC medical license
FABER, Steven Mark, MD (000035892) Elizabeth City, NC	05/22/2009.	Concerns about quality of care	Reprimand; NC license placed on probation for one year
GOOCH, Joel Robert, MD (009300706) Lenoir City, TN	06/11/2009	Entered into a consent order with Tennessee Board of Medical Examiners regarding misuse of the drug Ultram	Reprimand; must comply with Tennessee order
GOODSTEIN, Richard Stuart, DO (200800359) Marshall, MI	05/07/2009	Entered into consent order with Michigan medical regulatory authority after problems intubating a patient	Must comply with Michigan consent order
GREGORY, Ginger Dobbins, PA-C (000101410) Fuquay-Varina, NC	06/19/2009	Substance abuse	Indefinite suspension of PA license
HENSON, Joseph Bascom, Jr., MD (000007500) Greensboro, NC	07/30/2009	Mental and physical impairment; License summarily suspended on 06/17/2009; Voluntarily surrendered license on 06/17/2009.	Board accepts surrender of license as resolution of case.
INTINI, Ronald Samuel, MD (200100706) Wendell, NC	07/21/2009	Did not treat a patient with diffuse skin lesions as aggressively as he should have.	Reprimand; Must complete CME and comply with other conditions.

Name/license#/location	Date of action	Cause of action	Board action
JACKSON, Richard Thomas, MD (200500510) Radford, VA	06/12/2009	History of alcohol abuse	Reprimand; must comply with NCPHP contract
LONG, James Randall, MD (000033456) Lexington, NC	05/29/2009	Pleaded guilty to misdemeanor charges stemming from illegal decoding of satellite TV signals.	Reprimand; NC license placed on probation for one year
MARDER, Curtis Charles, MD (200901252) Marquette, MI	07/01/2009	Failed to disclose three payments made on his behalf in connection with allegations of negligence with regard to the care of three patients.	NC medical license issued, with a reprimand.
MCINTOSH, John Clark, MD (000036570) Asheville, NC	05/22/2009	Inappropriate prescribing of controlled substances; Continued to prescribe when warned by law enforcement that patients diverted drugs	Indefinite suspension of NC license
MENDOZA, Dominador Manguera, MD (000022149) Danbury, NC	06/15/2009	Concerns about quality of care provided to patients treated for chronic pain	License on probation for two years; Must not treat chronic pain
MESA, Gregory Robert, PA-C (000103090) Hendersonville, NC	07/17/2009	Pleaded guilty to misdemeanor larceny for embezzling funds; Corporate structure of practice resulted in unintentional fee-splitting and unintentional aiding and abetting of the unlicensed practice of medicine.	NC PA license suspended for a period of six months beginning Sept. 15, 2009. Beginning on October 30, 2009, the suspension shall be stayed. Must comply with conditions.
MESSNER, Keith Harold, MD (200600748) Fayetteville, NC	06/03/2009	History of alcohol abuse; Has completed residential treatment	Issued dated license to expire 9/30/2009; Must comply with conditions.
NICHOLAS, Theodore William, MD (200200059) Kill Devil Hills, NC	07/17/2009	Concerns about quality of neurodiagnostic studies performed; billing concerns.	Reprimand; Medical license placed on probation for two years.
NIEMEYER, Meindert Albert, MD (000030440) Elon, NC	07/17/2009	Concerns about prescribing of controlled substances; prior disciplinary history with Board. License summarily suspended 03/25/2009.	License suspended for three years. Suspension stayed, except for a period of eight months beginning on 03/25/09, and ending on 11/25/09. May not prescribe controlled substances Schedules I, II, IIN, III and IIIN.
NGUYEN, Mai Trang Le, MD (200901281) Greensboro, NC	07/13/2009	Prior boundary violation in MA that led to surrender of MA license in 2005.	NC medical license issued via consent order; Must complete a plan of reentry.
O'DELL, Kevin Bruce, MD (000039312) Gastonia, NC	07/06/2009	MD had reaction to Lexapro after consuming alcohol that led to erratic behavior and resulted in his being charged with a number of crimes. License surrendered 07/27/2007.	Board shall issue a dated medical license; Must comply with conditions.
PAUL, Robert Allen, Jr., PA-C (000102781) Greensboro, NC	07/21/2009	History of alcohol abuse; Diverted Vicodin for personal use; NCPHP advises he is safe to return to practice.	Issued temporary PA license to expire 11/30/2009; Must comply with conditions.
PERILSTEIN, Roger Sadhaka D., MD (000027837) Chapel Hill, NC	05/07/2009	Concerns about patient evaluations, documentation and assessments; Independent clinical assessment recommended several remedial steps	Must complete recommendations of clinical assessment
PIZARRO, Glenn, Sr., MD (009601772) Amsterdam, NY	06/23/2009	Entered a 9/04/2008 consent order with the medical licensing authority in New York.	NC license placed on probation for two years, to run concurrent with NY order; may not practice emergency medicine and meet other conditions.
TOMPKINS, Kenneth James, MD (009701625) Kitty Hawk, NC	07/21/2009	History of alcohol abuse; NCPHP advised MD is safe to return to practice.	MD shall be issued a temporary license for a period of four months; Must comply with conditions.
WEBSTER, Laurence Seaton, MD (009500269) High Point, NC	06/24/2009	Boundary violations; inappropriate self-diagnosis and treatment	Indefinite suspension of medical license
WHITE, Anne Litton, MD (000029552) Winston-Salem, NC	05/22/2009	MD ran inaccurate, misleading advertisements about her practice	Reprimand
WOODYEAR, John Montgomery, Jr., MD (009500278) Troy, NC	05/15/2009	MD advertised "free" evaluation that necessitated a patient have scans that cost more than $1,500	Reprimand; MD shall not perform neuro-scans and shall not treat patients with the Accu Spinea machine

