

forum

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

Australian Mutual Recognition - page 5
License Portability

President's Message

Moving Forward



Charles L. Garrett, Jr., MD

I never thought in January that I would be writing a "President's Message" for the *Forum* this year. As you are aware, Dr John Dees' untimely death in early February thrust me into the office of president of your Board. I owe a debt of gratitude to all of the Board members who came to my assistance, especially Steve Herring, MD, and Bob Moffatt, MD, who were elected to the offices of president elect and secretary. The Board staff has been extremely helpful

as we have had to reorganize our roles and duties. I believe that we are doing a good job and I think that Dr Dees would be pleased.

Your Board has undergone a number of staff changes in the past few months, which will allow us to serve our mandate of public protection and our licensees with increased efficiency and precision. David Henderson, JD, longtime member of the Board's Legal Department, has been employed as executive director since March. He had served as interim director since November 2002. Mr Henderson brings his vast knowledge and a new sense of direction to the Board. We are all very pleased that he has accepted this challenge.

Hari Gupta, treasurer and valued public member of the Board, has resigned his seat to take the position of director of the Operations Department. While we will miss Hari's service as a Board member, we are glad to know that he will remain with the Board in this most important role. Arthur McCulloch, MD, has been elected to replace Mr Gupta as treasurer. Jesse Roberts, MD, the Board's first medical director, has returned to that position bringing back his years of experience. Don Smelcer, who

had managed much of the Board's computer operations on a consulting basis, has become full time director of the IT Department. A new attorney, Amy Yonowitz, JD, has been hired to fill Mr Henderson's position in the Legal Department, returning that area to full staff. Curtis Ellis, formerly of the State Bureau of Investigation, has recently joined the Board as director of the Investigations Department, bringing his long experience in professional investigation to the Board.

Since the Board was first constituted in 1859, it has never had its own home. Earlier this year, we were able to purchase a building in Raleigh that will become the Board's permanent headquarters. We were leasing the first floor of two connected buildings. We are now the owner of the larger of the two and renovations are progressing. This facility, which is being remodeled to the Board's needs, will allow us to serve the public and our licensees more effectively and efficiently. This purchase was made possible by the dedication of previous Boards to accumulating monies in a reserve fund. Our licensees can be especially proud of this building because all of the funds were saved from license and renewal fees. The Board receives no funding from the state of North Carolina. We will completely occupy the new facility in July and plan a public dedication in September. We hope that you will join us and take a tour.

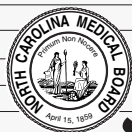
As we approach the end of our first three-year cycle of statutorily mandated CME for licensees, I take this opportunity to remind you to keep up with your CME documentation. Some licensees will be required to submit their documentation for review by the Board for compliance. Category I CME credits will need to be documented by an official statement or certificate from the accredited sponsoring agency. More detailed information will be forthcoming in future issues of the *Forum*.

I believe that it is a high honor to serve as president of your Board. I appreciate your support.

In This Issue of the FORUM

Item	Page
President's Message	
<i>Moving Forward</i>	1
Curtis Ellis Named NCMB Director of Investigations	2
Award-Winning Editorial	
<i>Doctor, Is It Time?</i>	3
100 Years of Professional Nursing in North Carolina	
Mary Lewis Wyche: Implementor of Dreams	4
License Portability	
Australian Mutual Recognition Registration System	
for Medical Practitioners.....	5
Apology: Best Practices.....	10

Item	Page
A Commentary on "Apology: Best Practices"	12
Amy L. Yonowitz, JD, Joins NCMB Staff.....	12
Hari Gupta Named NCMB Director of Operations.....	13
State Medical Board Executive Is Honored	13
How to Determine If Your Practice Could Use a	
Professional Practice Administrator	14
Stay Cool.....	16
Board Actions: 2/2003-4/2003	17
Board Calendar	24
Change of Address Form	24

Primum Non Nocere

forum

NC MEDICAL BOARD

Raleigh, NC

Vol. VIII, No. 2, 2003

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

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

North Carolina Medical Board

Charles L. Garrett, Jr, MD
President
Jacksonville
Term expires
October 31, 2005

Aloysius P. Walsh
Greensboro
Term expires
October 31, 2003

Stephen M. Herring, MD
President Elect
Fayetteville
Term expires
October 31, 2004

R. David Henderson, JD
Executive Director

Bryant D. Paris, Jr
Executive Director Emeritus

Robert C. Moffatt, MD
Secretary
Asheville
Term expires
October 31, 2004

Publisher
NC Medical Board

Editor
Dale G. Breaden

H. Arthur McCulloch, MD
Treasurer
Charlotte
Term expires
October 31, 2005

Assistant Editor
Shannon L. Kingston

E.K. Fretwell, Jr, PhD
Charlotte
Term expires
October 31, 2005

Street Address
1203 Front Street
Raleigh, NC 27609

Robin N. Hunter-Buskey, PA-C
Gastonia
Term expires
October 31, 2003

Mailing Address
PO Box 20007
Raleigh, NC 27619

Michael E. Norins, MD
Greensboro
Term expires
October 31, 2004

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

Walter J. Pories, MD
Greenville
Term expires
October 31, 2003

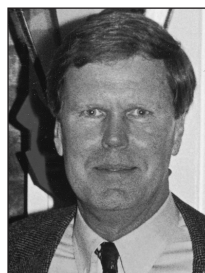
Fax
(919) 326-1130

Web Site:
www.ncmedboard.org

Edwin R. Swann, MD
Raleigh
Term expires
October 31, 2005

E-Mail:
info@ncmedboard.org

Curtis Ellis Named NCMB Director of Investigations



Mr Ellis

R. David Henderson, executive director of the North Carolina Medical Board, recently announced that Mr Curtis Ellis has joined the Board's staff as director of the Investigations Department.

Mr Ellis took a bachelor's degree in business administration from Barton College, in Wilson, NC, and a master's

degree in public administration from North Carolina State University. His career has included two years as a public accounts auditor for the North Carolina State Board of Education, responsible for conducting financial audits of local boards of education and community colleges that received federal funds. He then spent 17 years as a special agent for the North Carolina State Bureau of Investigation, assigned to the Financial Crimes Division. His duties included assisting local, state, and federal law enforcement agencies on a statewide basis in conducting financial crime investigations, including: embezzlement, false pretense, malfeasance of corporate officers, computer crimes, and other business related schemes. He also conducted analysis of financial records to determine possible motives for arson and homicide investigations. Among other duties, he interviewed suspects and witnesses, arrested suspects, assisted prosecutors in preparing indictments, made trial preparations, and gave testimony in court. He conducted sensitive investigations involving administrators, managers, and other employees of state, county, and municipal governments. In order to document these investigative activities, he prepared reports for state and federal prosecutors.

Mr Ellis was the special agent in charge of the Financial Crimes Division for the last 10 years of his tenure with the State Bureau of Investigation. As special agent in charge, his first priority was to ensure that all investigations were conducted in a professional and timely manner and were accurately reported to the appropriate authorities. His other responsibilities included: assigning investigative case loads to agents, monitoring all continuing investigations, coaching and counseling agents, offering encouragement and support to agents, ensuring that agents received proper training and equipment, researching and preparing grants, and maintaining close liaison with other law enforcement agencies. He was co-administrator of the SBI applicant selection committee and a special task force member for high profile, sensitive investigations. He is also a Certified Fraud Examiner.

"We are delighted to welcome Mr Ellis to the Board's staff. He brings us a wealth of experience that will be invaluable in fulfilling the Board's mission," Mr Henderson said.

*Award-Winning Editorial***Doctor, Is It Time?***Elizabeth P. Kanof, MD, Former President, NCMB**Dr Kanof*

The following is the President's Message written by Dr Kanof for the first number of the Forum in 2001. Its message was noted nationally and the piece was reprinted as an editorial in the Federation of State Medical Board's Journal of Medical Licensure and Discipline in 2002. At the Federation's Annual Meeting in April of 2003, Dr Kanof received the organization's "Award for Excellence in Editorial Writing" for this article. We reprint it here with pride and with congratulations to Dr Kanof for her well-deserved award.

My decision, in December 1999, to retire from active medical practice was far more difficult than the one 45 years earlier to embark on a medical career. Yet, one couldn't but notice a lowered threshold of fatigue; less enthusiasm contemplating heading for the office on Monday mornings; more discouragement and frustration with the erosion of physician and patient autonomy by the impact of managed care; impatience with onerous governmental rules and regulations; bothersome restrictions imposed by drug formularies; less willingness to be attentive and sympathetic to patients' psychosomatic complaints; even heightened irritation at minor oversights on the part of staff.

Particularly troublesome was the uncertainty of what it would be like to exit the fast lane, to not have a schedule with a set pur-

pose each day, to no longer have one's professional life supremely well organized, and, most disconcerting of all, to be out of the trenches of the profession.

My father had tried to warn me years earlier. Himself a physician, he had chided me repeatedly and lovingly to develop a passionate and demanding avocation, one that I could devote myself to upon retirement. I hadn't listened.

Now, a year and a half later, there are still days that I miss the patients. A few lab coats, which I am not ready to part with, hang in the closet. But, gradually, as a new life style evolves, the desire to return to the office enters my consciousness less and less.

Participating in the work of the North Carolina Medical Board has given me insight into the possible scenarios that may develop when a colleague is unable to recognize the fact that it is time to retire. We see physicians who, after many years of successful practice and unblemished careers, suddenly make a serious error in judgement that would never have happened when they were younger. Or a file, previously empty, begins to show a trend of multiple, justified complaints from patients or colleagues, or events that reflect less than optimal judgement or outcomes.

Senior physicians often fail to consider the sacrifices their families have made during the active years of practice. Only when they begin to experience serious illness personally or among their families, friends, or colleagues does the opportunity and pleasure of devoting time and interest to those who, so many times over the years, were willing to accept second place in their lives become a more important and compelling priority.

North Carolina's physicians, their families, and their patients deserve better than retirement forced by unfortunate and potentially harmful circumstances. As responsible professionals, all of us need to have a coherent and sensible plan that permits, facilitates, and even encourages us to quit while we are ahead.

"North Carolina's physicians . . . deserve better than retirement forced by unfortunate and potentially harmful circumstances"

100 Years of Professional Nursing in North Carolina

Mary Lewis Wyche: Implementor of Dreams

Sindy Barker, CAE, Executive Director, NC Nurses Association

Polly Johnson, MSN, RN, Executive Director, NC Board of Nursing

As founder of both the North Carolina Nurses Association and the North Carolina Board of Nursing, Mary Lewis Wyche has been heralded as the pioneer and leading force in organized nursing in the state. And perhaps because of having a shared “ancestor” and a common background and vision, the close ties between the two organizations have survived for 100 years.

Miss Wyche was born February 26, 1858, near Henderson in Vance County. She had six sisters and several brothers. She attended Henderson College and, while a student, taught in the primary department of that school. After graduating, she moved to Chapel Hill where she established a home for her younger brothers while they attended the University of North Carolina. While in Chapel Hill, she taught school part time and also kept boarders. Her strong belief in education led her to make small loans to a number of young students who might not have otherwise been able to enter college.

By the time Miss Wyche’s brothers no longer needed her assistance, most of her sisters were married. Although she had arrived at an age when she could have been designated an “old maid,” she was just beginning her own life as a professional woman. Initially, she had thought she wanted to become a physician, but then decided on a nursing career. She graduated from Philadelphia General Hospital in 1894 at the age of 36.

Upon her return to North Carolina, she was appointed superintendent of nurses at Rex Hospital in Raleigh. She served as head-nurse, matron, and bookkeeper, and received \$25 a month with room and board. As soon as she was situated, she organized the

Rex Hospital Training School for Nurses. There were five students in the initial class and four of them graduated.

Miss Wyche realized the great need for higher standards for nursing in North Carolina.

She attended a meeting of the International Council of Nurses in Buffalo, New York, and listened to discussions on legislation and registration. She returned home to form a state nurses association. Her first attempt was to organize the Raleigh Nurses Association in 1901. She sent postcards to Raleigh nurses with this request: “Please meet me at the office of Dr. A. W. Knox at four o’clock p.m. Wednesday, October 10, 1901.”

