Committees: The Inner Workings of the Board

The inner workings of the North Carolina Medical Board may appear complicated and confusing to those in the medical community unfamiliar with its structure. I thought some might find it helpful to receive a little more insight into the structure of the Board and how it works.

The Board has seven standing committees:
1. Complaint and Malpractice,
2. Emergency Medical Services/Nurse Practitioner/Physician Assistant,
3. Investigative,
4. Licensing,
5. Operations/Executive-Finance,
6. Physicians Health Program, and

These committees give the Board an opportunity to focus on topics relating to its responsibilities. The committees are chaired by individual members of the Board, with three to five members serving on each. We try not to have any Board member chair more than one committee.

It is important to note that no committee assignment is more or less important than another, although more time and attention is normally required by the Complaint and Malpractice Committee. It is the duty of this particular committee to review each complaint the Board receives and each malpractice judgment, settlement, and award reported to it. This process may require as many as 10 hours per month from each committee member. Should committee members have additional questions on any individual case, that case is referred to the Investigative Committee so further information can be gathered and evaluated.

Board members routinely devote as many as 40-50 hours per month to carrying out their duties. All committees meet a minimum of six times per year. Some meet 12 times a year; others are required to meet...
The Forum of the North Carolina Medical Board is published four times a year. Articles appearing in the Forum, including letters and reviews, represent the opinions of the authors and do not necessarily reflect the views of the North Carolina Medical Board, its members or staff, or the institutions or organizations with which the authors are affiliated. Official statements, policies, positions, or reports of the Board are clearly identified.

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

North Carolina Medical Board
A PERSONAL VIEW
Addiction and Recovery: One Investigator’s Thoughts

Edmund Kirby-Smith,
NCMB Investigator

As an investigator for the North Carolina Medical Board for the past eight years, I continue to be impressed, and saddened, by the number of physicians and physician extenders licensed in North Carolina that are discovered to have a substance abuse problem. I suspect those the Board identifies are actually a small percentage of the practitioners that have the problem. With the continuing growth of external pressures to produce being brought to bear on physicians, largely by managed care, and with the traditional, self-imposed pressures created by the idea that success is measured by income, the number of practitioners who succumb to substance abuse in an effort to deal with these pressures may increase.

Pressure and More Pressure
Many physicians are becoming burnt-out by managed care, by being relegated to playing a numbers game, having fees regulated, and being told what medical acts they can and cannot perform. Recent investigations prompted by adverse action reports from managed care programs to the North Carolina Medical Board suggest that those programs are looking more closely at their members’ productivity, or lack thereof, and are suspending physicians who don’t keep pace with their peers.

Some physicians caught up in the managed care squeeze are simply getting out of medicine, namely those who have been able to work long enough in traditional settings to establish some degree of financial independence. These are the doctors who worked in high income specialties, have finished raising and educating their children, and do not have to support sick relatives or former spouses.

Recently I interviewed a physician who was retiring from active practice because of the stress generated by managed care’s pressing her to see more patients in less time to increase productivity. This particular physician could walk away, however, because, at the age of 62, she had made and saved some money from her most productive years.

Despite still having financial commitments to some of her family members, she had discovered an income-generating marketing opportunity she expected would supplement her existing retirement assets.

Was I investigating this physician for suspected substance abuse or relapse? No, but if this physician had not been able to change her circumstances, she would have been at risk for substance abuse.

Three Cases
My initial investigation of an impaired physician was a memorable one. The first time I conducted a urine screen, I discovered the physician I was screening had been one of my college classmates! Needless to say, I didn’t pay too much attention to the screening process, confident any classmate of mine was certainly no alcoholic. I’ll never know for sure how many times this physician fooled me on screens, but I’m sure it was more than one. I later learned I wasn’t the first person he ever fooled. I might have been the last, however, because I finally got a positive alcohol reading during one of my screening visits.

He went into treatment the day following my confrontation with him, thanks to the intervention of Dr. Robert Vanderberry of the NCPHP. After five years in active recovery, he was practicing with a full license again. I still visit him from time to time. Unlike our first encounter, he is always glad to see me now.

What about the impaired physician practicing in a rural setting who carried a gun in his glove compartment? Makes you wonder what kind of patients he was making house calls on. At the time another investigator and I confronted him, he looked bloated, had cold sweats, was overweight, had skyrocketing blood pressure, and was addicted to pain killers and alcohol. His addiction began years before because of migraine headaches and escalated to the point that he contemplated taking his own life. He knew that he needed help but didn’t want to jeopardize his career in medicine.

Once again, Dr. Vanderberry and NCPHP intervened and got him into treatment immediately. Today, this physician has achieved many years of sobriety, is successful in his personal and professional life, has his blood pressure and cholesterol under control, runs three miles a day, and looks great. He still has an occasional problem with migraines, but he calls on the NCPHP as needed. Although he now has his full license back, he still likes for me to visit him from time to time and screen him to reinforce his recovery.

Cocaine
I recently interviewed two physicians I randomly screened — one for suspected cocaine use and the other for alcohol — test positive for cocaine. Coincidentally, both explained the positive readings as having occurred during sexual encounters with partners who had been using cocaine. Both have lost their licenses — one is in recovery, the other is not.

I couldn’t understand why a physician, knowing he was suspected by the Board of substance abuse and thus subject to random urine screens, would risk losing his license

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by continuing use of what is sometimes
called “a party drug.” I’m not sure I know
the answer even now, except that cocaine,
while easy to detect in a screen, generates
what must be one of the most difficult addic-
tions to control, an addiction that evidently
lurks within between intervals of use, to be
awakened from its lethargy by some trigger
message to the brain that tells the body it
must have the drug right now and at all
costs.

Relapse prevention must be a terrible
struggle with cocaine addiction. If you have
seen the film “The Manchurian Candidate,”
which deals with brainwashing, you will
know what I mean. At least with recovery
which deals with brainwashing, you will

have more to consider. At the time of
hooking, you have the prospect of a
bright hope for the addicted. I have
made reference to the NCPHP in the cases
noted above, and for good reason: without
an entity such as the NCPHP to organize
assessment and recovery, practitioners who
are addicts, in my opinion, would die a slow
death.

I know that many physicians think they
are larger than life and can deal with their
own problems, but from my experiences
in dealing with physicians who fail to con-
trol their disease because they tried
unsuccessfully to go it alone, addicted
practitioners need to confront their prob-
lem in a structured setting with a structured monitoring pro-
gram in order to find success in recovery. The NCPHP does this
without destroying the self-esteem and self-worth of the practi-
tioner, largely because it is directed by a physician and profes-
sional staff that have been through addiction themselves. Yes,
there are members of the Medical Board on the NCPHP’s Board of Directors and the Medical Board funds the NCPHP, but that
does not make the NCPHP simply a branch of the Medical Board. It is separately orga-
nized to work both with physicians (and

physician assistants) who come to it on their
own or under pressure from relatives,
friends, or colleagues, and with those
referred to it by the Medical Board.

Through the NCPHP, the impaired prac-
titioner can seek and obtain the structure
and support needed to recover from his or
her addiction. Many recovering practition-
ers who participate in the NCPHP are
anonymous and remain so as long as they are
compliant in their recovery. However,
should their participation falter, they will be
reported to the Medical Board — the first
principle is always protection of the public.

No Panacea
It must be said that recovery is not a
panacea for addiction — there is no such
thing — nor can it insure that relapse will
not occur. In my monitoring of impaired
physicians in recovery, I have confronted
relapse several times in the positive results of
random urine screens. In the past, when I first
began with the Board in 1991, relapse was often
seen as a failure of recovery that called for sus-
pension or revocation of the license. It still does in
some cases, but odds are against relapse except where the impaired
physician is not in a structured recovery pro-
gram. I believe the current thinking of the
Board is that relapse is an unfortunate part
of the recovery process, but only a part, and,
as such, should not necessarily signal the
death knell for the practitioner’s license.

Additionally, relapse prevention is a con-
cept that was absent when I first began with
the Board. Structured relapse prevention
 programs now exist and, based on my expe-
rience, are effective in minimizing relapse or
the effect of relapse.

Value of Monitoring
I enjoy visiting practitioners in a struc-
tured recovery program orchestrated by the
NCPHP and approved by the Board. I don’t
enjoy the technical aspect of monitoring the
recovering physician — random urine
screening — but I do it, not only because it
is directed by the Board but also because I
believe it reinforces the practitioner in his
recovery. In fact, I have been told exactly
that by many of those I monitor. One in
particular, who will know himself when he
reads this, prides himself on being one of the
first impaired practitioners ever confronted
by the Board, even before the inception of
the NCPHP. I visit him often at his practice
site and he visits the Board often for period-
ic updates on his practice and recovery, as

much by his request as by the Board’s need
to see him. He is doing great, but has had
to fight through several relapses over the
years.

This physician feels he owes his life to the
Board and the NCPHP, and he probably
does. But he owes his life to himself as well,
because he knew he couldn’t fight his battles
with addiction and relapse alone, and he had
the presence of mind, even when contemplating taking his own life, to ask for help
and to know where to find it. I’ll probably
continue to visit this physician indefinitely,
not just professionally, but also because his
outlook on recovery and on those who have
helped make it possible for him has been an
inspiration to me in my own life.

Importance of Support
I have often heard from physicians that I
monitor that the first step to recovery is to
admit the problem. Surely, the second step
has to be the willingness
to reach out for help in
the form of a structured
assessment process and
recovery program. And
a strong support group is
essential. In my dealings
with impaired practition-
ers, especially those in
structured recovery programs, I am continu-
ously impressed by the emphasis they place on
their families and other sources of support,
such as Alcoholics Anonymous, Narcotics
Anonymous, and Caduceus.

I believe that the pressures of family life
can contribute to both the addiction and
relapse of practitioners and that a strong
family support system can go a
long way to achieving success in
recovery.

“At the same time, however, a word of
advice — ‘misery loves company’ bespeaks this
fact. Several practitioners now in successful
recovery have said to me that they didn’t
begin to get their lives back in order until
their relationship with a non-supportive,
enabling spouse changed.

Come Forward Voluntarily
Finally, I hope that practitioners with a
substance abuse problem can take heart that
there is life after addiction, that neither the
Board nor its investigators are out to ham-
mer those who seek help with the problem.
At the same time, however, a word of
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Addiction and Recovery  
continued from page 4

admonishment to those who have a problem but refuse to come forward with it; at some point the Board will find out about your problem from some concerned spouse, co-worker, or patient. That being the case, you will likely have your medical license suspended while the Board refers you to the NCPHP for assessment and treatment. Far better to come forward voluntarily and take advantage of the assessment, treatment, and recovery programs the Board and the NCPHP have worked to make available to you.

