Embracing the Future, Thoughtfully

As we embrace the computerization of the practice of medicine, the North Carolina Medical Board and other regulatory boards must begin to anticipate and to "think outside the box" to prepare for what's ahead. Those who want to push modern technologies to the practical limits will draw their own style of "freehand medicine" by incorporating their own version of what they think is appropriate. It will be up to medical regulatory boards and legislatures and Congress to respond appropriately.

The computer is one of the most fantastic tools ever created, and the Internet is an effective communication and learning instrument that exceeds all others in our lifetime so far. Yet we are often reminded that there is a huge difference between "Internet medicine" and the real-world practice of medicine. Web-based Internet health sites offer excellent vistas in educating the citizen patient and the health care provider, too. However, when it comes to diagnosing and treating a patient, Internet medicine is often narrowly focused to steer you into limited diagnostic categories to provide the pharmaceutical product that is effective communication and learning tools ever created, and the Internet is an effective communication and learning instrument that exceeds all others in our lifetime so far. Yet we are often reminded that there is a huge difference between "Internet medicine" and the real-world practice of medicine. Web-based Internet health sites offer excellent vistas in educating the citizen patient and the health care provider, too. However, when it comes to diagnosing and treating a patient, Internet medicine is often narrowly focused to steer you into limited diagnostic categories to provide the pharmaceutical product that is effective communication and learning tools ever created, and the Internet is an effective communication and learning instrument that exceeds all others in our lifetime so far. Yet we are often reminded that there is a huge difference between "Internet medicine" and the real-world practice of medicine. Web-based Internet health sites offer excellent vistas in educating the citizen patient and the health care provider, too. However, when it comes to diagnosing and treating a patient, Internet medicine is often narrowly focused to steer you into limited diagnostic categories to provide the pharmaceutical product that is effective communication and learning tools ever created, and the Internet is an effective communication and learning instrument that exceeds all others in our lifetime so far. Yet we are often reminded that there is a huge difference between "Internet medicine" and the real-world practice of medicine. Web-based Internet health sites offer excellent vistas in educating the citizen patient and the health care provider, too. However, when it comes to diagnosing and treating a patient, Internet medicine is often narrowly focused to steer you into limited diagnostic categories to provide the pharmaceutical product that...
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.

Trends in Fragmentation of Medical Care

My concern is that, with full utilization of new technologies, the space between the physician and the patient has the potential to keep growing. Already, we have seen how the telephone can contribute to prolonging the effort to gain access, with all its voicemail messages, agonizing multiple menus, and the tendency to increase the frustration of our patients. The pressure to “do more work with less staff” is a constant factor in increasing the levels of stress in medicine and the dissatisfaction of patients. Paperwork overload for physicians’ past patients, with concurrent computer use for new patients, may cause many to use a bifurcated system in which neither approach provides complete access to all patient information.

Fragmentation of health care delivery also occurs when some specialists predetermine that certain problems fall outside the range of their choice of whom to serve and refuse to provide primary health care services. Patients must ascertain the exact specialty of practice of a provider and hope that they have chosen the right doctor for the problem they think they have. This factor alone seems to be contributing to the long wait times to obtain appointments with specialists in many areas. Now hospitalists may actually manage a patient’s hospital care, and your personal physician may not be involved in your hospital care until you leave to reenter the outpatient setting. This can directly affect continuity of care unless safeguards of excellent communication are in place and functioning well.

With more surgical procedures being done in the outpatient office setting (often outside JCAHO review), medical regulatory boards will need to devote increased attention to this trend to assure that outpatient surgery can be done safely and does not place the public at an increased risk. Simply being overloaded with information, there may be a tendency to become dull to the importance of the message and the real live sender of the message.

As You Practice Your Style of Freehand Medicine

As we incorporate the computer, new technologies, and the Internet into our medical practices, we must keep the following priorities in mind: 

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Freehand Medicine

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- provide competent service with fairness and efficiency;
- enrich the time you invest in each encounter with your patients;
- maintain diligent attention to good communication skills and accuracy in documentation of real-time events;
- always remember to sort the worthwhile from the worthless, or in other words, be discerning in separating the “pioneering technology” from the “irresponsible, irrational, or dangerous”;
- try to integrate your services to provide patients easy access;
- be well informed, and trust that your professional knowledge and skills and your interpersonal abilities will earn your patients’ respect;
- make a practice of getting feedback from your patients to seek ways to improve the quality of the delivery of your medical services;
- anticipate technology’s potentials and pitfalls and be willing to make changes.

In any age, there will be those few who will make the mistake of trying to “color outside the lines” when it comes to practicing their version of freehand medicine, and a few others who will make the mistake of refusing to change or to see the potential for progress. Most, however, know good medicine is founded on the scientific method that is inquiry driven and is open to new opportunities for the advancement of medical knowledge. Today’s physicians have a strong track record of being able and willing to incorporate usable technology and to apply it for the better health of their patients. They recognize that continuing medical education, continuing professional growth, is a lifetime investment in the welfare of their patients and the survival of their careers.

The North Carolina Medical Board helps to provide a framework for health professionals to assist the public in making healthy choices. The Board assures the public of properly trained and regulated health care professionals to meet the needs that exist today. Those professionals must choose their own styles of medicine in a responsible and thoughtful way. They must also have the flexibility to learn and to change to meet the needs of the future. What an exciting time in which to live and to practice medicine!

Patient Access to Records

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altered that landscape; large practices are being bought and sold like businesses. In this process, sometimes patients fall through the cracks. There are complex contracts involving these practice changes, and these contracts include typical business provisions, such as no-compete clauses and disposition of and ownership of records clauses. Patient records are brokered as commodities in these business transactions. When this is done, unfortunately, patient interests are too often secondary to business interests. As a result, patients are left in the lurch, not knowing who is going to treat them next, who has access to their records, and whether or not their records are in a secure location; and they are left without appropriate mechanisms for getting these records to a new health care provider in order to provide continuity of care. This is a problem for two reasons: first, it is not in the best interest of the patient; second, it can precipitate legislation that can have the unintended effect of making things worse instead of better.

When we get these complaints, we contact the treating physician. Often, the treating physician has relinquished control of or involvement in the issue of medical records by signing a contract. This makes no difference to the Board. The Board, adhering to the fundamental principle of putting the patient first, will not accept as a defense that a physician signed away his or her interest in medical records. The Board may hold the physician accountable in spite of these contractual provisions. The Board, in other words, fully expects its licensees to put patients first. Thus, when a physician becomes inadvertently involved in a failed health care delivery business, and his or her patients are having difficulty getting their records, the physician should comply with the Board’s position statements, such as Access to Physician Records, that may be found at www.ncmedboard.org/tsc.

Another situation we see with increasing regularity is the physician holding records until payment is made for an unsettled account or for the copying of the records themselves. This is contrary to the Board’s position statements on medical records. Maintaining and keeping files is a cost of doing business, and it is recognized that in many businesses it is acceptable to withhold services until fees are paid. For the most part, this is not so in medicine. One can certainly sympathize with a physician who incurs costs for assembling, copying, and maintaining records in the relatively rare instances in which a patient refuses to pay. However, holding back records until fees are paid has the effect of interrupting continuity of care. In these few cases, it is far better to write off the costs or send the matter for collections than to cause a break in care with all the consequences that might ensue for both the patient and the treating physician.

Legislation Could Be a Problem

I made the point earlier that it is probably better to handle this problem at the Board level than the legislative level. Here is why I think that is the case. There is great variety in the medical practice environment. It is certainly not a situation where one size fits all, but that is what you get with legislation. If there is a perception that patients are being abandoned or ignored, you are likely to have legislation that specifies who has ownership of the records, how quickly the practitioner has to make these records available to a patient, and even what the reasonable charge can be for copying these records. This has happened in some other states. This does not seem to be a superior alternative to handling these problems as they arise, thereby obviating the need for legislation.

The down side of such legislation is that it may have unintended consequences. In days past, when a patient migrated from the care of one physician to another, there was a clear mechanism for forwarding records. The new physician or the patient would request that the records be sent on by the old physician, who would, in many instances, transmit the records at no cost to the patient. One down side of legislation stipulating costs would be that many patients who might not have otherwise been charged for copies of their records might now be charged. Another possible unintended consequence could well be that larger practices might be more inclined to broker their copying out to a third party, which would have the effect of increasing costs to patients.

North Carolina Medical Board

1-800-253-9653

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**Patient Access to Records**

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**Do the Right Thing**

All this is to say that, in considering the options, it seems the best one may be the present one. That is, physicians should make diligent efforts to comply with the Board’s position statements on medical records and should make diligent efforts to transmit these records to new health care providers in a timely way to ensure continuity of care. A simple rule of thumb for physicians is to ask themselves how they would want these records treated if they were the patient. Charges for the transfer of records need not be specified in law. Physicians and patients can be allowed flexibility on that point, providing the issue is handled with good sense, good judgment, and good will, and providing the patient knows what the transfer policy is from the beginning of the physician-patient relationship.

The bottom-line recommendation to physicians is simply this: you will be better off making sure this element of your practice is appropriately dealt with to ensure continuity of care for your patients. If you as a physician plan to become part of a managed care enterprise, I would recommend you address the issue of how patient records are to be handled prior to negotiating a contract. This would be prudent as a point of negotiation so it does not become a problem if the managed care entity is sold, dissolved, or goes bankrupt. You will be doing your peers and, most importantly, your patients a service by taking care of this important element of medical practice before problems occur.

**On-Line Registration:**

*It’s on the Way*

Good news! Physicians will soon be able to register their North Carolina medical licenses on line, which will include payment of the registration fee by credit card. This system will significantly reduce the administrative burden that pen and paper registration places on the physician and the Board. It will allow immediate feedback and much more timely confirmation.

Watch the Board’s Web site (www.docboard.org/nc) and see the back cover of this Forum for more details.

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**Special Topic**

**Domestic Violence**

*Laura A. Queen*

Outreach Coordinator, Women’s Aid In Crisis, Upshur County, WV

**Family Violence.** Two words that chill to the bone. They should be an oxymoron but they are not, instead describing a problem ravaging society and increasingly becoming a public concern, no longer considered a private matter within only a few families. Battled domestic partners, like the poor, have been with us always, but now we count their numbers as legion.

**Leading Cause of Injury to Women**

Batterings occur on a daily basis in even the smallest towns. Spouse abuse used to be considered a private matter, a lovers’ quarrel soon resolved. This attitude is no longer acceptable because we now know violence between intimates is rarely an isolated incident, instead becoming over time more frequent, more intense, and its resultant injuries more severe, even to the point of death.

Women are at the greatest risk of being murdered when attempting to report abuse or leave an abusive relationship. Every year, between two and three million women here in the United States are battered by their intimate partners. Today, domestic violence is the leading cause of serious injury to women in the U.S., more common than injuries sustained in muggings and motor vehicle accidents combined. Approximately 2,000 women die each year as a result of domestic violence, and here in West Virginia a domestic homicide occurs every 14 days.

At least 25% of female domestic violence victims are pregnant when beaten, and each year approximately 3.3 million children witness violent acts against their mothers. Domestic violence is responsible for 15% of all emergency department visits by women, and 28% of women seen in ambulatory medical clinics report having been battered at some time. There are 3,800 animal shelters in the United States and only 1,500 domestic violence shelters.

Domestic violence is defined as coercive behavior (including economic coercion) plus physical, sexual, verbal, or psychological assault committed by adults or adolescents against their intimate partners or other family members. The perpetrator and victim may be dating, married, cohabitating, divorced, or separated. Either or both may be male, female, straight, gay, lesbian, young, or old. Some perpetrators consistently repeat specific abusive acts, while others employ a wide variety of various assaults. The assaults are intended to keep victims compliant under the control of their abusers.

**Reluctant Health Care Professionals**

Because physicians are often the first nonfamily members to become aware of violence in the home, they have a responsibility to protect those incapable of protecting themselves from further injury. They also have an unsurpassed opportunity to provide appropriate, sensitive interventions. Why then have health care professionals failed in adequately responding to these victims’ needs? The biggest reasons are lack of domestic violence training and long-standing popular misconceptions with their resultant bias and prejudice.