Not one single nurse showed up, but this did not stop Miss Wyche. Two weeks later, a second postcard went out to her fellow nurses. This notice read: “There will be another important meeting of the Raleigh Nurses Association at 4 o’clock p.m. Wednesday, October 24, 1901.”

Curiosity took the place of indifference. The ruse worked. Every nurse heeded the second notice. Miss Wyche, after confessing the trick she had played in order to bring them together, presented her plans for the organization and asked their opinions.

The following year, with the help of the Raleigh Nurses Association, she set out to organize the state nurses association. Questionnaires were sent to every nurse in the state whose address could be secured. The response was favorable, so plans were made for these nurses to meet in Raleigh during Fair Week when railroads offered special rates. Fourteen nurses met with the Raleigh Nurses Association in the

“Miss Wyche realized the great need for higher standards for nursing in North Carolina”



Mary Lewis Wyche

Olivia Raney Library on October 28, 1902, and the North Carolina State Nurses Association was formed.

Miss Wyche's next step was to have a law enacted for the registration of nurses. This was her plan for raising standards and assuring better education in theory and skill in practice so that the public would have confidence in the registered nurse. It was accomplished through the NC State Nurses Association. This law, signed by governor Charles Aycock on March 3, 1903, made North Carolina the first state to establish registration of nurses.

Josephine Burton, of Craven County, was registered on June 4, 1903, becoming the first registered nurse in the country. In addition, another 85 women were licensed "without examination" in 1903. One of these nurses, Annie Lowe Rutherford, who graduated from Freedmen's Hospital School of Nursing, became the first African-American nurse to be licensed in the United States. Qualified individuals could be licensed "without examination" through 1909. After that year, all registered nurses were required to pass a licensing examination.

The original Board of Nurse Examiners was composed of two physicians appointed by the North Carolina Medical Society and three registered nurses appointed by the North Carolina State Nurses Association. Twenty years later, the law was changed so that the North Carolina Hospital Association could appoint one of the physician members. Eventually, the governor of North Carolina made all the appoint-

ments. In 1981, in perhaps one of the most significant revisions of the Nursing Practice Act, North Carolina became (and remains) the only state to elect its nurse members to the Board of Nursing.

Miss Wyche was made honorary president of the NC State Nurses Association for life in 1907. She served six years on the North Carolina Board of Examiners for Trained Nurses. She alternated her years in the nursing profession between private duty nursing and hospital nursing. She retired in 1925 after serving as superintendent of nurses at Watts Hospital in Durham for 10 years and Sarah Elizabeth Hospital in Henderson for two years. She compiled a history of nursing in North Carolina that was published in 1938, two years after her death.

For almost half a century, the Association and the Board either shared office space or had offices adjacent to each other. Although separated geographically, the close philosophical relationship continues today. In recent years, the two organizations have worked closely to help secure passage of legislation to protect the title of "nurse," to require all health care providers to have credentials on their name badges, and to enter into a multi-state compact that allows North Carolina nurses to practice in other compact states without securing a license in those states.

During the next century, may North Carolina continue to see these two organizations working collaboratively to assure quality nursing care for the citizens of the state.

"Josephine Burton, of Craven County, was registered on June 4, 1903, becoming the first registered nurse in the country"

License Portability

Australian Mutual Recognition Registration System for Medical Practitioners

*David H. Wilde, Registrar
Medical Board of South Australia*



Mr Wilde

Australia is made up of six independent States and has two Territories: South Australia; Western Australia; Tasmania; Victoria; New South Wales; Queensland; the Australian Capital Territory, and the Northern Territory.

Each of these independent bodies has a Medical Board or Council that is responsible for registration and disciplining of the medical profession in its geographic area.

All have separate Medical Acts that contain distinct differences as well as some similarities.

Before the advent of Mutual Recognition (MR),

these differences included the recognition of different basic and specialist qualifications for the purposes of registration. This led to the difficult situation where a practitioner could be eligible to be registered in one jurisdiction but ineligible to be registered and work in another.

Attempts to rectify this situation occupied annual joint meetings of Presidents and Registrars of the Medical Boards and Councils for many years, and whilst some progress was made, significant difficulties and differences remained.

When the Australian Medical Council (AMC) was formed (in 1984) as a joint initiative of the Commonwealth, State, and Territory Governments and the eight State and Territory Medical Boards, one of its main tasks was to give advice and make recom-

Australian Mutual Recognition System

“When the Australian Medical Council was formed . . . one of its main tasks was to give advice and make recommendations . . . on uniform approaches to registration”

mentations to the Medical Boards and Councils on uniform approaches to registration.

As a point of clarification, the relationship between the AMC and the State and Territory Boards and Councils is one of equals inasmuch as the AMC does not have directional powers over the Boards and Councils. It is the Boards and Councils who exercise statutory power and responsibility through the powers of their respective Acts.

Whilst discussion and debate was ongoing in regard to uniform approaches to registration between the Boards, the Commonwealth and State and Territory Governments reached an agreement on MR within each State and Territory, “...of regulatory standards adopted elsewhere in Australia regarding goods and occupations.”¹

This resulted in the Commonwealth Mutual Recognition Act, 1992 (the MR Act), the principal purpose of which is:

*“...to enact legislation authorised by the Parliaments of States under paragraph (xxxvii) of Section 51 of the Commonwealth Constitution and requested by the legislatures of the Australian Capital Territory and the Northern Territory, for the purpose of promoting the goal of freedom of movement of goods and service providers in a national market in Australia ...”*²

This Act clearly covered more areas than just the practise of medicine, but just as clearly could be applied to the practise of medicine.

*“...occupation means any occupation, trade, professional calling of any kind that may be carried on only by registered persons, where registration is wholly or partly dependent on the attainment or possession of some qualification...”*³

For the MR Act to apply in each of the States and Territories, they had to be a participating jurisdiction. To become a participating jurisdiction, a State or Territory had to pass enabling legislation that recognised the Commonwealth MR Act to apply in their particular jurisdiction.

Not all States and Territories enacted legislation to enable them to become participating jurisdictions at the same time. Furthermore, at least in relation to medical practice and the Medical Acts in existence in each jurisdiction, much consideration and advice concerning necessary amendment to the individual Medical Acts was necessary.

Implementing Mutual Recognition

To assist in this implementation process, the Australian Health Minister's Advisory Committee (AHMAC) appointed a Technical Advisory Group (TAG) to assist each of the Boards and Councils in the implementation of MR. This group consisted of the Secretary of the AMC, the Registrar of the New South

Wales Medical Board, and the author, as Registrar/CEO of the Medical Board of South Australia.

The necessity for the formation of the TAG group can be understood when it is realised that the complexities concerning registration and disciplinary matters (which increase almost everyday) are the province and expertise of the CEOs and Registrars of the Boards and Councils who deal with these issues on a daily basis.

The task of this group was to visit (on one or more occasions) each State and Territory and hold discussion with the relevant:

- Medical Board or Council;
- Minister of Health or a person representing the Minister; and
- Parliamentary drafts person who is responsible for drafting legislation and amendments to legislation.

It was to explain the implications of the MR Act in terms of each jurisdiction's medical registration requirements.

It became obvious to TAG that the MR Act had both broad implications and very specific implications, which varied to some degree within each jurisdiction.

Broad, in respect that if a Board or Council was registering a person for the first time, particularly if that person were from overseas with foreign qualifications, then that Board or Council would be registering that person on behalf of every other medical registering authority, given the implications of the MR Act.

It was apparent from the requirements of the MR Act that a geographic registration (eg, to practise psychiatry in Brisbane, QLD, only) was not sufficient to restrict the practice of that person to the city of Brisbane or the State of Queensland. The practise of psychiatry (and any other discipline of medicine) would be held to be the same (an equivalent occupation) as the practise of psychiatry in Adelaide or any other location in Australia. In other words, greater mobility across State lines would be a reality.

This led, as a consequence, to the need for each registering authority to have in place rigorous and efficient methods of auditing applications for registration before registration would be granted.

This would require stringent checking of authenticity of qualifications by contact with the issuing institution (where considered necessary), contacting referees to ensure that claimed experience and areas of practice were genuine, and establishment of current ‘Good Standing’ status and verification of identity.

For some considerable time in Australia, the production of fraudulent or bogus qualifications had not been an issue, and it was common for acceptance of documentation to be taken at more or less face value. More recent events have brought home the need for

far greater vigilance in this area.

Some of the more specific issues that became obvious were the differences in legal meaning in the various jurisdictions of Specialist Registration, Full Registration, Conditional Registration, and Provisional Registration, which in many instances either had different legal implications or simply did not exist at all. Similarly, some Boards and Councils did not have the ability to impose conditions on a person's registration or could only do so in specific instances.

There was yet a further issue of those who were already registered in the various jurisdictions and were working permanently in those areas (either citizens or permanent residents) and those who were registered to work for a given period of time, either to fill area of need positions or to undergo specific training. The latter two groups would have immigration visas that had specific conditions attached to them (either geographic boundaries or to a specific training institution). It was and is possible for these visa conditions to be varied, where the immigration authorities are persuaded it is reasonable to do so.

All these questions and others were raised by various groups to TAG.

In essence, the MR Act requires that if a person is registered to carry out a profession in one jurisdiction, they are entitled to be registered to carry out that profession in any other jurisdiction within the Commonwealth.

This principle is subject to certain caveats, which include:

"...that the recognition does not affect the operation of laws that regulate the manner of carrying on an occupation in the second State, so long as those laws:

- a) Apply equally to all persons carrying on or seeking to carry on the occupation under the law of the second State; and*
- b) Are not based on the attainment or possession of some qualification or experience relating to fitness to carry on the occupation..."*⁴

Mechanics: How Does a Person Use MR to Become Registered?

Section 19 of the MR Act states:

"...Division 2 - Entitlement to registration

19 Notification to local registration authority

- (1) A person who is registered in the first State for an occupation may lodge a written notice with the local registration authority of the second State for the equivalent occupation, seeking registration for the equivalent occupation in accordance with the mutual recognition principle.*
- (2) The notice must:*
 - (a) state that the person is registered for the occupation in the first State and specify that State; and*
 - (b) state the occupation for which registration is*

sought and that it is being sought in accordance with the mutual recognition principle; and

- (c) specify all the States in which the person has substantive registration for equivalent occupations; and*
 - (d) state that the person is not the subject of disciplinary proceedings in any State (including any preliminary investigations or action that might lead to disciplinary proceedings) in relation to those occupations; and*
 - (e) state that the person's registration in any State is not cancelled or currently suspended as a result of disciplinary action; and*
 - (f) state that the person is not otherwise personally prohibited from carrying on any such occupation in any State, and is not subject to any special conditions in carrying on that occupation, as a result of criminal, civil or disciplinary proceedings in any State; and*
 - (g) specify any special conditions to which the person is subject in carrying on any such occupation in any State; and*
 - (h) give consent to the making of inquiries of, and the exchange of information with, the authorities of any State regarding the person's activities in the relevant occupation or occupations or otherwise regarding matters relevant to the notice.*
- (3) The notice must be accompanied by a document that is either the original or a copy of the instrument evidencing the person's existing registration (or, if there is no such instrument, by sufficient information to identify the person and the person's registration).*
 - (4) As regards the instrument evidencing the person's existing registration, the person must certify in the notice that the accompanying document is the original or a complete and accurate copy of the original.*
 - (5) The statements and other information in the notice must be verified by statutory declaration.*
 - (6) The local registration authority may permit the notice to be amended after it is lodged..."*⁵

These requirements are included in the common application form. Commonality relates to the information required, not necessarily to the "lay out" of the form. Persons applying may do so by completing the form and posting it to the relevant Board. Personal appearance at the Board's office is not required.

Once the application form has been lodged and is seen to be in order, deemed registration applies. The jurisdiction with which the form is lodged has one month to satisfy itself that all is as it appears.

If during that one-month period it is shown that:

- any of the statements or information in the notice required by Section 19 are materially false or misleading, or
- any document or information required has not been provided, or
- the circumstances of the person lodging the notice have materially changed since the date of notice or the date it was lodged⁶,

"The MR Act requires that if a person is registered to carry out a profession in one jurisdiction, they are entitled to be registered to carry out that profession in any other jurisdiction within the Commonwealth"

Australian Mutual Recognition System

the receiving jurisdiction may postpone granting registration until those concerns are satisfied or refuse registration in its entirety.