Name/license#/location	Date of action	Cause of action	Board action
MISCELLANEOUS ACTIONS			
CRAWFORD, Edward Coleman, MD (200600164) Saint Simmons Island, GA	06/18/2009	Entered a 08/08/2009 order with the GA board that placed license on probation, imposed several conditions.	NC license placed on probation, to run concurrent with Georgia order
DENIALS OF LICENSE/APPROVAL			
DENIS, Guy Joseph, MD (000026649) Orchard Park, NY	07/30/2009	Disciplined in NY for multiple allegations of negligence/misconduct.	Application for reinstatement of NC medical license denied
GECKLER, Thomas Alan, PA (NA) Dahlonega, GA	07/31/2009	Failed to disclose a 1971 arrest for possession of heroin with intent to sell; Subsequent explanation to the Board was inadequate.	Application for NC PA license denied
LOWE, James Edward, Jr., MD (000037887) Fayetteville, NC	05/05/2009	Prior disciplinary history in NC; license revoked by medical regulator in NY	Application for reinstatement of NC license denied; Hearing set 08/19/09
MASSI, Daniel Spong, MD (NA) Chicago, IL	06/19/2009	False statements and misrepresentations made on NC license application	Application for NC medical license denied
OKSANEN, Owen David, MD (NA) Port St. Joe, FL	06/15/2009	Failed to disclose information, including suspension of hospital privileges for inappropriate treatment, on application.	Application for NC medical license denied
TADKOD, Altaf Husain, MD (NA) Duluth, GA	05/14/2009	Concerns about professional competence	Application for NC medical license denied; Hearing set for August 19, 2009
SURRENDERS			
ALFORD, Todd Michael, MD (200701869) Kings Mountain, NC	05/26/2009		Voluntary surrender of NC medical license
BOOK, Roy Dewayne, MD (009701700) Greensboro, NC	05/01/2009		Voluntary surrender of NC medical license
HALL, Charles Daniel, MD (009401205) Supply, NC	05/08/2009		Voluntary surrender of NC medical license
HENSON, Joseph Bascom, Jr., MD (000007500) Greensboro, NC	06/17/2009	See previous entry for Summary Suspension.	Voluntary surrender of NC medical license.
MCANALLEN, Terry Joseph, DO (200301013) Boone, NC	06/22/2009		Voluntary surrender of NC medical license.
MCALISTER, Linda Theresa, MD (000028667) Fayetteville, NC	06/12/2009		Voluntary surrender of NC medical license.
NOWLAN, Ashley, PA-C (001001770) High Point, NC	07/21/2009		Voluntary surrender of NC PA license.
SIEGEL, Drew Kevin, MD (000039999) Burlington, NC	06/16/2009		Voluntary surrender of NC medical license.
THOMPSON, Robert Bruce, MD (000040006) Charlotte, NC	06/04/2009		Voluntary surrender of NC medical license.
WEBSTER, Laurence Seaton, MD (009500269) High Point, NC	05/18/2009		Voluntary surrender of NC medical license.
PUBLIC LETTER OF CONCERN			
BAIRD, Charlotte Leak, PA (000102027) Cary, NC	06/25/2009	Failure to renew PA license; practicing without a valid license.	Public letter of concern issued
BERMAN, Lorraine Mayer-Wolpert, MD (200901449) Richmond, VA	07/31/2009	Concerns about allegations regarding MD's care of two patients ; MD urged to maintain the level of skill needed to avoid future problems.	Public letter of concern issued
BERTRAND, Susan True, MD (200900836) Anchorage, AK	05/12/2009	Concerns about multiple allegations of medical negligence that came to light during Board's review of application.	NC license issued, with a public letter of concern
BRODSKY, Hal Marc, MD (000033347) Pembroke Pines, FL	05/28/2009	Concerns about a quality of care issue that led to a settlement agreement with the medical board in Florida	Public letter of concern issued
COUCH, Gordon Thames, MD (200900976) Pensacola, FL	06/02/2009	Disciplined by medical board in Florida	Public letter of concern issued