There are many reasons why physicians may be reluctant to ask about problems at home. Some may have current or prior personal experience with domestic violence as observers, victims or even perpetrators. Others may be concerned about perceived increased demands on their already limited time allotted for patient visits. There is also the fear of becoming entangled in criminal investigations or prosecutions, viewing these as someone else’s responsibility. Instead, by virtue of their profession, they are uniquely situated to relieve the suffering of domestic violence victims. These patients commonly visit emergency departments for treatment of their injuries, but other physicians also frequently encounter the results of domestic violence.

Obstetricians and gynecologists have an excellent opportunity to help their abused patients. Prenatal patients report a 10% to 32% incidence of past domestic violence, and physical assaults during pregnancy jeopardize both mother and fetus. Abused women have higher rates of miscarriage, stillbirth, intrauterine trauma, premature

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Domestic Violence  
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labor, and low birth weight infants compared to those not experiencing abuse. 
Pediatricians often see children whom they suspect of being physically or sexually 
assaulted in addition to those brought by concerned parents or family. 
Psychiatrists and allied mental health workers see many anxious, depressed, 
substance abusing, suicidal patients. Orthopedists daily set fractures and treat 
other musculoskeletal complaints or injuries. Otolaryngologists treat facial fractures and 
dislocations, ear traumas, and temporomandibular joint syndromes. Dentists 
see broken teeth plus jaw and intraoral injuries. Ophthalmologists encounter trauma 
to the orbit or globe, including fractures, lacerations, hyphemas, and other retinal/ 
corneal/scleral injuries. Surgeons are called to attend patients with severe lacerations, 
stab wounds, gunshot wounds, and traumas, both blunt and sharp. All may be 
confronted by patients complaining of dyspareunia, chronic pelvic pain, vaginismus, 
headaches, chronic aches and pains, or functional disorders. Any of these common 
conditions can be the result of domestic violence, yet domestic violence victims’ present- 
ing complaints often are correctly diagnosed only when the abuse is obvious.

Learn to Ask and Help

This is no longer acceptable. Current clinical guidelines recommend that physicians routinely discuss domestic violence with all female patients. Such routine screening is justified and can be lifesaving. Routinely discussing these issues with all patients will decrease the physician’s perceptible discomfort or embarrassment. Clinicians should routinely inquire about domestic violence, understand its dynamics, famil- iarize themselves with services in their community available to victims of violence, and appropriately refer patients. They can also put their patients at ease by framing questions in language that tells victims they are not alone, no one deserves to be abused, their problem is taken seriously; and help is available.

When discussing domestic violence with patients, it is important to ask direct and specific questions such as the following.

• We now know domestic violence is a very common problem. About 20% of women in this country have been abused. Has that ever happened to you?

• Because violence against women is so common in today’s world, I now discuss domestic violence with every patient I see. Has anyone ever hurt you?

• Some patients are uncomfortable bringing up their abusive relationships or other problems at home, so I’ve started asking everyone about it. Has this ever been a problem for you?

• How did you get that bruise? Did someone hit you? Who? Was it your partner/husband?

• I’m concerned that your injuries may be from someone hitting you. Has someone been hurting you?

• Does your partner/husband ever try to control you by threatening harm to you, your children or family?

• Has your partner ever forced sex on you?

• Do you feel controlled or isolated by your partner?

• Do you ever fear your partner? Do you feel safe at home?

Routinely asking such questions will put both patients and physicians at ease. Abused patients may not respond the first, second, or even third time the subject is broached, but they will eventually realize their physician is sincerely interested in their welfare and wants to help, that she or he is not just nosy.

The Family Violence Prevention Fund founded the National Health Initiative on Domestic Violence, a project designed to train medical, paramedical, and nonmedical personnel to reliably recognize clinical signs of abuse in battered women and then intervene effectively. The Initiative is based on a successful project the Fund first developed in Arizona, California, and Pennsylvania hospitals, then expanded to Alabama, Florida, Nevada, New Hampshire, New Mexico, Texas, Washington, and West Virginia. Within each state, multidisciplinary teams from 15 hospitals and other healthcare organizations were trained in:

• routine screening techniques intended to identify battered patients;

• development and adoption of domestic violence response protocols;

• development of resource materials for patients and staff;

• effective strategies for expanding their institution’s response into a broader community response utilizing available resources;

• establishing continuing education programs on domestic violence for all their organization’s staff.

The Fund also has available on request guidelines and a pocket-sized reference card outlining how to help battered patients.

As a women’s advocate in rural West Virginia, I have become acutely aware of the importance of medical and paramedical personnel’s reaction and response to family violence victims. You may be their only chance for help, and that chance is severely compromised by a lack of awareness, training, and/or initiative. Are you prepared to be an advocate for your battered patients and help them end their misery, even remove a real threat to their and their children’s safety or lives?

For more information on the National Health Initiative on Domestic Violence or to obtain the materials mentioned above, contact:

Health Resource Center on Domestic Violence
1-888-RX-ABUSE (792-2873)
Weekdays 9:00 AM - 5:00 PM Pacific

Family Violence Prevention Fund
Suite 304
383 Rhode Island Street
San Francisco, California 94103-5133
Telephone: 415-252-8900
Fax: 415-252-8991
www.fvpf.org/fund/healthcare/emergency.htm

About the Author

Ms Queen is a talented West Virginia artisan who, along with her husband, handcrafts unique and beautiful kitchen utensils from native woods: maple, cherry, walnut, and hickory. But much of her time is spent in the frontline fight against spouse and child abuse. She has helped rescue untold numbers of women and children from all types of abuse, assisting them in putting their lives back together. Her voice has the ring of truth tempered by experience and she can tell stories that will bring tears to anyone’s eyes.

From The Medicolegal Ob/Gyn Newsletter, Vol.VIII, No. 2, 2000, published by The American Society of Forensic Obstetricians and Gynecologists, PO Box 536, Buckhannon, WV 26201-0536. •
Commentaries on Domestic Violence

Patients Are Waiting for Us to Ask

In the preceding article, Ms Queen has done an excellent job conveying the unacceptably high prevalence of a tragic social and medical problem. Yes, it is a medical problem. Our professional literature strongly supports the increased incidence of a gamut of gynecologic complaints, chronic pain syndromes, mental illnesses, drug treatment and usage, and higher medical costs in women previously as well as currently subjected to domestic violence, sexual abuse, and sexual assault. Its medical complications are seen more frequently than those of gestational diabetes, genetically abnormal pregnancies, neural tube defects, syphilis, or cervical cancer, yet most of us still do not routinely ask about domestic partner violence or sexual assaults as a child, adolescent, or adult.

Why do we avoid asking about these problems? Some of us plead a lack of available time in the physician-patient interaction. Nonmedical or paramedical office personnel have long obtained medical histories. Properly trained, caring, and sensitive office staff can also ask about violence and abuse. Others plead lack of knowledge or ability, but we are known to be quick learners, else we would never have finished medical school or residency. Many cry they are afraid of offending their patients with such personal questions, yet we routinely ask our patients the most personal of questions possible. Studies have shown that abused women are actually grateful when anyone offers concern for their safety and supportive assistance if they decide to leave an abusive relationship.

Another concern expressed is the fear of becoming involved in an already violent situation or future legal action requiring unpleasant court testimony, but legal expert Sherri Schornstein has advised that a well-documented medical record will benefit patients if they seek relief in the courts, at the same time lessening the chances of our being called as a witness. For those who wish more information, Schornstein has authored an excellent book entitled Domestic Violence and Health Care: What Every Health Professional Needs to Know, published by Sage Publications in 1997.

Would you ever consider prescribing oral contraceptives without questioning your patient regarding her previous history of deep vein thrombophlebitis, smoking, and hypertension? Would you even consider following a prenatal patient without question-
Gov Hunt Appoints Aloysius P. Walsh, of Greensboro, to the North Carolina Medical Board

Andrew W. Watry, executive director of the North Carolina Medical Board, has announced that Governor James B. Hunt, Jr, has appointed Mr Aloysius P. Walsh, of Greensboro, as a public member of the North Carolina Medical Board. Mr Walsh is to complete an unexpired term that ends October 31, 2000, and will be eligible for reappointment at that time.

Mr Walsh is a graduate of the University of Scranton and was a non-degree student at the Temple University School of Law. He pursued studies in business management at Mercer University and North Carolina State University. He is currently a consultant for the Medical Management Institute. Mr Walsh and his wife moved to Greensboro in 1975 and are active members of their church and community.

For over 30 years, Mr Walsh worked in various capacities for the Prudential Insurance Company, focusing for much of that time on the Medicare program in several states, including New Jersey, Georgia, and North Carolina. During his time with Prudential Medicare, he was responsible for professional relations with the North Carolina Medical Society; and when Prudential left the Medicare program, he was commended by the Society for his efforts in developing effective interaction between the two organizations. He also worked closely with the North Carolina Society of Medical Assistants and holds an honorary membership in that group. From 1988 to 1990, he was Medicare consultant to EQUICOR (CIGNA).

In his current position, he conducts Medicare and related seminars nationwide.

NCMB Retitles and Revises Position Statement:
“Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist”

At its regular meeting in May 2000, the North Carolina Medical Board considered and formally adopted a revised version of its position statement titled Treatment of and Prescribing for Family Members. To reflect the statement’s enhanced coverage, the title was changed to Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist. The revised position statement appears below. It was posted on the NCMB’s Web site on May 27, 2000.

Self-Treatment and Treatment of Family Members and Others With Whom Significant Emotional Relationships Exist

- It is the position of the North Carolina Medical Board that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. The Board strongly believes that such treatment and prescribing practices are inappropriate and may result in less than optimal care being provided. A variety of factors, including personal feelings and attitudes that will inevitably color judgment, will compromise the objectivity of the physician and make the delivery of sound medical care problematic in such situations, while real patient autonomy and informed consent may be sacrificed.
- When a minor illness or emergency requires self-treatment or treatment of a family member or other person with whom the physician has a significant emotional relationship, the physician must prepare and keep a proper written record of that treatment, including but not limited to prescriptions written for controlled substances and the medical indications for them. Record keeping is too frequently neglected when physicians manage such cases.
- The Board expects physicians to delegate the medical and surgical care of themselves, their families, and those with whom they have significant emotional relationships to one or more of their colleagues in order to ensure appropriate and objective care is provided and to avoid misunderstandings related to their prescribing practices.

(Adopted May 1991)
(Amended May 1996; May 2000)
Continuing Medical Education Requirements in North Carolina
Andrew W. Watry
Executive Director, NCMB

By the time you read this, a continuing medical education (CME) rule for physician licensees of the North Carolina Medical Board will be in effect. We have tried to facilitate implementation and assist our licensees to prepare for this rule for several years now. The rule is the result of a legislative mandate (NCGS 90-14 (a)(15)). As the rule migrated through the public comment process, the Board mailed it to all licensees, held public hearings, and published the proposed text in the Forum.

The final stage of the rule making process, as required by law, was to wait through a 30 day period beginning with the opening of the current session of the North Carolina General Assembly. That period is now over and we are printing the final rule next to this article.

All licensees will need to obtain and document for their files the required CME starting with their birthdays on or after January 1, 2001. Licensees will report approved CME each year on their annual license registration forms, but will have three (3) years to meet the requirement. Thus, the first group that will be required to have at least the 150 hour total (as defined in the rule) will be those with January birthdays who register in 2004, and all other licensees will have to meet that requirement by the month in which they register.

The vast majority of physicians are getting CME without any requirement to do so. As a rehearsal for next year, I would suggest that each licensee set up his or her own system now for demonstrating compliance. This should be easier than waiting until the last minute. That is why we have been asking for CME reports on annual registration forms even though there has not been a CME requirement in place. If licensees start thinking now about CME reporting in the context of their annual license registration, it should make transition a little easier. Those who hold licenses in other states requiring CME can get a jump on melding our requirement into documentation requirements for those other states.

Helpful Hints
We know from questions we get that the Board’s new CME requirement, like any new requirement of the kind, can cause some confusion. Our first choice was to make it a simple annual requirement rather than a triennial requirement – this would have made it easier to keep up with. In fact, the concept of an annual requirement was one of the items in the Board’s first proposal, but it didn’t survive the process of rule making, in part because of the language of the legislation.