Additional Information Can Be Sought

Once registration pursuant to MR has been granted, an individual Board or Council can then seek such additional information from the practitioner as may be required pursuant to that particular Board/Council's specific legislation. For example, my own Board is required to keep residential address, e-mail address (where applicable), and private telephone numbers. Whilst this information is not available to the public, it is held to cover situations of a national emergency and ease of contact in such circumstances.

At the time that MR was under consideration, the TAG team argued strongly that personal application was necessary but its advice did not prevail.

Rejection of an Application

An MR application may be rejected or postponed on several grounds:

- because all information required is not to hand;
- the information provided is established as being fraudulent;
- the conditions that apply to the registration in the first jurisdiction cannot be reasonably applied in the second jurisdiction.

Disciplinary Matters/Decisions

It is not only registration that is transferable. The results of disciplinary proceedings taken in the first or subsequent jurisdictions where a person is registered apply to all registering jurisdictions in the Commonwealth.

For example, if a practitioner's registration is suspended in one jurisdiction, that suspension applies in all other jurisdictions where the practitioner is registered and would prevent registration in another jurisdiction where registration may be sought under the provisions of the MR Act.

As with most legislation that attempts to override separate State or Territory legislative requirements, whilst generally working very well, there are both actual difficulties that have arisen and identified difficulties that could arise.

On the positive side, a practitioner holding unrestricted (Full) registration on the General Register and who is engaged in general practice, may exercise the provisions of the MR Act without difficulty, provided of course that appropriate documentation is received and fees are paid.

The situation regarding Specialist practice is somewhat more complex. At the present time, only two States (South Australia and Queensland) have methods of identifying practitioners engaged in Specialist

practice. Whilst MR works well in relation to applications between these States, applications from practitioners in other States and Territories require a split approach. Where legislation requires entry onto the General Register before entry onto the Specialist Register, MR can be used for the former, but application for entry onto the Specialist Register requires personal application and the requirements outside of the MR Act to obtain registration.

Area of Need

In common with many other countries, Australia has a situation of both a maldistribution of its medical workforce and an outright shortage of practitioners in some specialties and/or geographical areas.

In order to address this problem, which is more pressing in some States and Territories than others, a system of 'Area of Need' registration has been developed.

Put simply, in order to fill an area of need (a shortage or actual complete lack of medically trained persons in some areas) registration with conditions will be granted to practitioners who, under normal circumstances, would not qualify for Full Registration. These persons do go through a form of assessment and are granted immigration visas to practise, usually for a fixed duration (but the duration can in some instances be extended) in specific geographic areas of practice, or, in some instances, a particular hospital department.

The difficulties that arise in relation to MR and 'Area of Need' registration include the following.

1. Areas of need exist in all States and Territories to differing degrees of magnitude (and some geographic areas are far more desirable than others).
2. Practitioners are, therefore, able to use MR to move across State and Territory borders from one area of need position to another area of need position.
3. Even if a practitioner does not move, it may be the case that they remain in practice for many years without complaint being received regarding their standard of practice. At some stage, such a practitioner may well petition a Board and or a Court of jurisdiction to have their registration converted to full, unrestricted status.
4. It cannot be assumed that such practitioners are capable of unrestricted practice. Patients are by and large discerning and will quickly assess those areas of practice - perhaps some of the more complex areas - that they would be better off consulting the doctor in the next town about.

(Whilst as yet such an event as proposed in 3 and 4 above has not occurred, the potential for it to occur remains.)

"If a practitioner's registration is suspended in one jurisdiction, that suspension applies in all other jurisdictions where the practitioner is registered and would prevent registration in another jurisdiction"

5. Area of need registration, therefore, at least has the potential to allow a practitioner to bypass the Australian Medical Council's Examination, which is the examination applied to all overseas trained practitioners seeking to have unrestricted rights of general practice in Australia.

Some Other Difficulties

Previously in this article, reference was made to the inability of a Board or Council in a second or subsequent jurisdiction to require personal attendance when seeking registration under MR. Because of the geographic nature of the Commonwealth (this has been referred to as the "tyranny of distance") and the maldistribution of practitioners, there are great distances between towns and capital cities (where registering authorities are situated). It is, therefore, possible for a practitioner who is unwell or subject to a pending complaint to gain registration in a second or subsequent jurisdiction before the difficulty that exists with the practitioner comes to the notice of the original or subsequent registering authority. Indeed, this has happened. This is particularly relevant when psychiatric disturbance or major behavioural issues such as boundary violations are present. Whilst the incidence of such occurrence is very low, it is an identified difficulty that is currently being addressed.

A further difficulty, or perhaps more of an inconsistency, is that a person does not have to use MR and can apply to be registered in the non-MR way. Once again, this only happens very occasionally. When it does, it is usually from a situation where a practitioner allows his/her registration to lapse in the first jurisdiction (where perhaps certain conditions may apply to that registration), applies in the second jurisdiction, is able to obtain unconditional registration, and then returns to the first jurisdiction to use MR to obtain unconditional registration in that jurisdiction.

As the majority of Medical Boards and Councils in Australia are self-funding, that is, they meet all running costs from registration fees and receive no input from general revenue (the Government), it is essential that MR applicants pay the annual registration fee applicable in each State and Territory in which they wish to practise. Similarly, it is essential that each State and Territory authority knows who is practising in their jurisdiction. The MR system operative in Australia ensures this happens.

In regard to Telemedicine, agreement has been reached amongst the Boards and Councils that the consultation is to be held as taking place where the patient is located and thus the practitioner should be registered with the jurisdiction where the patient is. The MR system allows this to occur, with less difficulty than before its inception.

The Way Ahead

More recent events in Australia have led to a

requirement for an even greater ease of portability of registration between the States and Territories. This is to be achieved by enhancement of the current MR system.

Active consideration is therefore being given to the following.

- The creation of a National Index of practitioners registered to practise (with a unique identification). This is not to be confused with a National Register.
- Consolidation of registration categories so that the same categories apply in the same way and indicate the same status in each of the States and Territories.
- Identifying in a meaningful way where a practitioner is qualified to engage in a particular area or areas of specialist medical practice.
- Accurate and confidential means of communication between Boards and Councils relating to the health and disciplinary status of an individual practitioner.
- What information should be available to individual members of the public concerning individual practitioners.
- The possibility of increasing the use of computerisation in the whole process.

These issues are not without difficulty, but are the subject of ongoing consideration and debate.

As with most Federations, the member States and Territories of this Federal system are fiercely protective of their identity and autonomy. "Friendly" rivalry exists over many issues. These rivalries notwithstanding, there are differences in the way some aspects of medicine are practised. In addition, there are wide variations in climate in Australia, from tropical to rain-forest to temperate to Mediterranean. Disease patterns do vary considerably in some areas. Perhaps the most significant differences relate to politics and budgets. It is now the case that each of the States and Territories have Governments of the same political persuasion. The Federal Government, on the other hand, is of a different political persuasion.

These facts notwithstanding, there is a genuine and general willingness to make MR work and to improve upon it so that it becomes even more efficient and "user friendly."

When the overall picture is considered, there are far more similarities to build upon than there are difficulties and differences to overcome. The trick will be to achieve the improvements required and at the same time have sufficient flexibility to cater for a particular State or Territory's particular need.

NOTES

1 Commonwealth of Australia Mutual Recognition Act, 1992 (Act No: 198 of 1992)

2 Ibid

3 Ibid (Page 2)

4 Ibid (Page 8 - Part 3 Occupations)

5 Ibid (Pages 10 & 11)

6 Ibid (Page 12)

"More recent events in Australia have led to a requirement for an even greater ease of portability of registration between States and Territories"

Apology: Best Practices

Susan M. Rakley, MD

Veterans Administration Medical Center, Durham, NC

Associate, Center for Professional Well-Being



Dr Rakley

After a harrowing night on call, you arrive at clinic to find five new patients on your schedule. You have told your receptionist never, ever to schedule new patients after a call night. You are certain to have a stressful, rushed day on top of little sleep. You storm up to the receptionist and let her know how incompetent you think she is. She bursts into tears.

An hour ago, the nurse called you in a panic. Mrs Block, who is depressed and hospitalized for cellulitis, was discovered short of breath, covered with urticaria. After some epinephrine, diphenhydramine, and steroids, she's doing better. On reviewing the medication sheet you realize that, instead of the Celexa® you ordered, she was given Celebrex®. She has a well documented aspirin allergy. Speaking to the pharmacist, you realize that your sloppy handwriting caused the mix-up. At this moment, the family arrives. They are clearly anxious and angry.

What do these two scenarios have in common? In both, an action on the part of the physician caused another person distress: physical, mental, or both. Because of what has transpired, the relationships are strained and unstable. Trust is broken.

How does one reestablish equilibrium and trust after harm has been done? All too often, the response is to do nothing. One waits until the other party "gets over it," hopes it's forgotten, or pretends it didn't happen. Stonewalling, however, is a high-risk response. If the relationship is not brought into balance in a positive way, the injured party may seek retribution to "even the score." The need for information and prevention of future incidents fuels many lawsuits. The current emphasis on openness in the face of medical errors will likely increase patients' awareness of real or potential harm.

Apology is the method by which positive relationships are reestablished after an incident of harm. The goal of apology is forgiveness. Forgiveness is not too strong a word to describe the desired outcome of apology, even for minor things. Forgiveness, in the context of apology, means the willingness of the harmed party to continue the relationship, not seek revenge, to feel the incident is closed, and to look to the future.

Like anything else, apology can be done poorly or it can be done well. We have the sense that mumbling, "I'm sorry," probably isn't enough. Most of us, however, don't know what steps must be taken to best increase the likelihood of forgiveness. I call these steps

the best-practices model of apology. As described by Leonard Marcus of the Harvard School of Public Health, a best-practices apology has five elements: acknowledgement of the other person's experience; acceptance that one's actions resulted in that experience; articulation of regret; offer of remedy; and plan for preventing future similar harm. Each of these will be examined in more detail.

Step 1: Acknowledgment

The first step of a state of the art apology is to acknowledge the other person's experience of harm. Through acknowledgement, the other person comes to know that you understand the harm they have experienced in a very direct way: "Mary, I can see that you're upset," or, "Mrs Block has had an allergic reaction to Celebrex®; I can imagine it must be worrisome to see her covered in red splotches." Acknowledgement recognizes the other person's subjective experience. It does not involve trying to agree on what is objectively true. Arguing about how the other party should feel moves the parties further away from forgiveness. Of course, if you don't know what the other person's experience has been, the task is to question and listen. This simple demonstration of concern, rather than judgment of the person's response, will go a long way toward encouraging forgiveness.

Notice from the examples given that there is no assignment of blame in the acknowledgement step. The stance is: "I can see you're upset," not, "I have upset you," or, "Why are you so upset?" This means that acknowledgement can be given even in cases where there was no intention of harm or where harm occurred despite doing everything correctly.

Step 2: Acceptance

In the acceptance step, you accept that there is a relationship between one's actions and the harm that has been experienced. This is done by explaining what led up to the event. The person offering the apology narrates, from their own viewpoint, what circumstances and actions led up to the incident. The injured party is given an opportunity to ask questions and offer their own narrative.

By relating your role in the events, you accept that there is a causal link between your actions and the harm experienced. It is appropriate to discuss one's intentions and motivations within

"How does one reestablish equilibrium and trust after harm has been done?"

that context. However, the emphasis is on what actually happened. "I saw five new patients on the schedule, lost my temper, and yelled at you." This is not a judgment or an acceptance of blame. It is not an admission that one's actions were negligent, ill-intentioned, mean, nasty, misinformed, or just plain wrong. It's simply an articulation that you accept that harm occurred that was, in some way, dependent on your actions. Again, this step is appropriate even if everything was done absolutely correctly.

Step 3: Articulation of Regret

The third step is what people most commonly think of as an apology. It is expression of one's own distress at having been part of the other's experience of harm. "I'm sorry that I yelled at you," "I deeply regret that the medication error caused your mother's discomfort, your worry, and prolonged her hospitalization." It is a moment of vulnerability because it requires the revealing of emotion: sorrow, regret, remorse. It can be difficult for physicians to acknowledge those feelings, even to themselves. It is a profoundly human moment. Sincerity is essential. If you don't feel badly in some way about what happened, what you're doing is not an apology.