Name/license#/location	Date of action	Cause of action	Board action
DAVIS, John Blevins, MD (000029252) Winston-Salem, NC	07/02/2009	Felony conviction for obtaining controlled substances by misrepresentation/fraud; Conduct that led to the conviction led to a 2006 consent order with the Board.	Public letter of concern issued
FINGER, Frederick Eli, MD (000029567) Charlotte, NC	**06/31/2009**	Implanted artificial lumbar disc at the incorrect level.	Public letter of concern issued
FRIEDMAN, Kenneth Stan, MD (200100535) Clayton, NC	05/11/2009	Concerns about MD's guilty plea surrounding use of an escort service	Public letter of concern issued
GUARINO, Clinton Toms Andrews, MD (009900062) Hickory, NC	06/02/2009	Concerns about quality of patient care, supervision of mid-level providers	Public letter of concern issued
HADAR, Eldad Joseph, MD (200100542) Chapel Hill, NC	05/06/2009	Performed lumbar decompression at incorrect level	Public letter of concern issued
HARRISON, William Henry, III, MD (000024913) Advance, NC	05/20/2009	Prescribed to family in a manner inconsistent with the Board's position statement on care of self/family	Public letter of concern issued
ILUNGA, Christine Kabunga, MD (009800069) Goldsboro, NC	07/22/2009	MD failed to adequately inform patients of decision to close her practice.	Public letter of concern issued
JEFFERSON, Henry Dawson, MD (000026015) Cary, NC	05/04/2009	Concerns about adequacy of supervision of mid-level practitioners	Public letter of concern issued
JONES, Vickie Denese, MD (200900936) Lithonia, GA	05/28/2009	Provided inaccurate or incomplete information on NC license application	NC license issued, with a public letter of concern
MEDLIN, Laura Ann, PA-C (000102545) Rocky Mount, NC	07/01/2009	Concerns about prescribing of controlled substances.	Public letter of concern issued
RAYNOR, Eileen Margolies, MD (200900984) Durham, NC	06/05/2009	Provided incorrect or incomplete information on NC license application.	Public letter of concern issued
ROCA, Margo Hirshman, MD (200901239) Port Charlotte, FL	06/29/2009	Provided incorrect or incomplete information on NC license application.	Public letter of concern issued
SHROPSHIRE-ATKINS, Wendy Yvonne, PA (001000036) Wilmington, NC	05/29/2009	Practiced without valid PA license after failing to timely renew with the Board	Public letter of concern issued
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
AUGUSTINE, Santhosh, MD (009600445) Lumberton, NC	05/21/2009		Full medical license issued
BLISS, Laura Katherine, MD (009500018) Efland, NC	05/21/2009		Dated medical license issued to expire 05/31/2010
HENSLER, Rachel Hurst, PA (001000107) Wilmington, NC	07/16/2009		Full PA license issued
HUMBLE, Scott David, MD (200700897) Salisbury, NC	05/21/2009		Full medical license issued
KELLER, Philip Arthur, PA (000102305) Currituck, NC	07/16/2009		Full PA license issued
MORALES, Sergio Eli, MD (200900131) Greenville, NC	07/16/2009		Dated medical license issued to expire 11/30/2009
ROGERS, Bruce William, MD (000032563) Greensboro, NC	05/21/2009		Full medical license issued
ROSNER, Michael John, MD (000026865) Hendersonville, NC	05/01/2009		Dated medical license issued to expire 09/30/2009
STROTHER, Eric Furman, MD (009901620) Raleigh, NC	05/21/2009		Dated medical license issued to expire 11/30/2009
WARD, Amy Elizabeth, MD (009600833) Pfafftown, NC	05/21/2009		Dated medical license issued to expire 11/30/2009
YOUNG, Jordon Terrell, MD (200701009) Goldsboro, NC	05/21/2009		Dated medical license issued to expire 11/30/2009
DISMISSALS			
MCKINNEY, Gisele, MD (200401273) Williamston, NC	05/11/2009		Dismissal without prejudice; Notice of Charges & Allegations dated 03/16/09