As finally approved, the rule roughly parallels the American Medical Association’s Physician Recognition Award (PRA), which has a 3 year cycle. Thus, this element of the rule has the benefit of providing the same cycle as that used by those licensees keeping current on the PRA. However, because of the need to report during the licensee’s birth month as part of North Carolina’s annual registration process, our system is a bit more complicated. It may be better to give examples to demonstrate some of the permutations. Here are some cases I hope will clarify the process for those who have questions about how the system will work as reporting begins. (Each example assumes the hours mentioned represent relevant CME and that the 150 hour minimum includes the required level of provider-initiated CME, as noted in the rule.)

• Physician A: Licensed in NC during 2000 or before, birthday in January.
  Doesn’t need to have the 150 hours meeting the requirement until January registration, 2004. Reports 0 hours in January 2001 (didn’t have to start counting yet). Has several options. Can get 150 hours in March 2001, report 150 hours on next registration in January, 2002, report 0 hours in January 2003 and 2004 respectively. That will meet the CME requirement as of 2004. Then, the licensee starts over, counting for the 150 hour total that will be needed by 2007. Optionally, the licensee can get 150 hours in November 2003, reporting 0 in January 2002 and January 2003, and reporting 150 in January 2004. Finally, the licensee can break it up, reporting combinations such as 50 hours of approved CME January 2002, January 2003, and January 2004. In any case, the licensee starts with a clean slate in January 2004, as the cycle starts over.

• Physician B: Licensed in February 2001, birthday in January.
  Doesn’t have to start counting and reporting toward the 150 hours until January registration, 2002. Doesn’t have to have all 150 hours until January 2005.

• Physician C: Licensed in October 2002, birthday in November.
  Only gets one free month. Receives a registration form in November 2002. Has to start counting and documenting CME in November 2002, has to have 150 hours by November 2005.

• Physician D: February birthday, gets 150 hours of CME between February 1, 2001, and February 1, 2002.
  Meets the requirement early. Reports the 150 hours on February 2002 registration, doesn’t need to report any CME in February 2003 or 2004. However, licensee is diligent about CME and gets and reports 150 hours in 2003 and 2004 respectively. Easily meets the requirement for 150 hours for registration in 2004: had to get 150 hours but reports 450 hours cumulatively over 3 years since his registration in February 2001. However, doesn’t get to bank and report excess hours for next cycle. Has to start with a clean slate with registration in 2004 and accumulate 150 new approved hours before February 2007.

• Physician E: February birthday, gets only 50 hours, receives excess, cannot document.
  Case doesn’t work. Has to get 150 hours at one time. Has no excess for next cycle. Has to start with a clean slate with registration in 2004.

• Physician F: In California, keeps license active, doesn’t have to start counting for any renewal.
  Location doesn’t matter, has to meet requirement. However, if licensee applies for or allows license to go inactive for failure to register, does not have to comply until license is reactivated.

• Physician G: Can only document 50 hours at a time, has to accumulate 150.
  Following full due process, including notice and hearing, has exposure to public disciplinary order. Though it may not seem as serious as some other disciplinary matters, it may or may not be considered by another state as a bar to licensure, may or may not affect hospital privileges or eligibility for reimbursement by Medicare or Medicaid. Whatever the case, not worth it to licensee. Compliance a much better option.

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CME Requirements in NC

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• Physician H: Has specialty board certification with a board that has CME requirements that meet or exceed the requirements of the NCMB; specialty board documentation

No problem, so long as licensee complies with the rule, including a) reporting approved CME hours that meet the NCMB’s requirements at annual registration, and b), if he is one of those randomly selected for inspection for CME compliance, the specialty board’s documentation meets the NCMB’s requirements.

The CME rule may be found on our Web site, both in the Rules heading and under a special CME heading. Please e-mail us at info@ncmedboard.org if you have a question not answered here.

CME RULE

TITLE 21 CHAPTER 32
NORTH CAROLINA MEDICAL BOARD
SUBCHAPTER 32R - CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

.0101 CONTINUING MEDICAL EDUCATION (CME) REQUIRED
(a) CME is defined as knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of healthcare to the public. CME should maintain, develop, or improve the physician’s knowledge, skills, professional performance and relationships which physicians use to provide services for their patients, their practice, the public, or the profession.
(b) Each person licensed to practice medicine in the State of North Carolina shall complete no less than 150 hours of practice relevant CME every three years in order to enhance current medical competence, performance or patient care outcome. At least 60 hours shall be in the educational provider-initiated category as defined in Rule .0102 of this Subchapter. The remaining hours, if any, shall be in the physician-initiated category as defined in Rule .0102 of this Subchapter.
(c) The three year period described in paragraph (b) above shall run from the physician’s birthday beginning in the year 2001 or the first birthday following initial licensure.

.0102 APPROVED CATEGORIES OF CME

The following are the approved categories of CME.
(1) Educational Provider-Initiated CME: All education offered by institutions or organizations accredited by the Accreditation Council on Continuing Medical Education (ACCME) and reciprocating organizations or the American Osteopathic Association (AOA).
   (a) Formal courses
   (b) Scientific/clinical presentations, or publications
   (c) Enduring Material (Audio-Video)
   (d) Skill development
(2) Physician-Initiated CME:
   (a) Practice based self-study
   (b) Colleague Consultations
   (c) Office based outcomes research
   (d) Study initiated by patient inquiries
   (e) Study of community health problems
   (f) Successful Specialty Board Exam for certification or recertification
   (g) Teaching (professional, patient/public health)
   (h) Mentoring
   (i) Morbidity and Mortality (M&M) conference
   (j) Journal clubs
   (k) Creation of generic patient care pathways and guidelines
   (l) Competency Assessment

.0103 EXCEPTIONS
A licensee currently enrolled in an AOA or Graduate Medical Education (ACGME) accredited graduate medical education program is exempt from the requirements of Rule .0101 of this Section.

.0104 REPORTING
At the time of annual registration immediately following the CME reporting period, each Licensee shall report on the Board’s annual registration form the number of hours of practice-relevant CME obtained in compliance with section .0101 of this Subchapter. Records documenting CME hours must be documented by categories for six consecutive years and may be inspected by the Board or its agents.

Reminder Notice: Registration and Inactive Status

Beginning on January 1, 1998, annual date-of-birth registration was implemented. All physicians are to register their medical licenses each year within 30 days of their birthdays. (Should a physician register more than 30 days after his or her birthday, a late fee of $20 is required in addition to the $100 registration fee.)

Registration Procedure
The Board sends a registration form by first class mail to registered physicians approximately one month before their birthdays. (If physicians have an address change at any time after their last registration, they should notify the Board of the change promptly to assure they receive proper registration notification and other Board information.) Should any physicians not receive such a mailing, they must contact the Board within a day or two of their birthdays and request a registration form. Physicians who complete the registration form and send it and the required $100 fee to the Board receive a new annual registration certificate.

The Board sends a notice of failure to regist-
ter to any physician who is 30 days delinquent in registering his or her license. (Notices are sent to the physician's last known address.) If there is no response from the physician within 30 days, the license automatically becomes inactive. No other notices are sent.

Inactive by Choice
Physicians that practice in another state or retire from active practice and do not plan to practice in North Carolina in the foreseeable future may request inactive status on the registration form or simply not return the form. In either case, their licenses will be made inactive and they will no longer be permitted to practice in North Carolina. While inactive, they do not need to register, pay the annual fee, or meet the continuing medical education (CME) requirement. However, they should maintain the appropriate level of CME if they intend to reactivate their North Carolina licenses at some future date. (Those physicians considering retirement and an inactive license should understand that they will not be permitted to write prescriptions for anyone, including family members or friends, or otherwise practice medicine in any form in North Carolina.)

Inactive Through Neglect
Those physicians who neglect to register their licenses annually should be aware that a physician may not practice medicine in North Carolina while his or her license is inactive. Doing so will open the physician to charges of practicing medicine without a license. Additionally, a physician practicing while his or her license is inactive will have no legal claim to payment for any services rendered that require a medical license, including Medicare, Medicaid, and other health insurance payments. Practicing with an inactive license will also jeopardize liability coverage and hospital privileges.

Reactivation/Reinstatement
If not more than a year has passed since his or her license became inactive, a physician may seek to reactivate the license by completing and submitting a reactivation form, being interviewed by a committee of the Board, and paying a fee, which is currently $120.

If the physician decides to seek reinstatement of the license after more than a year has passed, he or she must complete and submit a reinstatement form, have a personal interview with a committee of the Board, verify licenses held in other states, provide letters of reference, and meet other requirements for licensure in place at that time. The current fee for reinstatement is $250.

The North Carolina Medical Board trusts this information will help licensees avoid the serious consequences that can result from the failure to register each year. Inactive status can be useful for many out of state and retired physicians, but it can mean serious problems for the practicing North Carolina physician.
Medical Boards Get a New National Voice: 
Dynamic Dr George Barrett Will Oversee the Regulation of About 700,000 Doctors

Karen Garloch
The Charlotte Observer

As a teen-ager, George Barrett ate dinner each evening with a group of teachers who lived at his mother’s boardinghouse in Roxboro. He always tried to find a seat at the large table for eight, where the liveliest discussions took place.

“I was permitted to argue with them,” the Charlotte physician recalled. “That’s how I learned that conversation at the table was fun.”

Later, as a radiologist at Presbyterian Hospital, Barrett became well-known for gathering interesting people around the dining table in his home, for dinner at the City Club or for informal lunches. Often, his goal was to talk about some idea that he thought had merit—controlling health-care costs, improving end-of-life care, applying ethics to managed care.

“He’s like the conductor at this symphony,” said Rosemarie Tong, a medical ethicist at UNC Charlotte. “He makes sure that the people are more than likely going to disagree. And always towards the end, he’s trying to get the harmony going. And then he assigns tasks. You’re going to have to get something done. And it’s going to be something for the benefit of a whole lot of people.”

“More good work gets done at his lunches and dinner parties than at other meetings in the community,” said George Stiles, a Charlotte-based health-care consultant who worked with Barrett in the 1980s. “He really is one of the community’s most important behind-the-scenes operators.”

This year, Barrett, 73 and retired after more than 30 years of medical practice, is taking a front seat, before one of the largest and most influential groups yet.

He is the new president of the Federation of State Medical Boards of the United States, an organization that advises and serves 68 boards that license and regulate about 700,000 doctors.

Ideas That Stand Out
As always, he’s pushing ideas that haven’t yet been accepted by many of his peers.

He believes doctors should volunteer for periodic assessments instead of passing the licensing exam once and never again having to prove their competency.

He believes state medical boards should make it easier for doctors to become licensed in multiple states and then should share information more readily so they can track doctors who move around to avoid accountability.

Many doctors oppose making malpractice data readily available, suggesting that patients won’t understand.

“I feel the public is capable of understanding when the information is properly presented,” Barrett said in a recent interview.

That includes more than a list of lawsuits and monetary awards. It should be explained that “bad things happen to good doctors. And bad things happen to good patients. And it isn’t necessarily a reflection of bad practice if a physician is successfully sued.”

Barrett enjoys the challenge of persuading people to his point of view. But he knows these ideas may take some time.

“My fantasy is, and I’m sure I’ll be dead before it happens, that we will have the profession coming forward saying ‘We believe it is important for physicians to be evaluated over the life of their practice,’” he said.

“Then we will have met our full responsibility to the public.”

His ‘Home Away from Home’
George Carlyle Barrett was named for his father, a farmer who died before his only child was born in 1927.

Left alone with a son to raise, Barrett’s mother moved into Roxboro, north of Durham, where she built a house with eight bedrooms and opened Miss Molly’s, “a home for guests away from home.”

“She would never let it be called a boarding-house,” Barrett said, because boarding-houses had bad reputations.

During meals with boarders, Barrett learned to consider ideas different from his own.

At one, a Presbyterian minister questioned the accuracy of the motto—“the church of a warm heart”—used by Roxboro Baptist Church, which Barrett attended.

“He said ‘You think you’re the only church that has a warm heart? You don’t know the difference between ‘the’ and ‘a,’’” Barrett said.

“He taught me the significance of one word.”

Barrett honed his debating skills under “Miss Mildred” Nichols, his high school English teacher and debate team coach. She taught her students never to speak with a Southern drawl, and to this day, Barrett’s deep, commanding voice would never be identified as the product of small-town North Carolina.