Step 4: Remedy

At this point in the process you have acknowledged the other's perceived harm, explained what actions led up to it, and expressed regret that the harm occurred and that you had a part. The next step in the state-of-the-art apology is to offer remedy to mitigate the effects of the harm. For example: "I've given your mother medication to stop the effects of the allergic reaction and she is responding well. I've told the nurses to be sure to keep me informed and I plan to stop back to see her at 4 PM." The goal is to try, as much as possible, to obviate the harm.

You may not know what would make it right. If you aren't sure, or don't know, ask directly. "Mary, I'd like to make this up to you but I'm not sure how. What do you think would make things right?" If you do have a plan for remedy, you should check with the other person to make sure it suits their needs. It's not necessary to immediately agree to give the person what they think they need. Negotiation may be appropriate. It is, however, necessary to demonstrate that their request is taken seriously.

Step 5: Plan for the Future

Studies of professional liability lawsuits show that, in addition to wanting an explanation and

apology, many plaintiffs bring lawsuits in an attempt to assure that no one else suffers as they did. The fifth step, plan for the future, gives that assurance directly to the injured party. The giver of the apology outlines what steps they themselves will take to prevent future, similar events. "In the future I will print medication orders. Also, the hospital has a reporting system for medication errors so processes can be improved for the hospital as a whole. I'll make sure a report on this gets to them." The benefit of this step goes beyond reassuring the injured party. It also moves the focus towards the future and improvement and away from the past and harm.

Conclusion

We have described the best practices of apology. Does every circumstance require every step to rebalance the relationship and reestablish trust? Of course not. An analogy can be drawn to the use of the state of the art in medicine. There are times where, say, a pulmonary angiogram would be the state of the art in the diagnosis of pulmonary embolism. In any particular circumstance, a ventilation/perfusion scan will do nicely. However, the greater the risk, the greater the uncertainty, the greater the potential gain. In such circumstances, actual practice must approach the state of the art.

It is the same in our professional, clinical, collegial, and personal relationships. The state of the art apology is required for incidents that result in significant harm or the perception of harm, that threaten an important relationship, where the other party is likely to seek retribution, and where remorse is felt regardless of harm. Failure to take each step will likely leave you with a burden of guilt or fear and the other person with a load of anger and resentment. The opportunity to exchange valuable information will be lost. The opportunity to problem-solve together will be lost.

A best-practices apology may not always result in forgiveness. It is certainly more likely to produce forgiveness than stony silence, denial, or defensiveness. Just knowing these five steps is like starting a difficult surgical case with the right instruments and the time-tested approach in hand. That in itself does not guarantee results. However, by going through each of the five steps, openly and sincerely, you can be assured that your apology is the best anyone could do. Acknowledgment, acceptance, articulation of regret, remedy, and plan for the future open a door through which parties can walk together to a restoration of positive interactions and trust.

"You may not know what would make it right. If you aren't sure, or don't know, ask directly"

[See following Commentary]

A Commentary on “Apology: Best Practices”

Understanding the framework for a “best-practices” approach to apology in the context of medical practice is good not only for decreasing unremitting anger and/or lawsuits but also for enhancing medicine as a noble and healing profession. As each physician decides that some or all facets of apologizing are necessary, some significant professional outcomes are possible from essentially simple acts. The apology itself will encourage the patient to view the doctor as a human being, not an automaton, and medicine as a truly humane endeavor. Should forgiveness then be forthcoming, it will allow trust to be re-cemented and a potentially broken bond restored. Apology and forgiveness are done for their own sakes. They are acts of humanity. We all gain in the transaction. In a sense, we are refusing to allow the actuality of medical imperfection to blind us to our essentially caring role.

When physicians have described to us their feelings in articulating their regret, even when they were not sure of the actual causal chain, they have said they approached the patients as someone sensitive to their distress. The physicians acknowledged their own personhood and feelings. More specifically, they used the first person: “I recognize the anxiety or pain or uncertainty you suffered.” Compassion was thus demonstrated. They listened to the concerns of the patients and communicated deeply. We contribute to healing by val-

uating an intention to remain honest in spite of harm or bad things happening.

As Dr Rakley aptly describes, allowing vulnerability, the revealing of emotions, is profoundly human, and all interactions give you this opportunity. In the throes of potential harm, some self-disclosure is essential. Rarely have these experiences been given the validity they deserve by teaching faculty. It is especially important that whoever is involved in the apology transaction make a personal statement that: “I am committed to doing all I can to assure such ‘accidents’ do not continue.” Those few words will portend well for future trust, partnerships, and commitment to honest dealings.

Dr Rakley’s article causes us to consider the parallels between this “best-practices” model and what a healing relationship requires: truth, clarity, objective and subjective awareness, and compassion for another human being in an anxiety-provoking state. From our bias in caring for caregivers in distress, appropriate apologies allow the future to exist less clouded by past events. Dispensing appropriate apologies is good physician self-care. Art and caring are still needed in this technological age of overburden.

John-Henry Pfifferling, PhD
Director, Center for Professional Well-Being
Durham, North Carolina

Amy L. Yonowitz, JD, Joins NCMB Legal Staff

R. David Henderson, executive director of the North Carolina Medical Board, and Thomas W. Mansfield, JD, director of the Board’s Legal Department, recently announced that Amy L. Yonowitz, JD, has joined the staff of the Board’s Legal Department.

Ms Yonowitz earned her BA degree from Rutgers University and her JD from the University of North Carolina School of Law. At Rutgers, she was a Douglass Scholar and president of the Rutgers University Women’s Political Caucus. At UNC, where she was on the Dean’s List, she was 3L class president and Honor Court justice. She is a member of the Wake County Bar and North Carolina State Bar.

Her experience has included several years as an assistant district attorney in the District Attorney’s Office of the First Judicial District in Elizabeth City, NC. There she conducted Superior and District Court prosecutions, planned and conducted criminal jury and bench trials, and oversaw training of new employees and interns.

Following that, she served as special counsel to the Governor’s Advocacy Council for Persons with Disabilities. In that role, she represented mentally ill

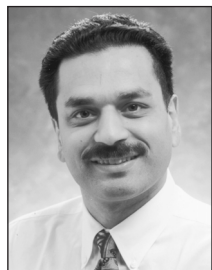
clients pursuant to federal statutes, conducted administrative hearings and special proceedings, analyzed legislation affecting persons with disabilities, and participated in educational outreach in the community.

Immediately prior to coming to the Board, Ms Yonowitz was an assistant attorney general in the North Carolina Department of Justice. There she served as legal counsel to the North Carolina Criminal Justice Education and Training Standards Commission and the North Carolina Alcoholic Beverage Control Commission; conducted federal, state, and administrative litigation; wrote appellate briefs and presented oral arguments to the North Carolina Court of Appeals; and drafted and analyzed legislation and rules affecting law enforcement and alcoholic beverage control laws.

In her new role, Ms Yonowitz joins Mr Mansfield; Brian L. Blankenship, JD; Marcus Jimison, JD; and Mary B. Wells, JD.

“Ms Yonowitz brings a strong background to the Board and we are very pleased to have her with us. She will contribute significantly to the Board’s efforts to serve the people of North Carolina,” said Mr Henderson.

Hari Gupta Named NCMB Director of Operations



Mr Gupta

R. David Henderson, executive director of the North Carolina Medical Board, has announced that Hari Gupta, who recently resigned from the Board, on which he served as treasurer, has joined the Board's staff as director of the Operations Department.

Mr Gupta, who lives in Morrisville, was born in London, England, and grew up in Vancouver, British Columbia, Canada. He earned two bachelor of science degrees, one in computer science and the other in civil engineering, from Washington State University.

Mr Gupta began his career as a programmer and systems analyst in Toronto, Canada, and soon moved on to a consultant's post with the Computer Task Group in Columbus, Ohio. In 1990, he joined SAS Institute in Cary, North Carolina, beginning as a software developer and then moving to applications development. In 1996, he became consulting director for SAS Asia Pacific/Latin America, and doubled AP/LA consulting revenues for two consecutive years. In 2000, he assumed the role of general manager for SAS Global Services, building and managing a 70-member team of software consultants based in India and the United States.

In 2001, Mr Gupta became director of SAS Consulting Partners, responsible for building and managing alliances with key SAS partners and for developing and monitoring guidelines for the SAS Consulting Partner program.

He left SAS in late 2001 to develop other business interests in residential and commercial real estate.

Mr Gupta was appointed to the Board in February 2002. While on the Board, he served on the Legal and Complaints Committees and took office as treasurer in November 2002. He resigned from the Board in April 2003.

In making the announcement, Mr Henderson said: "We are pleased that Hari is remaining with the Board in this new role. He brings valuable business experience with him, combined with practical experience as a Board member."

**North Carolina
Medical Board**



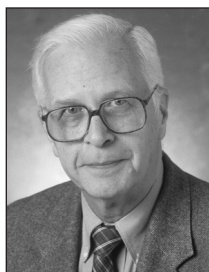
1-800-253-9653

State Medical Board Executive Is Honored

Jim Shamp

Medical Reporter, Durham Herald-Sun

[Reprinted with permission from
The Herald-Sun of May 9, 2003.]



Mr Breaden

Dale Breaden, director of the North Carolina Medical Board's Public Affairs Department, has received the 2003 Special Recognition Award from the Federation of State Medical Boards.

Breaden, who lives in Durham, was associate executive vice president of the Federation for 14 years before joining the North Carolina Board's staff in 1995. The Federation is the national association of the 70 state medical licensing and disciplinary authorities in the United States and its territories.

Breaden received the award at the organization's annual meeting in Chicago in April for conceiving and organizing the first International Conference on Medical Licensure/Regulation and Discipline. That 1994 conference evolved into the International Association of Medical Regulatory Authorities.

In 1983, during a thaw in U.S.-Soviet relations, Breaden led a group of state medical board officials on a visit to major medical facilities in the former Soviet Union and the People's Republic of China.

"I began to think that a continuing international dialogue on the issues that confront medical licensure and registration in all modern societies was long overdue," he said.

In 1989 and 1993, he made extended visits to Australia to study that country's medical registration system. He began communicating with medical leaders in several countries, he said, about the need for an international conference system in the field of licensure, registration, and discipline.

He got a \$100,000 federal contract from the Bureau of Health Professions in the U.S. Department of Health and Human Services, plus a \$5,000 foundation grant, and organized the first international medical licensure conference. Thirty-five representatives from seven nations attended the three-day conference in Washington, D.C., along with more than 30 observers.

The organization, which has grown and continued to meet every two years, Breaden said, will meet next year in Dublin, Ireland.

How to Determine If Your Practice Could Use a Professional Practice Administrator

Marjorie A. Satinsky, MA, MBA
President, Satinsky Consulting, LLC



Ms Satinsky

The business of practicing medicine presents many management challenges for physician practices. Practices that strive for excellence in balancing financial stability, operational efficiency, compliance with legal and regulatory requirements, and provision of high quality care might benefit from the services of a professional practice administrator.

To determine whether hiring a professional administrator is the right approach for your practice, it is important to have a good understanding of your practice's current needs and readiness to hire a professional practice administrator. If you are ready to make a change, you'll need a strategy for recruitment and hiring.

Assessing Your Practice's Management Needs

An effective way to assess your practice's need for a management change is to take a broad look at how you currently manage your practice. Focus your review on: daily practice operations, planning and marketing, financial management including dealing with managed care, human resources, facilities, information technology, legal and regulatory compliance, relationships with external individuals/organizations/agencies, and use of outside consultants. Here are sample questions in each of these categories.

Sample Survey of Current Practice Management

Daily Practice Operations

- Do our current methods for overseeing daily practice operations meet the needs of physicians, managers, staff, and patients?
- Do we work well as a team to identify operational problems, determine feasible alternatives, and implement changes on a timely basis?
- Do we develop and communicate practice plans and policies to physicians and staff clearly and on a timely basis?

Planning and Marketing

- Have we developed and do we annually update a strategic plan that addresses long- and short-term priorities? A short-term priority might be implementation of an electronic medical record system, and a long-term priority might be moving into a larger space.

- Do we have current knowledge of demographic trends, community dynamics, new laws and regulations, and competition so our practice can respond to changes in the external environment?
- Do we have a marketing plan that supports the objectives set forth in our current strategic plan?

