

forum

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IN NORTH CAROLINA
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President's Message

Paul Saperstein

A Tribute to 25 Years of Service

The North Carolina Medical Board honored its executive director emeritus, Bryant D. "Pete" Paris, Jr, on the evening of May 21. Bryant retired as the Board's executive director in March of 1998 after serving 25 years in that position and has continued to work with the Board in his capacity as executive director emeritus ever since. The reception given in his honor was well deserved and proved to be a memorable event, with more than 80 friends and colleagues gathering to express their appreciation for Bryant's years of dedicated public service. (See photographs accompanying this article.)

It is impossible to do justice to such a record with a reception or a few paragraphs, but I would like to give you a brief, personal glimpse at what Bryant did for the citizens of North Carolina over the years.

- Responded to his constituents, the public and the licensee community, every work day. Whether it was a complainant unhappy because a doctor was not disciplined, a doctor who was unhappy because he or she was disciplined, or a member of the news media applying 20/20 hindsight to either event, he was the point man — the buck stopped with him and he handled it professionally and gracefully.
- Responded to national issues. The North Carolina Medical Board is part of a national licensing community with common issues and problems. You either lead, follow, or get out of the way in this process. Bryant was an integral part of the leadership team of the Board in shaping and influencing national medical licensing issues.
- Supported the Board tirelessly. This involved managing staff and resources, seeking appropriate legislation, representing the Board before the public, and helping the Board meet its public mandate as effectively as possible.

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From the Executive Director



Andrew W. Watry

Physician CME Requirements: Where We Are Now

There is understandable confusion about the continuing medical education (CME) requirements for physicians in North Carolina. The comments that follow are directed toward our physician licensees in an effort to provide some clarification.

I recognize that some of you have less interest in the details of the CME process than others, so I will begin with a brief synopsis of where we are in the development of the CME requirements and then move on to a more detailed description of the process and development of the CME rule.

Summary

There is no CME requirement for physicians in North Carolina now. The Board is developing rules that will have the effect of requiring all actively licensed physicians in North Carolina to document CME to maintain their license. If the Board's proposed rules are implemented, physicians will need to start documenting their CME on January 1, 2001. Beginning on that date, there will be a three-year interval before you will have to demonstrate compliance to the Board on your registration form. The mechanism will be simple: you will simply answer a yes/no question on the form. You will maintain the documentation in your own records and a small sample of physicians will be periodically audited for compliance.

The CME requirements will be very close to the requirements of the American Medical Association's Physician's Recognition Award, with a total of 150 hours of documented CME over the three-year period. A mini-

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forum

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

Raleigh, NC

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

North Carolina Medical Board

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follow rigid statutory guidelines for implementing rules. The purpose of these guidelines is to ensure that the public has an adequate forum for input in the rule-making process. In developing a proposed rule, the Board wanted to make sure it identified an approach to CME that was relevant to practice, useful for licensees, and meaningful to the public.

The Board convened a special task force consisting of 12 individuals representing expertise from a broad range of interested groups. This task force developed a truly cutting-edge CME proposal. To make a long story short, the Board felt the resulting proposal would be consistent with future CME guidelines now being developed by several professional groups and associations, including the American Medical Association. Included in the proposal was a shift away from the old CME nomenclature of Category 1 and Category 2. There were to be two categories of CME: provider-initiated (which was parallel to the old Category 1 in many respects), and physician-initiated (somewhat parallel to the old Category 2, but with a strong emphasis on practice-relevant CME).

The rule that came from this process was viewed by the Board as being a model for North Carolina physicians, placing emphasis on practice-relevant CME on an annual cycle. As the rule was going through the last stages of adoption, however, a problem arose. In April 1999, a group of physicians registered concern with the proposed rule. They felt the rule diverged too much from what was commonly accepted in the old Category 1/Category 2 construct. Also in April, a bill was introduced in the General Assembly that had the effect of challenging the rule. Although the bill (S463) did not contain language that substantively altered the rule, it did present a vehicle for amendment for that purpose at a later time. The Board had diligently pursued public input

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CME Requirements

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imum of 60 of these hours will be in a CME category roughly equivalent to the AMA and the American Osteopathic Association Category 1 credit. The proposed CME rule will be sent to all physicians and will be published several times in the *Forum*. You will have an opportunity for comment, in writing and/or in person, and provided that the rule passes through all of the required elements of the adoption process, documentation of CME for purposes of registration will begin on January 1, 2001. Validation will not begin until annual registration for January birthdays in 2004.

Background

In August 1997, the North Carolina General Assembly passed a requirement that physicians obtain CME in accord with rules to be developed by the Board. The language appears in NCGS §90-14, where one of the enumerated grounds for disciplinary action is as follows: "(15) Failure to complete an amount not to exceed one hundred and fifty hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board." This is a public mandate, so a discussion of why CME is required for

physicians is moot. However, the majority of states require CME of physicians and continuing education is a firmly entrenched part of licensure in other professions, including law, real estate, and other health fields.

The Board now had the challenge of implementing the CME requirement by developing rules. The development of rules is a normal process for implementing legislation. An agency such as the Board has to

Old Proposed Rule

Annual enforcement cycle on the registration form by answering a yes/no question concerning compliance with the CME rule.

Total of 50 hours of approved CME required annually.

Thirty hours of provider-initiated CME required each year and 20 hours of physician-initiated CME required each year.

New Proposed Rule

Three-year enforcement cycle by answering a yes/no question on the registration form every third year.

Total of 150 hours of approved CME required every three years.

Minimum of 60 hours provider-initiated CME required every three years, with the option that all CME can be in this category if the licensee wishes. The difference between provider-initiated CME and the total of 150 hours, if any, must be in approved physician-initiated CME. The detailed definitions of these two categories will be in the new proposed rule.

CME Requirements

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during the course of rule development but determined, with these two events, that it needed to make some changes. Therefore, the Board has posted an amended rule. In the next issue of the *Forum*, it will post the amended rule in its entirety for your review and comment. The key changes made by the Board are briefly noted in the box that appears with this article.

The rule-making process will provide a period for public input, which can be done in writing, in person, or through both mechanisms. The process will be described in the next number of the *Forum* with appropriate deadlines for public comment.

Conclusion

To summarize, the rule-making process for implementing a CME rule has been delayed for reasons described above, and this delay has probably caused confusion. I hope you find this explanation helpful and that you appreciate the Board's determination to meet its legislative mandate in a way that will be responsive to the needs and concerns of both the physicians and the people of North Carolina.

The Board knows the vast majority of our physicians share a commitment to lifetime learning. It knows those physicians obtain appropriate CME on a regular basis. It knows the CME that is necessary for specialty board recertification, hospital credentials, professional memberships, and other purposes will, in all likelihood, fully comply with the Board's CME rule in spirit and detail. Finally, it knows we have remarkable CME resources in this state, provided through hospitals, medical schools, AHECs, and other entities. Through the CME rule, the Board reinforces all of this and makes clear that none of it should be taken for granted. The Board's fulfillment of its legal mandate has provided an opportunity to emphasize that relevant CME is fundamental to medical practice and to the meaning of medical professionalism.

Please watch for the newly proposed CME rule in the next number of the *Forum*. We encourage your comments and suggestions. ♦

North Carolina Medical Board



1-800-253-9653

A Tribute to 25 Years

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He was (and is) an integral part of an important public process, and he enters retirement with a large group of supporters who are thankful for his commitment and dedication. First and foremost, of course, is his family, his wife, Patsy, and his son, Bryant; close behind is his Board family, including past and present Board members and staff, and associates and peers in other states.

Congratulations, Bryant, and thanks for all you have done and all you have accomplished for the people of this state. The greatest tribute we can pay you is to promise we will work to continue in that tradition of service. ♦



Mr Paul Saperstein, president of the NCMB, opens the evening by reviewing the highlights of Mr Paris' career and contributions to the Board.



Mr Paris, on left, speaks with former Board member Dr Joyce Reynolds and her son, Richard.



Mr Paris' wife, Patsy, on right, and son, Bryant, listen to friends and colleagues paying tribute to Mr Paris.



Bryant and Patsy Paris thank everyone for their kind words and thoughts.

How We Die in North Carolina

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Prof Dellinger

In June 1998, the *Wall Street Journal* reported on 70-year-old North Carolinian Claude Marion, who thought that he had prepared for death 10 years ahead of time, but still did not receive the care he wanted.¹ After he died, one of his daughters described the experience of acting as his advocate. Speaking of the divisions that emerged among patient, family, and physician, and eventually within the family, she said:

[My father] just tried really hard to do the right thing. And he died in a very undignified way. I felt so helpless. . . . My sister and I felt we had been to war. . . . I don't think there's a good guy and a bad guy here. . . . I think people were doing what they were taught.²

Following Mr Marion's emergency surgery at Wake Forest University Baptist Medical Center in Winston-Salem, he slipped in and out of consciousness, unable to make his wishes known. Although four successive complications repeatedly brought him close to death, the attending physician would not honor the living will, believing that Mr Marion was not "terminal" (defined by the physician as having no chance for recovery).³ A hospital ethics council was convened, which agreed with Mr Marion's daughters that his condition was terminal. Rejecting the council's opinion, the physician said he would continue to treat aggressively. A judge appointed Mr Marion's daughters his guardians. Meanwhile, though, some of their aunts and uncles took the physician's side, and the family began arguing. While his daughters were finding another physician, Mr Marion passed the

point before which he might have been sustained at home. Still in the hospital, he was eventually freed from the feeding tube and given morphine for comfort. He died 57 days after admission, during a third bout of pneumonia.