Barrett planned to become a college biology professor. But during one vacation from Wake Forest University, he talked with a teacher who had lived at Miss Molly’s. He recalls that she said, “Oh George, you would have made such a good doctor.”

He began to think about the doctors in Roxboro. “They were highly respected and

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they seemed happy.” He decided to attend medical school at Bowman Gray in Winston-Salem.

There, he was impressed by professors who “still had something of (Sir William) Osler’s concern for communication and compassion.” One of Barrett’s favorites, Dr Ernie Yount, taught him to read at least one medical journal article a day. “He said ‘if you’re going to be a doctor, you’ve got to be a student all of your professional life,’” Barrett recalled.

After graduation in 1952, Barrett married, served a medical internship and spent two years in the Air Force. He returned to North Carolina as a general practitioner in Baden. But after a year, he wanted a change. “Not because I didn’t enjoy the people. But all of the, quote, interesting cases, I had to send away.”

He returned to Bowman Gray, specializing in radiology because “it cut across all of the specialties.” In 1966, he went to work at Presbyterian, where he interpreted X-rays as well as ultrasound – until he retired in 1998.

Treatment and Ethics

In the late 1970s, Barrett heard about a plan that started him on the road to activism.

Presbyterian had bought its first linear accelerator for treating cancer with radiation. Charlotte Memorial Hospital (now Carolinas Medical Center) wanted to buy one too. Barrett spoke against Memorial’s request at a public hearing, suggesting that the hospitals share a machine. Memorial won on appeal, and Barrett has never been able to convince the hospitals to cooperate as he thinks they should.

“That was my biggest and, in many respects, most traumatic learning experience,” he said. “I have learned that if I have an idea, it doesn’t work for me to get in front but rather to be sure that I am just behind the people who should be just in front.”

In 1982, the man in front was Dr John Foust.

Foust was president of the Mecklenburg County Medical Society when the organization received a $1.2 million grant to develop a program to control health-care costs. He went to Barrett, his friend and colleague, for advice on getting broad-based support.

“George is a clear thinker. He thinks problems through and comes up with very logical solutions,” said Foust, who today serves on the NC Medical Board with Barrett. “I don’t think we would have ever gotten that grant if it hadn’t been for George’s help. He went around and talked to several of the big rollers and wheelers and dealers. He had more clout there than I did.”

The resulting Council on Health Costs came up with treatment guidelines for delivering cost-effective care. The council disbanded in 1993, but it was credited with keeping the Charlotte region’s health-care costs below those of other major cities.

Barrett was also instrumental in the 1985 creation of the Bioethics Resource Group, an organization that encourages public discussion of medical ethics. The presence of the BRG led area hospitals to form their own ethics committees and to adopt uniform guidelines on do-not-resuscitate orders for the terminally ill.

Other communities have copied the BRG idea, but Barrett realized before many people that medical ethics would become important.

“George is an omnivorous reader. He’s always ahead of the curve,” said Tong, UNCC’s first Mecklenburg County Medical Society distinguished professor of healthcare ethics, a position for which Barrett helped raise money.

A Tired Persuader

In recent years, as managed care frustrated doctors and patients, Barrett worried about the state of medicine. Scott Lindsay, Presbyterian’s chaplain and a longtime friend, said he and Barrett spent many hours talking, “wringing our hands over managed care, that the patient was the one who was suffering most.”

That was the beginning of another Barrett project – a subcommittee of the NC Medical Society to develop ethical guidelines for delivering managed care. Barrett chaired the group, which recently published a booklet listing expectations and responsibilities for patients, employers, doctors and managed-care organizations.

Both Tong and Lindsay, who served on the subcommittee, said Barrett was unrelenting.

They would ride to Raleigh in a van and return home after long days of writing and revising. “The rest of us would just want to take a nap,” Lindsay said. “But Barrett would be in the back of the van with his briefcase, dishing out assignments.”

Andrew Watry, executive director of the NC Medical Board, where Barrett is serving a three-year term, thinks Barrett is right for the Federation job.

“It’s like herding cats to get state boards together on something,” Watry said. “George brings divergent views together at a table. He has the power of persuasion. He calls, he connects with folks, asks them what they think, rather than just steam-rolling.”

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Dr George Carlyle Barrett

Born: January 11, 1927, Roxboro.

Education and career: Bowman Gray School of Medicine, 1952; internships, Buffalo General Hospital and Duke University; fellowship, Bowman Gray; Radiology Group, Presbyterian Hospital, 1966 to 1998.

Professional service: President, Federation of State Medical Boards of the United States; member and past president, NC Medical Board; past president, Mecklenburg County Medical Society; former chairman, NC Medical Society’s Bioethics Committee, Bioethics Subcommittee on Managed Care, and Task Force on Death and Dying.

Awards: 1999 Distinguished Service Award from UNC Charlotte, leadership in medical ethics.


Pets: Dallas, a Dalmatian.


Memorable vacation: On a biking trip through Provence, Barrett, then 52, and another man in his 30s were the only two who reached the top of a hill without pushing their bikes.

Recent books read: The Last Apocalypse: Europe at the Year 1000AD, by James Reston Jr.; How the Irish Saved Civilization and The Gifts of the Jews, by Thomas Cahill; The Spirit Catches You and You Fall Down, by Anne Fadiman; In the Arms of Others: A Cultural History of the Right-to-Die in America, by Peter G. Flene; Blind Eye: How the Medical Establishment Let a Doctor Get Away With Murder, by James B. Stewart.

Religion: Myers Park Baptist Church; Committee to Arrange Jesus 2000 Seminar.

Quote: “I’m fully persuaded that life is now. Some years ago, I started wondering to myself why the Baptists put all the emphasis on being saved. Saved from what? It seems to me you should work in this life not to go to heaven, but to see what you can do for your community and for others.”

Reprinted with permission from The Charlotte Observer of May 15, 2000.
A Personal View

HMOs: Have We Painted Ourselves into a Corner?
Walter M. Roufail, MD
Former Member and President, NCMB

The alleged good old days of American medicine span roughly the era between the end of the Second World War and the late 1960s. If my calculations are right, most physicians who experienced that era are 55 years or older. If one considers a transitional period of 10 to 15 years, those who were in their early forties may have wondered about their future, but did not heed the darkening clouds.

The Golden Age
The connotation of the “Golden Age” is financial success. I beg to differ. I believe those were the days of fulfillment for practitioners, fulfillment of their “Call” and of their personal ego (and there is nothing wrong with that). Those were the times of contracts with your patients foremost and, by extension, your community. Patients were your extended family. Nurses in your office knew them by their first names, were familiar with their families and their circumstances, as well as their mode of payment (or non-payment). You often went fishing or hunting with some of them and often were invited to their tables. Most physicians, both “town and gown,” attended the local medical society meetings to socialize and hear about the burgeoning medical technologies. Referral of patients to academic medical centers was often made to take advantage of such technologies. Although “town and gown” relations were far from perfect, they were civil and often cordial.

Those were also the times of liquid antacids, three or four antibiotics, thyroid extract USP, regular insulin, reserpine, digitals, and quinidine. On inpatient rounds, after long days in the office, and often on Saturday and Sunday mornings, one glanced at rows of patients clapsed to a pale yellow fluid that sustained them to their spontaneous recovery or their ultimate demise. Sitting on the bedside, one often heard “I ain” or “Mama” is “ready to go,” and you were expected to be present at the time they went. Those were also the times of 12 to 15 hour workdays, burned dinners, telephone numbers left with hospital operators, casual acquaintance with your children, Ozzie and Harriet, and Marcus Welby, MD.

Changes in Medicine
There are times in history during which seemingly unrelated events occur simultaneously, converging to dislocate the accepted norms of society and frequently to transform society itself. Some historians are fond of tracing those changes to a single event, which anchors those ostensibly disparate happenings. I propose that such a moment in time in the medical history of the United States was the assassination of a young President. It led (possibly unintentionally) to the Great Society and that program’s crown jewels, Medicare and Medicaid. We were soon exposed to more assassinations, a divisive war, riots in Chicago, shootings in Ohio, Woodstock, Flower Children, communes, and the rise and entrenchment of free love and the drug culture.

Medicine was going through subtler and less dramatic changes. I remember facing the director of my residency program in the very early ‘sixties. Prominent on his desk was a cardboard model of a double spiral, bound by parallel pieces of colored paper. On inquiry, he stated: “My young friend, this will make everything we teach you in this institution somewhat irrelevant a few years from now.”

This will make everything we teach you in this institution somewhat irrelevant a few years from now.”

“The old view of seeking medical expertise when you were ill is being gradually replaced by what is being referred to as “managed care.” That, I am told by very learned sources, is the wave of the future. Apparently, what we have been doing up until now, under the guise of managing care, is, in fact, managing costs.”

Managed Care
The old view of seeking medical expertise when you were ill is being gradually replaced by what is being referred to as “managed care.” That, I am told by very learned sources, is the wave of the future. Apparently, what we have been doing up until now, under the guise of managing care, is, in fact, managing costs. Successful managed care organizations have wrung the turnip dry. Costs are at their bottom without jeopardizing the health of “covered lives.” Costs will unavoidably rise, doubling in the next decade as reported by reliable government sources. If indeed costs will augment, competition will be on the expanded services provided to the consumer. Future insurance companies will have to provide security from cradle to grave, not only in health, but also those newly acquired powers. While able to visualize and understand more about the common and uncommon diseases of the human lot, our individual capabilities of logic and deduction were gradually eroded. Our baggage of knowledge and experience was seemingly more and more irrelevant.

The Orwellian view of the present state of medicine is one of computer models determining clinical outcomes, reducing practitioners to inputting data. The most vivid example of “computer power” is its use in the transmission of medical knowledge to the undergraduate, graduate, and lifelong students of medicine. As a teacher, I am personally involved in this endeavor and find it quite efficient. I cannot help but notice, however, that students prefer small group encounters in which a teacher uses chalk and blackboard and shuns slides and clicking. The obvious question is, what do we want to transmit? If it is to convey science, computer’s are the most efficient means of doing so. However, if we do believe that the profession of medicine transcends science, then we must acknowledge that the present Osler’s of this world cannot be relegated to the archaeological archives.

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in life, transportation, liability, disasters, and walking across the street. This does not come cheap. Employers, who have traditionally in the past half century provided some if not most of those benefits, will try to limit them. Health coverage may be one of the many options in the package.

Historically, young employees often opt for professional football, NASCAR, or Grateful Dead tickets rather than invest in the potentiality of their own mortality. Employees who have encountered the unpleasant brush with chronic or potentially terminal illnesses will choose health care benefits as their favorite option. This flies against the basic premise of insurance, which is to spread the risk among healthy and ill. To accommodate the losses inherent in “adverse selection,” health insurance companies usually increase their premiums, diversify, or consolidate into national megainstitutions. Two or three of these conglomerates may eventually control the whole private delivery of health care in this country. This does not bode well for either consumer or provider, and the backlash is already evident. The contention of the consumer is that, presently, HMOs do not provide choice, provider, and the backlash is already evident. The contention of the consumer is that, presently, HMOs do not provide choice, unlimited coverage, or expand the deep pockets of future litigations. Employers realize that this proposes the return of the double-digit inflation of the ‘seventies and ‘eighties. They may eventually offer only catastrophic coverage or none at all.

Physicians demand more autonomy, what they perceive as fair compensation, and continuity of care for their patients. Although all those wish lists are quite laudable, they realize that this proposes the return of the double-digit inflation of the ‘seventies and ‘eighties. They may eventually offer only catastrophic coverage or none at all.

The contention of the consumer is that, presently, HMOs do not provide choice, unlimited coverage, or expand the deep pockets of future litigations. Employers realize that this proposes the return of the double-digit inflation of the ‘seventies and ‘eighties. They may eventually offer only catastrophic coverage or none at all. Physicians demand more autonomy, what they perceive as fair compensation, and continuity of care for their patients. Although all those wish lists are quite laudable, they realize that this proposes the return of the double-digit inflation of the ‘seventies and ‘eighties. They may eventually offer only catastrophic coverage or none at all. Physicians demand more autonomy, what they perceive as fair compensation, and continuity of care for their patients. Although all those wish lists are quite laudable, they

Where to Now?