North Carolina Medical Board
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Raleigh, NC 27609

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This publication is printed on 70# Opus Dull Text. It is a Forest Stewardship Council paper.
Environmental savings realized by using this paper are summarized below:
4,455 lbs of paper used | 710 lbs of wood saved | 1,350 gallons of water saved | Landfill waste reduced by 710 lbs

EXAMINATIONS

Residents Please Note USMLE Information

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

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

BOARD MEETING DATES

November 18-20, 2009 (Full Board)
December 17, 2009 (Conference Call)
January 20-22, 2010 (Full Board)

Meeting agendas, minutes and a full list of meeting dates can be found on the Board's website
ncmedboard.org

Visit the Board's website at *www.ncmedboard.org* to change your address online. 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 30 days of a move.

Update your Licensee Information: There's still time!

In September, the Board mailed notices asking its more than 35,000 physician and physician assistant licensees to update and expand their public information pages on the Board's website. This process is separate from the annual renewal, so it is necessary to update your information even if you have already renewed your license this year.

Expanded licensee information pages are expected to go live on the Board's website in December. The Board anticipates the launch will be widely covered by the mainstream press. That could send unprecedented numbers of patients and others to the Board's site for information about North Carolina medical practitioners.

Viewing and updating your information now is the only way to ensure your page is accurate and complete before the pages go live. The Board has added a number of optional categories of information that allow licensees to highlight their unique skills and training. Don't miss out on this opportunity to market yourself and your practice!

As of mid-October, more than half of all active, licensed physician assistants and nearly half of all active, licensed physicians had logged in to the Board's online data-entry system. The Board appreciates its licensees' assistance with this important project.

To update your Licensee Information page, go to *www.ncmedboard.org* and select 'Update Licensee Info Page' from the green Quick Links box at the right of the screen. The system is available 24 hours a day, seven days a week.