A health care power of attorney giving decision-making power to a daughter might have prevented most of these problems, but like most people, Mr Marion did not have one. Tailoring the language of his living will to make it effective earlier probably would have helped too. Simply by having a living will, he did more to plan for his death than most North Carolinians have done. Yet clearly his living will was not enough.

In October 1998, three North Carolina licensing boards — medicine, nursing, and pharmacy — met to consider how to help

law of England and was later in the American colonies and states. Because suicide was a crime, helping someone carry it out was too.⁷

In 1973, the General Assembly abolished the crime of committing suicide and thereby, implicitly, the crimes of attempting and assisting in a suicide.⁸ Still, these acts continue to carry a substantial stigma. For instance, in August 1998 a *Raleigh News & Observer* reporter interviewed a terminally ill person as he prepared to kill himself. (The reporter declined to be present at the death, however.) Later, her editors debated whether publishing the account would "implicitly endorse" the man's act. The executive editor did decide to publish it but pointedly denied any endorsement. Instead, with careful neutrality he called the story "a



L to R: Andrew W. Watry, Mary P. "Polly" Johnson, and David R. Work, executive directors of the state boards of medicine, nursing, and pharmacy, respectively. The staffs of the boards developed and organized the End-of-Life Decisions Forum in October 1998.

people avoid their worst nightmares surrounding death.⁴ The meeting examined people's needs, current state and federal law, and both actual and ideal health care for the terminally ill. This article summarizes the law on suicide, assisted suicide, euthanasia, treatment, and withdrawal of treatment for those who are seriously ill. It also describes the three licensing boards' first step toward what may be a historic collaboration.⁵

Background

To understand how we die in North Carolina today, as well as what choices we may have in the future, some history is useful. It is surprising how recently suicide and suicide attempts were crimes in this state. In fact, North Carolina was the last of the states to prosecute an attempt at suicide. In 1961, the supreme court found the act criminal,⁶ as it had been for centuries under the common

fair and honest account of one man's search for what he believed was a dignified death."⁹

North Carolina's highest court has dealt very harshly with "mercy killing," or euthanasia. For shooting his father in a hospital bed, a man was convicted of first-degree murder and received a mandatory life sentence, which was upheld on appeal. At trial, the judge told the jury that they could infer malice¹⁰ (though they did not have to do so) from the defendant's use of a deadly weapon, and that the defendant's knowledge that his father was at the brink of death was not a defense (though they could consider that knowledge). Both instructions were challenged on appeal. The supreme court upheld them, but not unanimously. The chief justice urged a distinction in punishment because the son's intentions were good.¹¹

This article takes part of its title from the book *How We Die: Reflections on Life's Last Chapter*, by S.B. Nuland (New York: Alfred A. Knopf, 1994).

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How We Die in NC

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In 1982, Asheville was the scene of a prosecution that was particularly troubling because the event on which it was based was hard to classify as euthanasia or assisted suicide. The defendant, an elderly woman, said that, in accord with her sister's wishes, she had connected a hose to a car's exhaust and left the garage so that her sister could turn on the ignition. Investigators from the sheriff's department accepted this account.¹² The medical examiner, however, called the death a homicide, carried out against the victim's will. In his opinion, "a person who'd taken that drug dosage — particularly a cardiac patient dependent on a walker to move about — would not have been able to carry out the suicide that reportedly took place."¹³ Nearly a year after her sister's death, the defendant was charged with second-degree murder but allowed to plead guilty to voluntary manslaughter. She received a six-year suspended sentence, a \$2,000 fine, and probation for five years.¹⁴

A member of the state attorney general's staff may have played an important part in the decision to prosecute, although the office issued no formal opinion. According to news reports, Lester Chalmers, special deputy attorney general, advised the local prosecutor that an indictment for second-degree murder would be appropriate.¹⁵ Chalmers also implied doubt about the legality of assisted suicide.¹⁶ State and local medical examiners involved in the inquest urged a murder prosecution.¹⁷ Initially inclined against any charge, much less murder, the prosecutor finally did bring the second-degree murder charge, noting, "Suicide is legal, and so is aiding and abetting a suicide. But the thin line between suicide and homicide in such a case is a legal dilemma."¹⁸ Fixing that line continues to be a problem.

At least once, a decade ago, the state boards of medicine and nursing reviewed actions by a doctor and a nurse that raised the possibility of euthanasia.¹⁹ An elderly, terminally ill woman who had a living will was removed from a respirator at her request and her family's. Just before and for some time after removal, she received morphine.²⁰ When that did not "stop the struggling and suffering,"²¹ a nurse recommended that the doctor use Pavulon.

According to the board of nursing,

Pavulon is a paralytic agent whose action works on the respiratory muscles. Its primary use is in anesthesia. The drug is used in some instances in which patients on respirators are "fighting" the respirators, and for the pur-

poses of controlling the patient's breathing. There is no clinical usage for Pavulon in a patient that is not on a respirator.²²

Indeed, the nurses assigned to the patient would not administer the drug after the doctor ordered it. The supervising nurse, who made the recommendation, then administered four doses of Pavulon within seven minutes. The patient was pronounced dead within two minutes of the last injection.

Both boards reviewed the circumstances of the death, questioning the appropriateness of several aspects of the care. The board of medicine formally revoked the physician's license but immediately restored it without further penalty.²³ The board of nursing was more severe. It suspended the nurse's license for 18 months for three reasons: administering excessive morphine, suggesting that the doctor use Pavulon, and administering it.²⁴

The Present

There is no social consensus now on most of the issues surrounding dying — not even pain relief. Moreover, the risk of disapproval from some quarters is not the only or even the most serious problem. More troubling is

There is no social consensus now on most of the issues surrounding dying — not even pain relief.

the frequent confusion about the nature of acts that might lead to a wished-for death and the uncertainty about their legality. For example, polls indicate that the public sees little difference between assisted suicide and patient-requested euthanasia and would like both available.²⁵ A study of physicians shows similar results: physicians, and therefore probably other health professionals, often confuse assisted suicide and euthanasia.²⁶ On the other hand, judges, prosecutors, and the law sharply distinguish between the two acts (although the evidence may not clearly reveal which was committed).

The following sections describe the current legal status of certain aspects of dying.

Suicide

"Suicide" is "the act or an instance of taking one's own life voluntarily and intentionally."²⁷ Committing or attempting to commit suicide is not a crime in North Carolina.

Assisted Suicide

A leading treatise on death and dying discusses at length what "assisted suicide" means and how it differs from euthanasia and homicide (if it does).²⁸ The treatise cites a source that says the difference is illusory, and, as noted earlier, much of the public and

a significant minority of physicians do not distinguish meaningfully between assisted suicide and euthanasia. Most people, however, continue to draw a moral distinction between responding affirmatively to "Help me kill myself" and responding affirmatively to "Kill me." How to treat the two acts, and what constitutes each, are problems for all interested parties (patients, health providers, courts, district attorneys, health licensing boards, legislatures, the United States attorney general, and the Drug Enforcement Agency). For present purposes, though, a loose definition of "assisted suicide" may be helpful: it can be thought of as the act of providing a competent person with the means to take his or her own life.

In general, assisting someone in committing suicide is legal. That is, an ordinary person who hands a knife to someone who is desperate or holds a ladder for that someone to reach a window ledge should have no legal problem. But the situation can be more complicated if there is a special, legally recognized relationship between the helper and the person wanting to die. In certain relationships — parent and minor child, bank trustee and depositor, and doctor and patient, to name a few — one party is legally obligated to protect the other to some extent.²⁹

We simply do not know whether or when a health professional will be seen as failing to protect a patient if he or she helps the patient die. (Some patients and professionals think that the professional's duty to the patient should include easing death in a variety of ways.) The means of assistance most often discussed — now legal in Oregon — is providing medication for a patient to administer to herself or himself.³⁰ A legal question for all health professionals is whether helping patients die is a normal, appropriate part of their practice. If not, then their doing so might make them liable under tort law.

For physicians and pharmacists, there is a second legal problem. If they provide prescription drugs to a patient outside "the usual course of . . . professional practice," they are guilty, like anyone else, of violating state and federal controlled substances acts.³¹ The severe penalties associated with violations are in addition to any discipline imposed by licensing boards or any tort actions filed by a patient's estate or family.

Two voluntary associations, the North Carolina Medical Society³² and the North Carolina Licensed Practical Nurses Association,³³ are on record as opposing their members helping with suicides, but no state appellate court has passed on the issue, and the North Carolina Department of

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Justice has not issued a formal opinion.³⁴ Health practitioner licensing boards, especially the boards of medicine, nursing, and pharmacy, could help clarify the situation for their members, but so far they have not done so.