Historically, developed countries have offered a variation of the same basic model for the delivery of health care: universal coverage and centralized (usually government) control. In the Soviet dominated countries prior to the dissolution of that empire, the health appropriations were part of the non-essential budget. The state was the sole purveyor of health care. Physicians, the state’s employees, were compensated less than meagerly. The services available were what a non-essential budget could provide. The citizenry accepted the fact that was the best medicine could offer. Other socialized Western countries offered more services, less rationing, and compensated their physicians more realistically. The less populated and the more homogeneous societies did well under that system. Others, due to the unavoidable strains on their budgets, have instituted more control, fewer services, or limited privatization.

At the end of this century, the United States remains the last bastion where a slim majority of health coverage still remains in the private sector. The state, through Medicare and Medicaid, is expanding its role by including more citizens under its umbrella. To remain within its balanced budget, it is wringing a dry turnip drier, while, paradoxically, mandating more and more services to all health insurers. Forty-five million of our citizens are uninsured. The balance of our population depends on employers for health benefits. Employers depend on HMOs to provide their employees with expanding quality health benefits at shrinking costs. Physicians and other health care providers are expected, often required, to provide those services (often under threat of litigation) under a system of increasing controls and diminished financial resources. Nobody appears to be satisfied by the present system and the apparent solution is for the federal Congress to pass a Bill of Patient Rights, which will, if anything, make the situation worse.

So here we are, in the very last moments of the millennium, taking our test on the future of our profession. Which of the following do you think is the most plausible course in the next decade? (You may choose more than one.)

1. The dismantling of HMOs and the return of fee for service and indemnity insurance.
2. The present system (or non-system), a mixture of public and private coverage, where multiple national and local managed care organizations compete for contracts of “covered lives” from employers and government.
3. The emergence of two or three national megacompanies that will control the delivery of health care in the private sector.
4. The gradual expansion of the public sector to include children, uninsured, and early retirees.
5. Employers moving to gradually discontinue health coverage as one of the options of their benefit packages, raising wages to allow employees to choose their individual health insurance.
6. National health insurance, Washington, DC, being the single payer.

Have we painted ourselves into a corner?

Living Will: We Forgot to Teach You About Death

Walter J. Pories, MD
Secretary/Treasurer, NCMB

Each year, the graduating class of the East Carolina University School of Medicine invites members of the faculty to present “Pearls,” a session in which these teachers are allowed three minutes to offer their final advice. Living Will was presented by Dr. Pories on April 14, 2000.

Please stay another three minutes. We forgot to teach you about death.

Oh, I know that we spent months teaching you about birthing, but it is so easy to forget about dying. After all, you just write “do not resuscitate,” and after that, it’s easy. Someone will pull down the shades, turn out the light, and close the door. The trays will be brought in and taken away untouched. And within a matter of days, even the visits stop. It usually doesn’t take long until a nameless attendant secretly takes the wrapped body to a hidden place.

That’s why we didn’t teach it. Death is easy. We don’t even test you about death. It’s just one of those secrets we don’t talk about.

But when I die, don’t exile me to the elephant’s hidden burial ground. Don’t sentence me to the dark.

No, I want the softness of the sun to light my bed; I want the touch of those I love to comfort me.

Even though I am dying, or perhaps because I am dying, I want to laugh and I want to cry. I want permission to be angry and to repair the many wrongs I have done to others. I want to die; death is not a failure. Death is not a defeat; death is not a failure.

Assist my family and ask how you can be of help. Don’t let them grieve too long. Rather,

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Living Will

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remember me with stories, with laughter, and with love.

Then go to your next patient, assured that you have given me the care and affection at the end of my existence that I enjoyed when I came into the world.

Good luck to all of you. ♦

AUDIO TAPE AVAILABLE

Order Directly from the North Carolina Medical Board

End-of-Life Decisions Forum

[4 hours; 1998]

Transcription of a conference developed by the staffs of the North Carolina Medical Board, the North Carolina Board of Nursing, and the North Carolina Board of Pharmacy. Held in Raleigh on October 23, 1998, the conference provided a forum for health care regulators, professionals, and policy makers to explore the ethical, legal, and other issues surrounding end-of-life decisions. Presenters included Lawrence O. Gostin, JD, LL.D (Hon.), Co-Director of the Johns Hopkins University and Georgetown University Program on Law and Public Health; George C. Barrett, MD, Vice President of the Federation of State Medical Boards and past president of the NCMB; Anne Dellinger, JD, Prof of Social Medicine at UNC; and eight other distinguished speakers. Question and answer periods and reports of small-group discussions were included. On two 120-minute audio cassettes. Available from the NCMB; (shipping outside the U.S.) charge. (Inquire for costs if requesting multiple copies.) $10.00 (which includes mailing charge.) (Inquire for costs if requesting shipping outside the U.S.) ♦

NCMB Physician Assistant Advisory Council

The North Carolina Medical Board’s Physician Assistant Advisory Council (PAAC) advises and communicates with the Board on issues affecting PA practice and regulation in the state. The PAAC does not have authority to license or discipline PAs, but it provides valuable insights to the Board’s PA Committee and to the full Board.

The members of the PAAC are nominated by the PA Committee and appointed by vote of the full Board for terms of two years. They may be reappointed by Board action. The PAAC’s members represent the leadership of the North Carolina Academy of Physician Assistants, the PA Section of the North Carolina Medical Society, and each PA training program in North Carolina. They also include other PA and physician members chosen for their particular expertise on issues facing the Board.

North Carolina Medical Board

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NOTICE: Proposed Rules for Clinical Pharmacist Practitioner

During the 1999 legislative session, the General Assembly passed a bill requiring the North Carolina Medical Board and the North Carolina Board of Pharmacy to form a Joint Committee that would develop rules for the clinical pharmacist practitioner.

The proposed rules presented below were prepared by the Joint Committee pursuant to the action of the General Assembly and were approved by both boards. The date proposed for the public hearing on these rules is September 19, 2000. The hearing will be held at 3:00 p.m. at the offices of the North Carolina Medical Board, 1201 Front Street, Suite 100, Raleigh, NC 27609. Please telephone (919) 326-1100 to verify the date and time. The date and time may also be verified by checking the Board’s Web site at www.ncmedboard.org.

Public comments may be submitted by e-mail (diane.meelheim@ncmedboard.org) or by post (Rules Coordinator – CPP, North Carolina Medical Board, PO Box 20007, Raleigh, NC 27619).

NC ADMINISTRATIVE CODE,
Title 21, 32T:
Occupational Licensing Boards

.0101 CLINICAL PHARMACIST PRACTITIONER
(1) Definitions:
(a) ‘Medical Board’ means the North Carolina Medical Board.
(b) ‘Pharmacy Board’ means the North Carolina Board of Pharmacy.
(c) ‘Joint Subcommittee’ means the subcommittee composed of four members of the Pharmacy Board and four members of the Medical Board to whom responsibility is given by G.S. 90-6(c) to develop rules to govern the provision of drug therapy management by the Clinical Pharmacist Practitioner in North Carolina.
(d) ‘Clinical Pharmacist Practitioner or CPP’ means a licensed pharmacist in good standing who is approved to provide drug therapy management under the direction of, or under the supervision of a licensed physician who has provided written instructions for a patient and disease specific drug therapy which may include ordering, changing, substituting therapies or ordering tests. Only a pharmacist approved by the Pharmacy Board and the Medical Board may legally identify oneself as a CPP.
(e) ‘Supervising Physician’ means a licensed physician who, by signing the CPP agreement, is held accountable for the on-going supervision and evaluation of the drug therapy management performed by the CPP as defined in the physician, patient, pharmacist and disease specific written agreement. Only a physician approved by the Medical Board may legally identify himself or herself as a supervising physician.
(f) ‘Approval’ means authorization by the Medical Board and the Pharmacy Board for a pharmacist to practice as a CPP in accordance with this Rule.
(g) ‘Drug therapy management’ means the implementation of a predetermined drug therapy which shall include:
(i) diagnosis and product selection by the patient’s physician;
(ii) allowances for modification of prescribed drug dosages, dosage forms, dosage schedules, and tests which may be ordered; and
(iii) shall be pursuant to an agreement on a standard form approved by the Boards that is physician, pharmacist, patient and disease specific.
(h) Continuing Education or CE is defined as courses or materials which have been approved for credit by the American Council on Pharmaceutical Education.
(2) CPP application for approval.
(a) The requirements for application for CPP approval include that the pharmacist:
(i) has an unrestricted and current license to practice as a pharmacist in North Carolina,
(ii) meets one of the following qualifications:
(A) has earned Certification from the Board of Pharmaceutical Specialties, is a Certified Geriatric Practitioner, or has completed an American Society of Health System Pharmacists (ASHP) accredited residency program, which includes two years of clinical experience approved by the Boards,
(B) has successfully completed the course of study and holds the academic degree of Doctor of Pharmacy and has three years of clinical experience approved by the Boards and has completed a North Carolina Center for Pharmaceutical Care (NCCPC) or American Council on Pharmaceutical Education (ACPE) approved certificate program in the area of practice covered by the CPP agreement,
(C) has successfully completed the course of study and holds the academic degree of Bachelor of Science in Pharmacy and has five years of clinical experience approved by the Boards and has completed two NCCPC or ACPE approved certificate programs with at least one program in the area of practice covered by the CPP agreement;
(iii) submits the required application, a written endorsement from the Pharmacy Board and the fee to the Medical Board
(iv) submits any information deemed necessary by the Medical Board in order to evaluate the application; and
(v) has a signed supervising physician agreement.
If for any reason a CPP discontinues working in the approved physician arrangement, both Boards shall be notified in writing within ten days and the CPP’s approval shall automatically terminate or be placed on an inactive status until such time as a new application is approved in accordance with this Subchapter.
(b) all certificate programs referred to in paragraph (2)(a)(ii) of the rule must contain a core curriculum including at a minimum the following components:
(A) communicating with health care professionals and patients regarding drug therapy, wellness, and health promotion,
(B) designing, implementing, monitoring, evaluating, and modifying or recommending modifications in drug therapy to insure effective, safe, and economical patient care,
(C) identifying, assessing and solving medication-related problems and providing a clinical judgment as to the continuing effectiveness of individualized therapeutic plans and intended therapeutic outcomes,
(D) conducting physical assessments, evaluating patient problems, ordering and monitoring medications and/or lab-
Clinical Pharmacist  
continued from page 15

oratory tests in accordance with established standards of practice,
(E) referring patients to other health professionals as appropriate,
(F) administering medications,
(G) monitoring patients and patient populations regarding the purposes, uses, effects and pharmacoeconomics of their medication and related therapy,
(H) counseling patients regarding the purposes, uses, and effects of their medication and related therapy;
(I) integrating relevant diet, nutritional and non-drug therapy with pharmaceutical care,
(J) recommending, counseling, and monitoring patient use of non-prescription drugs, herbal remedies and alternative medicine practices,
(K) devices, and durable medical equipment,
(L) providing emergency first care,
(M) retrieving, evaluating, utilizing, and managing data and professional resources,
(N) using clinical data to optimize therapeutic drug regimens,
(O) collaborating with other health professionals,
(P) documenting interventions and evaluating pharmaceutical care outcomes,
(Q) integrating pharmacy practice within healthcare environments,
(R) integrating national standards for the quality of healthcare, and
(S) conducting outcomes and other research.

(c) The completed application for approval to practice as a CPP will be reviewed by the Medical Board upon verification of a full and unrestricted license to practice as a pharmacist in North Carolina.

(i) The application shall be approved and at the time of approval the Medical Board shall issue a number which shall be printed on each prescription written by the CPP, or
(ii) the application shall be denied, or
(iii) the application shall be approved with restrictions.

(3) Annual Renewal.

(a) Each CPP will register annually on the anniversary of his or her birth date by:
   (i) verifying a current Pharmacist license;
   (ii) submitting the renewal fee as specified in (10)(b) of this subchapter;
   (iii) completing the Medical Board’s renewal form; and
   (iv) reporting continuing education credits as specified by the Medical Board.

(b) If the CPP has not renewed within 30 days of the anniversary of the CPP’s birth date, the approval to practice as a CPP shall lapse.