U S M L E C B T  
Administration on the H orizon

Administration of Steps 1, 2, and 3 of the United States Medical Licensing Examination (USMLE) is scheduled to be computerized in 1999. The computer-based test (CBT), will be given at more than 350 Sylvan Prometric test centers in the United States and in Europe, Asia, Africa, Latin America, and the Middle East.

The first CBT administration of USMLE Step 1 is currently planned for April 1999, Step 2 for July 1999, and Step 3 for October 1999.

One benefit of CBT administration will be year-round availability. Another will be the elimination of the need for elaborate security systems that are required when using paper-and-pencil tests. Computer adaptive sequential testing allows the computer to draw test items at random from a large bank of questions, virtually creating a new examination each time the test is taken, reducing the likelihood that identical sets of questions will be selected for multiple examinees.

CBT administration will also allow use of Computer Case Simulations (CCS). The hope is that CCS can be introduced as part of the October 1999 USMLE Step 3. Interactive CCS allows examinees to provide care for a computer simulated patient. They may request information from the patient’s history and physical, order laboratory studies, order medications, etc, while monitoring the patient’s response.

For more information on the computerized administration of USMLE, contact the Federation of State Medical Boards’ office of Examination and Board Action Data Bank Services at (817) 868-4043.

Call for Comments on U se of Lasers

Elizabeth P. Kanof, M.D.  
Member, Scope of Practice Subcommittee, N C M B Policy Committee

The North Carolina Medical Board periodically issues position statements after thorough research and debate. These statements are not legally binding. However, they do promulgate professional and ethical guidelines for our licensees: physicians, physician assistants, and nurse practitioners. These guidelines are essential to fulfilling the Board’s mandate to protect the public by regulating the professionals we license. Violation of the guidelines is relatively uncommon; hopefully, there will continue to be few instances in which the Board is forced to charge a licensee with unprofessional conduct or impose sanctions due to such a violation.

Lasers and laser-like devices have exploded on the scene in recent years and have been used by many physicians in various specialties and by other professionals. The Board is now developing a position statement on the use of these devices and would welcome comments and suggestions from the community of licensees. If you would like to share your thoughts with us, please address your correspondence to the Scope of Practice Subcommittee, North Carolina Medical Board, PO Box 20007, Raleigh, NC 27619, by May 31, 1999.

Key issues the Subcommittee will examine include the following.

1. Should licensees use only FDA approved devices or should the purchase of this rapidly changing technology be left to the judgment of the purchaser?
2. What documentation should be required indicating that the physician using these devices has attended appropriate laser courses, including instruction in basic laser physics, laser safety, didactic lectures on clinical application of lasers, and hands-on experience under the supervision of an appropriately trained and experienced laser surgeon?
3. Are lasers or laser-like devices (eg, Epilight) within the scope of practice of PAs and NPs? If so, which devices necessitate a physician being on site? If a physician need not be on site, how far from the site, in time, should he or she be? What documentation of PA/NP training to use these devices should be required?
4. Should trained non-PA/NP staff be allowed to operate lasers or laser-like devices (eg, Epilight) only when a physician is on site? If a physician need not be on site, how far from the site, in time, should he or she be? What documentation of training for non-PA/NP staff should be required? Should such trained staff be allowed to operate these devices at a satellite clinic independent of any direct physician supervision?

Call for Comments on Use of Lasers

Clearly, there are other issues not noted above that you may wish to raise and comment on in your letter to the Subcommittee and we hope you will feel free to do so. Meanwhile, the Board’s special thanks is extended to all of you who take the time to participate in this effort to develop a sound policy statement on the use of lasers and laser-like devices.

ATTENTION PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS  
Rules Changes and New Registration Information

RULE CHANGES:
On pages 8 and 11 of this issue of the Forum are special articles by Wayne W. VonSeggen, PA-C, vice president of the North Carolina Medical Board, and Cheryl Y. Proctor, MSN, RN, CS, FNP, reviewing changes in the Board’s Rules relating to physician assistants and nurse practitioners that will go into effect on May 1, 1999. PLEASE TAKE TIME TO READ THE ARTICLE THAT APPLIES TO YOUR FIELD and review the rules that were published in full in the last number (#4, 1998) of the Forum and are posted on the N C M B’s Web site.

NEW REGISTRATION INFORMATION:
Please read the official statement of the North Carolina Medical Board regarding registration of physician assistants and nurse practitioners that appears on the back of this number of the Forum. THAT STATEMENT SHOULD BE CLIPPED OR COPIED AND ATTACHED TO YOUR CURRENT REGISTRATION CERTIFICATE IF THE EXPIRATION DATE IS LISTED AS JUNE 1999. In accord with changes in 21 NCAC 325.0105 and 21 NCAC 32M.0105, all licensed physician assistants and nurse practitioners will be required annually to register their licenses within 30 days of their birthdays beginning in June 1999. Important details about this new registration schedule are included in the Board’s official statement.
To Carry This Message and Practice These Principles
A North Carolina Physician

Our program of recovery [in Alcoholics Anonymous] invites us to continue our spiritual awakening by taking the Twelfth Step. In this step, we bring the message of a way up and out of the hell from which we have escaped to those that continue to be confined there. We take the Twelfth Step by telling what it used to be like, what happened, and what it’s like now. In the process, we bring hope to the hopeless and maintain a sharp edge on our own tools of recovery.

Ruled by Drugs, Alcohol, Resentment, and Fear

What it used to be like for me was a life ruled by drugs, alcohol, resentment, and fear. At times, I thought I had some strange and rare mental illness, treatable only with my increasingly unorthodox concoctions. At other times, I thought I was simply too weak to solve my problem or not smart enough to come up with an effective cure. My futile attempts at self-detoxification became less and less frequent as I lost hope that I could ever return to the relatively normal life I had once known.

Friends, family, and the medical community became of little interest to me. My self-esteem dissolved. As I approached the end of my rope, I hung on tight to the notion that my patients needed me and that I could still treat them safely. That confidence was stripped away when I discovered evidence that I was having blackouts. I knew I was indeed powerless and it was painfully clear that my life was unmanageable. In that First Step, there was a loud ring of truth. Later that night, I tried to be honest with another addict-alcoholic about my life. I told him about my guilt and resentment towards God for sacrificing two lives to save me. He told me something I will never forget. He told me I was arrogant and that God had simply allowed me to be there. That for me was the first moment of spiritual awakening. I changed from being resentful towards God to being grateful.

“I was indeed powerless and it was painfully clear that my life was unmanageable.”

The Beginning of Hope

Such was the sad and twisted state of mind I had a short time later when a Medical Board investigator showed up to suggest I go talk with Dr Vanderberry, the medical director of the North Carolina Physicians Health Program. In his kindly and direct fashion, Dr Vanderberry suggested that I might be an addict-alcoholic! I countered that I was fairly confident that my problem was mental illness, most likely manic-depression. He thought not. But he suggested I go see Dr Talbott in Atlanta and find out.

And so I found myself in detox one bright morning, staring up at something called the Twelve Steps. That was the beginning of hope. It struck me that I was indeed powerless and it was painfully clear that my life was unmanageable. In that First Step, there was a loud ring of truth. Later that night, I tried to be honest with another addict-alcoholic about my life. I told him about my guilt and resentment towards God for sacrificing two lives to save me. He told me something I will never forget. He told me I was arrogant and that God had simply allowed me to be there. That for me was the first moment of spiritual awakening. I changed from being resentful towards God to being grateful.

He went on to tell me that I was obviously very sick and that I needed help from the God of my understanding. He told me I needed to pray and told me how to accomplish this. He told me that all alcoholics were arrogant and that I needed to humble myself and pray on my knees. He told me that we don’t listen well so I should pray out loud. He even told me what to pray for, that being knowledge of God’s will for me and the strength to carry that out.

I had not slept for three days and was beyond exhaustion. I had an incredible burden of fear. At that point, I had nothing left to lose and no way to go but up, so I surrendered and followed instructions. And when I was through praying and up from my knees, I found that I had been relieved of fear and fatigue. I had the certain awareness that everything was going to be O.K. And so it was. And so it continues to be.

One Day at a Time

Today, I carry the abridged version of the Twelve Steps with me at all times. “Trust God, Clean House, Help Others.” I try to practice these simple principles in all my affairs and the program continues to work for me, one day at a time. I have been given a lot to do in recovery and I have had a lot of spiritual homework, which is what my first sponsor used to call problems.

I have been entrusted with the responsibilities of chief of staff in our hospital. I have been given the opportunity to work with those whose lives have been wrecked by addictive disease as medical director of a treatment center. I have been treasurer and coffee maker for my home group that meets just down the block from my hospital. My physical health has been restored and my family life continues to improve.

My eyes have been opened and my attitude has changed thanks to the love and protection of my Higher Power and the program of Alcoholics Anonymous.

Reprinted with permission from the North Carolina Physicians Health Program’s publication, Metamorphosis.

The author would be pleased to talk with others interested in the issue of physician impairment. Please write the editor of the Forum, Dale Braden, at the NCMB for information on contacting the author.

North Carolina Medical Board

1-800-253-9653

Large Step 12 behind Text
Dr Roufail

“From the simple one page document that Hippocrates wrote two and a half millennia ago, the AMA has updated medical ethics into a 175-page volume.”

“My Perspective

The Spheres of Medical Ethics

Walter M. Roufail, MD
Former President, NCMB

One would think that the definition of ethics would be straightforward and relatively constant: do what is right. Do what is good and avoid what is evil. Do no harm! It is apparently not as simple or obvious in the waning years of this millennium. Ethics is dissected as assiduously as the DNA helices. The debate is being carried on in innumerable articles in the lay and scientific press, in specialized publications, in expert seminars, and in public forums. In the medical profession, the appearance and entrenchment of managed care have invigorated it. This intellectual overload has resulted in different definitions of the word relative to the subject or the circumstances at hand.

From the simple one page document that Hippocrates wrote two and a half millennia ago, the AMA has updated medical ethics into a 175-page volume. I do realize that life may have been simpler in ancient Greece, but I do not believe that the relationship between physicians and their patients has changed so much as to require this prolific intellectual activity. Sociobiologists have also recently entered the fray, suggesting that morality (read ethics) may be encoded in the human genome, assuring the survival of the human species. Whether the product of the lofty minds of philosophers or in the test tube of cellular biologists, ethics has been part of the human condition since recorded history, across cultures, religions, and in liberal secular societies.

Three Concentric Circles

Ethics appears to affect the physician in three concentric circles, the largest one encompassing the mores of society in general. This is usually a reflection of tradition, religion, and the particular form of government that happens to rule society at that time. Ethics in our secular Western societies is codified in what we understand as the law. Laws may be good or bad, but they nevertheless supersede and may conflict with professional and personal ethics.

Professional ethics is in the second sphere, representing the values shared by groups engaged in the same endeavor: physicians, lawyers, etc. These values may be transmitted by tradition, as in the Hippocratic Oath, modified, as in the AMA Code of Ethics, or arrived at by the consensus of wise men, as with the bar. An implicit threat flows from breaching professional ethics, from loss of the respect of your peers (shame, another word fast losing its meaning) to actual exclusion from the group.