Medicine's and nursing's practice acts, which authorize the boards to issue and revoke licenses, contain language that they might use to forbid their licensees from assisting in suicides. The board of medicine could find, for instance, that a doctor who provided a lethal prescription or instructed a patient in a suicide technique was guilty of "unprofessional conduct" or "departure from . . . the standards of acceptable and prevailing medical practice, or the ethics of the medical profession." Because both are grounds for disciplining physicians, the board could then suspend or revoke a doctor's license to practice.³⁵

The definition of nursing in the Nursing Practice Act does include helping patients to "the achievement of a dignified death."³⁶ Another part of the act, however, allows board action against a nurse who "[e]ngages in conduct that endangers the public health,"³⁷ and a court has held that the section may apply to a case involving a single patient.³⁸ The statute also lets the board discipline a nurse who "[i]s unfit or incompetent to practice nursing by reason of deliberate or negligent acts or omissions" or "[e]ngages in conduct that . . . harms the public in the course of any professional activities or services."³⁹ In addition, regulations under the statute forbid a nurse's "practicing . . . beyond the scope permitted by law."⁴⁰

The state board of pharmacy would have more difficulty using its practice statute to prevent pharmacists from filling a lethal prescription for a patient. The Pharmacy Practice Act is more specific about what is improper practice, and none of its language seems easily applicable to suicide. The most nearly relevant provision allows adverse action if someone is "negligent in the practice of pharmacy."⁴¹

Euthanasia

"Euthanasia" may be defined as "the intentional putting to death of a person with an incurable or painful disease intended as an act of mercy."⁴² This act very likely is murder under North Carolina law. In fact, personally administering lethal medication to a patient could be first-degree murder, either as "murder by poison" or simply as

deliberate and premeditated killing.⁴³ In other words, like the man who shot his father, a doctor or a nurse would not escape punishment because she or he meant to benefit the patient — not even if the patient has asked for death.

Pain Relief

Pain relief is probably the most important of the end-of-life issues because of the effect of pain on dying people and the fear it engenders in nearly everyone who contemplates dying in the United States today. Despite efforts from several directions to clarify the legality of giving pain-relieving medication that may shorten life or even kill, the matter is not yet clear enough.

Health professionals know that a number of drugs may depress breathing, especially opioids (derivatives of opium or similar, synthetic narcotics), which are among the most effective painkillers.⁴⁴ They also know that relieving pain is among the highest goals of their professions, that United States medicine has been widely criticized by its practitioners and others for failing in that regard,⁴⁵ and that a major malpractice suit for failure to relieve pain succeeded in North Carolina. In that case, a Hertford County jury returned a verdict of \$15 million against Hillhaven Corporation for a nursing home's refusal to administer pain medication ordered by a physician for a man dying of cancer.⁴⁶

About 20 states expressly approve the use of pain-relieving medication, even though it may shorten life.⁴⁷ North Carolina has no statute, regulation, or case law to that effect. However, in a recent position statement, North Carolina's board of medicine addressed one of the most difficult areas of pain management, the use of opioids to treat chronic nonmalignant pain. The board said, "It should be understood that the Board recognizes opioids can be an appropriate treatment for chronic pain."⁴⁸ Because the board

takes that position for the harder question of chronic illness, perhaps its doing so for terminal illness should be assumed. In the position statement on chronic illness, the board does call attention to federal guidelines encouraging greater use of opioids for the terminally ill, but it makes no further comment. If the board approves North Carolina physicians' use of the federal guidelines, its saying so explicitly — perhaps by incorporating the guidelines into its own position statement — would be helpful.

Because of the fear of severe penalties for violating controlled substances acts, pharmacists and physicians would pay close attention to any position announced by the North Carolina Board of Pharmacy. The pharmacy board has not spoken, however. A single item in its newsletter (not a report of a board action or even a board discussion) is the only indication of the extent to which the board wants pharmacists to help relieve the pain of the terminally ill. The statement reads,

[T]he alleviation of pain through prescription drugs, including narcotics, is a normal part of medical care. In short, pharmacists should not fear action from the Board of Pharmacy if they are dispensing substantial amounts of narcotics for a legitimate medical need, such as to relieve pain for patients who will not be with us six months or one year hence due to their deteriorating health.⁴⁹

The federal controlled substances act points practitioners in the same direction — that is, toward relieving pain, even if doing so jeopardizes the patient's life. The act requires doctors who prescribe medication for purposes of maintaining a drug addict to register with the Drug Enforcement Agency,⁵⁰ but regulations state that the act is not meant to limit a physician who prescribes opioids for intractable pain when no relief or cure is possible or has been found after reasonable effort.⁵¹ Some states have amended their controlled substances acts to make the same assurance. North Carolina has not. If the General Assembly wanted to encourage physicians to relieve pain without fear of legal consequences, one avenue would be to amend the definition of "Drug dependent person" in state law⁵² to exclude the dying.

Life-Sustaining Treatment

Refusal, withholding, and withdrawal of life-sustaining treatment all are legal choices

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Recommended Reading

N.M.P. King and A.M. Davis: Advance Directives for Medical Decision Making in North Carolina: Rights, Duties, and Questions, *Popular Government*, 62(3):2-11 (Spring 1997) and 62(4):38-49 (Summer 1997), Institute of Government of The University of North Carolina at Chapel Hill.

N.M.P. King: New Portable DNR Order Advances Patient Rights, *Forum*, 3(1):6-8 (1998), North Carolina Medical Board.

How We Die in NC

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under state law. (As noted earlier, the difficulty may lie in getting the choices honored.) North Carolina has long allowed residents to express preferences about how they die. The state enacted the Right to Natural Death Act⁵³ in 1978, not so much to create new rights as to recognize existing ones.⁵⁴ A person may refuse extraordinary medical interventions, including artificial nutrition and hydration, or ask to have them discontinued.⁵⁵ State law also permits residents to name an agent to choose their health care in certain circumstances.⁵⁶

On the other hand, the statutes creating patient rights in terminal care caution that the state does not “authorize any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.”⁵⁷ Furthermore, whether North Carolina doctors and hospitals or other facilities must carry out a patient’s wishes is not settled. Some states require this by statute. An attorney general’s opinion advises that a physician or a facility need not follow a patient’s wishes or transfer the patient to caretakers who will. But the opinion also says that providers may be liable for assault and battery if they force treatment on a patient.⁵⁸

The United States Supreme Court seems to acknowledge that competent people have a constitutional right to refuse medical treatment.⁵⁹ A federal statute requires health facilities, as a condition of Medicare or Medicaid participation, to ask every patient about advance directives and to explain the options available under state law for creating them.⁶⁰

The Future

The receptivity of North Carolina law to letting people control important aspects of their death is comforting. However, a writer (and North Carolinian) recently referred to laws like those described earlier as being for some Americans only “feeble protections against their dread of modern dying.”⁶¹ Health professionals, and each person considering her or his own death, want expanded rights — or at least opportunities — as well as enough certainty about the law to exercise the rights that are nominally available. It was to pursue those goals that the End-of-Life Decisions Forum met on October 23, 1998, in Raleigh.

The approximately 120 participants in the forum were members of the boards of medicine, nursing, and pharmacy; the boards’ staffs, including legal counsel; employees of other state agencies; health professionals

who work directly with dying people; a few interested citizens; and invited speakers. In most ways, the group was typical: everyone, after all, is “competent” to discuss dying. In a few ways, though, the group’s greater-than-average expertise and concern about the subject were evident. For example, when a speaker asked how many had an advance directive, everyone raised a hand. Among Americans in general, fewer than 10 percent have taken that step.

The forum’s principal speaker, Lawrence Gostin,⁶² established the context of the meeting. He described social and historical forces, and mistakes and fears, that have made it hard in the United States to regulate dying. He noted that many Americans fear too much care at the end of life, accurately sensing a strong bias in American medical

The receptivity of North Carolina law to letting people control important aspects of their death is comforting.

education and practice toward continuing treatment. The bias may be traced to (1) the technological imperative — that is, pressure to use the marvelous lifesaving machines and techniques that the United States health care system has perfected; (2) defensive medicine — that is, health care providers’ misuse of treatment to protect themselves against liability; and (3) confusion about who may decide for the (incompetent) dying person.

In recent decades, the law has resolved two important issues by abandoning the distinctions between not beginning treatment and stopping it, and between ordinary and extraordinary care. In 1997, the United States Supreme Court gave the states permission to retain a third distinction, between letting nature take its course and actively helping someone to die.⁶³ At the same time, by declining to review the Oregon statute allowing physician-assisted suicide, the court indicated that states are free to make the opposite choice. Clearly, every state may decide a range of issues about how people die.

The ultimate goal of law and medicine in this area is helping people die well, and an essential component of the goal is pain relief. The keynote speaker urged forum participants to debate the nature of a high-quality death: What resources are needed? How can every person’s pain be made tolerable? How can the mental anguish and the mental disabilities of dying be addressed? His own recommendations included a closer relationship among the medical, nursing, and pharmacy professions.

After brief presentations by other speak-

ers,⁶⁴ participants divided into seven small groups, each with a mix of experience and interests, to discuss the following questions:

- Should North Carolina licensing boards set standards for end-of-life care? Should health professions’ practice acts or rules further define the standards? If so, what should the standards be?
- Are patterns of practice (treatment) changing? How? If not, should they be?
- What are the major barriers to patient choice with respect to dying?
- What aspects of end-of-life care in North Carolina need attention to bring about policy development, education, or regulation?

The seven groups split three ways on whether licensing boards should adopt standards. Some thought it essential so that professionals could treat pain adequately and help patients fulfill their last wishes. Others were cautious because of political risks and a feeling that state regulation of dying is anti-democratic. They preferred that the three boards follow rather than lead society in its evolution on these matters. A middle group wanted flexible standards, or none at all, for the time being. To them, process seemed more important now than answers.