Financial Management

- Do our systems for billing, claims processing, and collections result in accounts receivable management that meets benchmarks for our specialty?
- Are we satisfied with our current systems for preparing and regularly monitoring our operating budget and capital equipment plan?
- Does our managed care strategy include review and negotiation of contract language and reimbursement rates, monitoring actual vs. expected payments, and making sure that operational systems comply with managed care requirements?

Human Resources

- Are responsibilities and accountabilities for both clinical and non-clinical staff clear?
- Do we have standardized job descriptions and a job classification system?
- Do we use a performance review system to manage orientation, training, regular review, and disciplinary action for managers and staff?
- Do we have systems for physician recruitment, hiring, orientation, and performance review?

Facilities

- Does the size of our facility meet our current and projected needs?

Information Technology

- Do we use information technology to support the administration of our practice and the direct provision of patient care in ways that meet our needs and budget?

Quality Assurance

- Do we have effective methods for responding on a timely basis to inquiries about claims and patient complaints?
- Do we use satisfaction surveys regularly to determine our ability to meet the needs of patients and of all those individuals, organizations, and agencies with which we regularly relate?

Legal and Regulatory Compliance

- Is legal and regulatory compliance a priority for our practice?

"An effective way to assess your practice's need for a management change is to take a broad look at how you currently manage your practice"

- Are we satisfied with the ways in which we learn about, meet, and monitor requirements?

Relationships

- Have we identified the external individuals, organizations, and agencies with which we need to develop relationships? Examples are other physicians' practices, hospitals, managed care plans, professional organizations, and regulatory agencies.
- Are responsibilities for maintaining these relationships clear?

Use of External Consultants

- Do we use consultants to help us with tasks we cannot perform internally?
- Do we manage the consultants that we have identified as appropriate resources for our practice?

Is Your Practice Ready for a Professional Practice Administrator?

If the responses to the questions above identify aspects of your current practice that need improvement, take the next step and examine your practice's readiness for a professional administrator. In many situations, a professional practice administrator can relieve physicians and other staff of responsibilities they ought not have. The important question is whether or not your physicians and staff are receptive to change. Here are questions that can help you determine readiness for hiring a professional practice administrator.

- Are we are satisfied with the role that physicians now play in the management of our practice?
- In our opinion, does the current practice manager have the vision and skill to make the practice flourish?
- Are our current physician leaders intellectually receptive to sharing power with a professional practice administrator in order to improve the practice?
- Given the individual personalities of everyone in our practice, what is the likelihood that we can adjust to hiring a professional practice administrator?
- Would we be willing to support a financial package for a professional practice administrator that includes salary, benefits, and bonus?
- If necessary, are we willing to revisit our governance structure, organizational chart, and policies and procedures to hire a professional practice administrator into our practice?
- When we look at the current distribution of management responsibilities, would hiring a professional practice administrator increase the time that physicians can spend on patient care, practice planning, and professional education?
- By centralizing appropriate functions under a professional practice administrator, can we improve the performance of multiple sites currently functioning under the direction of local practice managers?
- Are our physicians receptive to working in partner-

ship with a qualified and experienced non-physician professional practice administrator on practice finances and other appropriate issues?

- Would we be comfortable having a professional practice administrator work with us to develop a vision for the practice and assume responsibility for assuring that our operations support that vision?

Finding the Right Practice Administrator

If the responses to this second set of questions clearly indicate that your practice is receptive to hiring a professional practice administrator, how do you find the right one? You have some important decisions to make in order to develop a job description and employment agreement, advertise, identify qualified candidates, interview candidates by telephone and in person, and select the best candidate for the job.

Begin the recruitment process by developing a job description and an employment agreement. Start internally by listing the responsibilities that you want the practice administrator to assume. Compare your list with job descriptions that colleagues in other practices are willing to share with you. Then make the job description part of a formal employment agreement that covers salary, benefits, profit sharing, bonus, leadership development, and professional education.

Newspaper advertising is suitable for local and regional exposure. If you decide to do a national search, contact the professional practice management association to which many practice administrators belong. You may want to use an executive search firm to help you further refine the job description and identify and screen qualified candidates. If you take this approach, check the internet to identify firms that specialize in medical practice management.

If you already have a practice manager who has some, but not all, of the skills required by a practice administrator, invite him or her to apply for the position. By using your structured job description, you can objectively match skills against requirements and minimize discomfort if your current staff person isn't qualified to do the job. You may find that your current employee is willing and able to do the job with appropriate education and coaching.

Structure the interview process so that you convey and obtain information that will help you make an informed decision. Probe about technical knowledge, ability to manage resources, communication skills, leadership and decision-making abilities, management style, and experience with change and innovation. Share with candidates both the job responsibilities and the values of your practice; both are important and should be made clear from the outset. Use the face-to-face interview to inquire about and observe qualities of an outstanding administrator that resumes don't reveal, such as management style, entrepreneurial skill, determination, and people skills. Develop a formal method for gathering and summarizing the

"The important question is whether or not your physicians and staff are receptive to change"

Professional Practice Administrator

impressions of everyone with whom the candidates meet so you can create a composite profile for each candidate. Check references carefully. Finally, consider using a numerical ranking system to order your choices. Your decision is important, and you want to be as objective as you can.

Conclusion

By doing an honest assessment of your practice, determining the practice's readiness for a professional practice administrator, and using a thoughtful and objective process for recruiting and hiring, you can make sure that the management of your practice meets the highest standards of excellence.

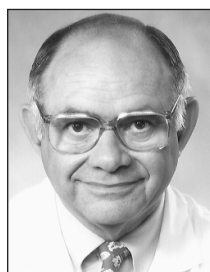
The author gratefully acknowledges the assistance of John-Henry Pfifferling, PhD, Director, The Center for Professional Well-Being, Durham, NC, in preparation of this article.

.....
Ms Satinsky is president of Satinsky Consulting, LLC. She earned her BA in history from Brown University, her MA in political science from the University of Pennsylvania, and her MBA in health-care administration from the Wharton School of the University of Pennsylvania. She is the author of two books: *The Foundation of Integrated Care: Facing the Challenges of Change* (American Hospital Publishing, 1997) and *An Executive Guide to Case Management Strategies* (American Hospital Publishing, 1995). She is also author of an article titled Advanced Practice Nursing: Changing Roles and Clinical Applications, which appears in the book *The Advanced Practice Nurse in a Managed Care Environment*, edited by J.V. Hickey, et al (Lippincott, 1996, and Lippincott, 2000). *Forum* #4, 2002 featured her article Managing the Implementation of HIPAA and the Privacy Rule. An adjunct faculty member at the University of North Carolina School of Public Health and the Duke University School of Nursing, Ms Satinsky is also a fellow of the American College of Healthcare Executives and a member of the Medical Group Management Association. She may be reached at (919) 383-5998 or msatinsky@satinskyconsulting.com.

A Lesson Learned

Stay Cool!

Walter J. Pories, MD, Former President, NCMB



Dr Pories

I served my first year in the Air Force at the University of Rochester as a mixed obstetric and surgical intern, six months in each specialty, just long enough to know that I didn't know very much.

At the completion of the internship, I was sent to Toul Rosieres Air Force Base, a tiny, 25-bed hospital in the western part of France. We cared for

5,000 troops who seemed to have no other activity than to make babies.

Talk about learning on the job! It soon turned out that I was the busiest obstetrician in the area, personally delivering 30 babies per month. Fortunately, Mother Nature was kind and my work was pretty easy.

One afternoon, however, I received an emergency call requesting my immediate help with a woman who was in trouble at a neighboring base in Germany: a case of shoulder dystocia. They needed me immediately.

Further, they already had a fighter plane on the flight line to whip me over there.

A fighter? A ride in a fighter? In no time, I was suited up in a silver outfit with a huge helmet and boots—the very picture of macho. Now remember, I didn't always look like I do now. At that time, I weighed 136 pounds and even had a head of hair. I looked cool.

Although I looked great, I was a quaking wreck inside. I had no idea what to do; I had never even

done a Caesarian. How did I ever get into this mess?

The flight, however, was great: black dials and bright orange handles, a stick with all sorts of triggers, streaking through the sky in quick turns; but as I savored the adventure, every few seconds the fears would return. "Stay cool," I told myself.

The flight was far too brief and soon I saw the field, the waiting ambulance and escort car, the flashing red lights, the people—and I knew that I was in trouble.

I climbed out, a silver bullet with my big helmet now under my arm, trying to look confident. I was pushed into the ambulance and soon the convoy dropped me at the little hospital. "Oh, good, he's here"; "I hope she'll be OK"; "Over here, doc."

After changing into scrubs under the eyes of the commander, I walked into the delivery room. It was a sight: crowded, the mother crying, the nurses weeping. Fortunately, the stuck baby still had good fetal heart sounds.

I walked over to the mother to feel her abdomen. Just as I touched her, without doing anything at all, she gave a push and out came the baby, screaming, apparently healthy—I barely managed to catch it.

Now all cool, I told the mother it was a little girl, handed the baby off to the nurse, and then pronounced: "You can take it from here."

There were lots of cheers on the way back. It seemed that only I knew that I had nothing to do with the outcome.

So my lesson is: "Stay cool." There is a God and she will be there to help you throughout your life if you only let her.

"There is a God and she will be there to help you"

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

February - March - April 2003

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

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

Consent Order:

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

Denial:

Final decision denying an application for practice authorization or a motion/request for reconsider-

ation/modification of a previous Board action.

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program.

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

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

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

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

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

The practitioner's relinquishing of the authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.

ANNULMENTS

NONE

REVOCATIONS

NONE

SUSPENSIONS

HAYES, Lonnie Manchester, MD

Location: Goldsboro, NC (Wayne Co)
 DOB: 1/01/1932
 License #: 0000-14020
 Specialty: GP/GS (as reported by physician)
 Medical Ed: Howard University (1958)
 Cause: At a hearing on 2/20/2003, the Board found that Dr Hayes failed to maintain proper records for seven patients.
 Action: 3/10/2003. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Hayes' license is suspended indefinitely on service of this order and he may not petition for reinstatement for at least six months. Should he then make petition for reinstatement, he must complete a CME course on record-keeping approved by the Board president and implement processes in his practice that will demonstrate organization of medical records consistent with prevailing and acceptable standards.

ROSNER, Michael John, MD

Location: Hendersonville, NC (Henderson Co)
 DOB: 12/04/1946
 License #: 0000-26865
 Specialty: NS/NCC (as reported by physician)
 Medical Ed: Medical College of Virginia (1972)
 Cause: At a hearing on 1/23-25/2003, the Board found that Dr Rosner had performed surgery that was not medically indicated on eight patients.
 Action: 2/05/2003. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Rosner's medical license is suspended indefinitely and he may not petition for reinstatement for at least six months.

See Consent Orders:

MARBACH, James Christian, MD

MATTESON, Sharon Elaine, Physician Assistant

MUNCHING, Aaron A, Physician Assistant

NEWTON, Jimmie Isaac, MD

SILVER, Jeffrey Alan, MD

SUMMARY SUSPENSIONS

NONE

CONSENT ORDERS

CARLSON, James Lennart, MD

Location: Cerro Gordo, NC (Columbus Co)
 DOB: 11/20/1959
 License #: 2002-00010
 Specialty: FP (as reported by physician)
 Medical Ed: Medical College of Wisconsin (1991)
 Cause: In 2002, Dr Carlson sexually harassed two nurses during the final year of his residency at Carolinas Medical Center. He has a history of sexually harassing co-workers and, in an effort to address the issues underlying his conduct and prevent its recurrence, he received therapy from Dr Abel at the Behavioral Medicine Institute from August to October 2002. He will continue his therapy with Dr Gullick or another NCPHP approved therapist. He has entered a contract with the NCPHP.
 Action: 2/13/2003. Consent Order executed: Dr Carlson surrenders his license immediately; the Board issues Dr Carlson a license to expire on the date shown on the license [6/30/2003]; he shall maintain and abide by a contract with the NCPHP; he shall comply with all therapy, report, and meeting requirements; he shall continue his therapy and shall comply with recommendations of his therapist; he shall direct his therapist to provide the Board quarterly reports of his progress; he shall provide a copy of the Consent Order to all current and prospective employers; he shall ensure a female chaperone, who has read the Consent Order, is present any time he exams a female patient; the chaperone shall document her presence and record whether any violations or misconduct occurs; on a quarterly basis, the chaperone's record shall be provided to the therapist; Dr Carlson shall see each of his patients receives the "Principles of Medical Practice" statement and that a copy of the statement be posted in his office; every three months he shall ensure all patients he sees in a one-week period are given a "Patient Satisfaction Survey" to complete; the Satisfaction surveys shall

be given to the therapist for inclusion in the quarterly report to the Board; every six months, Dr Carlson shall undergo a polygraph examination, the results to be included in the therapist's report; each month Dr Carlson shall have three staff members, who have read the Consent Order, complete a "Staff Surveillance Form," which shall be provided to the therapist to be reported to the Board; he shall receive written approval of his current and future practice settings by the president of the Board, which approval the president is under no obligation to give; must comply with other conditions.