(4) Continuing Education.

(a) Each CPP shall earn 35 hours of approved practice relevant CE each year approved by the Pharmacy Board.

(b) Documentation of these hours shall be kept at the CPP practice site and made available for inspection by agents of the Medical Board or Pharmacy Board.

(5) The supervising physician who has a signed agreement with the CPP shall be readily available for consultation with the CPP, and will review and countersign each order written by the CPP within seven days.

(6) The written CPP agreement shall:

(a) be approved and signed by both the supervising physician and the CPP and a copy shall be maintained in each practice site for inspection by agents of either Board upon request;

(b) be specific in regards to the physician, the pharmacist, the patient and the disease;

(c) specify the predetermined drug therapy which shall include the diagnosis and product selection by the patient’s physician; any modifications which may be permitted, dosage forms, dosage schedules and tests which may be ordered;

(d) prohibit the substitution of a chemically dissimilar drug product by the CPP for the product prescribed by the patient’s physician without first obtaining written consent of the physician;

(e) include a pre-determined plan for emergency services;

(f) include a plan and schedule for weekly quality control, review and countersignature of all orders written by the CPP in a face-to-face conference between the physician and CPP;

(g) require that the patient be notified of the collaborative relationship; and

(h) be terminated when patient care is transferred to another physician and new orders shall be written by the succeeding physician.

(7) The supervising physician of the CPP shall:

(a) be fully licensed, engaged in clinical practice, and in good standing with the Medical Board;

(b) not be serving in a postgraduate medical training program;

(c) be approved in accordance with this Subchapter before the CPP supervision occurs; and

(d) supervise no more than three pharmacists.

(8) The CPP shall wear an appropriate nametag spelling out the words ‘Clinical Pharmacist Practitioner’.

(9) The approval of a CPP may be restricted, denied, or terminated by the Medical Board and the pharmacist’s license may be restricted, denied, or terminated by the Pharmacy Board, in accordance with provisions of N.C.G.S. 150B if the appropriate Board finds one or more of the following:

(a) the CPP has held himself or herself out or permitted another to represent the CPP as a licensed physician;

(b) the CPP has engaged or attempted to engage in the provision of drug therapy management other than at the direction of, or under the supervision of, a physician licensed and approved by the Medical Board to be that CPP’s supervising physician;

(c) the CPP has performed or attempted to provide medical management outside the approved drug therapy agreement or for which the CPP is not qualified by education and training to perform;

(d) the CPP is adjudicated mentally incompetent;

(e) the CPP’s mental or physical condition renders the CPP unable to safely function as a CPP; or

(f) the CPP has failed to comply with any of the provisions of this Rule.

(10) Any modification of treatment for financial gain on the part of the supervising physician or CPP shall be grounds for denial of Board approval of the agreement.

(11) Fees:

(a) An application fee of one hundred dollars ($100.00) shall be paid at the time of initial application for approval and each subsequent application for approval to practice.

(b) The fee for annual renewal of approval, due on the CPP’s anniversary of birth date is fifty dollars ($50.00).

(c) No portion of any fee in this Rule is refundable.
I Applaud Dr Tucker

To the Editor: Thank you for including House Calls in the recent edition of the Forum [Vol. V, No. 1, 2000].

Certainly, Dr Tucker sets an excellent example for physicians by bringing the care to the patient in his or her own environment. The examples he gave are very real to the everyday world of the home care professional. The home care professional makes a major contribution to patient care by communicating observations to the physician. However, there is immutable value in situations where the physician makes that visit and sees and hears first hand.

I applaud the effort of Dr Tucker and all who take the time to make home visits.

Audrey W. Belk, MPH, RN,
Administrator
Rowan Regional Home
Health & Hospice
Salisbury, NC

An Idea Whose Time Has Come

To the Editor: [Mr Watry’s article, Myopia in Licensure, that appeared in the Forum, Vol. V, No. 1, 2000 was] most interesting and thorough! Commendations! The Federation of State Medical Boards Credentials Verification Service: an idea whose time has come (I think it did a long time ago, in fact). As a foreign medical graduate who has had licenses in Iowa, Missouri, Kansas, Colorado, and New York, as well as in North Carolina, my memories of repeatedly obtaining credentials to meet requirements is a bad dream.

I had an excellent education at one of England’s best schools. By the time I was 15, I was completely familiar with calculus, physics, organic chemistry, botany, and zoology at the U.S. college level. I could recite long passages of Virgil, Homer, Shakespeare, and the Bible! I knew about, for example, the history of Mesopotamia and Egypt, the Peloponnesian Wars, the Roman Empire, the Medieval world, and 19th century European and American history. Similarly with geography, we were expected to be familiar in depth with such topics as the agriculture and trade of the Hudson Valley and the economic consequences of the Civil War on the growth of tobacco and cotton in the Carolinas. All of this was documented on various college matriculation exams. But it counted for naught for most American medical licensing boards who had defined an adequate education in terms of semester hours, an American measure not reflected in the standards of British education.

Establishing my medical education was a little easier, at least in terms of classroom hours, but when I tried to convert house officer posts to internships and residencies, total confusion returned. Moving to North Carolina 43 years after graduation added to the difficulties, since many of my old teachers were dead, and British National Health Insurance executives of the 90s were unwilling to certify anything! If only I could have had all this attested to years ago, and deposited in some credentials bank, the doubt (and dangers!) could have been avoided.

I have had the shoe on the other foot, too, and have had altogether too close an encounter with at least two proven medical imposters, having been at first taken in by them as colleagues, so I do know of the difficulties.

When you begin to apply these experiences to the problems inherent to making state boundaries more permeable, I can see some of the hazards. East Carolina University has pioneered in telemedicine, and I am perfectly sure that computer technology, which is creating some of the problems of interstate certification, must be made to yield the answers to our security needs.

Best of luck, and, again, thanks for a stimulating article.

Raymond Vickers, MD
Greenville, NC

Will & Charlie

To the Editor: I just had to respond to Mr VonSeggen’s article [The Spirit of Collegiality] in the NCMB Forum [Vol. IV, No. 4, 1999]! Good job. He really did a nice job with the article. I thought it was very inclusive and sensitive.

But then, because he mentioned Will and Charlie [Mayo], I certainly had to respond. I grew up 60 miles from Rochester, MN, and then was a Rochester Franciscan for nine years. That is where I got my nurse’s training – so I heard Will and Charlie stories most of my life and have an old copy of the book, The Mayo Brothers. They were amazing people, as was Mother Alfred, who twisted their arms into building the first hospital there. Great examples to all of us.

Kathy Johnson, FNP
Raleigh, NC

Putting One Over

To the Editor: [In reference to Board attorney James Wilson’s response to the letter, Lying to the Board, in Vol. V, No. 1, 2000, of the Forum.] Let me assure you, nearly every physician who was asked during their interview whether marijuana had ever entered their system lied. (I’m probably one of the exceptions – and probably the only student who attended my university who didn’t smoke dope. I actually thought the question was an attempt to verify that we out-of-staters did attend undergraduate school!)

But for years and years and years, as our medical community grew, one common experience that was shared over dinners, lunches, in ORs and ERs, was the lie that physicians were dead, and British National Health Insurance executives of the 90s were unwilling to certify anything! If only I could have had all this attested to years ago, and deposited in some credentials bank, the doubt (and dangers!) could have been avoided.

I have had the shoe on the other foot, too, and have had altogether too close an encounter with at least two proven medical imposters, having been at first taken in by them as colleagues, so I do know of the difficulties.

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Raymond Vickers, MD
Greenville, NC
Buncombe County’s Black Physicians: A Tribute

Forum Staff

The city of Asheville was first incorporated in 1797 and almost a century passed before a black physician arrived in the community. During the following century, up to 1999, only about 30 black physicians had come to serve the area. Unfortunately, old records provide little information about many of these physicians, men and women who “came to do for their suffering people, and in many cases, did so without receiving ‘a cent’ for their professional services.” This little book by Annye S. Holt is a series of notes, the best she could gather, on that group of professionals.

According to the author, there are five black physicians in Buncombe County today, including Dr Robin Diane Wright, the first black female gastroenterologist west of Charlotte, and Dr Cornell Keith Yager, the only black ER physician in western North Carolina. The pioneer black physician in the community, who arrived in 1890, was Marcus W. Alston, MD, a graduate of Leonard Medical School. Leonard, a part of Shaw University in Raleigh, was the third medical school organized for blacks in the United States and was established in 1882 through the generous gift of J.W. Leonard of Hampden, Massachusetts. It closed in 1918. (Interestingly, Leonard’s faculty was white and a number of its members became the core faculty of the short-lived University of North Carolina Medical Department at Raleigh, which opened in 1902 and closed in 1910.) Dr Alston held North Carolina medical license number 630, issued May 30, 1890, and practiced until 1901. His office was in the Young Men’s Institute Building.

Ms Holt provides brief sketches of each of the other black physicians who practiced in Asheville, including her husband, Dr John Plummer Holt, who was the first black member of the Buncombe County Medical Society, and his father, Dr John Walker Holt. (Their son, Dr John Plummer Holt, Jr, practices in Raleigh.) Where possible, she includes information on each physician’s civic accomplishments. She also notes the development of black hospitals in the area and provides news clippings and other “scrapbook” materials on her subject.

Her sources were clearly limited: Asheville city directories; clippings from the Black Highlander at the Southern Highlands Research Center of UNC, Asheville; data from the North Carolina Section of the Pack Memorial Library in Asheville and from the Young Men’s Institute of Asheville; letters from relatives of some of her subjects; and information provided by Ms Ann Norris of the North Carolina Medical Board. Despite its limitations, however, this little book was worth her good effort, and it will soon be amplified by her husband, who is writing a more extensive work on the subject that will be a section of the commemorative publication being prepared by the Buncombe County Medical Society for its centenary.

“You Are the Angel Gabriel”

Forum Staff

Late one night in 1960, an unconscious woman who had suffered a massive heart attack and had ventricular fibrillation, her blood pressure unattainable and her lungs gurgling with edema, was connected to a direct current defibrillator that weighed over 60 pounds and had been dragged on a small trolley from the Harvard School of Public Health to the Peter Bent Brigham Hospital by its developer, Dr Bernard Lown, and an assistant. During their progress along the streets of Boston, the machine had slipped from its precarious perch and toppled to the pavement, but when tested at the patient’s bedside, by some miracle it worked. Dr Lown then gave the patient a single direct current shock, the first one ever administered to a human being with ventricular tachycardia. “A minute later, she awoke, very much alive and very much better.” The edema subsided, pulses returned, and the heart rhythm was regular and steady. Not surprisingly, the patient believed she was now in heaven. “You are the angel Gabriel,” she said, looking up at Dr Lown in his white coat. It took some time to convince her that her angel was simply an exhausted but exhilarated physician.

This incident reflects a great deal about the man and the physician Bernard Lown. It is found in a new edition of a small book first issued in 1995 and now presented in an edition prepared by Robert L. Bloomfield, MD, and Carolyn F. Pedley, MD, both of Winston-Salem. Titled Practicing the Art While Mastering the Science: A Cardiologist Reflects on Healing, the book was originally published by the Lown Cardiovascular Research Foundation in Boston. It is basically a compilation of selected essays written by Dr Lown over 16 years for the newsletter of his foundation. The new edition is expanded with commentaries by colleagues, including Harvey Estes, MD, and Eugene Stead, MD, editorial notes, a brief biographical sketch of the author, and a bibliography. Originally designed to introduce the work and accomplishments of Dr Lown, the book is also a clear expression of his belief that “the art of medicine is a process for nurturing a special human relationship that champions a partnership for healing.” Medical students, residents, physicians, other health care professionals, and patients will find these essays, and the life of the man, clearly demonstrate Dr Lown’s commitment to the idea that “healing is different from treating. The latter deals with a malfunctioning organ system; the former with a distressed human being.” As several of his colleagues remark in the last sections of the book, here is a role model indeed.