All the groups believed, however, that professional standards for terminal care are changing, mostly for the better. They credited the hospice movement, patients’ insistence on “palliative” care (treatment intended to reduce the severity of symptoms without curing the disease), the emergence of nursing as a more independent profession, and recognition of that development by medicine.

The groups offered a number of reasons for patients’ wishes being overlooked so often: patients’ and health care providers’ reluctance to plan for death; time pressures and the cost of care; a perception that abandoning aggressive treatment is immoral; and the difficulty of communicating patients’ preferences to the necessary parties.

On the last question, there was again more agreement. All participants supported education in end-of-life choices for the public, legislators, other policy makers, and health professionals. Many preferred permissive rather than mandatory legal regulation of these issues. Above all, they hoped that the forum itself would be reconvened and that the boards of medicine, nursing, and pharmacy would establish procedures for cooperating on behalf of the terminally ill and the dying.

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NOTES

1. Becky Bull, "Best-Laid Plans: Living Wills Are Supposed to Eliminate Many Painful Decisions for Family Members. So Why Don't They?" *Wall Street Journal Interactive Edition*, June 1, 1998, available at <http://www.wsj.com>.

2. Bull, "Best-Laid Plans."

3. Bull, "Best-Laid Plans."

4. End-of-Life Decisions Forum, Raleigh, NC, Oct 23, 1998.

5. The forum itself was a milestone in the boards' relationship. Although they have met together occasionally in recent years, the forum was the first time they agreed to explore jointly an issue with serious implications for regulation by all three. Together, their staffs planned what the objectives of the forum would be, what points should be covered, and who would speak. The focus of the meeting was what board members needed to know about their profession's role in the process of dying and what more needed to be done in North Carolina to bring about desirable change. (Telephone conversation with Mary P. Johnson, executive director, North Carolina Board of Nursing, Jan 12, 1999.)

6. *State v Willis*, 255 NC 473, 121 SE2d 854 (1961).

7. "Since suicide is a crime, one who aids or abets another in, or is accessory before the fact to, selfmurder is amenable to the law." *Willis*, 255 NC at 477, 121 SE2d at 856-57.

8. "Such offenses [assisting suicide], in the absence of statute to the contrary, would not be criminal offenses in a jurisdiction in which suicide is not a crime." *Willis*, 255 NC at 477, 121 SE2d at 857.

9. Martha Quillin, "A Good Death: The Last Days of Sam Niver," *Raleigh News & Observer*, Aug 23, 1998, available at <http://search.news-observer.com>. The editorial note is by Anders Gyllenhaal.

10. Malice is a necessary element of murder.

11. According to the dissent,

Almost all would agree that someone who kills because of a desire to end a loved one's physical suffering caused by an illness which is both terminal and incurable should not be deemed in law as culpable and deserving of the same punishment as one who kills because of unmitigated spite, hatred or ill will. Yet the court's decision in this case essentially says there is no legal distinction between the two kinds of killing.

State v Forrest, 321 NC 186, 200, 362 SE2d 252, 260 (1987).

12. United Press International, "Mercy Killing' Trial to Begin Today," *Asheville Citizen*, May 25, 1982.

13. Ron DuBois, "Woman Indicted in Sister's Death," *Asheville Citizen*, April 8, 1982.

14. Barbara Blake, "Sentence Suspended in Mercy Killing," *Asheville Times*, May 26, 1982.

15. United Press International, "Mercy Killing' Trial."

16. AP Wire Service, "Murder Trial May Address Mercy Killing," *Asheville Times*, April 19, 1982.

17. AP Wire Service, "Murder Trial."

18. Dubois, "Woman Indicted."

19. North Carolina Board of Nursing, Order in

the Matter of _____ [name omitted by author], RN, Certificate #59124, June 16, 1989, p 5 (hereinafter "Order").

20. 44 mg of Morphine IV-push in 45 minutes. "Order," p 3.

21. In its investigation, the board of nursing found that the patient's "struggle was with breathing. She did not appear to be having discomfort or pain." "Order," p 3.

22. "Order," p 4.

23. Telephone conversation with James Wilson, general counsel, North Carolina Medical Board, Sept 15, 1998.

24. "Order," pp 7-9.

25. Peter G. Filene, *In the Arms of Others: A Cultural History of the Right-to-Die in America* (Chicago: Ivan R. Dee, 1998), 195.

26. Ezekiel Emanuel et al, "The Practice of Euthanasia and Physician-Assisted Suicide in the United States," *JAMA* 280 (Aug 12, 1998): 507-13.

27. *Merriam-Webster's Collegiate Dictionary* (10th ed) (Springfield, Mass: Merriam-Webster, 1997), sv "suicide."

28. Alan Meisel, "Criminal Liability: Assisted Suicide and Euthanasia," chap 18 in *The Right to Die* (2d ed), vol 2 (New York: Wiley Law Publications, 1995).

29. The closeness and the intensity of the relationship are not the issue. Spouses, for example, do not have such protective obligations to each other.

30. As used here, "providing" means prescribing, filling a prescription, or, in the case of a nurse, delivering a dose ordered by a doctor.

31. According to regulations under North Carolina's statute, anyone "dispensing" (writing or filling a prescription for) controlled substances must register, but doctors and pharmacists are exempt when practicing and when licensed in North Carolina "by their respective boards to the extent authorized by their boards." 10 NC ADMIN CODE 45G.0108. Likewise, federal regulations (incorporated into the state's code at 10 NC ADMIN CODE 45G.0301) say,

A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

21 CFR §1306.04.

32. North Carolina Medical Society, *Physician-Assisted Suicide*, Substitute Report PP-1992, adopted Nov 8, 1992. The society's office is in Raleigh, NC.

33. North Carolina Licensed Practical Nurses Association, *Position Statement on Assisted Suicide*, adopted May 1, 1998. The association's office is in Durham, NC.

34. Telephone conversation with Gayl Manthei, special deputy attorney general, Health and Public Assistance Section, Aug 1998.

35. The language is from NC Gen Stat §90-14(a)(6). Hereinafter, the North Carolina Statutes will be cited as GS.

36. GS 90-171.20(7). The statement was probably meant to recognize the important role of nursing in hospice care. (Telephone conversation with Howard Kramer, general counsel to the North Carolina Board of Nursing, Sept 2, 1998.)

37. GS 90-171.37.

38. *In re Cafiero v North Carolina Board of Nursing*, 102 NC App 610, 403 SE2d 582 (1991).

39. GS 90-171.37(5), (6).

40. 21 NC ADMIN CODE 36.0217(7).

41. GS 90-85.38(9).

42. *Stedman's Medical Dictionary* (26th ed) (Baltimore: Williams & Wilkins, 1995), sv "euthanasia."

43. GS 14-17. See also Thomas H. Thornburg (ed), *North Carolina Crimes* (4th ed) (Chapel Hill, NC: Institute of Government, The University of North Carolina at Chapel Hill, 1995), 61-65.

44. Law enforcement concerns on this point may be exaggerated, however. A federal government panel concluded,

[R]espiratory depression is infrequently a significant limiting factor in pain management because, with repeated doses, tolerance develops. This tolerance allows adequate pain treatment without much risk of respiratory compromise. [A dying patient] should not be allowed to live out life with unrelieved pain because of a fear of side effects; rather, appropriate, aggressive, palliative support should be given.

A. Jacox et al, *Management of Cancer Pain*, Clinical Guideline No 9, AHCPH Publication No 94-0592 (Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services, March 1994), 8.

45. See North Carolina Medical Board, *Position Statement: Management of Chronic Non-Malignant Pain* (Raleigh, NC: NCMB, adopted Sept 13, 1996). The statement begins, "It has become increasingly apparent to physicians and their patients that the use of effective pain management has not kept pace with other advances in medical practice."

46. "Hillhaven Is Ordered to Pay \$15 Million to Ex-Patient's Estate," *Wall Street Journal*, Nov 26, 1990. The case, brought by the administrator of Henry James' estate, was *Falson v Hillhaven Corporation*. The parties reached a private settlement, and the verdict was not appealed. (Telephone conversation with Ronald Manasco, plaintiff's attorney, Rocky Mount, NC, Sept 23, 1998.)

47. Thomas R. Reardon, Statement of the American Medical Association to the Subcommittee on the Constitution of the House Judiciary Committee, July 14, 1998, available at <http://www.ama-assn.org>.

48. NCMB, *Position Statement: Management of Chronic Non-Malignant Pain*.

49. *N.C. Board of Pharmacy* 13, no 4 (April 1992): 1.

50. 21 USC §823(g).

51. 21 CFR §1306.07(c).

52. GS 90-87(13). The Uniform Commission on State Laws recommends such amendments.

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Jacox et al, *Management of Cancer Pain*, 14.

53. GS Art 23, Ch 90.

54. See Opinion of Attorney General to C. Robin Britt, Sr, secretary, NC Dept of Human Resources, Jan 5, 1995. ___N.C.A.G.___, available at www.jus.state.nc.us. The act and its amendments emphasize that North Carolinians retain additional common law rights to control the circumstances of their death. GS 90-320.

55. GS 90-321.

56. GS 32A-15 through -26. The law names dire circumstances (terminal illness, permanent coma, severe dementia, and persistent vegetative state) [GS 32A-25(3)(e)], but the person appointing an agent is free to identify other circumstances in which the agent would begin to act [GS 32A-25(4)].