Personal ethics is within the third and smallest circle. It is the residue of one’s upbringing, of family and religious values transmitted through generations and modified individually with maturity. Although subliminally affected by the two larger circles, most physicians subconsciously rely on personal ethics in their day-to-day relationships with patients. It is the sum of these individual values that controls pragmatically the behavior of the profession. To consider all physicians as a monolithic entity abiding by a rigid set of rules is naive. There are physicians who will or will not perform abortions, believe in or strongly oppose euthanasia, will or will not participate in capital punishment, and may or may not ration or overutilize care for financial gain. To expect all of us to behave identically in a free society is unrealistic.

Let us consider, then, that professional ethics is a consensus of individual ethics found over generations to be shared by the vast majority of practicing physicians.

Euthanasia and Lethal Injection

Of all the admonishments to physicians, none is more universally accepted and, hopefully, practiced than the principle of “do no harm.” It includes both physical and psychological (moral) harm to patients and their immediate families. Following that golden rule, all ethical matters should become almost self-evident. Not so, apparently. At the risk of trivializing the debate, we do not seem to agree on the meaning of the word harm. Apparently it means injury to some and compassion to others. The most vivid example is euthanasia.

Whenever allowed by law, some physicians have been willing to help in the premature death of their patients. A leading proponent and perpetrator of this idea in this country, Dr. E. Kevorkian, was and is still ostracized by numerous professional and nonprofessional organizations. However, when the citizens of Oregon voted to make it lawful, the objections were far from unanimous. Thus, if you are a physician in Portland, Oregon, you are allowed by state law (reinforced recently by a Justice Department pronouncement that it is not a violation of federal law) to assist in suicide. You have little or no guidance from your profession and you are left to grapple with your individual ethics to make a moral professional decision.

The case against lethal injection of a person sentenced to death is even stronger. Here, one is performing a medical act on a presumably well individual with the express goal of his or her death. I cannot find in any medical code where such an action could be condoned or tolerated.

Abortion

A quarter century ago (1973), the Supreme Court of the United States found for Roe against Wade. Abortion was now legal for both the pregnant woman and the physician who performed it. Chief Justice Warren Burger commented then:

I do not read the Court’s holdings today as having the sweeping consequences attributed to them by the dissenting justices; the dissenting views discount the reality that the vast majority of physicians observe the standards their pro-

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fession and act only on the basis of carefully deliberated medical judgements relating to life and health. Plainly the court rejects any claim that the Constitution requires abortion on demand. The Chief Justice could not have foreseen that a quarter century later that is precisely what is happening: abortion on demand.

In the professional sphere, the Hippocratic Oath is quite explicit: "I will not perform abortions." To accommodate the times, the Code of Ethics of the AMA reads: "The principles of medical ethics do not prohibit a physician from performing an abortion in accordance with good medical practice [emphasis mine] and under circumstances that do not violate the law." The statement is so nebulous that it is of little if any value. The Accreditation Council on Graduate Medical Education was more forceful by requiring residency programs in obstetrics and gynecology to teach induced abortion, exempting both residents and institutions that may have religious or moral objections. One has to interpret this requirement as condoning the morality of abortion or, at least, that there are two moralities to the problem, which, although opposite, are nonetheless both acceptable.

This type of obfuscation may be politically correct but certainly does not provide a clear stand on an ethical matter of great significance to the profession. It is thus left to each individual physician to evaluate whether abortion falls under the definition of "relief of pain and suffering" and "doing no harm" and whether it is a medical or a social problem.

Managed Care

No discussion of modern medical ethics would be acceptable without mentioning ethics and managed care. I submit that this is not a new problem, that it is in the continuum of financial gain and the practice of medicine. Do not think there are different medical decision-making processes for different patients, i.e., the indigent, the uninsured, those on Medicare or Medicaid, those belonging to HMOs. It is incumbent on each physician to remain the patient's advocate and to assure that the contract he or she is signing with any third party does not hinder his or her ability to do the best he or she knows how by patients.

Managed care organizations do not practice medicine — physicians do. I would hope that we would not compromise our cherished autonomy for financial greed or to follow the dictates of an amorphous corporation. For those who knowingly accept the terms, I would predict that they will face a breach of their professional and individual ethics.

Conclusion

In the waning years of this century, the practice of medicine is dominated by external forces. To accommodate societal needs, we physicians are gradually losing our decision-making autonomy. We have to obey the laws that are becoming more numerous and more complex, we sign contracts with a multitude of entities that sooner or later tend to dictate rather than discuss, and we live with the perpetual threat of court actions for the most trivial reasons. Professional ethics is becoming more relative than clearly defined. We have to rely on our individual ethics to do the best for our patients under whatever mode of practice prevails. After all, this is why we received the call in the first place.

A Guide to Understanding the New PA Rules: Revised and Refined

Wayne W. VonSeggen, PA-C
Vice President, NCMB

In January 1998, the North Carolina Medical Board approved a significant revision of the physician assistant regulations, with some subsequent changes during the fall of 1998. Comments from the public at an open hearing on October 30, 1998, were all favorable. The proposed PA regulations were approved by the Rules Review Commission in December and the General Assembly is expected to allow their implementation in a few days of this writing. The new regulations will take effect on May 1, 1999. (A copy of the proposed regulations appeared in the Forum #4, 1998.)

Necessary Changes

Several changes were simply intended to make the language of the rules consistent with recent changes in statutes. Anywhere the term North Carolina Board of Medical Examiners was used, for example, the current name, North Carolina Medical Board, has been inserted. Previously, PAs were "approved," now they are "licensed." The American Medical Association's Council on Medical Education, which accredited PA training programs, has been renamed the Commission on Accreditation of Allied Health Education Programs.

Because of legislation adopted in August 1997, the Board has been allowed to remove the limitation of "two physician assistants per primary supervising physician" from the rules, and to adopt rules regarding volunteer practice and service during disasters by PAs.

Summary of Additional Changes

• Volunteer practice by PAs is defined and a reduced-cost PA limited volunteer license is authorized. There is no fee for the PA limited volunteer license and the annual registration fee is only $25. We hope the lower fee will encourage retired PAs or those not in active practice to volunteer their skills where they are most needed. It is important to remember, however, that the other requirements for the PA license, such as CME, documentation, scope of practice statements, and physician supervision, still apply to those using the volunteer license.

• Disaster practice is defined and the rule enables PAs to rapidly respond during disasters. The streamlined licensing process described for use during a disaster will apply only for those PAs actually working in a county in which a state of disaster has been declared or counties contiguous to such a county. This is a significant and creative response by the Board to the valuable lessons North Carolina has learned from hurricanes Hugo and Fran and from various local disasters, such as severe flooding and tornadoes. This new section of the rules may become a model for similar changes in rules for PAs in other states, making PAs a valuable national resource in times of disaster.

• Provision for an inactive license and procedures for reactivation of such a license are described. The new rules also require that PAs who completed training more than two years before January 1998 may begin practice on a limited basis. They must complete at least 50 hours of continuing medical education in each year of inactive practice.

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Understand PA Rules
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years before their license application must demonstrate they have accrued at least 100 hours of CME during the two years prior to their application. The Board is insisting that PAs provide services that are up-to-date and current with today’s fast-moving medical technologies.

• There is provision to allow annual registration of a PA’s license “no later than 30 days after his or her birthday,” rather than “no later than July 1st.” This allows the Board to stagger PA license registrations by birth month, the system used for physician registrations since January 1998. This will save time for the Board’s staff, remove the June bolus of paperwork, and improve service to PAs and their employers.

• The new rules increase the amount of Schedule II and III controlled medications a PA may prescribe from a legitimate supply for seven days to a legitimate supply for 30 days. Since 1994, when PAs were granted authority to prescribe limited quantities of controlled medications, there have been very few problems related to the exercise of this authority. PAs who have obtained DEA privileges have been required to have at least three hours of CME every two years on the abuse of alcohol, nicotine, prescription drugs (including controlled substances) and illicit drugs.” This requirement remains in effect.

• A specific change in the scope of practice section now requires that “the delegation of medical tasks to a PA should be appropriate to the skills of the supervising physician(s) as well as the PA’s level of competence.” The principle the Board applies is that the supervising physician must be able to maintain a level of expertise and competence satisfactory for proper supervision of the PA no matter what tasks are delegated. As new technologies emerge and “hands-on skills” improve, the physician and the PA will function as a competent team for the betterment of the patient.

• The new rules clarify when a PA may actually begin practice with a supervising physician. “The physician assistant shall not commence practice until acknowledgment of the notification of intent to practice form is received from the Board.” In the past, the rules did not specifically delineate when a PA could start practice: when the PA sent in the notification of intent to practice form? when the Board received the form? when the PA received a letter or call from the Board? This will allow the Board to respond to the PA by letter, fax, or telephone.

Clarifying the Disciplinary Authority of the Board

Under the revised rules, the Board may discipline PAs following the exercise of due process by refusing to grant a license, revoking, suspending, annulling, limiting, or otherwise restricting a license. The failure to function in accord with the new rules or the commission of acts or conduct specified in NCGS 90-14 shall constitute unprofessional or dishonorable conduct. These new provisions mirror those relating to physicians. Representing oneself as a physician constitutes dishonorable or unethical conduct.

Temporary License Rules

During the past three years, the Board has had several hearings regarding issues involving the temporary license rules for PAs. Problems have included situations where PAs took the NCCPA examination, failed it, and did not tell the Board. (There was no requirement to report the scores to the Board.) There were instances where PAs would choose not to take or would claim to be “too busy” to take the certifying examination and would then request an extension of the temporary license. There have been problems in getting prompt reporting of scores from the NCCPA without the permission of the examinee. If PAs had already failed the test, they (by the previous rules) could not legally be granted a temporary license until they were “technically waiting for the scores.” Part of the concern the Board had was the exposure of the public to a person who had not passed the Board’s licensing examination for almost two years before the extended temporary license would finally expire.

With guidance from the Board’s PA Advisory Committee, the Board adopted the following goals related to the newly licensed PA:

1. Approve the Physician Assistant National Certification Examination (PANCE) as the PA licensing examination.
2. Develop rules that permit phasing in of a one year temporary license for PAs without any extension, with an ultimate goal of requiring the NCCPA’s PANCE to be the standard for initial licensure in North Carolina.
3. Require that the results of all attempts to pass the PANCE while a PA has a temporary license be reported to the Board within 15 days after the PA receives the results.