Practicing the Art While Mastering the Science: A Cardiologist Reflects on Healing

Bernard Lown

(Edited by R.L. Bloomfield and C.F. Pedley)

Habinger Medical Press, Winston-Salem, NC, 2000
98 pages (commentaries, notes, bibliography)
$22.00 hardcover
(961224-4-X)

Born in Lithuania in 1921, Dr Lown is a graduate of the Johns Hopkins University School of Medicine, and is currently professor emeritus of cardiology at the Harvard School of Public Health and senior physician at the Brigham and Women’s Hospital. He was the first to use DC electrical shock for normalizing heart rhythms and he discovered or promoted several basic tenets of modern cardiology, including lidocaine drips, CCUs, and an arrhythmia grading system. He co-founded the International Physicians for the Prevention of Nuclear War and in 1985, along with Evgeni Chazov, accepted the Nobel Prize for Peace on that organization’s behalf. He has also founded an organization specializing in the use of the Internet and other technologies to send medical information throughout the developing world. Andrew G. Wallace, MD, dean emeritus of Dartmouth College and Medical School, has said: “I can think of no physician in this century who has had the breadth of impact Dr Lown has had.”
## NORTH CAROLINA MEDICAL BOARD

### Board Orders/Consent Orders/Other Board Actions

**February-March-April 2000**

### DEFINITIONS

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

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

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

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

**Information not available.**

**NCPHP:**
North Carolina Physicians Health Program

**RTL:**
Resident Training License

**Revocation:**
Cancellation of the authorization to practice.

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

**Suspension:**
Temporary withdrawal of the authorization to practice.

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

**Voluntary Dismissal:**
Board action dismissing a contested case.

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

### ANNULMENTS

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<tr>
<th>NAME</th>
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<th>LICENSE #</th>
<th>SPECIALTY</th>
<th>MEDICAL ED</th>
<th>FACTS</th>
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<tbody>
<tr>
<td>DOLIN</td>
<td>Rockville Centre, NY</td>
<td>7/14/1945</td>
<td>0094-00779</td>
<td>ORS</td>
<td>New York Medical College</td>
<td>Dr Dolin failed to adhere to the standards of his Consent Order with the New York Board, misrepresented himself when applying for hospital privileges, misrepresented himself to the U.S. Department of Justice, DEA, when applying for registration to prescribe controlled substances, and unlawfully prescribed controlled substances. Based on these findings, the New York Board revoked Dr Dolin’s license.</td>
<td>3/17/2000. Order issued revoking Dr Dolin’s North Carolina medical license, effective 3/20/2000.</td>
</tr>
<tr>
<td>GOURBAN</td>
<td>Durham, NC (Durham Co)</td>
<td>2/15/1938</td>
<td>0000-21039</td>
<td>ORG</td>
<td>University of Tennessee</td>
<td>A hearing was held on March 16, 2000: the Board found that Dr Goubran intentionally discharged a surgical staple gun into the finger of a second-year medical student during a surgical procedure; that he required her to place her hands in the sterile field where blood and other bodily fluids were present even though she was not gloved or gowned, placing the patient and the student at risk and increasing the risk of a surgical site infection; that by placing the staple gun and the forceps used on the student on the Mayo stand he potentially placed the patient at risk for infectious disease and potentially increased the risk of a surgical site infection.</td>
<td>3/27/2000. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Goubran’s medical license is suspended indefinitely effective midnight, April 1, 2000. He shall deliver his license and registration certificates to the Board and wind down his practice to maintain continuity of patient care. All but six months of the suspension may be stayed if Dr Goubran signs a consent order attached to the Findings of Fact, Conclusions of Law, and Order of Discipline.</td>
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<td>MACKEY</td>
<td>Chapel Hill, NC (Orange Co)</td>
<td>10/20/1944</td>
<td>0000-19801</td>
<td>CHP</td>
<td>University of Tennessee</td>
<td>A hearing was held on March 16-17, 2000: the Board found that Dr Mackey sought treatment for his abuse of alcohol in December 1994 and February 1995, at which time he entered into a contract with the NCPhP; in December 1995, he was arrested on charges of driving while under the influence, at which time he admitted he had a drink that day; his abuse of alcohol escalated in 1998, during 1999, he became intoxicated on several occasions; in November 1999, on a day on which he was treating patients, he was noted to have a strong odor of alcohol about him during lunch; a similar odor was noticed by a sheriff’s officer on a February morning when Dr Mackey had patients scheduled; testimony indicated Dr Mackey’s abuse of alcohol adversely affected his care of a patient. The Board concluded Dr Mackey’s use of alcohol interferes with his ability to provide proper care for his patients. It also noted his testimony on the second day of his hearing contradicted much of his previous testimony.</td>
<td>4/10/2000. Findings of Fact, Conclusions of Law, and Order issued: Dr Mackey’s license is suspended indefinitely and he is to return his license certificate and registration certificate to the Board within 10 days. (The summary suspension of his license dated 3/01/2000 and effective 3/03/2000 is dissolved.)</td>
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### SUSPENSIONS

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<tr>
<td>BOYD</td>
<td>Ithaca, NY</td>
<td>7/05/1948</td>
<td>0000-21744</td>
<td>OBG</td>
<td>University of North Carolina School of Medicine</td>
<td>Charges against Dr Boyd was also filed by the Board on 2/09/2000 and is available on request.</td>
<td>2/09/2000. Order of Summary Suspension of License issued: New York having ordered Dr Boyd to cease practice and having reported to the North Carolina Medical Board that Dr Boyd appears to have fled New York to relocate in North Carolina, the Board finds the public health, safety, or welfare requires emergency action and orders Dr Boyd’s license suspended upon service of this Order at her last address. (A formal Notice of Charges against Dr Boyd was also filed by the Board on 2/09/2000 and is available on request.)</td>
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<tr>
<td>MACKEY</td>
<td>Chapel Hill, NC (Orange Co)</td>
<td>10/20/1944</td>
<td>0000-19801</td>
<td>CHP</td>
<td>University of Tennessee</td>
<td>Dr Mackey may be unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of a physical or mental abnormality.</td>
<td>3/01/2000. Order of Summary Suspension of License issued, effective 3/03/2000. [Notice of Charges and Allegations issued 3/01/2000.]</td>
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### CONSENT ORDERS

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<th>FACTS</th>
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<tr>
<td>CHEEK</td>
<td>Smithfield, NC</td>
<td>3/02/1957</td>
<td>0097-01906</td>
<td>AN</td>
<td>Medical College of Pennsylvania</td>
<td>The Michigan Board of Medicine summarily suspended Dr Zylanoff’s medical license on 10/01/1999, saying that public health, safety, or welfare required emergency action. This action by Michigan is grounds for action by the North Carolina Board.</td>
<td>3/18/2000. Order of Summary Suspension of License issued, effective 4/10/2000. [Notice of Charges and Allegations issued 3/18/2000.]</td>
</tr>
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</table>
COYNE, Mark Dennis, MD
Location: Stoney Creek, NC (Guilford Co)
DOB: 8/12/1949
License #: 0000-34493
Specialty: PTH (as reported by physician)
Medical Ed: Chicago Medical School (1983)
Cause: On a request to amend Dr Coyne's Consent Order of 2/16/2000, which resulted from his problems with alcohol. That Consent Order restricts Dr Coyne to emergency and urgent care medicine. He has requested that limitation be eliminated and the Board has agreed with certain conditions. 2/21/2000. Consent Order executed: Dr Coyne is issued a license to expire on the date shown on the license [7/31/2000]; he shall practice only in a setting approved in writing by the Board's president, unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissue samples for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall attend AA meetings as recommended by the NCPHP; he shall provide a copy of this Consent Order to all prospective employers; he shall not possess any controlled substances, and he shall refrain from the use of all mind or mood altering substances and all controlled substances. The numbered paragraphs of this Consent Order supersede those in any prior consent order except those regarding the public nature of such consent orders.

COYNE, Mark Dennis, MD
Location: Stoney Creek, NC (Guilford Co)
DOB: 8/12/1949
License #: 0000-34493
Specialty: PTH (as reported by physician)
Medical Ed: Chicago Medical School (1983)
Cause: Application for reinstatement of license. Dr Coyne surrendered his license on 9/30/1993 to seek treatment for substance abuse; his license was reissued under a new consent order in December 1994; the Board and Dr Gottschalk entered consent orders in March 1995 and September 1995 modifying the 1994 order; in August 1997, the Board relieved him of all conditions. 9/21/2000. Consent Order executed: Dr Coyne is issued a license to expire on the date shown on the license [9/30/2000]; he shall maintain and abide by a contract with the NCPHP; he shall attend AA meetings as recommended by the NCPHP; he shall provide a copy of this Consent Order to all prospective employers; he shall maintain and abide by a contract with the NCPHP; he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall attend AA, NA, and Caduceus meetings as recommended by the NCPHP; she shall supply a copy of this Consent Order to all prospective employers; he shall maintain and abide by a contract with the NCPHP; he shall attend AA and NA meetings as recommended by the NCPHP; he shall surrender his DEA registrations and shall not reapply for them; he shall not order, prescribe, administer, or dispense, and, except as prescribed lawfully by another, shall not possess any controlled substances; he shall practice only in a setting approved in writing by the Board's president; he may not supervise PAs, NPs, or nurse midwives; must comply with other conditions.

GOTTschalk, Bernard Joseph, MD
Location: Mill Spring, NC (Polk Co)
DOB: 5/10/1955
License #: 0000-30162
Specialty: IM (as reported by physician)
Medical Ed: University of Pittsburgh (1981)
Cause: Application for reissuance of license. Dr Gottschalk surrendered his license on 9/30/1993 to seek treatment for substance abuse; his license was reissued under a new consent order in December 1994; the Board and Dr Gottschalk entered consent orders in March 1995 and September 1995 modifying the 1994 order; in August 1997, the Board relieved him of all conditions. 9/21/2000. Consent Order executed: Dr Gottschalk is issued a license to expire on the date shown on the license [9/30/2000]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissue samples for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall attend AA meetings as recommended by the NCPHP; he shall provide a copy of this Consent Order to all prospective employers; he shall maintain and abide by a contract with the NCPHP; he shall attend AA and NA meetings as recommended by the NCPHP; he shall surrender his DEA registrations and shall not reapply for them; he shall not order, prescribe, administer, or dispense, and, except as prescribed lawfully by another, shall not possess any controlled substances; he shall practice only in a setting approved in writing by the Board's president; he may not supervise PAs, NPs, or nurse midwives; must comply with other conditions.

HORowitz, Jack Charles, MD
Location: Wilmington, DE
DOB: 11/09/1962
License #: 2000-00340
Specialty: PD (as reported by physician)
Medical Ed: University of Connecticut (1991)
Cause: On Dr Horowitz’s request, the Delaware Board of Medical Practice, in an order of that date, found Dr Horowitz, while on duty at a hospital, engaged in inappropriate telephonic calls with a 14 year old girl. The Delaware Board took into consideration that this behavior was unprofessional conduct and suspended his license for up to one year pending evaluation by a psychiatrist. In June 1997, the Delaware Board dismissed the case. In June 1998, it reinstated his unrestricted license. The state of Delaware charged Dr Horowitz with aggravated harassment due to the telephone calls noted. To avoid the delay and expense of litigation, in February 1999 the attorney general of Delaware and Dr Horowitz executed an Attorney General’s Probation in the case in which Dr Horowitz admitted making the calls in May 1995. Pursuant to the Attorney General’s Probation, the charges against Dr Horowitz were dismissed following a six month probation.

GIFFFONE, Anthony Frederick, Jr, MD
Location: Staten Island, NY
DOB: 7/01/1925
License #: 0000-20774
Specialty: OBG (as reported by physician)
Medical Ed: University of Leiden, Netherlands (1952)
Cause: Dr Giffone's medical license was revoked by New York on 9/29/1998 (for outrageous sexual misconduct) 3/09/2000. Consent Order executed: Dr Giffone surrenders the license and the Board accepts the surrender of his North Carolina medical license.

GORSKI, Karen, Physician Assistant
Location: Hunterville, NC (Mecklenburg Co)
License #: 0001-02145
Bt Education: State University of New York, Stonybrook (1982)
Cause: On the request of Ms Gorski to amend her consent order of 8/06/1998 to allow her to register with the DEA. It appears she is complying with the terms and conditions of her consent order with the NCMB, and that the prohibition on DEA registration is no longer needed. The requirement that she obtain a medical evaluation has also been satisfied.
Action: 4/19/2000. Consent Order executed: Ms Gorski is issued a license dated to expire on the date shown on the license [3/31/2001]; unless lawfully prescribed for him by someone other than herself, she shall refrain from the use of any of the substances noted above; she shall not order, prescribe, administer, or dispense, and, except as prescribed lawfully by another, shall not possess any controlled substances; she shall practice only in a setting approved in writing by the Board’s president; he may not supervise PAs, NPs, or nurse midwives; must comply with other conditions.