57. GS 90-320(b).

58. Advisory opinion to R. Marcus Lodge, general counsel, NC Dept of Human Resources, from Ann Reed, senior deputy attorney general, and James A. Wellons, special deputy attorney general, NC Dept of Justice, May 23, 1996.

59. *Cruzan v Director, Mo Dep't of Health*, 497 U.S. 261 (1990). Justice Sandra Day O'Connor's concurrence states the point more forcefully than the majority opinion, which merely assumes a liberty interest for purposes of the specific case. In a later case, a majority of the Supreme Court shows the same reluctance to acknowledge this right fully: "We have . . . assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment." *Washington v Glucksberg*, 521 U.S. 702 (1997).

60. Patient Self-Determination Act, 42 USC §§1395cc (Medicare), 1396a (Medicaid).

61. Filene, *In the Arms of Others*, 184. Filene notes that the most commonly used forms of living wills do not apply to those dying slowly of severe chronic illnesses or to people living in a persistent vegetative state. He also points out that "both a living will and a proxy can be thwarted by doctors, hospital administrators, or right-to-life groups." Filene, *In the Arms of Others*, 185.

62. Lawrence O. Gostin, professor of law, Georgetown University; professor of law and public health, the Johns Hopkins University; formerly executive director, American Society of Law, Medicine & Ethics.

63. *Glucksberg*, 521 U.S. 702 (holding that Washington's ban on assisted suicide does not violate fundamental liberty interest); *Vacco v Quill*, 521 U.S. 793 (1997) (holding that New York's ban on assisted suicide does not violate Equal Protection Clause).

64. Nancy King, associate professor, Dept of Social Medicine, UNC-CH -- "Bioethical Issues"; George C. Barrett, member, NC Medical Board, and chair, Committee on Ethics, NC Medical Society -- "Medical Regulatory and Professional Issues"; William Campbell, dean, School of Pharmacy, UNC-CH -- "Preparing Health Professionals in the Academic Setting"; Catherine Clabby, medical reporter, *Raleigh News & Observer* -- "The Media"; Sharon Dixon, senior vice president, Hospice at Charlotte -- "The Hospice Perspective"; Joseph Buckwalter, past president, Hemlock Society -- "The Hemlock Society Perspective"; David Swankin, president, Citizen Advocacy Center -- "Consumer Protection"; and Anne M. Dellinger, professor, Institute of Government, UNC-CH -- "North Carolina Law." ♦

Medicine and the Media

*Glinda S. Cooper, Ph.D., Epidemiology Branch,
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Dr Cooper

During the past decade, the amount of news coverage of medical research has vastly increased. Institutions and journals send out press releases about articles that previously would have passed unnoticed by the general public. Based on these

press releases, newspapers, radio, and television news programs often feature a medical story as a front-page or lead-in report. The result, for the practicing physician and for the public, can be confusion.

Confusion arises when the news stories present such limited information that it is not possible to fully evaluate the real meaning of the story. Confusion also arises when, as is very common, one research report contradicts, or seems to contradict, another. Some of this confusion may be an inevitable result of "sound-bites" and "headline news," but some results from a basic contradiction between the aims of news reporting (immediate dissemination of information to as wide an audience as possible) and the aims

"The process one goes through when reading a news story about a medical report is similar to the process one goes through when reading (or writing) the actual report."

of research (an often slow process of discovery, review, questioning, and either acceptance or rejection by what may be a small group of peers).

The process one goes through when reading a news story about a medical report is similar to the process one goes through when reading (or writing) the actual report. There are specific questions that need to be addressed in order to interpret the significance of the study. Physicians, reporters, and the public can all benefit from being aware of what to beware of when reviewing medical research.

How Large Is the Study?

In real estate, the most important criteria are said to be "location, location, location." In research, this axiom could be "sample size, sample size, sample size." Nothing else

has as large an influence on the interpretation of the study.

- Beware of small samples: small studies that produce results that are "not statistically significant" may simply be too small to provide a precise estimate or to differentiate between a "positive" and a "negative" result. Small studies that produce "statistically significant" results are also problematic: a "statistically significant" result means that it is unlikely that the result would have occurred by chance. But statistical tests provide no protection from odd things, or odd people, affecting results. One or two "outliers" will have a much bigger effect in a study with 10 people than in a study with 100.

- Beware of reports in which it is not possible to determine how many people (or observations) are included in each of the major analyses. This is particularly important in situations in which a strong effect is reported in one, and only one, sub-group. This sub-group could be very small, in which case you are back to the situation of "Beware of small samples."

How small is small? It depends on the type of study and what is being studied: clinical studies with less than 20 patients and case-control studies with less than 100 total participants could be considered "small." In cohort studies (where a group of people is followed over time, such as clinical trials or epidemiologic studies like the Nurses' Health Study), the relevant number is not the size of the group, but rather the number of the "outcome" that is being studied (eg, the number of drug complications, or the number of women who develop breast cancer).

What Does the Study Measure and How Does It Measure It?

The level of detail and the information sources used in medical research can vary substantially. This is true for both "outcomes" (eg, the presence or absence of a particular symptom, diagnosis, clinical feature, or complication) and for "exposures" (eg, medications, diet, medical conditions, smoking habits). For example, the presence of

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hypertension could be measured by self-report or by three blood pressure measurements conducted using a standardized protocol. Use of a specific drug could be based on a single question with a yes or no answer; extensive year-by-year histories of medication use including information about dose and compliance, or records of prescriptions ordered or filled. At the very least, you should be able to tell what was measured and how the measurement was obtained; at the very best, you will also be given a sense of the reliability and accuracy (compared to some kind of gold-standard) of the measures.

- Beware of measures based on people's memory, particularly for events or experiences that happened many years ago. Some things are remembered with a high level of accuracy (eg, age at first pregnancy), but others (often the less significant events) are not.
- Beware of measures based on blood samples obtained *after* someone has gotten sick. Many illnesses (especially those that cause weight loss) can affect blood levels of a variety of compounds.

What Did the Study Find?

"The results were highly significant." This is a common statement in news reports and, all too often, in the medical journal reports of research studies. But the statistical significance of the results does not provide any information about the magnitude of the results. In a large study, very small differences between two groups may be statistically significant (the differences are unlikely to have occurred because of variability due to chance), but of no real clinical or biological importance.

- Beware of reports that do not provide both a measure of the magnitude of the effect and a measure of the variability in this estimated effect. This measure of variability could be in terms of a standard error of the estimate, a confidence interval around the estimate, or a test of statistical "significance" (p-value). But to be meaningful, the measure of the

magnitude of the effect must also be provided.

How Should the Results of the Study Be Interpreted?

The news media, by their very nature, emphasize "new" stories. But it may take many years before the significance of a particular research report is fully known or appreciated. On the other hand, time may bring retractions or lack of confirmation of the initial "breakthrough" findings. An example is the highly publicized report in *Nature* in 1994 by Morrison, et al, of a strong association between osteoporosis (low bone density) and a particular gene for the vitamin D receptor. Part of the data for this study was later retracted because of discrepancies in the laboratory assays that were discovered in subsequent research by the same group and the association has received only limited support in subsequent studies.

- Beware of first reports. First reports, even if they come from a well-conceived, well-done study, are often not confirmed by subsequent research.

Researchers are often urged to include a discussion of the contribution of their work to the understanding of basic biologic mechanisms or significance to public health. It can be tempting to speculate about the far-reaching importance of a particular study.

"Beware of first reports. First reports, even if they come from a well-conceived, well-done study, are often not confirmed by subsequent research."

17,077 African-American and white girls ages 3 to 12. Based on a variety of measures, African-Americans matured an average of a year earlier than whites. But a major focus of some of the news articles about this report was speculation about the role of estrogen-like chemicals, found in some pesticides, plastics, and hair products, in producing early sexual development. This particular study did not measure any of these products or chemicals, so this emphasis was a potentially misleading "spin" to the study. It may be that estrogen-like chemicals effect age at menarche, but that was not demonstrated in

this particular study.

- Beware of the urge to over-interpret, or over-extend, the results of a study beyond the specific question it was designed to address.

Why Was This Particular Study Done?

It is important to place any new study in the context of previous related research. Consistency between studies, in terms of the results, strengthens the findings. But differences between studies do not necessarily signify that one is "right" and the others "wrong." The reasons that different results may have been found (such as differences in the age groups that were studied, or differences in the measures that were used) may provide important insights that could not be obtained in a single study.

"Differences between studies do not necessarily signify that one is 'right' and the others 'wrong.'"

- Beware of news reports that emphasize conflicts between studies or researchers. In war or politics, the conflicts and differences of opinion may be the main point that the news story needs to convey. This is not the case for medical research.

Conclusion

A research study published in a medical journal should provide information about the issues described above. In most cases, a well-written 200 word abstract can do the same. A well-written news story should strive for this same level of information; anything less is a disservice to researchers, health care providers, and the public.

Resources:

IFIC Review: How to Understand and Interpret Food and Health-Related Scientific Studies. International Food Information Council. July 1997. (<http://ificinfo.health.org/brochure/ificrevu.htm>)

Victor Cohn. *News & Numbers: A Guide to Reporting Statistical Claims and Controversies in Health and Other Fields.* Ames Iowa: Iowa State University Press, 1989. (abbreviated version, http://www.facsnet.org/report_tools/news_numbers/main.htm) ♦

Physician Supply in North Carolina: 1993-1997

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Data

The growth in the number of patient care physicians in North Carolina between 1993 and 1997 was nearly identical to that for the U.S. as a whole. The state's physician supply grew by 13.1 percent compared to 13.0 percent for the nation (Table 1).