Continuous Regulatory Refinement

While no regulations are perfect, the new PA rules certainly improve the ability of the Board to more clearly define its interactions with PAs. The few shortcomings in the previous regulations for PAs have been reengineered into improvements in the way the Board can manage regulatory questions about PA practice. The North Carolina Medical Board appreciates the open dialogue and cooperation it has enjoyed with PA leaders, PA educators, and the interested public in the development of these new regulations. We hope these refinements will make the services of PAs in North Carolina even more effective in meeting the health care needs of our citizens.

Kenneth H. Chambers, M.D., of Charlotte, Reappointed to NC Medical Board; John W. Foust, M.D., of Charlotte, and Stephen M. Herring, M.D., of Fayetteville, Named New Board Members

Andrew W. Watry, executive director of the North Carolina Medical Board, has announced that Governor James B. Hunt, Jr., has reappointed Kenneth Henley Chambers, M.D., of Charlotte, to the North Carolina Medical Board. Governor Hunt has also named John Worth Foust, M.D., of Charlotte, and Stephen Mitchell Herring, M.D., of Fayetteville, as new members of the Board, he said.

Dr. Chambers

Dr. Chambers was born in Mount Gilead, North Carolina, and received his BS degree from North Carolina College at Durham. He took his MD from Meharry Medical School in Nashville, Tennessee, and did his internship at George W. Hubbard Hospital in that city. He pursued his postgraduate medical training at Harlem Hospital in New York City.

Dr. Chambers practices obstetrics and gynecology in Charlotte, is certified by the American Board of Obstetrics and Gynecology, and is a fellow of the American College of Obstetrics and Gynecology. He is

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**Appointments**

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currently affiliated with Carolinas Medical Center, Charlotte; Mercy Hospital, Charlotte; and Presbyterian Hospital, Charlotte. He has taught at Columbia Presbyterian University Medical Center. He has served on the Board since 1995.

**Dr Foust**

John W. Foust, MD, of Charlotte, was born in Lexington, North Carolina, and earned his BS and MD degrees from the University of North Carolina, Chapel Hill. He did his internship in general surgery at the North Carolina Memorial Hospital, Chapel Hill, and his residency in otolaryngology at the same institution. Dr Foust is certified by the American Board of Otolaryngology. Currently retired, he has been affiliated with Carolinas Medical Center, Charlotte; Mercy Hospital, Charlotte; and Presbyterian Hospital, Charlotte. He has served as a clinical professor at the UNC School of Medicine.

Active in the Mecklenburg County Medical Society and the North Carolina Medical Society for many years, he served as president of the MCMS in 1982 and the NCMS in 1986. He was an NCMS delegate to the American Medical Association from 1989 to 1994. He is a member of the American College of Surgeons, the Southern Medical Society, and numerous other professional and community organizations. In 1988, he was presented the Distinguished Service Award of the University of North Carolina School of Medicine Alumni Council.

**Dr Herring**

Stephen M. Herring, MD, of Fayetteville, a native of Chapel Hill, North Carolina, took his BA degree at the University of North Carolina, Chapel Hill. He earned a DDS from the University of North Carolina School of Dentistry, followed by an MD from the Wake Forest University/Bowman Gray School of Medicine. He did his internship in general surgery and a residency in general surgery and plastic surgery at Bowman Gray. He is certified by the American Board of Plastic Surgery and holds licenses in both medicine and dentistry.

Currently in the private practice of plastic surgery in Fayetteville, Dr Herring is affiliated with Cape Fear Valley Medical Center and Highsmith-Rainey Memorial Hospital. He is a member of the American Society of Plastic and Reconstructive Surgeons and is active in state and local professional organizations, now serving as president elect of the Cumberland County Medical Society. He is also author and co-author of several journal articles.

Mr Watry said, “The Board welcomes the reappointment of Dr Chambers, who has made significant contributions to the work of the Board, and the appointments of Dr Foust and Dr Herring, two distinguished physicians who personify the highest degree of commitment and responsibility.”

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**REVIEWS**

**Voice of a Modern Herbalist**

Staff Review

Even though the majority of Americans continue to seek orthodox medical care, alternative therapies are gaining in popularity. According to John K. Crellin and Jane Philpott, the authors of Trying to Give Ease: Tommie Bass and the Story of Herbal Medicine, “a vast array of advocacy literature dealing with alternative health care exists, but, unfortunately, few balanced and analytical approaches are available.” This book on the life of A.L. “Tommie” Bass, a popular herbalist of the Appalachians, is an attempt to “describe and evaluate impartially one alternative practice in an Anglo-Saxon setting.” It is accompanied by A Reference Guide to Medicinal Plants Herbal Medicines Past and Present.

Born in 1908, Bass, whose family had drifted down from Tennessee, grew up in northeast Alabama and lived in the Mackey-Leesburg area. He was an active herbalist until his death in 1996, about eight years after the books were completed and a year before the paperback editions were issued. The books were written with his full cooperation and are alive with his comments and conversation.

The authors, John K. Crellin, MD, a professor of the history of medicine at Memorial University of Newfoundland, and Jane Philpott, professor emerita in the Department of Botany and the School of Forestry and Environmental Studies at Duke University, have done a remarkable job in capturing the spirit of the man and the context of his practice.

Trying to Give Ease begins with a chapter giving an historical perspective on the introduction and use of herbal medicine in North America, concentrating on the Appalachian mountains where Bass practiced. The discovery of medicinal properties in plants, naturalized and indigenous remedies, and the influence of sensory properties are explored. This chapter concludes with a commentary on “regular” or conventional medicine in relation to herbal treatments.

Trying to Give Ease: Tommie Bass and the Story of Herbal Medicine

John K. Crellin and Jane Philpott


Chapter two, I’ve Always Got By: The Voice of A Modern Herbalist, outlines Bass’ life, drawing heavily on verbatim quotes from his conversation. Bass’ recollections of his community and alternative practices reveal to the reader his geographical and social environment.

The next few chapters are more biographical and less vernacular. Crellin and Philpott record specific events in Bass’ personal life, as well as the community and cultural forces affecting him and his practices, that further illuminate his situation as a community healer and his success in that role.

Sections regarding self-treatment (packaged herbs, family and store-bought medicines, patent medicines, Sears and Roebuck) contribute to the authors’ development of the forces that affect Bass’ community and, consequently, his alternative practices. Also presented is information on how and where Bass acquired his knowledge of plants and their medicinal properties, as well as how he essentially capitalized on the commercialization of such remedies beyond his traditionalist community and into popular culture.

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Reviews

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The last two chapters deal with the specifics of Bass' practices. In addition to descriptions of the setting ("from the yard, shack, or woods") and visitors, information on symptoms, ailments, treatments, and medicines is documented in great detail. From a recipe for a dry-cough formula, including slippery elm bark and mullein leaves (among other things), to Bass' remedies for "rheumatism," the reader will be intrigued and even charmed.

The book ends with a chapter titled Reflections on the Region and Beyond, addressing cultural and social faith in the efficacy of herbs.

In conclusion, Crellin and Philpott pose the question: whither traditional medicine? "We must search for the existence of diverse attitudes," they say, "and, if they exist, we must examine the reasons for them, the social functions of folk beliefs, the dynamic interface between regular and alternative practice, flexible patterns of health care and self-treatment, and how to maintain the delicate balance between the needs of society and those of the individual."

Very detailed notes, a fully annotated bibliography, and an index take up the last 110 pages of the book.

Trying to Give Ease is supplemented with Crellin and Philpott's A Reference Guide to Medicinal Plants: Herbal Medicine Past and Present. This guide focuses on the medicinal plants used by Bass, even though a few analogous species are referred to. There are "two purposes of this guide...to record in detail the knowledge of herbalist Bass and to assess the knowledge in the context of historical usage and scientific, chemical, and pharmacological knowledge."

A Reference Guide to Medicinal Plants - Herbal Medicine Past and Present
John K. Crellin and Jane Philpott

The introduction has a guide to the harvesting seasons, drying and storage, preparation and doses, and cautions applicable to the herbs referenced. There is also a glossary of chemical, pharmacological, and pharmaceutical terms.

Monographs on individual herbs follow in alphabetical order. Each entry is qualified by the anatomical part of the plant intended for use, ie, tops or root. A verbatim account, or "The Herbalist's Account," documents all of Bass' knowledge about the history and use of the herb referenced. A commentary section follows, providing plant taxonomy, comparisons of use, and, when applicable, any historical precedent for Bass' account. Each entry is concluded with a section containing the authors' notes.

An excellent 50-page annotated bibliography and a thorough 20-page index conclude the Guide.

Changes in Nurse Practitioner Rules
Cheryl Y. Proctor, M SN, RN, CS, FNP

Who was it that said: "All roads lead to..."? Fellow nurse practitioners, we are almost at our destination. The Task Force on Physician Supervision of Nurse Practitioners' Performance of Medical Acts began meeting in January 1997. The fruits of our labor, the revised NP rules, were approved by the Board of Nursing in May 1998. The proposed rules were approved by the Medical Board as well. A public hearing was held on October 30 and written testimony was received by both boards until November 16, 1998. Testimony was positive. The proposed rules changes were sent to the Rules Review Commission for consideration and from there to the General Assembly, which took no action to modify them. They are being codified by the Office of Administrative Hearings and will become official on May 1, 1999.

The addition of a definition of collaborative practice agreement, which means the arrangement for the nurse practitioner's and physician's continuous availability to each other for supervision, consultation, collaboration, referral, and evaluation of care provided by the NP.

The reinsertion of the definition of supervision. This was an important point that the Medical Board did not feel comfortable deleting.

The addition of a definition of volunteer practice, which means practice without expectation of compensation or payment to the NP. Application for this approval costs $20 and renewal costs $10. The NP must still meet all requirements for practice as an NP.

The addition of a definition of practice during a disaster under which the NP must notify the Medical and Nursing Boards in writing within 15 days of his or her first performance of medical acts, tasks, or functions in such a setting and is exempt from certain requirements for practice.

The addition of the definition of interim status, which means the privilege given to a new graduate or a registered nurse seeking initial approval in North Carolina while awaiting final approval to practice as an NP.

The addition of a definition of temporary approval to practice, which means, beginning January 1, 2000, authorization by both boards to practice as an NP while awaiting notification of successful completion of the national certification examination. This period will not exceed 18 months.

In seeking approval to practice, the NP must have a collaborative practice agreement with a primary supervising physician.

Beginning January 1, 2000, NPs must be nationally certified in lieu of the current process of approving the NP's educational program prior to practice in North Carolina.

Controlled substances may now be procured by the NP in addition to being prescribed or ordered as established in the written standing protocols, providing all previously described requirements are met.

NPs may prescribe a 30 day supply of controlled substances classified as Schedules 2, 2N, 3, and 3N.

A major change in the rules is the replacement of the previous Section .009, Physician Supervision, with a new section titled Quality Assurance Standards for a Collaborative Practice Agreement. The quality improvement process replaces the physician chart signature. The minimum standard is a process for the continuing review of care provided at each practice site, to include a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problems.