KELL, Michael Jon, MD
Location: Atlanta, GA
DOB: 11/01/1949
License #: 0000-35005
Specialty: OBG (as reported by physician)
Medical Ed: Emory University (1985)
Cause: On May 12, 1998, the Georgia Composite State Board of Medical Examiners revoked, timed, and placed Dr Kell on probation for 5 years, finding he had run Methadone Maintenance Treatment Program clinics in violation of federal and state regulations.
Action: 2/16/2000. Consent Order executed: Dr Kell shall comply with the final decision of the Georgia Board; while his probation in Georgia remains in effect, if Dr Kell practices in North Carolina, he shall: practice only in a setting approved in writing by the Board president, use triplicate pre-
scriptions for all controlled substances except methadone, with one copy of each prescription being sent to the Board quarterly, cause his office staff to maintain an accurate log verified by his signature of all Schedule II, III, IV, and V controlled substances with the exception of methadone prescribed by him or any physician employed by him, justify in the patient's record any controlled substances prescribed, administered, or dispensed to the same patient more than once, provide a copy of this Consent Order to each hospital or other North Carolina institution where he applies for or maintains staff privileges and to any person with whom he is currently associated in practice; must comply with other conditions.

MARTIN, Carol Ann, MD
Location: Raleigh, NC (Wake Co)
DOB: 7/17/1951
License #: 0000-20834
Specialty: P (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1990)
Cause: On application for reinstatement of temporary/dated license that was expired on the date shown on the license [5/31/2000]; he shall practice on or before the expiration date on the license; he shall maintain an accurate log verified by his signature of all Schedule II, III, IV, and V controlled substances prescribed, administered, or dispensed to any patient more than once; must comply with all other conditions.

PFLIEGER, Kurt Loring, MD
Location: Heath, TX
DOB: 7/16/1952
License #: 0000-34848
Specialty: FP (as reported by physician)
Medical Ed: University of Mississippi (1980)
Cause: On a petition for reinstatement of license. In a Consent Order of 12/17/1999, which limits her to 10 hours work per week. She has asked she be permitted to work up to 25 hours per week. It appears she is complying with her consent order, including the requirement the continue outpatient therapy, and her therapist believes increasing her working week will not interfere with her therapy. It also appears allowing her to work up to 25 hours a week will not impair her ability to practice safely.

PRESSLY, Margaret Rose, MD
Location: Sylva, NC (Jackson Co)
DOB: 5/10/1956
License #: 0000-39893
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1990)
Cause: On application for reinstatement of temporary/dated license that was expired on the date shown on the license [7/6/2000]; unless lawfully prescribed for him by someone else, he shall refrain from use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board proceedings began; in light of these circumstances, Dr Onwukwe, who was convicted of driving under the influence of alcohol in 1990 and in 1992. He currently has an active contract with the NCPHP, he has retracted from the use or possession of all mind or mood altering substances and all controlled substances not prescribed for him by another physician, and has not consumed alcohol since September 1999.

TIDMORE, Hollis Daniel, MD
Location: Wake Forest, NC (Wake Co)
DOB: 1/21/1954
License #: 0000-20834
Specialty: FP (as reported by physician)
Medical Ed: University of Mississippi (1980)
Cause: On a petition for reinstatement of license. In a Consent Order of 12/17/1999, which limits her to 10 hours work per week. She has asked she be permitted to work up to 25 hours per week. It appears she is complying with her consent order, including the requirement the continue outpatient therapy, and her therapist believes increasing her working week will not interfere with her therapy. It also appears allowing her to work up to 25 hours a week will not impair her ability to practice safely.
completed six weeks of cognitive-behavioral treatment there with a strong relapse prevention component; he has continued his treatment at BMI on an outpatient basis.

3/30/2000. Consent Order executed: Dr. Williams is issued a license to expire on the date shown on the license [7/31/2000]; he shall ensure that a female chaperone, who has read this Consent Order, is present any time he is in an examination room with a female patient; the chaperone shall document that she was present during the examination and that no boundary violations or other misconduct occurred; he shall post a copy of the Principles of Medical Practice on his office wall, examination room walls, the reception area wall, and any other places where it can be easily read by patients; each month, he shall ask all his staff members who have read this Consent Order to complete a Patient/Patient's Family Satisfaction Survey, which shall also be sent to BMI for inclusion in the quarterly report; each six months, Dr. Williams shall undergo a polygraph examination to determine if he has been involved in sexual misconduct with his patients or female staff members, results to be sent to BMI for inclusion in the quarterly report; he shall continue his relapse therapy with BMI or such other place as is approved in writing by the president of the Board, and he shall comply with all recommendations made by BMI regarding his practice; BMI shall continue to periodically evaluate Dr. Williams for any recurrence of depressive symptomatology; Dr. Williams shall direct BMI to provide quarterly reports on his progress to the Board; he shall continue his therapy with Dr. Johnson or such other person as the president of the Board approves in writing; and Dr. Williams shall direct that therapist to provide quarterly reports to the Board on his progress; must comply with other conditions.

DENIALS OF LICENSE/APPROVAL

SCHER, Stephen Barry, MD
Location: Lincolnton, NC (Lincoln Co)
DOB: 5/10/1949
License #: 0000-22366
Specialty: FP (as reported by physician)
Medical Ed: Indiana University (1975)
Cause: On the application of Dr. Scher for restoration of his revoked license. Dr. Scher's conviction in Pennsylvania for first-degree murder is a felony conviction and is grounds under NC law to deny his application for a medical license; revocation of his license by the Pennsylvania State Board of Medicine is grounds under NC law for denial of his application; under NC law, no revoked license may be restored for a period of two years following the date of revocation and two years have not passed; though Dr. Scher's conviction was reversed by the Pennsylvania Supreme Court on June 1999 and he was released on bail, the Commonwealth of Pennsylvania is pursuing further proceedings in the Pennsylvania Supreme Court.

YOUNG, Richard Lane, MD
Location: Sunset Beach, NC (Brunswick Co)
DOB: 8/12/1951
License #: 0000-219090
Specialty: ORS (as reported by physician)
Medical Ed: Medical University of South Carolina (1979)

See Consent Orders:

GIFFONE, Anthony Frederick, Jr, MD

CONSENT ORDERS LIFTED

BEDINGTON, William David, Physician Assistant
Location: Conover, NC (Catawba Co)
DOB: 11/14/1959
License #: 0001-02524
PA Education: Butler University (1998)

KEEVER, Richard Alan, MD
Location: High Point, NC (Guilford Co)
DOB: 6/11/1941
License #: 0000-164080
Specialty: OTO (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1969)

LOWE, James Edward, Jr, MD
Location: Roseboro, NC (Sampson Co)
DOB: 12/05/1950
License #: 0000-37887
Specialty: HS (as reported by physician)
Medical Ed: Meharry Medical College (1975)

MINARD, John Lawrence, MD
Location: Morganton, NC (Burke Co)
DOB: 1/12/1958
License #: 0000-29447
Specialty: CHP (as reported by physician)
Medical Ed: University of Pittsburgh (1961)

TEMPORARY/DATED LICENSES:

SUSPENDED, EXTENDED, EXPIRED OR REPLACED BY FULL LICENSES

CHEEK, John Christopher, MD
Location: Smithfield, NC (Johnston Co)
DOB: 3/03/1957
License #: 0000-01906
Specialty: GP/CN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1984)

COYNE, Mark Dennis, MD
Location: Stoney Creek, NC (Guilford Co)
DOB: 8/12/1949
License #: 0000-03499
Specialty: PTH (as reported by physician)
Medical Ed: Chicago Medical School (1983)

FORD, Stephen Mitchell, MD
Location: Durham, NC (Durham Co)
DOB: 12/05/1952
License #: 0000-29570
Specialty: P (as reported by physician)
Medical Ed: East Tennessee State University (1984)

GALEA, Lawrence Joseph, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 10/19/1948
License #: 0000-27046
Specialty: FP (as reported by physician)
Medical Ed: University of Cincinnati (1960)

GLENN, Robert Alan, Physician Assistant
Location: Asheville, NC (Buncombe Co)
DOB: 3/13/1959
License #: 0000-01972
PA Education: George Washington University (1989)

GORSKI, Karen, Physician Assistant
Location: Huntersville, NC (Mecklenburg Co)
DOB: 1/08/1957
License #: 0001-02145
PA Education: State University of New York, Stonybrooke (1982)

KHOT, Prakash Nalkant, MD
Location: King, NC (Stokes Co)
DOB: 5/10/1984
License #: 0000-19016
Specialty: FP (as reported by physician)
Medical Ed: Napur Medical College, India (1967)

LUTZ, Robert Paul, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 5/04/1948
License #: 0000-27387
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1982)

MARTIN, Carol Ann, MD
Location: Raleigh, NC (Wake Co)
DOB: 10/14/1952
License #: 0009-01651
Specialty: FP (as reported by physician)
Medical Ed: Stanford University (1979)

MCCALL, Michael Alvin, MD
Location: Atlanta, GA
DOB: 11/04/1964
License #: 0000-36569
Specialty: OBG (as reported by physician)
Medical Ed: University of Florida College of Medicine (1989)
North Carolina Medical Board

Meeting Calendar, Application Deadlines, Examinations

July 2000 -- May 2001

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

North Carolina Medical Board

July Meeting Deadlines:
- Nurse Practitioner Approval Applications: June 5, 2000
- Physician Assistant Applications: July 5, 2000
- Physician Licensure Applications: July 5, 2000

North Carolina Medical Board

September Meeting Deadlines:
- Nurse Practitioner Approval Applications: August 7, 2000
- Physician Assistant Applications: September 5, 2000
- Physician Licensure Applications: September 5, 2000

North Carolina Medical Board

November Meeting Deadlines:
- Nurse Practitioner Approval Applications: October 2, 2000
- Physician Assistant Applications: October 31, 2000
- Physician Licensure Applications: October 31, 2000

North Carolina Medical Board

January Meeting Deadlines:
- Nurse Practitioner Approval Applications: December 11, 2000
- Physician Assistant Applications: January 10, 2001
- Physician Licensure Applications: January 9, 2001

North Carolina Medical Board

March Meeting Deadlines:
- Nurse Practitioner Approval Applications: February 5, 2001
- Physician Assistant Applications: March 7, 2001
- Physician Licensure Applications: March 6, 2001

North Carolina Medical Board

May Meeting Deadlines:
- Nurse Practitioner Approval Applications: April 2, 2001
- Physician Assistant Applications: May 2, 2001
- Physician Licensure Applications: May 1, 2001

 Residents Please Note USMLE Information

United States Medical Licensing Examination Information

(USMLE Step 3)

The May 1999 administration of the USMLE Step 3 was the last pencil and paper administration. Computer-based testing for Step 3 became available on a daily basis in November 1999. Applications may be obtained from the office of the North Carolina Medical Board by telephoning (919) 320-1100. Details on administration of the examination will be included in the application packet.

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, Eutless, TX 76039 or telephone (817) 868-4000.
FOR SEPTEMBER BIRTHDAYS
Physicians, physician assistants, and nurse practitioners with September birthdays will be the first to have the opportunity to handle their annual registration with the North Carolina Medical Board via the Internet, using a valid Mastercard® or Visa® credit card. They will find instructions for doing this enclosed with the usual paper registration form sent to them in the mail prior to their birthdays. If you are one of the September registrants, please remember to register ONLY ONCE, either by mail OR by Internet – not both.

FOR BIRTHDAYS AFTER SEPTEMBER
Those registrants whose birthdays fall after September 2000 will receive ONLY a postcard notice with instructions telling them how to register by Internet and how to obtain a paper registration form if they prefer to register by mail. You, or whoever handles mail for you, should make note of this new system to ensure the Board’s postcard notice is not misplaced when it arrives.