1993 and 22.8/10,000 in 1997, an increase of 8.2 percent. There were similar comparative trends for primary care physicians. The nation as a whole saw a ratio improvement of 10.6 percent and North Carolina's primary physician to population ratio grew by only 6.4 percent (Table 2).

associations. The data that are maintained in this system are contributed by licensed physicians who fill out a brief series of descriptive questions as part of the annual registration process. The data remain the property of the North Carolina Medical Board and are released only with permission of the Board or its executive director.

This cooperative effort between the University of North Carolina and the Medical Board is unique to our state. As a result, North Carolina has the only comprehensive longitudinal data set describing the location, distribution, and practice characteristics of physicians in the United States. Statistical data collected in the 1998 license renewal cycle will soon be available, and the change in physician supply will be examined closely to determine if the divergence between North Carolina's and the nation's physicians growth rates has continued.

The Sheps Center also conducts detailed analysis of the geographic distribution of physicians and makes use of the location data to help the state identify areas where the physician supply might cause problems in accessing health care services. At the same time, the Center works with other licensing boards to compile data on 14 other categories of licensed health professionals.

Over the next year, Sheps Center staff will be producing a report on 20-year trends in physician and other health professional distribution and practice. This 20-year trend book and other health work force research at the Center are possible through the cooperation of the North Carolina Medical Board and the licensed physicians in the state, who have supported this data collection and use since 1977. Reliable, timely data describing the numbers of practicing health care professionals are essential in a system that depends on a mix of private initiative and public support. North Carolina has made effective use of these data to help plan for the future as well as resist the urge to make changes for change's sake.

Information Available

These data are available to interested individuals and organizations through the Center's reports and publications. We annually publish the *North Carolina Health Professions Data Book*. This publication includes state-, region-, and county-level statistics from the health professions licensing

Table 1. US and North Carolina Active, Patient Care Physician Supply

	Total Patient Care Physicians		Primary Care Physicians		Percent Change Total	Percent Change Primary Care
	1993	1997	1993	1997		
North Carolina	12,704	14,366	5,174	5,886	13.1%	13.8%
United States	543,156	613,720	245,064	283,115	13.0%	15.5%

Sources: *Physician Characteristics and Distribution in the US*, American Medical Association, 1993, 1994, 1995/96, 1996/97, 1997/98; *North Carolina Health Professions Data Book*, Cecil G. Sheps Center for Health Services Research, 1993, 1997

A more revealing analysis of the physician supply of the state and the nation takes account of population growth. North Carolina is a rapidly growing sun-belt state and population growth is faster here than in other states. In this time period, North Carolina's population grew by 6.9 percent compared to the nation's 4.4 percent. This is reflected in the relative change in physician-to-population ratios. North Carolina had 18.3 physicians for every 10,000 people in 1993. That ratio improved by 5.8 percent by 1997 to 19.3 physicians per 10,000. However, the increase in physicians to population in the state lagged the nation; across the United States, there were 21.1/10,000 in

Cooperative Effort

These trends can be tracked because of the 20 years of cooperation between the North Carolina Medical Board, the North Carolina Area Health Education Centers (AHEC) Program, and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill.

Since 1976, the North Carolina Medical Board has shared statistical and demographic data with the Sheps Center. The Center has, in turn, published an annual report on the numbers and locations of the practicing physicians in the state and conducted analyses of the supply and distribution of physicians for policy makers and professional

Table 2. Active Patient Care Physicians per 10,000 Population

	Total Patient Care Physicians/10,000		Primary Care Physicians/10,000		Percent Change Total	Percent Change Primary Care
	1993	1997	1993	1997		
North Carolina	18.3	19.3	7.5	7.9	5.8%	6.4%
United States	21.1	22.8	9.5	10.5	8.2%	10.6%

Sources: *Physician Characteristics and Distribution in the US*, American Medical Association, 1993, 1994, 1995/96, 1996/97, 1997/98; *North Carolina Health Professions Data Book*, Cecil G. Sheps Center for Health Services Research, 1993, 1997

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boards, as well as demographic and health-related information, and is available at cost for \$20.00. The *NC Health Professions Supply by County Pocket Guide*, a two-page pamphlet designed to give basic information about the supply of active health professionals by county, is available at no charge. To order the *Data Book* or the *Pocket Guide*, contact the Health Professions Data Coordinator at (919) 966-7112, or by e-mail at (nchp@unc.edu). The *Pocket Guide* may also be accessed and downloaded at our web site: HYPERLINK <http://www.sheps-center.unc.edu/hp/>.

Acknowledgement

Special thanks to Laura M. Smith and Hazel L. Hadley of the Sheps Center for their efforts.

Notes:

Primary care physicians are defined as the following specialties: family practice, general practice, general internal medicine, general pediatrics, and obstetrics/gynecology.

The Data System updates files by comparing new license renewal information to existing records. This updating practice includes changes in practice specialty and other characteristics included on the renewal forms.

Due to incomplete reporting, the data must be carefully compared to prior information before public release. This process of updating means final statistical data are available one year after their submission ♦

National Practitioner Data Bank Reports: Numbers at the End of 1998

Data released by the federal National Practitioner Data Bank, operated by the Division of Quality Assurance of the Health Resources and Services Administration's Bureau of Health Professions, indicates there were more than 200,000 reports on physicians and other health care practitioners in the NPDB as of December 31, 1998. Of those,

- malpractice payments numbered 154,372;
- state licensing actions numbered 29,372;
- clinical privilege reports numbered 7,680;
- actions by professional societies numbered 358; and
- Medicare exclusions numbered 10,231.

Authorized by Congress in 1986, the NPDB has been in actual operation for almost 10 years. It is currently proposing to modify its rules on malpractice reporting by calling for reports on physicians who are not named as defendants but whose actions are involved in claims against corporate entities (hospitals, groups, etc) that lead to payments. According to those in charge of the NPDB, this change could as much as double the number of malpractice reports to the NPDB.

The Impaired Physician: All in the Family

Daniel M. Avery, MD, Past President

American Society of Forensic Obstetricians and Gynecologists

The effects of alcoholism or addiction on families are devastating. Patients so impaired usually deny family problems even exist.



Dr Avery

A young physician I know was recently admitted to a residential program for treatment of his alcoholism. When told his wife was to be interviewed by a family counselor, he asked: "Why? This is my problem. It certainly hasn't affected my family." His 17-year-old daughter ran away from home at the height of his impairment. His 16-year-old son was a very angry young man with an attitude, doing poorly in school. His 13-year-old daughter didn't know if she would pass to the next grade in school and wasn't sleeping well for worry that her parents might divorce. But, no, his addiction to alcohol was having no effect whatsoever on his family.

The Family Knows

The family knows something is wrong long before the alcoholic or addict ever realizes a potentially fatal disease is ravaging both his or her personal and the family's health, work, social life, and finances. Denial is such that the consequences to the family are always overlooked. Alcoholics think their families don't know, but they almost always do. Spouses, parents, significant others, and even the youngest children know something is wrong, they just don't know what.

Treatment programs consider families a major priority. Some of the greatest rewards in treating substance abusers are found in the families. Many addicts enter treatment under the threat of impending divorce or being driven from their home. Later, they discover that family therapy can save a good marriage gone bad and revitalize shattered family relationships. Most residential treatment programs include a family week when spouses, children, significant others, parents, and siblings participate in therapeutic and educational programs. This is a time for processing anger, disturbing thoughts, and problems, but most of all a time for healing. It's also often a launching pad for saving marriages and families.

Addiction is a dreadful disease for everyone involved and not all marriages are salvageable, but, surprisingly, most are. The commitment to seek treatment and try to work through family problems together is at least a beginning. Family members can expect to be involved in group counseling, individual family and marital counseling, and, of course, personal counseling.

Education and Understanding

Education is foremost in any treatment program and addiction medicine is no different. Most family members come to the treatment center thinking this is all their fault, not realizing they are being affected by and are not the cause of their loved one's serious disease. The best analogy is uncontrolled diabetes mellitus. Most understand and accept this disease concept of addiction but some don't. Some others never will.

His or her family will eventually realize the alcoholic/addict will never be cured of the disease, but in treatment they will also realize there is a relatively good prognosis. If they must cope with a member's life-threatening illness, this is the one to have. My friend, with support from his family, can control his disease by not drinking, reading the *Big Book*, and going to meetings. These are infinitely easier than treatment of malignancies or severe diseases of the liver, heart, or kidneys.

We all know there are no guarantees with medical or surgical treatment, but treatment of alcoholism and other addictions does have a guarantee: as long as you don't drink or use, you won't get drunk or stoned. Substance abuse is just another aspect of life — it's all about the choices you make.

Monthly individual counseling sessions for the couple, in addition to family week, allow an opportunity to resolve past and current problems. Individual counseling for some family members may be necessary and can often be arranged closer to home.

One of the biggest problems with residential treatment is that the patient receives counseling every day in the round-the-clock therapeutic milieu while family members receive only intermittent counseling. Therefore, the patient logically should be therapeutically well ahead of the family, and when the patient returns home the family commonly expects him or her to be completely back to normal. Such is almost never

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Impaired Physician

continued from page 12

the case. Addicts leave the residential treatment program with tools to start solving life's problems, but the vast majority of those problems have been addressed only minimally if at all.