Documentation of each meeting must include clinical problem(s) discussed, process toward outcomes, recommendations (if any) for changes in treatment plans, and the meeting date and signatures of those attending. Documentation must be available for review by either board for the previous two calendar years. The required minimum frequency of meetings varies according to the length of time and the stability of the nurse practitioner-primary supervising physician collaborative relationship.

What does not change is that the primary supervising physician must still be approved by the Board of Medicine, you must still keep on-site written protocols, and the NP and physician must still be continuously available to each other. Written protocols

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North Carolina Medical Board Reports to the People of North Carolina: A Review of 1998

On March 4, 1999, Mr. Paul Saperstein, of Greensboro, president of the North Carolina Medical Board, released to the public a report on the Board’s work over the past year and called attention to the Board’s recommendations for changes in the Medical Practice Act that would enhance the Board’s ability to serve the public interest. The following is an edited summary of that report.

Introduction
Mr. Saperstein is the first public member of the North Carolina Medical Board to be elected its president. It is his intention to emphasize the Board’s efforts to serve the consumers of North Carolina as effectively and efficiently as possible. “The Board’s interest is the public interest,” he has said, and he has seen that clearly demonstrated during his time on the Board. He wants the people of North Carolina to know about the Board’s accomplishments over the past year and call attention to the Board’s determination to serve the needs of consumers responsibly and sensitively. In this report, the focus is on some of the Board’s accomplishments over the past year that reflect that principle and demonstrate the Board’s commitment to that principle.

In this report, the Board has recommended several revisions of the Medical Practice Act and it expects a bill offering these revisions will be presented to the current (1999) session of the General Assembly. The following are among the more significant changes proposed.

1. LEGISLATIVE RECOMMENDATIONS
The Board has recommended several revisions of the Medical Practice Act and it expects a bill offering these revisions will be presented to the current (1999) session of the General Assembly. The following are among the more significant changes proposed.

- **Licensure Issue**
  - Remove the statutory provisions requiring the Board to administer the examination for medical licensure. Since about 1970, all medical boards in the country, including North Carolina, have used a national examination: the Federation Licensing Examination (FLEX) until the early 90s and the United States Medical Licensing Examination (USMLE) since then. The existing language regarding examination is outdated and keeps the Board from taking advantage of more efficient mechanisms for examination administration.

- **Disciplinary Improvements**
  - Make the unlicensed practice of medicine a felony rather than a misdemeanor. Unlicensed practice can cause serious public harm and should be penalized accordingly. Many of the functions performed by physicians have felony provisions when violations are involved, including filing false birth certificates or writing illegal prescriptions. These same violations, however, are misdemeanors when committed by someone without a license.
  - Improve the enumerated grounds for disciplinary action by adding items such as aiding in unlicensed practice, repeated prescribing of controlled substances for personal or family use, fee-splitting, and failure to make patient records available to another physician when legally requested to do so.
  - Improve immunity provisions for peer reviewers and physicians who provide expert testimony about medical standards in disciplinary cases.
  - Hold medical directors of insurance companies and managed care organizations accountable for decisions that affect the quality of patient care.

- **Funding**
  - Increase the annual license registration fee from $100 to $125. The national median annual fee is $131. This fee increase is needed to assure the Board a positive cash flow and to fund improvements such as a post-licensure assessment/remediation program.

2. HIGHLIGHTS OF 1998

**Special Conference on End-of-Life Decisions Is Successful**
Tackling one of the most important issues of the day, the Board’s staff, in cooperation with staffs of the Pharmacy and Nursing Boards, developed and presented a special program on end-of-life decisions on October 23. Presentations on this vital subject, which is of great concern to the public and the health care professions, were given by, among others, Lawrence O. Gostin, JD, LLD (Hon), of the Johns Hopkins and Georgetown Universities; Bill Campbell, PhD, Dean of Pharmacy at UNC; Anne Dellinger, JD, of UNC; and the Board’s own George C. Barrett, MD, currently vice president of the Federation of State Medical Board.
Board Reports to People
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Boards. Polly Johnson, executive director of the North Carolina Board of Nursing, chaired the conference, which was attended by over 100 interested professionals and members of the public.

An active effort is being made to continue the work begun at the Forum, led in part by the executive directors of the three boards that arranged that conference.

The Medical Board produced a four-hour audio tape of the conference, which is available for $10 from its Public Affairs Department.

1-800 Telephone Number
Introduced to Increase Access to Board

During 1998, the Board established a toll-free long distance number to allow anyone in North Carolina to telephone the Board without paying for the call. This was a significant step in improving consumer access to the Board. It makes asking about a physician, seeking information about the Medical Practice Act or the Board, or requesting a complaint form just that much easier for the consumer.

The Board is doing all it can to distribute its new 800 number and it encourages the news media across the state to let the public know about the number: 1 (800) 253-9653.

Education and Information Programs Continue to Expand

- Educational Outreach: In 1998, the Board presented some 20 educational outreach programs to medical schools, public groups, and civic and professional organizations. These presentations are available to any group in the state and the Board encourages those who are interested to contact its Public Affairs Department to make arrangements. Board staff and Board members are available, with reasonable notice, to talk about any aspect of the Board’s work.

- Informational Efforts: The Board’s information and communication program continued to expand throughout 1998 and included its third full news conference, held in March 1998. Activities included further efforts to increase widespread public and media contact: producing the quarterly Forum, a quality publication sent to over 36,000 licensees and others; beginning revision of the Board’s widely distributed brochure for the public, the media, and the health care professions; appearing on statewide radio and television programs; providing news releases and special reports to the state’s news media; and distributing a detailed bimonthly disciplinary report, which goes to the media and medical institutions and which is also printed in the Forum. This approach keeps the public and profession better informed and has a distinct educational impact on licensees.

The Board’s recently introduced 1-800 telephone number also improves the consumer’s ability to seek information from the Board.

- Web Site and E-Mail: The Board maintained its Web site (www.docboard.org) as a basic informational resource for those with on-line computer access. It also began planning a major improvement in the site, which is noted in Section 3 of this report.

The Board also continued operating its electronic mailbox. The address is ncmed-brd@interpath.com. Requests for complaint forms may be sent to the Board by e-mail (postal addresses should be included in the request) and comments for the Board’s consideration are welcome.

Four Position Statements Adopted

- Prescribing Legend or Controlled Substances: During 1998, the Board developed a position statement titled “Prescribing Legend or Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties.” A significant aspect of this statement concerns the use of anabolic steroids to enhance athletic performance, a topic of serious concern to many people.

- Retention of Patient Records: In another statement, the Board declared its support of the American Medical Association’s position regarding the “Retention of Medical Records,” which outlines the physician’s obligations in regard to maintaining records over time.

- Professional’s Obligation to Report Problem Colleagues: The Board also adopted a statement on “The Professional Obligation to Report Incompetence, Impairment, and Unethical Conduct” of colleagues to appropriate authorities or agencies. This makes clear the Board’s expectation that professionals will act responsibly and in the public interest when they learn of a colleague who, for whatever reason, may be a threat to patient health or safety.

- Terminating the Relationship Between Physician and Patient: During 1998, the Board expanded its Position Statement on The Physician-Patient Relationship by adding a section covering the manner in which a physician should approach terminating a physician-patient relationship, making clear, among other things, that termination should be done through appropriate written notice, protecting the patient’s rights and assuring the patient of care during a reason-

able period following notice.

Copies of these four statements, and all the Board’s Position Statements, are available to the public on request and at the Board’s Web site.

Complaints Process Enhanced

Thanks to the reorganization of the Board’s complaints process in 1997 and 1998, which included creation of a separate Complaints Department, an increase in staffing, the close involvement of the Board’s medical coordinator, Dr. Jesse Roberts, and rapid review of complaints by Board and staff members, the Board now acknowledges complaints and begins their processing within 72 hours of their receipt. Whereas the review and disposition of complaints could once take up to a year or more, the average is now from three to six months.

Special Projects

- Physician Assessment and Remedial Education: During the year, the Board examined a range of issues related to physician qualifications and the assessment of practicing physicians. Of particular significance was the Board’s decision to explore specific approaches to assessment and the upgrading of physician skills. This process will extend over some time. Just as the Board led the way in addressing the problems of the impaired physician, it hopes to encourage sound assessment and remedial education programs as part of its effort to stimulate the enhancement of medical practice.

- Effective Pain Management: The Board also continued to encourage physicians to become familiar with effective methods of pain management, building on its major effort on this subject in 1997.

Dr. George Barrett Elected Vice President of FSMB

In the spring of 1998, the Board’s Dr. George C. Barrett was elected vice president of the Federation of State Medical Boards, the national private sector organization of state medical boards. This continues North Carolina’s long history of leadership at the national level in the field of medical regulation. Three members of the North Carolina Medical Board have served as president of the Federation and one served as that organization’s executive vice president. Dr. Barrett will become president-elect of the Federation in April and will serve as its president in 2000.

Two Smooth Transitions

- From Bryant Paristo Andrew Watry at the NCMB: It is appropriate to note here continued on page 14
that 1998 saw the retirement of Bryant D. Paris, Jr, as executive director of the North Carolina Medical Board and the arrival of Andrew W. Watry as the Board's new executive. Mr Paris served in that post for 25 years and brought distinction to all he did. Fortunately, he remains as executive director emeritus of the Board and we frequently draw on his skills and experience. In November, he received the prestigious John Huske Anderson Award from the North Carolina Medical Society in honor of his years of service to the Board, the state, and the medical profession. Mr Watry, after 17 years of service as director of the medical board in Georgia, brings rich experience and enthusiasm to the North Carolina Medical Board, and we are pleased to have him guiding the Board into the next century.

- From Dr Vanderberry to Dr Wilkerson at the NCPHP: Also, in October, Robert C. Vanderberry, MD, medical director of the North Carolina Physicians Health Program, retired from that post after 10 years of dedicated service. His work with and for impaired physicians developed the most successful program of its kind in the nation. On a plaque presented to him by the Board, it says: "He saved physicians' lives; He saved physicians' families; And through his contributions, He made it possible, again, for these physicians To save their patients." Replacing Dr Vanderberry is Michael Wilkerson, MD, who has worked with the NCPHP for some time and is well equipped to continue that organization's work without skipping a beat.

3. MOVING INTO 1999

- Web Site

As part of its commitment to continually improving its service to the public and the professions, the Board has now dramatically enhanced its Web site, completely revising and updating its contents and features.

It can be used to access the Medical Practice Act, the rules of the Board, all the Board's position statements, a list of one year's disciplinary actions, the Board's calendar and membership list, short essays on special topics such as licensure and the filing of complaints, and much, much more. It also contains the full text, in published format, of the two most recent issues of the Board's Forum, which can be printed out. For the first time, this useful publication is available to anyone with access to an on-line computer. A narrated slide presentation about the Board and its work will also be mounted on the Web site shortly. Copies of the Board's Complaint Form and other items can also be printed out.