GASTON, Johnny Eugene, MD

Location: Fayetteville, NC (Cumberland Co)
 DOB: 8/09/1948
 License #: 0000-22112
 Specialty: PD (as reported by physician)
 Medical Ed: Medical College of Ohio (1974)
 Cause: On information that Dr Gaston pre-signed blank prescription forms. One of Dr Gaston's nurses wrote prescription refills for his patients using pre-signed blank prescription forms. The North Carolina Nursing Board reprimanded the nurse for this action. Dr Gaston no longer pre-signs blank prescription forms.
 Action: 3/31/2003. Consent Order executed: Dr Gaston is reprimanded for pre-signing blank prescription forms.

GOTTSCHALK, Bernard Joseph, MD

Location: Wilmington, NC (New Hanover Co)
 DOB: 5/10/1955
 License #: 0000-30162
 Specialty: IM/ON (as reported by physician)
 Medical Ed: University of Pittsburgh (1981)
 Cause: On application for reissuance of a license. Dr Gottschalk surrendered his license on 9/01/1993 and sought treatment for substance abuse. The Board reissued his license on 12/19/1994 via a Consent Order. Further Consent Orders were entered into in March 1995 and September 1995. In August 1997, the Board relieved him of further obligations under the 1994 and 1995 Consent Orders. In June 1999, he surrendered his license, having relapsed. He reestablished his relationship with the NCPHP and received a temporary license in April 2000, but he failed to register in September 2000, which caused his license to become inactive. He has now applied for reinstatement. He has continued his relationship with the NCPHP and has remained clean and sober.
 Action: 4/17/2003. Consent Order executed: Dr Gottschalk is issued a license to expire on the date shown on the license [7/31/2003]; 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 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 and NA meetings as recommended by the NCPHP; he may not supervise PAs, NPs, or nurse midwives; must comply with other conditions.

GOUBRAN, Michel Zaki, MD

Location: Dunn, NC (Harnett)
 DOB: 2/15/1935
 License #: 0000-21039
 Specialty: OBG/REN (as reported by physician)
 Medical Ed: University Ein Shams, Egypt (1962)
 Cause: To amend the Consent Order of 8/29/2002. Dr Goubbran has asked that paragraph #3 of his Consent Order of 8/29/2002 be removed. That paragraph requires prior approval by the Board's president of any practice setting.
 Action: 4/30/2003. Amendment to Consent Order executed: paragraph #3 of the Consent Order of 8/29/2002 is stricken and Dr Goubbran is no longer obligated to comport with that paragraph; Dr Goubbran is issued a license to expire on the date shown on the license [issued earlier]; all other terms and conditions of the 8/29/2002 Consent Order remain in effect.

LAVINE, Gary Harold, MD

Location: Kinston, NC (Lenoir Co)
 DOB: 11/04/1964

License #: 2001-00403
 Specialty: EM (as reported by physician)
 Medical Ed: University of South Alabama (1989)
 Cause: Dr Lavine has had a problem with abuse of Darvocet®. When confronted by others about his substance abuse, he submitted himself to and signed a contract with the NCPHP. At that point, he voluntarily stopped the practice of medicine. He successfully completed a 28-day residential treatment program and the NCPHP reports he is in compliance with its recommendations.
 Action: 3/06/2003. Consent Order executed: Dr Lavine is reprimanded; he surrenders his license and the Board issues him a license to expire on the date shown on the license [6/30/2003]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind- or mood-altering substances and he shall refrain from the use of alcohol; he shall notify the Board within 10 days 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 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; must comply with other conditions.

LEMAIRE, Pierre-Arnaud P., MD

Location: Wilson, NC (Wilson Co)
 DOB: 3/24/1960
 License #: 0000-39440
 Specialty: GS/VS (as reported by physician)
 Medical Ed: University of Medicine and Dentistry of New Jersey (1985)
 Cause: Reference is made to the Notice of Charges and Allegations of 9/14/2002. On 2/14/2002, Dr Lemaire was referred by his wife to the NCPHP because of alcohol problems. He met with the NCPHP, admitted he was an alcoholic, and signed a contract with the NCPHP in which he agreed to enter a 28-day inpatient alcohol treatment program. There were several reasons for this, including the fact he had tested positive for cannabinoids. Dr Lemaire initially did not enter the agreed on treatment program because he was under subpoena in a malpractice case. Because of the scheduling difficulties, the NCPHP agreed to let him undergo outpatient treatment rather than the 28-day inpatient treatment program and Dr Lemaire began outpatient treatment. In May 2002, in light of positive drug screens, Dr Lemaire was asked by the NCPHP to complete a four-day drug and alcohol assessment to determine if intensive inpatient treatment was necessary. Dr Lemaire agreed to the assessment and the result was a diagnosis of alcohol dependence and cannabis abuse with a recommendation for intensive residential treatment. It was also recommended he not return to practice until successfully undergoing treatment. Dr Lemaire agreed to select one of four options: he would begin the treatment recommended; he would seek a second opinion at an NCPHP approved center; he would surrender his license; if he decided to resume practice without treatment or a second opinion, the NCPHP would break his anonymity to the Board. In July 2002, Dr Lemaire surrendered his license and, as a result, it was his view the Board then had no jurisdiction over him. The Board contends it does have such jurisdiction. To resolve all issues between himself and the Board, Dr Lemaire has agreed to relinquish his jurisdictional contentions.
 Action: 3/31/2003. Consent Order executed: Dr Lemaire's medical license shall remain surrendered and it is understood he shall not practice until or unless he satisfies the Board he can do so with reasonable skill and safety, unaffected by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of physical or mental abnormality.

MARBACH, James Christian, MD

Location: Temple, TX
 DOB: 2/10/1957
 License #: 2002-00050
 Specialty: R (as reported by physician)
 Medical Ed: Baylor College of Medicine (1983)
 Cause: Reference is made to the Notice of Charges and Allegations dated 4/04/2002. On 3/15/2002, the Wyoming Board of Medicine issued an Order of Summary Suspension of Temporary Physician's License that suspended Dr Marbach's Wyoming medical license. That Order was later dismissed. The Order found, among other things, there were reasonable grounds to believe Dr Marbach is unable to practice safely

because of a series of incidents that demonstrate his incapacity or incompetence. On 4/04/2002, the North Carolina Medical Board summarily suspended Dr Marbach's license due to his inability to practice safely. On 10/04/2002, his Texas medical license was suspended pursuant to a Consent Order entered into by Dr Marbach and the Texas Board. Dr Marbach admits he is currently unable to practice with reasonable skill and safety. He has been diagnosed with bipolar disorder and is undergoing treatment in Texas.

Action: 4/17/2003. Consent Order executed: Dr Marbach's license is suspended indefinitely.

MATTESON, Sharon Elaine, Physician Assistant

Location: Swansboro, NC (Onslow Co)

DOB: 9/06/1945

License #: 0001-01900

PA Education: George Washington University (1985)

Cause: Ms Matteson developed a social relationship with a patient, riding on his father's boat, often in company with the patient's parents and with her own grandchildren, calling on the patient and his parents at their home at their request, exchanging cards and gifts, driving the patient on errands, discussing intimate family matters with the patient, providing letters on the patient's behalf to the NC Family Court Division of the Child Support Agency and to the Social Security Administration, and providing the patient \$500 to open an investment account sharing both the patient's and Ms Matteson's name. In May 2000, as a result of this developing friendship, Ms Matteson turned over the care of the patient to Dr Quick. She knew the patient had a history of severe depression and anxiety, as well as suicidal ideations. In the summer of 2000, she ended the social relationship with the patient because he was calling her while intoxicated. In October 2000, the patient committed suicide by shooting himself in the head. On the day of his suicide, the patient was reported to have been drinking alcohol and taking Xanax®. During the police investigation, the patient's mother said the patient was divorced and "that his girlfriend had left him." The Board believes the "girlfriend" was Ms Matteson. Ms Matteson agrees that her relationship with the patient was unprofessional conduct.

Action: 2/20/2003. Consent Order executed: Ms Matteson's PA license is suspended for six months, but suspension is stayed on the following terms: at her own expense, she shall enroll and participate in a boundary course chosen by the Board; she shall meet with the Board when requested; and she shall obey all regulations related to the practice of medicine.

MATTHEWS, Charles Joseph, MD

Location: Raleigh, NC (Wake Co)

DOB: 2/03/1955

License #: 0000-27245

Specialty: N (as reported by physician)

Medical Ed: University of Virginia (1978)

Cause: On application for reissuance of Dr Matthews' license. Dr Matthews engaged in a sexual relationship with Patient A in 1998. He transferred care of Patient A to another physician that same year. He began treating Patient A again in 2001 and had a sexual relationship with Patient A in 2001. Also in 1998, Dr Matthews began treating Patient B and engaged in a sexual relationship with Patient B. On 5/15/2002, Dr Matthews surrendered his medical license. He successfully completed four weeks of an inpatient treatment program at the Behavioral Medicine Institute in August 2002. He has continued his treatment on an outpatient basis with Dr C. Norris. Dr Matthews has signed a contract with the NCPHP and the NCPHP reports he has been compliant. Because of the Board's concern about his prescribing practices, Dr Matthews will no longer prescribe opiates to chronic pain patients and will transfer their care should they need opiates.

Action: 4/17/2003. Consent Order executed: Dr Matthews is issued a license to expire on the date shown on the license [8/31/2003]; he shall ensure a female chaperone who has read the Consent Order is present any time he is in a room with a female patient; the chaperone shall document she was present and no boundary violations or misconduct occurred; Dr Matthews shall post the "Principles of Medical Practice" where it can be seen in his office; once a month, he shall ask three members of his staff to complete the "Staff Surveillance Form," which shall be forwarded to Dr Norris for inclusion in his quarterly reports to the Board; during one week each quarter, Dr Matthews or his

staff will ask all patients seen that week to complete the "Patient/Patient's Family Satisfaction Survey," and these shall be forwarded to Dr Norris for inclusion in his quarterly report to the Board; Dr Matthews shall continue his therapy with Dr Norris, or such other person as may be approved by the president of the Board, and shall comply with all recommendations made; he shall direct Dr Norris or his successor to provide quarterly reports of his progress to the Board; he shall continue his treatment with Dr Barringer, or such other psychiatrist as may be approved by the president of the Board, and shall comply with all recommendations made by Dr Barringer regarding his practice; he shall direct Dr Barringer to provide quarterly reports to the Board on his progress; he shall maintain and abide by a contract with the NCPHP; he shall undergo a polygraph examination every six months to determine if he has been involved in sexual misconduct with his patients; the results of these polygraph examinations shall be forwarded to Dr Norris for his quarterly report to the Board; must comply with other conditions.