Real Work Begins at Home

Sobriety in and of itself does not eradicate all the other problems. The family may expect a brand new "fixed" spouse or parent, but the first month at home is when the work really begins. The character defects in AA's Fourth and Fifth Steps are still lurking in the background, and anger, denial, and isolation can quickly reemerge. Imagine a wife expecting her alcoholic husband to be cured, only to find he still gets angry and screams at the children. Immediately, things seem no better, perhaps even worse, than before.

Most treatment programs require 90 AA or NA meetings within the first 90 days back at home, and this may seem onerous to the family. Daddy or mommy has been away in treatment for a long time, so how come he or she must still go to these meetings every day? It's absurd even to consider going to three AA meetings within 24 hours, but meetings are one of the tools vital to alcoholic recovery. Actually, there are some 20 points in a good recovery program, including:

- meetings;
- meditation;
- time with family;
- therapy;
- marriage counseling;
- medical care;
- adequate rest;
- reading the *Big Book*;
- talking to others in recovery;
- pursuing a spiritual life;
- placing reasonable limits on work;
- avoiding hunger, anger, loneliness, and fatigue;
- working a Twelve Step Recovery Program.

Spouses often are disturbed by meetings or therapy groups that interfere with family activities, failing to realize that sometimes it is necessary to place recovery above everything else lest everything else be lost. Marital and family therapy almost always must be continued on returning home, sometimes with additional individual therapy. Reason and proper planning can prevent many conflicts. Most large treatment programs provide quarterly visits allowing families to return for more focused therapy. Yearly retreats are also an opportunity for revitalization.

Where There's a Will There's a Way

Financial support is another common family problem. How is the family to sur-

vive while its breadwinner goes off to treatment and is out of work? Are there adequate savings? Can the remaining parent's salary alone forestall an impending mortgage foreclosure? Children commonly fear financially losing their home. Most centers offer plans for financing the cost of treatment when full insurance coverage is not available, but everyday living expenses, such as groceries, utilities, clothing, insurance, etc., can be intimidating.

There are many ways to get by and all include some form of help from others. Employers are far more likely today than in the past to allow time off for substance abuse treatment and rehabilitation rather than to terminate one's employment. Many times, loans from family members are necessary to financially survive treatment. But where there's a will there's a way, and far more make it than don't.

The effects of alcoholism or addiction on families are devastating. Patients so impaired usually deny family problems even exist, and this is the hallmark of their disease's denial. Fortunately, proper treatment and family therapy can save many marriages and families.

Reprinted with permission from the October 1998 number of the American Society of Forensic Obstetricians and Gynecologists publication *The Medicolegal OB/GYN Newsletter*. ♦

Dr Barrett Chosen President Elect of FSMB



George C. Barrett, MD

On Saturday, April 24, 1999, in St Louis, MO, at their Annual Meeting, the members of the Federation of State Medical Boards of the United States selected George C. Barrett, MD, of Charlotte, as the Federation's president elect. He will take office as president of that organization in April 2000.

Dr Barrett was a member of the North Carolina Medical Board from 1992 to 1998, chaired most of the Board's committees at one time or another, and was president of the Board in 1996-97. He was a member of the Federation's Board of Directors from 1996 to 1998, and became vice president of the group in 1998.

A native of Roxboro, North Carolina, he is a graduate of the Bowman Gray School of Medicine and did his postgraduate training

at Buffalo General Hospital, Duke University Medical Center, North Carolina Baptist Hospital and Bowman Gray School of Medicine.

He is certified by the American Board of Radiology, with a medallion in nuclear medicine. In 1986 and 1989, he pursued advanced studies in bioethics at the Kennedy Institute of Georgetown University in Washington, DC. He is a fellow of the American College of Radiology and a member of the North Carolina Medical Society, the Mecklenburg County Medical Society, and numerous other professional organizations. On April 16, 1999, just days before his selection as president elect of the Federation of State Medical Boards, he received the 1999 Distinguished Service Award of the University of North Carolina at Charlotte, which is the most prestigious non-academic tribute offered by that university.

The Federation of State Medical Boards of the United States, founded in 1912, is the national voluntary membership organization of state medical boards. It has 68 member boards representing every medical licensing jurisdiction in the United States, including Puerto Rico, Guam, and the Virgin Islands. (In some states, medical doctors — MDs — and doctors of osteopathy — DOs — are licensed by separate boards. All belong to the Federation, however.)

Among other things, the Federation, with the National Board of Medical Examiners, is responsible for the United States Medical Licensing Examination (USMLE). It also operates the Board Action Data Bank, which is a permanent record of disciplinary actions taken by all medical boards and which keeps each member board informed of disciplinary actions taken by other member boards.

Andrew Watry, executive director of the North Carolina Medical Board, has noted that Dr Barrett is continuing the Board's distinguished record of leadership in the Federation. Over past years, three members of the Board have served as president of the national organization: Joseph J. Combs, MD, in 1956-57; Frank L. Edmondson, MD, in 1971-72; and Bryant L. Galusha, MD, in 1981-82. The Board's David S. Citron, MD, served on the Federation's Board of Directors in the 1980s, and Dr Galusha served as the Federation's executive vice president from 1984 to 1989.

"Our national organization is fortunate to have such a remarkable person, a man of vision and integrity, to lead it into the new century and the new millennium," Mr Watry said. "He will bring the same creative dynamism to the Federation that he has shared with the Board." ♦

NCMB Presentations Featured in Course at Wake Forest University School of Medicine

On March 3, 1999, more than a hundred second-year medical students and some faculty members attended a seminar featuring the North Carolina Medical Board. This was one of a series of presentations in a course titled *Medicine as a Profession (MAAP)*, a required part of the curriculum at Wake Forest University School of Medicine.

This is the third year that a presentation concerning the Board was part of the MAAP course. Traditionally, the immediate past president of the Board is the featured speaker. Three past presidents were present in the audience this year: Dr Eben Alexander; Dr Walter Roufail; and Dr Charles Trado, who was to speak on the program. Also present were Mr James Wilson, director of the Board's legal department, who was making his third appearance as a speaker, and Dr Jesse Roberts, medical coordinator of the Board.

After a brief introduction by Dr Roufail, who is now on the faculty of the school, Mr Wilson presented an historical perspective on and evolutionary review of the Board. He followed with a detailed discussion of the Board's workings and the most common reasons a very small percentage of licensees have to come before the Board. The range of sanctions that could ensue was also outlined. Mr Wilson was asked a number of questions by the students, indicating a significant interest in the ethics of medical practice even at that stage of their education.

Dr Charles Trado followed with his view on the impact of managed care on medical practice. His presentation, forceful and unequivocal, was warmly received by the students. Asked specifically about the position of the Board on issues arising from conflicts between physicians and managed care organizations, Dr Trado reminded the students that the Board deals only with its licensees, not with organizations. He also urged them to read and keep the Board's Position Statement on the Physician-Patient Relationship. This, he said, is the basis on which the Board decides the ethical behavior of the physician without regard to the financial arrangements of his or her practice.

That same afternoon, small groups of students, with the help of faculty tutors, discussed the hypothetical case of a physician who may have committed a series of infractions stemming from sexual advances made to one of his patients. Material for this discussion was provided, in part, by the Board's counsel, Mr Wilson.

The following article by the director of Wake Forest's MAAP course, Chaplain S. Bryant Kendrick, DMin, provides an overview of the course and its purpose. ♦

Medicine as a Profession: The Wake Forest University School of Medicine Course

Chaplain S. Bryant Kendrick, DMin



Dr Kendrick

The *Medicine as a Profession (MAAP)* course at the Wake Forest University School of Medicine represents a significant component of the way the university seeks to educate its medical graduates in medical professionalism.

Impact of Professional Issues

Medical professionalism draws primarily from the three areas of ethics, law, and humanities. Through the MAAP course, students develop an appreciation of the impact of professional issues on the role of physicians in our society and on the physician-patient relationship. The course has been a part of the curriculum in the first and second years of medical school for some time.

A few of the course offerings are listed here to give an idea of the range of issues considered important for medical students to encounter in the area of professionalism:

- ethical and legal aspects of the physician-patient relationship;
- codes and oaths in medical ethics and managed care;
- confidentiality, assessing patient decision-making capacity, and informed consent;
- the role of medical boards in the professional lives of physicians;
- the physician and the arts;
- sexual discrimination and harassment;
- caring for patients with HIV;
- issues in death and dying (advance directives, palliative care, and Hospice);
- the relation of medicine and religion;
- ethical and legal issues in organ donation;
- general research ethics and the roles of animals in research;
- cultural diversity in medicine;

- barrier issues in the physician-patient relationship;
- stress in the life of the physician; and
- DNR orders and futile medical care.

MAAP Reinvented

The MAAP course is currently being reinvented as the curriculum of the medical school shifts to a case-based modality. In this new way of educating medical students, the professionalism content will be embedded in the weekly cases the students encounter. Each case is modeled on "real-life" patients so that the education of the medical student has a much more clinical orientation. This "in-context learning" allows the medical student to sense the relevance of the entire curriculum to her/his role as a physician because the biomedical and professional issues are embedded in the history of the patient and the encounter with the physician.

Another feature of the new curriculum is its use of computers. On entrance to the medical school, each student is issued a laptop computer. Through the medical school network, students can communicate with each other through e-mail, documents can be created in small group sessions and sent to faculty evaluators, and there is ready connection with important sites on the World Wide Web.