As has been the case over the past few years, the Board's full roster of licensees will be found under the DocFinder heading at the Web site — allowing anyone to get information about a licensee's background and learn if the Board has ever taken an action against her or him.

- Commitment to Upgrading Physician Qualifications

The evaluation of post-licensure competence, on which the Board has focused attention for some time, will remain a major interest, as will the related issue of remedial education for physicians found to have knowledge deficits.

The Board will also continue to participate with various medical groups and organizations on committees and task forces dealing with significant medical issues.

In all its efforts, the Board will continue to pursue its goal of upgrading physician qualifications and assuring effective consumer protection in North Carolina.

4. ON THE WORK OF A MEDICAL BOARD

Medical boards engage in a wide range of activities in fulfilling their obligation to protect the public. Even a brief review of the North Carolina Medical Board's work is evidence of that. It is important to recognize that a variety of factors will affect the nature and focus of a board's activity in any particular state.

The states differ in the quality of their medical environments, which will certainly influence the situations and conditions faced by their boards. The boards differ by law and by their approaches to their tasks. The nature of their original licensing procedures, their commitment to prevention, and their access to regulatory options and adequate resources will go a long way in explaining their individual activities and actions.

In North Carolina, the medical environment in which the Board functions benefits from having, among other things:

- four (4) of the nation's leading medical schools;
- fourteen (14) accredited residency training programs;
- nine (9) Area Health Education Centers; and
- a leading position in the field of clinical drug research and testing.

Added to this is the Board's relationship with the North Carolina Physicians Health Program. The NCPHP is a significant element in the regulatory approach of the Board and well reflects the Board's commitment to effective prevention.

The quality of the Board's efforts and its focus on prevention are further enhanced by, among other things:

- its verified photo identification and personal interview system at the time of initial licensure;
- its issuance of advice to licensees in the form of position statements on critical issues;
- its use of an informal interview system that strengthens its ability to deal with current and potential problems;
- its non-public, preventive letters of advice or recommendation to individual licensees; and
- its extensive public and professional information program.

Very few boards release the wide range of information and data the North Carolina Medical Board issues each year. These materials indicate the many facets of this Board's activity and the nature of its work, providing a wide perspective on the effectiveness of the Board.

The Board is pleased to release its official Board action figures each year, but it recognizes the number of disciplinary actions taken by a board reveals only one facet of a board's activity. Clearly, medical regulation is not a simple black and white process defined by the revocation or suspension of licenses.

SUMMARY OF NCMB 1998 BOARD ACTION REPORT: PARTS 1 AND 2 [With 1997 Comparisons]

PART 1—Actions by Category

License Denied after Hearing:
1 (1 physician)
1997: 4 Actions (3 physicians, 1 NP)

Annulments:
1 (1 physician)
1997: 0

Revocations:
4 (4 physicians)
1997: 4 Actions (4 physicians)

Suspensions:
11 [5 stayed] [8 by CO, 1 by Misc Order] (11 physicians)
1997: 9 Actions [3 stayed] [5 by C/O, 1 by Misc Order] (9 physicians)

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Summary Suspensions:
7 (5 physicians — 2 PAs)
1997: 8 Actions (7 physicians, 1 PA)

Consent Orders:
46 (8 modifying previous orders)
(34 physicians — 7 PAs — 5 EMTs)
1997: 69 Actions — [17 modifying previous] (51 physicians had 5 actions, 10 PAs had 13 actions)

Miscellaneous Actions After Hearings:
6 (4 physicians — 2 PAs)
1997: 7 actions (5 physicians, 2 PAs)

Surrender:
14 [3 by Consent Orders]
(9 physicians — 5 PAs)
1997: 21 Actions [6 by C/O]
(19 physicians, 1 PA, 1 N P)

Temporary/Dated Licenses Allowed to Expire:
0
1997: 2 Actions (1 physician, 1 PA)

Dismissal of Charges:
10 [4 by C/O, 1 by hearing, 1 by Order, 1 inactive, 3 surrendered]
(physicians — 2 PAs)
1997: 9 Actions [5 by C/O, 3 surrendered/expired, 1 after hearing] (7 physicians, 2 PAs)

Temporary/Dated Licenses Extended:
78 Actions—47 Persons
(39 physicians-8 PAs)
1997: 73 Actions—43 Persons
(36 physicians, 7 PAs)

Dated/Temporary License Becomes Full and Unlimited:
11 (9 physicians—2 PAs)
1997: 3 Actions (3 physicians)

Consent Orders Lifted:
20 (17 physicians—3 PAs)
1997: 21 Actions (21 physicians)

Revolutions Reinstituted:
0
1997: 0

PART 2—Total Actions

209 Board Actions of All Types Relating to 117 Persons
1997: 230 Board Actions of All Types Relating to 130 Persons

97 Physicians with 170 Actions
1997: 112 Physicians with 197 Actions

15 PAs with 34 Actions
1997: 16 PAs with 31 Actions

0 NPs with 0 Actions
1997: 2 NPs with 2 Actions

5 EMTs with 5 Actions
1997: 0 EMTs with 0 Actions

Learn By My Mistake
To the Editor: This is a letter I hope all physicians will read. Don’t make the mistake I did! I retired from my full-time practice in Maryland and came here to North Carolina in 1993 to be with my son’s family, enjoy this land of sunshine and pleasantness, and escape the new world of HMOs and all the other bureaucracies for which I had no training.

After a short time being here, I found I missed what I was educated to do: practice medicine. Unfortunately, I was not well versed in the fields of business, commerce, and law. I did not fully comprehend what the legal implications and responsibilities are when you hire yourself out to a part-time basis as an independent contractor to an entity/corporation that funds a medical clinic.

I worked one day per week working up and treating patients with impotence problems. (I was given specialized training prior to the beginning of this endeavor.)

The problem arose when, for whatever reason, the corporation had difficulty paying its bills and then suddenly, without notice, locked the clinic doors and discontinued the telephone service. Active patients no longer had access to medical care and the doctor no longer had access to the patient records.

Much worse, these corporate men became very inaccessible themselves, hidden behind voice mail that only exists in far off corporate offices in other cities and states where all calls are screened and never returned.

These patients have been abandoned. They are abandoned because the doctor is losing control of the practice of medicine. We cannot and should not let this continue to happen. Through our professional societies and organizations, we must come together and develop a legal solution so such a situation cannot occur in the future!

Any entity or corporation that takes any part in the care of patients for financial gain or loss should be held legally responsible for their acts that may endanger the care of those patients.

Joseph G. Lanzi, MD
Wilmington, NC

Comment
Lately, several practices controlled economically by someone other than the physicians practicing there have precipitously closed their doors, leaving patients without adequate continuity of care. Some authorities have not been clear and understanding about what to do next. Some such practice arrangements may not be legal. Physicians also may wish to consider what arrangements have been made for continuity of care in the event the enterprise fails. The Board may not view charitablely a physician’s claim that, given the structure of the overall practice, the physician has no responsibility for these matters.

James A. Wilson, JD
Director, NCMB Legal Department

Appreciating “An Ounce of Prevention”
To the Editor: This is just a brief note to express my appreciation for the Board’s reluctance to join the “notches on the gun belt” oversight style Mr. Watry notes to be prevalent in some other state medical boards (An Ounce of Prevention: Early Intervention and Helpful Hints, Forum #4, 1998). I recently had the opportunity to browse the current Irish medical code of conduct: simple declarative sentences, and phrases like, “Colleagues should strive to...” It is a long way we in the United States have fallen from that standard of civility.

I also have a license in Colorado, undoubtedly one of the hinging states Mr. Watry had in mind. What little space in their board newsletter is not occupied by the body count is taken up in pronouncements of new rules, assisted suicide and the like, and description of dire consequences to be visited on licensees as soon as they can be caught offending.

It is important to me to practice in a state where issues like assisted suicide, practice impairment, and other current topics can still be discussed in official publications from more than one angle or at least include a thoughtful rationale for Board positions and initiatives. The North Carolina Medical Board’s commitment to maintaining professional respect for ticklish issues and the front line practitioners who confront them does not go entirely unnoticed in the hinterlands.

Michael W. Hopping, MD
Asheville, NC

Keep Up Your Good Work
To the Editor: Thank you for the Forum and the information it contains. I write to remind you how unique your publication is compared to other state boards. As a locum tenens physician, I maintain active licensure in ten states. Most boards never communicate their work to the public or to physicians as you do through the Forum. Your publication is informative, interesting, and much better than the meager papers of all other state boards I’m aware of.

Keep up your good work! I’m very proud of my North Carolina license, and meeting the demanding standards which your board requires to maintain that license.

James L. Ornel, MD
Grand Island, NE
NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
November-December 1998/January 1999

DEFINITIONS

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

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

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

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

Information not available.

NCPH:
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.)

SUSPENSIONS
NONE

REVOCA TIONS
NONE

ECHO LS, Everett Raphael, II, MD
Location: Southern Pines, N C (Moore Co)
DOB: 6/12/54
License #: 95-00562
Specialty: P (as reported by physician)
Medical Ed: Meharry Medical College (1981)
Cause: This matter was heard on 11/19/98 on the Notice dated 8/04/97. In 1996, Dr. Echols pled guilty to and was convicted in U.S. District Court for the Middle District of North Carolina (U.S. v. Echols) on two counts of prescribing controlled substances while not registered with the DEA, a felony offense.
Action: 12/07/98. Dr. Echols license is suspended for 90 days and he shall appear before the Board for an informal interview in January 1999.

See Consent Orders:
HARISH, Gorli, MD

SUMMARY SUSPENSIONS

KHOT, Prakash Nilkanth, MD
Location: King, N C (Stokes Co)
DOB: 5/10/44
License #: 00-19016
Specialty: FP/EM (as reported by physician)
Medical Ed: Nagpur Medical College, India (1967)
Cause: Dr. Khot may lack professional competence to practice medicine with a reasonable degree of skill and safety.
Action: 12/23/98. Order of Summary Suspension of License issued: Dr. Khot’s license is suspended effective 1/02/99.

MIJANOVICH, James Robert, MD
Location: Columbus, N C (Polk Co)
DOB: 2/23/52
License #: 00-34405
Specialty: PTH/GP (as reported by physician)
Medical Ed: Loyola University Stritch School of Medicine (1980)
Cause: Dr. Mijanovich may have committed acts of immoral or dishonorable conduct.
Action: 11/25/98. Order of Summary Suspension of License issued: Dr. Mijanovich’s license is suspended effective 12/03/98.

SULLIVAN, Kevin Paul, MD
Location: Puyallup, WA
DOB: 10/21/51
License #: 00-32178

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.

Suvillaga’s license is suspended as of 12/03/98.

Sullivan’s license is suspended effective 11/30/98.