McCLELLAND, Scott Richard, DO

Location: Wilmington, NC (New Hanover Co)

DOB: 7/19/1948

License #: 0000-29064

Specialty: P (as reported by physician)

Medical Ed: Kirksville College of Osteopathy (1980)

Cause: On a request to amend the Consent Order of 12/14/2000. Pursuant to that Consent Order, the Board indefinitely suspended Dr McClelland's license based, among other things, on his sexual relationship with one of his patients and his attempts to engage in a sexual relationship with another patient. Dr McClelland has asked the Board to amend the 12/14/2000 Consent Order to allow him to resume practice. He has successfully completed inpatient treatment to address his boundary violations; he regularly attends therapy sessions that focus on boundary violations and his sexual misconduct; his therapist reports he is active in his sessions, understands the seriousness of his infractions, and has expressed his remorse; he regularly attends 12-step meetings on sexual addiction; he entered into a contract with the NCPHP, which reports he is compliant. At the time of his initial request for amendment, Dr McClelland had not obtained sufficient CME to resume practice and the Board approved a temporary license contingent on his working at an approved, supervised educational facility. He was unable to find such a position, however. He then asked the Board to accept an independent physician evaluation in lieu of the requirement he work at a supervised educational facility. The Board approved this request and in December 2002 Dr McClelland successfully completed the independent physician evaluation at the University of Florida. He was judged to have demonstrated sound medical skills with some minor deficiencies that could be easily addressed through traditional CME. The Board also reviewed the NCPHP recommendation that Dr McClelland be approved for a four-month temporary license contingent on completion of the recommended CME. He has now successfully completed a 22-hour Category I CME course on psychopharmacology.

Action: 4/22/2003. Consent Order executed: The Board issues Dr McClelland a license to expire on the date shown on the license [8/31/2003]; he may only practice at a site approved by the president of the Board; he shall maintain and abide by a contract with the NCPHP and by recommendations of the NCPHP medical staff, including approval from the NCPHP and the Board's president prior to treating female patients; must comply with other conditions.

MONTERO, Manuel, MD

Location: New Bern, NC (Craven Co)

DOB: 2/06/1957

License #: 0098-00097

Specialty: NEP/IM (as reported by physician)

Medical Ed: University Central Del Este, Dominican Republic (1988)

Cause: In May 2000, a patient bled to death while undergoing dialysis at the Total Renal Care Dialysis Center and was taken to Craven Regional Medical Center. Dr Montero examined the patient in the ER of the Medical Center but could not determine the cause of her bleeding to death. He did not report the death of the patient to the North Carolina Medical Examiner as required by law in suspicious, unusual, or unnatural circumstances. On May 19, he completed the death certificate regard-

ing the patient's death, but he failed to state the cause of death (bleeding to death) on the certificate as required by law.
 Action: 2/13/2003. Consent Order executed: Dr Montero is reprimanded.

MUNCHING, Aaron A, Physician Assistant

Location: Raleigh, NC (Wake Co)

DOB: 1/10/1961

License #: 0001-01325

PA Education: Alderson-Broadus (1990)

Cause: In July 2001, Mr Munching signed prescriptions for hydrocodone under the name of Dawn Quarfordt, MD. At the time, Dr Quarfordt was no longer licensed in North Carolina, did not possess a DEA registration, was no longer practicing in Wilmington, and had not authorized Mr Munching to sign her name on the prescriptions. Mr Munching also admits having written prescriptions for patients under other physicians' names and has been doing so for years. He also admits to diverting a portion of the hydrocodone he improperly prescribed to his father for his personal use. Mr Munching has a substance abuse problem that required inpatient care. He completed inpatient treatment and now maintains a contract with the NCPHP. When questioned by the Board, he voluntarily surrendered his PA license.

Action: 4/24/2003. Consent Order executed: Mr Munching's PA license is suspended indefinitely; he may petition for reinstatement no sooner than one year from the date of the Consent Order; he shall maintain a contract with the NCPHP; 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; he shall notify the Board within 10 days 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 tissues for screening to determine if he has used any of the substances noted above; he shall provide a copy of this Consent Order to his current and all prospective employers; must comply with other conditions.

NEWTON, Jimmie Isaac, MD

Location: Winston-Salem, NC (Forsyth Co)

DOB: 11/29/1938

License #: 0000-14269

Specialty: OBG (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1964)

Cause: Regarding the Notice of Charges and Allegations of 11/11/2002 and Dr Newton's applications for reinstatement of his license. In October 2002, Dr Newton made inappropriate sexual comments to Patient A and touched her breasts inappropriately. In August 2001, he made inappropriate sexual comments to Patient B, asking whether she enjoyed sex and whether she enjoyed oral sex; and on the following day, he telephoned Patient B at her home and said, "I have always been attracted to you. I would just like to take you to bed and do things that would make you feel wonderful." Dr Newton surrendered his license on 8/09/2002, and received treatment for his sexual misconduct from Gene Abel, MD, at the Behavioral Medicine Institute from 9/09/2002 to 10/31/2002. He has entered a contract with the NCPHP and is in compliance with all the terms and conditions of that contract. In November 2002, pursuant to Dr Abel's recommendation, Dr Newton began treatment with Eugenia Gullick, PhD, and he agrees to continue that treatment.

Action: 2/19/2003. Consent Order executed: Dr Newton's license is suspended indefinitely effective 8/09/2002. That suspension is stayed on the execution of this Consent Order; subject to the conditions stated here, the Board shall issue Dr Newton a license to expire on the date shown on the license [5/31/2003]; he shall maintain and abide by a contract with the NCPHP; he shall continue his therapy and comply with all recommendations made by his therapist; he shall direct his therapist to provide the Board quarterly reports on his progress; he shall provide a copy of this Consent Order to all current and prospective employers; he shall ensure a female chaperone, who has read this Consent Order, is present whenever he examines a female patient; the chaperone shall document she was present during the examination and whether any misconduct occurred; the chaperone's documentation shall be provided to Dr Newton's therapist for inclusion in the quarterly report to the Board; each month, Dr Newton shall ask three members of his staff, who have read this Consent Order, to complete a Staff

Surveillance Form, which shall be provided to his therapist for inclusion in the quarterly report; he shall abide by all discharge recommendations made by Dr Abel, including polygraph examinations every six months, the results of which shall be provided the therapist; must comply with other conditions.

PECKINPAUGH, James Matthew, MD

Location: Kannapolis, NC (Cabarrus Co)

DOB: 11/13/1959

License #: 0000-39059

Specialty: FP (as reported by physician)

Medical Ed: University of Cincinnati (1987)

Cause: Regarding the Notice of Charges and Allegations dated 8/14/2002. Dr Peckinpaugh began treating Patient A in 1994. From 4/14/1997 to 9/28/2000, Patient A was employed by Dr Peckinpaugh as his office medical assistant. In the fall of 1997, while still treating Patient A, he began an intimate and sexual relationship with Patient A that lasted about three months. He continued to treat Patient A after the intimate and sexual relationship ended in 1997, until June 2001. It appears the sexual relationship grew out of the co-working relationship rather than the physician-patient relationship. Dr Peckinpaugh admits he should have referred Patient A to another physician following their relationship and he accepts responsibility for this boundary violation. On 2/07/2002, he entered a contract with the NCPHP and the NCPHP reports he has been fully compliant. As part of his contract with NCPHP, he had obtained continuing psychotherapy with Eugenia Gullick, PhD, who reports it is her opinion Dr Peckinpaugh does not represent a danger to patients. Dr Peckinpaugh attended and successfully completed a three-day course on Maintaining Proper Boundaries at the Center for Professional Health at Vanderbilt University Medical Center in June 2002.

Action: 2/25/2003. Consent Order executed: Dr Peckinpaugh is reprimanded; he shall maintain and abide by a contract with the NCPHP; he shall continue his therapy and shall comply with all recommendations of the therapist; he shall direct the therapist to make quarterly reports on his progress to the Board; must comply with other conditions.

RAPALJE, James John, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)

DOB: 2/07/1947

License #: 0001-00077

PA Education: Medical University of South Carolina (1975)

Cause: A female co-worker alleged in a civil action that Mr Rapalje acted in an inappropriate manner toward her and made sexual comments to her; he also treated her on occasion and wrote three prescriptions for her that were undocumented in a medical record. He denies acting inappropriately or making inappropriate sexual comments. However, he admits in his civil deposition that he would "wrestle" and "play" with the co-worker, squeeze her neck in an "affectionate way," "bite" her arm "playfully," and engage in office "sex talk" with her. He also admitted in his civil deposition that he participated in an incident, which he calls "horseplay," with the co-worker in the office stairwell. The co-worker alleged he sexually assaulted her in the stairwell. Mr Rapalje and his employer entered an out-of-court settlement with the co-worker and agreed to pay an undisclosed sum of money in exchange for her dismissing her lawsuit. The Board, without determining the truth of all the allegations made, determines, and Mr Rapalje agrees, that the conduct he admits in his deposition constitutes unprofessional conduct.

Action: 4/24/2003. Consent Order executed: Mr Rapalje is reprimanded.

RAYMOND, Keith Allen, MD

Location: Newton, NC (Catawba Co)

DOB: 6/23/1956

License #: 0098-00369

Specialty: FP (as reported by physician)

Medical Ed: Jefferson Medical College (1992)

Cause: Reference is made to the Notice of Charges and Allegations issued 10/18/2002. In May 2002, the husband of a patient became involved in a verbal confrontation with Dr Raymond over issues regarding the patient's medication and demanded the return of those narcotics. Then, according to Dr Raymond, the confrontation culminated in Dr Raymond lightly touching the patient's husband, who was also a patient of the clinic, for

the purpose of escorting him from the office after repeated requests for him to leave. As a result of this confrontation, a police officer was summoned to the clinic by Dr Raymond. At the conclusion of the investigation, the police officer did not file any charges, nor did Dr Raymond. However, the patient's husband made a criminal complaint against Dr Raymond for assault. In court, Dr Raymond was found guilty of simple assault and the judge imposed a prayer for judgment continued. Dr Raymond denies committing assault but admits getting involved in an inappropriate manner with the patient's husband.

Action: 4/24/2003. Consent Order executed: Dr Raymond is reprimanded.

SILVER, Jeffrey Alan, MD

Location: Tarboro, NC (Edgecombe Co)

DOB: 1/27/1958

License #: 0095-01418

Specialty: PUD/CCM (as reported by physician)

Medical Ed: New York Medical College (1984)

Cause: Dr Silver prescribed for his wife's headaches and anxiety. On some occasions, he asked colleagues to prescribe for his wife in "hallway consultations," though she was not present and they had no access to her records. Some of his prescribing and that of his colleagues was not documented in any sort of patient record. It appears Dr Silver's only motive was to obtain relief for his wife's condition, and he acknowledges his wife's care should have been managed by a physician in the traditional physician-patient relationship.

Action: 2/05/2003. Consent Order executed: Dr Silver's license is suspended for six months, but that suspension is stayed on the condition he comply with the following terms: he shall not prescribe for or order the administration to his wife of any drug for which a prescription is needed; he must obey all laws; must comply with other conditions.

TAMBERELLI, Wayne Paul, Physician Assistant

Location: Roanoke Rapids, NC (Halifax Co)

DOB: 10/08/1951

License #: 0001-00379

PA Education: Albany Medical College (1977)

Cause: While employed at a clinic in Rocky Mount, Mr Tamberelli had access to large quantities of free sample drugs, some of which were controlled substances. He diverted an extremely large number of free samples to his home without his employer's permission, repackaged many of them in plastic bags, and dispensed them to family members. He treated family members from the stockpile of sample drugs and wrote prescriptions for family members without keeping a patient chart and without oversight by his supervising physician. He has informed the Board that during 2001 and early 2002 he was being abused by his wife and this contributed to his actions. In January 2002, he attempted suicide by consuming large amounts of alcohol and prescription drugs. He attributes this attempt to abuse by his wife. Following the suicide attempt, Mr Tamberelli's employer referred him to the NCPHP. He separated from his wife and moved in with a former patient. The NCPHP assessed him as suffering from depressive symptoms but determined there was no evidence of sexual boundary violations or chemical dependence. The NCPHP concluded he was able to safely resume practice as a PA. Mr Tamberelli now attends counseling sessions for victims of spousal abuse and is receiving psychiatric treatment.

Action: 3/06/2003. Consent Order executed: Mr Tamberelli is reprimanded; he agrees to continue spousal abuse counseling; he shall maintain and abide by a contract with the NCPHP; within one year he shall attend a designated course on prescribing controlled substances; he shall provide a copy of the Consent Order to all current and prospective employers; must comply with other conditions.

VAUGHAN, Howell Anderson, Physician Assistant

Location: Morrisville, NC (Wake Co)

DOB: 3/31/1958

License #: 0001-01513

PA Education: Wake Forest University (1992)

Cause: On Mr Vaughan's application to reinstate his license, which was surrendered in August 2001 due to his relapse in his recovery from substance abuse. He has signed a contract with the NCPHP that extends until March 2007 and the NCPHP

reports he has been compliant and has remained clean and sober for the past year.

Action: 2/05/2003. Consent Order executed: Mr Vaughan is issued a PA license to expire on the date shown on the license [5/11/2003]; 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 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 surrender all controlled substance registrations to the U.S. DEA; he shall not order, prescribe, administer, or dispense, and, except as noted above, shall not possess controlled substances; must comply with other conditions.

WEISNER, Larry Felix, MD

Location: Southport, NC (Brunswick Co)

DOB: 3/24/1958

License #: 0094-00669

Specialty: GS (as reported by physician)

Medical Ed: East Carolina University School of Medicine (1988)

Cause: Reference is made to the Notice of Charges and Allegations of 10/10/2002. As an independent contractor, Dr Weisner examined Physicians Weight Loss Center, Inc, patients in Greensboro to determine if they could safely attempt to lose weight with, among other things, the aid of the appetite suppressant Meridia®. At the time, the Center required patients attempting to lose weight with the aid of prescription drugs to buy those drugs through the Center. Therefore, the prescriptions were never given to the patients; instead, the prescriptions were placed in the patients' files to be filled through the Center. In March 1998, a patient at the Center signed up for the "System V diet," a drug therapy program that used Meridia®. As a Schedule IV drug, Meridia® may not be dispensed unless prescribed by a licensed practitioner and the patient was examined by Dr Weisner to determine if she could be prescribed the drug safely. Dr Weisner did prescribe the drug, which the patient purchased through the Center. The patient later learned she could get Meridia® more cheaply at a local pharmacy. As a result, the patient asked Dr Weisner for the prescription so she could fill it at the pharmacy. Dr Weisner refused, although he told her he would call the Center franchise president and ask what could be done. He was told by the franchise president that the patient was contractually obligated to buy through the Center and he was asked not to give the patient her prescription. Dr Weisner informed the patient he would not give her the prescription and she was contractually bound to purchase through the Center. By refusing to provide a copy of the prescription to the patient, Dr Weisner made a mistake in judgment and engaged in unprofessional conduct. Also, the Center was a business corporation, and under the "corporate practice doctrine," a business corporation generally may not practice medicine. At no time was the center a professional licensee or entity entitled to render medical care. The Board has charged Dr Weisner with aiding and abetting the unauthorized corporate practice of medicine by the Center and engaging in improper fee splitting with the Center arising out of his contractual relationship with it. Dr Weisner acknowledges this is true. However, he had no intent or knowledge at the relevant times that his contractual relationship with the Center could or would be seen by the Board in this way. Upon reflection, Dr Weisner recognizes and regrets his mistake of judgment and unprofessional conduct. His relationship with the Center only lasted about seven months and he ended the relationship in August 1998.

Action: 4/07/2003. Consent Order executed: Dr Weisner is reprimanded for refusing to provide the patient with her prescription. No additional discipline is imposed on the charges related to aiding and abetting the unauthorized corporate practice of medicine and improper fee splitting.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL
NONE

SURRENDERS

BRADLEY, Russell Loyd, MD

Location: Lenoir, NC (Caldwell Co)
DOB: 2/12/1951
License #: 0094-01138
Specialty: FP (as reported by physician)
Medical Ed: Mercer University (1993)
Action: 4/02/2003. Voluntary surrender of medical license.

MOIR, Ronald Jeffrey, MD

Location: Morganton, NC (Burke Co)
DOB: 12/30/1956
License #: 0000-31176
Specialty: AN (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1984)
Action: 3/21/2003. Voluntary surrender of medical license.

NIEMEYER, Meindert Albert, MD

Location: Elon, NC (Alamance Co)
DOB: 6/16/1956
License #: 0000-30440
Specialty: FP (as reported by physician)
Medical Ed: University of Utrecht, Netherlands (1981)
Action: 3/20/2003. Voluntary surrender of medical license.

RIDDLE, William Mark, MD

Location: Faison, NC (Duplin Co) and Greenville, NC (Pitt Co)
DOB: 3/20/1956
License #: 0000-39871
Specialty: FP/ADDM (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1985)
Action: 2/27/2003. Voluntary surrender of medical license.

SMITH, David Lewis, Physician Assistant

Location: Roanoke Rapids (Halifax Co)
DOB: 9/19/1951
License #: 0001-01503
PA Education: Not recorded
Action: 4/03/2003. Voluntary surrender of PA license.

STROUD, Joan Marie, Physician Assistant

Location: Gastonia, NC (Gaston Co)
DOB: 4/24/1956
License #: 0001-01476
PA Education: Pennsylvania State University (1980)
Action: 3/28/2003. Voluntary surrender of PA license.

WILLIAMS, Dwight Morrison, MD

Location: Roanoke Rapids, NC (Halifax Co)
DOB: 2/15/1952
License #: 0000-33577
Specialty: OBG (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1982)
Action: 2/19/2003. Voluntary surrender of medical license.

See Consent Orders:

CARLSON, James Lennart, MD
LAVINE, Gary Harold, MD

COURT APPEALS/STAYS
NONE

CONSENT ORDERS LIFTED

COYNE, Mark Dennis, MD

Location: Stoney Creek, NC (Guilford Co)
DOB: 8/12/1949
License #: 0000-33493
Specialty: EM/OS (as reported by physician)
Medical Ed: Chicago Medical School (1983)
Action: 4/02/2003. Order issued lifting Consent Order of 6/25/2001.

VAUGHN, Tom Jimison, Jr, MD

Location: Mount Airy, NC (Surry Co)
DOB: 3/30/1941
License #: 0000-23092

Specialty: OBG (as reported by physician)
Medical Ed: University of Virginia (1975)
Action: 3/11/2003. Order issued lifting Consent Order of 11/09/2001.

TEMPORARY/DATED LICENSES:

ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

BERRY, David Don, MD

Location: Hickory, NC (Catawba Co)
DOB: 4/20/1952
License #: 0000-30288
Specialty: NPM/PD (as reported by physician)
Medical Ed: University of Texas, Galveston (1978)
Action: 3/20/2003. Temporary/dated license extended to expire 3/31/2004.

BJORK, Paul Edward, Jr, MD

Location: Hamlet, NC (Richmond Co)
DOB: 3/06/1954
License #: 0000-36146
Specialty: GN (as reported by physician)
Medical Ed: University of South Carolina (1983)
Action: 4/24/2003. Temporary/dated license extended to expire 4/30/2004.

CARBALLO, Frank Edward, MD

Location: Lumberton, NC (Robeson Co)
DOB: 4/30/1963
License #: 0000-35291
Specialty: IM (as reported by physician)
Medical Ed: University of South Florida (1989)
Action: 2/20/2003. Temporary/dated license extended to expire 8/31/2003.

CARLSON, James Lennart, MD

Location: Cerro Gordo, NC (Columbus Co)
DOB: 11/20/1959
License #: 2002-00010
Specialty: FP (as reported by physician)
Medical Ed: Medical College of Wisconsin (1991)
Action: 4/24/2003. Temporary/dated license extended to expire 10/31/2003.

CONNINE, Tad Robert, MD

Location: Great Mills, MD
DOB: 1/19/1964
License #: 0099-00193
Specialty: RO (as reported by physician)
Medical Ed: University of Southern Florida (1992)
Action: 4/24/2003. Temporary/dated license extended to expire 6/30/2003.

DIAMOND, Patrick Francis, MD

Location: Wilmington, NC (New Hanover Co)
Evergreen, NC (Columbus Co)
DOB: 5/15/1946
License #: 0098-00042
Specialty: FP (as reported by physician)
Medical Ed: Autonomous University of Tamaulipas, Mexico (1987)
Action: 2/20/2003. Temporary/dated license extended to expire 8/31/2003.

EURE, Luther Haywood, Jr, MD

Location: Reidsville, NC (Rockingham Co)
DOB: 9/11/1963
License #: 0093-00102
Specialty: OBG (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1989)
Action: 3/20/2003. Temporary/dated license extended to expire 9/30/2003.

GOUBRAN, Michel Zaki, MD

Location: Dunn, NC (Harnett Co)
DOB: 2/15/1935
License #: 0000-21039
Specialty: OBG/REN (as reported by physician)
Medical Ed: University Ein Shams, Egypt (1962)

Action: 2/20/2003. Temporary/dated license extended to expire 8/31/2003.

HAMBLETON, Scott Lewis, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 4/15/1963
 License #: 2000-00444
 Specialty: FP/EM (as reported by physician)
 Medical Ed: University of Tennessee (1994)
 Action: 3/20/2003. Temporary/dated license extended to expire 3/31/2004.

LOCK, George Joseph, Physician Assistant

Location: Princeton, NC (Johnston Co)
 DOB: 8/26/1958
 License #: 0001-01050
 PA Education: Bowman Gray (1987)
 Action: 4/24/2003. Temporary/dated license extended to expire 4/30/2004.

LOVETTE, Kenneth Maurice, MD

Location: Tarboro, NC (Edgecombe Co)
 DOB: 12/27/1949
 License #: 0000-24606
 Specialty: GN (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1979)
 Action: 2/20/2003. Temporary/dated license extended to expire 10/21/2003.

MAYFIELD, Kelli Burgin, MD

Location: Ellenboro, NC (Rutherford Co)
 DOB: 8/15/1963
 License #: 0095-00998
 Specialty: FP (as reported by physician)
 Medical Ed: East Tennessee State University (1993)
 Action: 4/24/2003. Full and undated license issued.

NEWTON, Jimmie Isaac, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 11/29/1938
 License #: 0000-14269
 Specialty: OBG (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1964)
 Action: 4/24/2003. Temporary/dated license extended to expire 10/31/2003.

PARK, Hyunsoon Edie, MD

Location: Greenville, NC (Pitt Co)
 DOB: 3/06/1968
 License #: 2002-00581
 Specialty: P (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1994)
 Action: 3/20/2003. Full and unrestricted license issued.

VAUGHAN, Howell Anderson, Physician Assistant

Location: Morrisville, NC (Wake Co)
 DOB: 3/31/1958
 License #: 0001-01513
 PA Education: Wake Forest University (1992)
 Action: 3/20/2003. Temporary/dated license extended to expire 9/30/2003.

WARD, David Townsend, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 4/07/1960
 License #: 0095-00473
 Specialty: OTR (as reported by physician)
 Medical Ed: West Virginia University (1986)
 Action: 4/24/2003. Temporary/dated license extended to expire 4/30/2004.

WOLEBEN, Martyn Dean, MD

Location: High Point, NC (Guilford Co)
 DOB: 11/13/1956
 License #: 0097-00428
 Specialty: OBG (as reported by physician)
 Medical Ed: University of Mississippi (1988)
 Action: 4/24/2003. Temporary/dated license extended to expire 4/30/2004.

See Consent Orders:

CARLSON, James Lennart, MD
GOTTSCHALK, Bernard Joseph, MD
LAVINE, Gary Harold, MD
MATTHEWS, Charles Joseph, MD
McCLELLAND, Scott Richard, DO
NEWTON, Jimmie Isaac, MD
VAUGHAN, Howell Anderson, Physician Assistant

DISMISSALS

NONE

You Are Invited

*The members and staff of the
 North Carolina Medical Board
 cordially invite you to an
 Open House and Building Dedication
 at their new offices at
 1203 Front Street, Raleigh, North Carolina,
 on Wednesday, September 17, 2003,
 from 5:30 to 7:00 pm.*

CHANGE OF ADDRESS FORM

Mail Completed form to: North Carolina Medical Board
PO Box 20007, Raleigh, NC 27619

Please print or type.

Date: _____

Full Legal Name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

☐ Business: _____

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

☐ Home: _____

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

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



Prst Std
US Postage
PAID
Permit No. 1486
Raleigh, NC

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: August 20-22, 2003; September 17-19, 2003; October 15-17, 2003
November 19-21, 2003; December 17-18, 2003

Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the North Carolina Medical Board's Web site at <http://www.ncmedboard.org/exam.htm>. If you have additional questions, please e-mail Tammy O'Hare, GME/Examination Coordinator, at tammy.ohare@ncmedboard.org.

Special Purpose Examination (SPEX)

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

North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609