Suvillaga, Victor Ivan
Location: Wilmington, N C (New Hanover Co)
DOB: 10/19/48
License #: 00-26877
Specialty: GP/EM (as reported by physician)
Medical Ed: Universidad El Salvador (1979)
Cause: Dr. Suvillaga may have violated his Consent Orders with the Board, an act or acts constituting unprofessional conduct.
Action: 11/27/98. Order of Summary Suspension of License issued: Dr. Suvillaga’s license is suspended as of 12/03/98.

CONSENT ORDERS

BEDINGTON, William David, PA-C
Location: Conover, N C (Catawba Co)
DOB: 11/14/59
License #: 1-02534
Education: Butler University, IN (1998)
Cause: Application for PA license. Mr. Bedington holds a license to practice as a registered nurse in North Carolina; he engaged in inappropriate behavior in 1991 by taking a minor on an unchaperoned trip to the beach, sharing a condominium and a bed with the minor; he then performed a sports physical examination on the minor even though this was beyond the scope of his nursing license; as a result of this conduct, he was investigated by the NC Board of Nursing and surrendered his nursing license in July 1993. On his application for reinstatement, the Board of Nursing issued him a provisional nursing license in September 1994; the NC Medical Board issued him a provisional PA license in June 1998; he then underwent a complete psychological assessment and provided the Medical Board a copy of that assessment, which assures the Medical Board he can safely practice as a PA as provided in this Consent Order.
Action: 12/14/98. Consent Order executed: Mr Bedington is issued a PA license to expire on the date shown on the license (12/16/99); he shall have a chaperon present whenever he examines or treats any person of 18 years or younger; he shall provide a copy of this Consent Order to his primary supervising physician(s) and all chaperons; he shall meet with the Board in September 1999 and at such times as the Board requests; must comply with other conditions.

Suvillaga’s license is suspended as of 12/03/98.
**BENTLEY, Steven Edmunds, MD**

- **Location:** Raleigh, NC (Wake Co)
- **DOB:** 9/03/53
- **License #:** 00-23676
- **Specialty:** OB/GYN (as reported by physician)
- **Medical Ed.:** Medical College of Georgia (1987)
- **Cause:** Allegations of 7/20/81 against Dr Bentley is dismissed without prejudice and the Board accepts his surrender of his license; he is not required to seek readmission.
- **Action:** 11/18/99. Consent Order executed: Dr Bentley shall not apply for medical license in North Carolina unless lawfully prescribed for him by someone else, he shall not use mind or mood altering substances, controlled substances, or alcohol; he shall notify the Board in writing within 30 days of his use of such substances or alcohol, including identification of the prescriber and the pharmacy filling the prescription; on the Board's request, he shall supply bodily fluids or tissue samples for screening; he shall maintain and abide by his NCPHP contract; he shall obtain a psychotherapist and abide by all recommendations of and the treatment program prescribed by the psychotherapist; he shall have the psychotherapist submit reports of his progress to the Board; he shall obtain 50 hours of relevant Category I CME each year; must comply with other conditions.

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**BURSON, Jana Kaye, MD**

- **Location:** Moreoville, NC (Iredell Co)
- **DOB:** 5/14/61
- **License #:** 00-39164
- **Specialty:** OB/GYN (as reported by physician)
- **Medical Ed.:** Ohio State University (1987)
- **Cause:** She was arrested 9/28/97 and charged with driving while impaired, fleeing, resisting, and retaliation in Texas; he pled guilty to driving while impaired and was placed on probation after serving 16 days in jail; without adjudication of guilt, he was placed on supervised probation with respect to the other charges. To date, he has complied with all probation terms and continues to do community service and meet regularly with his probation officer; from 8/20/98 through 11/13/98, he attended and successfully completed a chemical treatment program; he recently signed a contract with the NCPHP and abide by its terms; he shall obtain a license to expire on the date shown on the license and obtain written approval of such plans from the Board prior to engaging in such practice, and, if he returns to North Carolina, he shall enter into a contract with the NCPHP; he shall obtain 50 hours of relevant Category I CME relevant to his practice each year; must comply with other conditions.
- **Action:** 1/12/99. Consent Order executed: Ms Kitchen may be approved as an NP; she shall abide by the terms of the restrictions on her nursing license; she shall produce bodily fluids or tissue samples for screening to determine if she has consumed any of these substances; she shall continue in therapy and have her therapist make quarterly reports to the Board; she shall provide a copy of this Consent Order to all her employers and have them send written confirmation of this fact to the Board prior to her beginning employment; must comply with other conditions.

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**KITCHEN, Constance Powell, Nurse Practitioner**

- **Location:** Jacksonville, NC (Onslow Co)
- **DOB:** 6/19/40
- **License #:** 2-00139
- **Education:** East Carolina University (1977)
- **Cause:** Regarding approval as an NP. Ms Kitchen admits and the Board finds that she obtained Nubain for her personal use by inappropriate means; she surrendered her nursing license in September 1997; her nursing license was reinstated with restrictions in November 1998; when reinstating her nursing license, the NCPHP Board approved Ms Kitchen as a nurse practitioner. She admits there are grounds for the Board to restrict or terminate her approval as an NP.
- **Action:** 11/21/98. Consent Order executed: Dr Harish’s North Carolina medical license is suspended; the suspension is stayed upon the following terms and conditions: Dr Harish shall notify the Board in writing of any plans to engage in practice in North Carolina and obtain written approval of such plans from the president of the Board prior to engaging in such practice, and, if he returns to North Carolina, he shall enter into a contract with the NCPHP and abide by its terms; he shall obtain 50 hours of relevant Category I CME relevant to his practice each year; must comply with other conditions.

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**MASSEY, Howard Todd, MD**

- **Location:** Durham, NC (Durham Co)
- **DOB:** 1/13/63
- **License #:** 98-01708
- **Specialty:** TS/GS (as reported by physician)
- **Education:** Medical College of Georgia (1990)
- **Cause:** Allegations of a recent random urine screens have all proven negative.
- **Action:** 12/98. Consent Order executed: Dr Massey was arrested 9/28/97 and charged with driving while impaired, fleeing, resisting, and retaliation in Texas; he pled guilty to driving while impaired and was placed on probation after serving 16 days in jail; without adjudication of guilt, he was placed on supervised probation with respect to the other charges. To date, he has complied with all probation terms and continues to do community service and meet regularly with his probation officer; from 8/20/98 through 11/13/98, he attended and successfully completed a chemical treatment program; he recently signed a contract with the NCPHP and abide by its terms; he shall obtain a license to expire on the date shown on the license and obtain written approval of such plans from the Board prior to engaging in such practice, and, if he returns to North Carolina, he shall enter into a contract with the NCPHP; he shall obtain 50 hours of relevant Category I CME relevant to his practice each year; must comply with other conditions.

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**MCALL, MICHAEL ALVIN, MD**

- **Location:** Atlanta, GA
- **DOB:** 11/04/61
- **License #:** 00-36569
- **Specialty:** OB/GYN (as reported by physician)
- **Education:** University of Florida College of Medicine (1989)
- **Cause:** Application for reinstatement of license. Dr McCull was arrested 9/28/97 and charged with driving while impaired, fleeing, resisting, and retaliation in Texas; he pled guilty to driving while impaired and was placed on probation after serving 16 days in jail; without adjudication of guilt, he was placed on supervised probation with respect to the other charges. To date, he has complied with all probation terms and continues to do community service and meet regularly with his probation officer; from 8/20/98 through 11/13/98, he attended and successfully completed a chemical treatment program; he recently signed a contract with the NCPHP and abide by its terms; he shall obtain a license to expire on the date shown on the license and obtain written approval of such plans from the Board prior to engaging in such practice, and, if he returns to North Carolina, he shall enter into a contract with the NCPHP; he shall obtain 50 hours of relevant Category I CME relevant to his practice each year; must comply with other conditions.

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**HARISH, Gorli, MD**

- **Location:** Charleston, WV
- **DOB:** 9/17/49
- **License #:** 00-19754
- **Specialty:** OB/GYN (as reported by physician)
- **Medical Ed.:** JNU University of Mysore, India (1971)
- **Cause:** Dr Harish has been disciplined by the medical board of another state; he surrendered his medical license in West Virginia in February 1996; in July 1996 the West Virginia Board of Medicine issued a Consent Order revoking Dr Harish’s medical license and staying the revocation for a probationary period of two years; he successfully completed his probationary period.
- **Action:** 11/21/98. Consent Order executed: Dr Harish’s North Carolina medical license is suspended; the suspension is stayed upon the following terms and conditions: Dr Harish shall notify the Board in writing of any plans to engage in practice in North Carolina and obtain written approval of such plans from the president of the Board prior to engaging in such practice, and, if he returns to North Carolina, he shall enter into a contract with the NCPHP and abide by its terms; he shall obtain 50 hours of relevant Category I CME relevant to his practice each year; must comply with other conditions.
abused alcohol and controlled substances; on 10/02/96, the
Georgia Board approved a Consent Order by which his license
there was suspended. He received treatment for his alcohol and
substance abuse between August 1995 and February 1996; since
his release from treatment, he has been involved in active recov-
er, regularly attending AA and NA meetings as well as psy-
chotherapy; he signed a contract with NCPH P on 11/14/95; as
of this date he has complied with his NCPH P contract.

**Action:** 11/09/98. Consent Order executed: Dr McCal is issued
a license to expire on the date shown on the license (5/11/99); he
shall work only in a setting first approved in writing by the pres-
ident of the Board, who may restrict Dr McCal’s work hours,
require evaluations of his work by colleagues or supervising
physicians, and impose other restrictions; he may not be a pri-
mary or back-up supervising physician for NPs or PAs; unless
lawfully prescribed for him by someone else, he shall not use
mind or mood altering substances, controlled substances, or
alcohol; he shall notify the Board in writing within 2 weeks of
his use of such substances or alcohol, including identification
of the prescriber and the pharmacy filling the prescription; on
the Board’s request, he shall supply bodily fluids or tissue samples
for screening; he shall maintain and abide by his NCPH P contract;
he shall continue his psychotherapy and cause his therapist to
provide quarterly reports of his progress to the Board; he shall
obtain 50 hours of relevant Category I CME each year; must
comply with other conditions.

**WILLIAMS, Warren Herbert, MD**

**Location:** Charlotte, NC (Mecklenburg Co)

**DOB:** 1/03/51

**License #:** 00-30111

**Specialty:** P (as reported by physician)

**Medical Ed:** Universidad Autonoma Guadalajara (1980)

**Cause:** Information received that Dr Williams surrendered his license in New York. He admits and the Board finds that New York accepted the surrender of his medical license there effective 8/25/98; at the time of his surrender in New York, allegations were pending against him in that state for unprofessional con-
duct; in surrendering his license in New York, he admitted an
allegation that he was negligent in his care of patients more than
once.

**Action:** 1/28/99. Consent Order executed: the Board reprimands Dr Williams.

**ZYLANOFF, Phillipa Louise, MD**

**Location:** Beverly Hills, M1

**DOB:** 2/02/43

**License #:** 00-30979

**Specialty:** AN (as reported by physician)

**Medical Ed:** Medical College of Pennsylvania (1972)

**Cause:** Action by another state's medical board. Dr Zylanoff admits and the Board finds that her Michigan medical license was summar-
ily suspended in October 1997 and a complaint was filed by the
Michigan Board alleging she was impaired by alcohol abuse and
was noncompliant with her treatment program; the Michigan
Board issued a Final Order in June 1998 dissolving the summa-

**Action:** 1/28/99. Consent Order executed: Dr Zylanoff shall comply with the Final Order of the Michigan Board. If she resides or
practices in North Carolina, she shall sign, maintain, and abide
by a contract with the NCPH P; unless lawfully prescribed for her
by someone other than herself, she shall refrain from the use of
mind or mood altering substances and all controlled substances
and from the use of alcohol; she shall inform the Board within
two weeks of her use of such substances or alcohol, identifying
the prescriber and the pharmacy filling the prescription; on the
Board’s request, she shall supply bodily fluids or tissue for screening
to determine if she has consumed any of these substances; must
comply with other conditions.

**MISCELLANEOUS BOARD ORDERS**

**DENIALS OF LICENSE/APPROVAL**

**NORRIS, Dolley Frances, MD**

**Location:** Wilmington, NC (New Hanover Co)

**DOB:** 10/03/66

**License #:** 96-01782

**Specialty:** GP (as reported by physician)

**Medical Ed:** Uniformed Services University of the Health Sciences (1992)

**Cause:** Application for license. Dr Norris has been found to have
engaged in immoral or dishonorable conduct, made false state-
ments or representations to or willfully concealed information
from the Board, engaged in unethical conduct and conduct con-
trary to honesty, justice, or good morals, by false representations
obtained or tried to obtain something of value, had a license
denied in another state, and not satisfied the Board she is of
good moral character—all of which are grounds under the law
for denial of the license to practice medicine.

**Action:** 1/11/99. Denial of license application issued.

**DENIALS OF RECONSIDERATION/MODIFICATION**

**NONE**

**SURRENDERS**

**DENTON, Beecher Tate, III, Physician Assistant**

**Location:** Salisbury, NC (Rowan Co)

**DOB:** 1/03/55

**License #:** 1-00993

**Education:** Bowman Gray (1987)

**Action:** 12/03/98. Voluntary surrender of PA license.

**HOWSARE, Charles Robert, MD**

**Location:** Durham, NC (Durham Co)

**DOB:** 2/08/65

**License #:** Resident Training License

**Specialty:** OM (as reported by physician)

**Medical Ed:** University of North Carolina School of Medicine (1989)

**Action:** 11/17/98. Voluntary surrender of resident training license.

**NEVIASER, Jules Salem, MD**

**Location:** New Smyrna Beach, FL

**DOB:** 3/28/34

**License #:** 00-14268

**Specialty:** ORS (as reported by physician)

**Medical Ed:** George Washington University (1964)

**Action:** 11/07/98. Voluntary surrender of medical license.

**SAPPINGTON, John Shannon**

**Location:** Baytown, TX

**DOB:** 1/30/62

**License #:** 94-00628

**Specialty:** P (as reported by physician)

**Medical Ed:** University of Texas (1989)

**Action:** 1/05/99. Voluntary surrender of medical license.

**CONSENT ORDERS LIFTED**

**BASHARA, Jerome George, MD**

**Location:** Des Moines, IA

**DOB:** 4/24/38

**License #:** 00-16569

**Specialty:** ORS (as reported by physician)

**Medical Ed:** University of Iowa (1964)


**HAWLEY, John Patrick, Physician Assistant**

**Location:** New Bern, NC (Craven Co)

**Hubert, NC (Onslow Co)

**DOB:** 4/27/46

**License #:** 1-02243

**Education:** Duke University (1977)

**Action:** 12/23/98. Order issued lifting Consent Order of 12/11/96

**HOWELL, David Alexander, MD**

**Location:** Latta, SC

**DOB:** 4/23/56

**License #:** 00-27468

**Specialty:** FP (as reported by physician)

**Medical Ed:** Medical University of South Carolina (1982)


**MCCALISTER, John David, Jr, MD**

**Location:** Fayetteville, NC (Cumberland Co)

**DOB:** 3/14/49

**License #:** 00-38271

**Specialty:** PCC (as reported by physician)

**Medical Ed:** University of North Carolina School of Medicine (1985)

**Action:** 12/23/98. Order issued lifting Consent Order of 10/04/96.
WOEBEN, Martyn Dean, MD
Location: High Point, NC (Guilford Co)
DOB: 6/11/41
License #: 1-08163
Specialty: N/CN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1969)

GORSKI, Karen, Physician Assistant
Location: Charlotte, NC (Mecklenburg Co)
DOB: 1/08/57
License #: 1-01445
Education: University of Texas, Southwest (1979)

LESTER, Allan John, MD
Location: Cary, NC (Wake Co)
DOB: 9/19/44
License #: 00-21059
Specialty: ORS/OSM (as reported by physician)
Medical Ed: University of North Carolina at Chapel Hill School of Medicine (1969)

COYLE, Cindy, PA
Location: Lincolnton, NC (Lincoln Co)
DOB: 1/22/98
License #: 00-34359
Specialty: SN (as reported by physician)
Medical Ed: Duke University School of Medicine (1977)

FOERCH, Jeffrey Scott, MD
Location: Wilkesboro, NC (Wilkes Co)
DOB: 10/10/52
License #: 96-000806
Specialty: P/PY (as reported by physician)
Medical Ed: Chicago Medical School (1977)

LOWE, James Edward, Jr, MD
Location: Briercliff Manor, NY
DOB: 12/05/50
License #: 00-30159
Specialty: ORS/OSM (as reported by physician)
Medical Ed: Meharry Medical College (1975)

MARSHALL, John Everett, MD
Location: Lincolnton, NC (Lincoln Co)
DOB: 7/13/54
License #: 1-00120
Specialty: ORS/OSM (as reported by physician)
Medical Ed: University of North Carolina at Chapel Hill School of Medicine (1969)
RUDISILL, Elbert Andrew, MD
Location: Hickory, NC (Catawba Co)
DOB: 1/14/47
License #: 00-21863
Specialty: FP (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1977)

SCHUETZOW, Mark Howard, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 8/19/57
License #: 97-00166
Specialty: PM (as reported by physician)
Medical Ed: Ohio State University (1993)
Action: 1/22/99. Full and unrestricted license reinstated.

STEWART-CARBALLO, Charles Willy, MD
Location: Marion, NC (McDowell Co)
DOB: 10/20/50
License #: 00-38215
Specialty: ORS (as reported by physician)
Medical Ed: University of Wisconsin (1977)

WOLEBEN, Martyn Dean, MD
Location: High Point, NC (Guilford Co)
DOB: 11/13/56
License #: 97-00428
Specialty: OB/GYN (as reported by physician)
Medical Ed: University of Mississippi School of Medicine (1988)
Action: 11/20/98. Full and unrestricted license reinstated.

BENTLEY, Steven Edmunds, MD
Location: Langley, MI
DOB: 7/24/53
License #: 00-31255
Specialty: P/PYM (as reported by physician)
Medical Ed: Michigan State University (1983)
Action: 12/21/98. Dr. Burt having failed to register his license as required by law and his license having become inactive, the Board dismisses without prejudice the case against him initiated by the Notice of Charges of 9/11/97.

NEVIASER, Jules Salem, MD
Location: New Smyrna Beach, FL
DOB: 11/30/99.
License #: 00-14268
Specialty: ORS (as reported by physician)
Medical Ed: University of Texas (1983)
Action: 11/20/98. Dr Neviser having surrendered his license, the Board dismisses without prejudice the case against him initiated by the Notice of Charges of 11/28/94.

SAPPINGTON, John Shannon
Location: Baytown, TX
DOB: 1/30/62
License #: 94-00628
Specialty: P (as reported by physician)
Medical Ed: University of Texas (1989)
Action: 1/23/99. Notice of Dismissal issued: Dr. Sappington having surrendered his license, the Board dismisses without prejudice the case against him initiated by the Notice of Charges dated 3/23/96.

See Consent Orders:
BENTLEY, Steven Edmunds, MD
North Carolina Medical Board
Meeting Calendar, Application Deadlines, Examinations
April 1999 -- March 2000

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

North Carolina Medical Board
May 19-22, 1999
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

May Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

North Carolina Medical Board
July 21-24, 1999
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

July Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

North Carolina Medical Board
September 15-18, 1999
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

September Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

North Carolina Medical Board
November 17-20, 1999
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

November Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

North Carolina Medical Board
January 19-22, 2000
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

January Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

LICENSES RECENTLY MADE INACTIVE
(Results from Failure to Register)
AUGUST 1998

Name (alphabetical) License # Name (alphabetical) License # Name (alphabetical) License # Name (alphabetical) License #
Abraham, Clara 00-36125 Abraham, Clara 00-36125 Abraham, Clara 00-36125 Abraham, Clara 00-36125
Abimbade, Thomas 00-39312 Abramson, Michele 00-39581 Abraham, Joseph 00-39335 Abraham, Charles A. 00-31019
Abimbade, Thomas 00-39312 Abramson, Michele 00-39581 Abraham, Joseph 00-39335 Abraham, Charles A. 00-31019

North Carolina Medical Board
March 15-18, 1999
March Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

Examinations Schedule
United States Medical Licensing Examination (USMLE)
Step 3
May 11-12, 1999 Sitting
Deadline for receipt of application: February 10, 1999
Deadline for receipt of application: September 7, 1999

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) 886-4000.
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The following is an official statement of the North Carolina Medical Board regarding registration of physician assistants and nurse practitioners. This statement should be clipped or copied and attached to your current registration certificate if the expiration date is listed as June 1999.

**PAs**

Because of changes in 21 NCAC 32S.0105, all licensed physician assistants will be required annually to register their licenses within 30 days of their birthdays beginning in June 1999. Those PAs who have birthdays between January 1, 1999, and June 1, 1999, will NOT be required to register until their birthday in 2000. Despite the wording on the face of the registration certificate, the certificate for those individuals will NOT expire until 2000.

**NPs**

Because of changes in 21 NCAC 32M.0105, all nurse practitioners will be required annually to register within 30 days of their birthdays beginning in June 1999. Those NPs who have birthdays between January 1, 1999, and June 1, 1999, will NOT be required to register until their birthday in 2000. Despite the wording on the face of the registration certificate, the certificate for those individuals will NOT expire until 2000. If Nurse Practitioners do not register within 60 days of their birthdays, the approval to practice will lapse.