In the MAAP course, for example, the students are presented with a list of Web sites relevant for developing an understanding of the professionalism issues involved in the week's cases. Working in small groups under the guidance of faculty mentors, these students use the computer-based resources, along with more traditional educational media and materials, to enhance their understanding of professionalism in medicine and develop reasonable strategies to respond to the professionalism challenge presented in the case.

The pedagogy of in-context learning enables the professionalism issues of modern medicine to be experienced as relevant to the care of patients on a par with the sciences of medicine, since these issues are presented to the student in the ways in which they will be encountered in the clinical experience of the physician: mixed in an encounter with a patient. ♦

Notes on the History of the North Carolina Medical Board: 1859-1999

Bryant D. Paris, Jr
Executive Director Emeritus, NCMB



Mr Paris

The North Carolina Medical Board is the oldest continuing medical regulatory board in the United States, tracing its direct history back 140 years to 1859.

Even before the Medical Society of the State of North Carolina was created in 1849, members of the medical profession and others supported the idea of regulating the practice of medicine in the state. Finally, thanks in part to the growth of the Medical Society's influence with the General Assembly, legislation was adopted on February 17, 1859, establishing what was then called the Board of Medical Examiners of the State of North Carolina. The legislation became effective on April 15, 1859, the date that now appears on the Board's logo.

The Medical Society, as authorized by the statute, elected the first Board of Medical Examiners on May 12, 1859. The Board consisted of seven members, all of whom were physicians. Until 1890, all seven Board members were elected as a group to serve for six years. Each newly elected Board replaced the previous Board and no Board member could succeed himself. In 1890, an attempt was made to stagger the members' terms of service. This experiment ended in 1902. In 1968, staggered terms were reintroduced and continue in use today.

The first public member was added in 1981. In 1993, two more public members were added, along with one "at large" member and a physician assistant or nurse practitioner. These five added members are appointed directly by the Governor and bring the total membership of the Board to twelve. (The Medical Society still elects seven physician members, who are nominat-

ed to and named by the Governor.)

Characteristics of the First Medical Practice Act

- ◆ The practice of medicine without a license was not declared a misdemeanor.
- ◆ There was no provision allowing licensure by endorsement, only authority to conduct an examination.
- ◆ The Board was to meet once a year, alternately in Raleigh and Morganton.
- ◆ The license fee was set at \$10.
- ◆ A medical degree was not required for a license. The applicant only had to be 21 years of age, be of good moral character, and pass the examination.
- ◆ The Board could rescind a license upon

Morganton; Dr Otis F. Manson, Townsville; Dr J. Graham Tull, New Bern; and Dr Caleb Winslow, Hertford. The Board's secretary was Samuel T. Iredell.

- ◆ The Board issued its first license to Dr Lucius C. Coke of Palmyra, in Martin County, at its first session on June 6, 1859.
- ◆ In 1885, legislation was adopted to require licensed physicians to register with the clerk of the Superior Court in the county in which they were practicing. (This requirement was repealed in 1967.)
- ◆ The first woman, Dr Annie Lowrie Alexander, Cowan's Ford, was licensed in May 1885.

◆ The first African American man, Dr M.T. Pope, Rich Square and Raleigh, was licensed in 1886, and the first African American woman, Dr Lucy Hughes Brown, was licensed in 1894. (The first African American graduate of a regular medical school to practice in North Carolina was James Francis Shober, MD, of Wilmington, who entered practice in 1878 and was exempt from the licensing requirement because he earned his degree prior to January 1, 1880.)

- ◆ Until 1899, the Board had to offer its examination to anyone who requested it, whether formally trained or not.

As a result, some non-graduates held licenses. An 1899 amendment to the law required an applicant to be a graduate of a regular medical school with at least three years of study.

- ◆ In the early 1920's, the Board accepted certification by the National Board of Medical Examiners in lieu of the Board's written examination. In 1953, this practice was discontinued on the basis of an opinion by the North Carolina Attorney

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FIRST BOARD — 1859-1866



Clockwise from lower left: Dr W.H. McKee, Raleigh; Dr Christopher Happoldt, Morganton; Dr C.E. Johnson, Raleigh; Dr O.F. Manson, Townsville; Dr J.G. Tull, New Bern; Dr Caleb Winslow, Hertford; *Center:* Dr J.H. Dickson, Wilmington.
Not pictured: Samuel T. Iredell, Secretary.

proof that a physician had been guilty of grossly immoral conduct.

- ◆ Those who were practicing medicine before passage of the act in 1859 were exempt from its provisions.

Through the Years

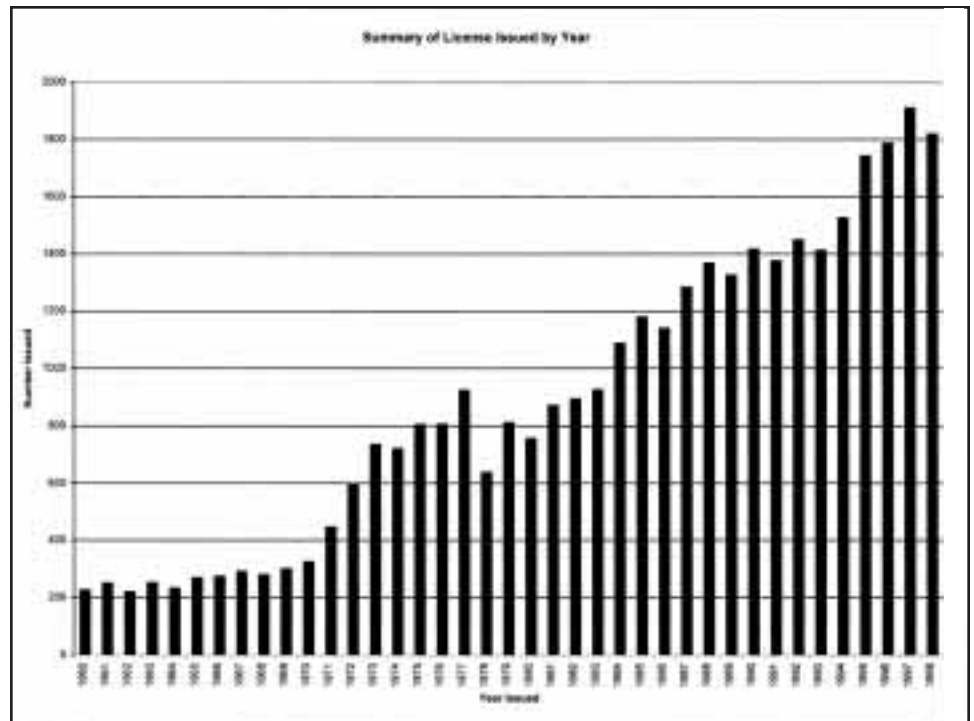
- ◆ The first Board (see photo) consisted of Dr James H. Dickson, Wilmington, president; Dr Charles E. Johnson, Raleigh; Dr William H. McKee, Raleigh; Dr Christopher Happoldt,

History of Medical Board

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General. In 1971, however, specific legislation was adopted authorizing the Board to issue a license on the basis of certification by the NBME.

- ◆ An illustrated history of the Board's first century was written by Dr Ivan M. Procter, a former secretary of the Board, and Dorothy Long, MA, and published by the Board in 1959.
- ◆ Between 1859 and 1959, the Board issued 11,721 licenses. Between 1960 and 1998, the Board issued 34,622 licenses. (See accompanying table.)
- ◆ Prior to the inception of the Federation Licensing Examination (FLEX) in 1968, the Board routinely used the "Blue Book" examination, a subjective method of testing. The FLEX was steadily altered and improved over the years in which it was used. Finally, between 1992 and 1994, the FLEX and the examination of the National Board of Medical Examiners were merged, creating the United States Medical Licensing Examination (USMLE), which is used by all states today.
- ◆ In 1975, the first woman physician was elected to the Board. In 1980, the first African American physician was elected.
- ◆ Physician Assistants:
In early 1971, legislation allowed the Board to approve PAs to perform medical acts. At first, PAs were not permitted to prescribe medications. In 1975, the law was amended to specifically permit PAs and nurse practitioners to prescribe. Today, licensed PAs number 1,743.
- ◆ Nurse Practitioners:
In 1973, legislation was adopted to allow NPs with advanced training to perform medical acts. Today, approved NPs number 1,369.
- ◆ Professional Corporations:
Prior to 1969, physicians were unable to incorporate. With legislation that year, physicians, individually and as groups, were able to form professional corporations. Since then, 4,854 professional corporations have been filed. Of these, 2,656 are currently active.
- ◆ Emergency Medical Personnel:
Beginning in 1973, the Board was given the authority to approve medical personnel who were performing acts above the basic life support level. Also with that responsibility came the Board's duty to approve non-physician individuals to administer epinephrine for insect stings.
- ◆ Post-Graduate Medical Education:



Prior to 1977, applicants for a license were not required to have post-graduate medical education or training. With an amendment to the Medical Practice Act at that time, applicants for a full license were required to have at least one year of post-graduate training. Then, in 1985, the law was modified to require three years of post-graduate training for foreign medical graduates.

- ◆ In 1995, the General Assembly changed the Board's name to the North Carolina Medical Board.
- ◆ After ten years publishing a small newsletter, the Board introduced its *Forum* at the opening of 1996. The

Forum soon became known as the best medical board publication in the country, combining essays, topical commentaries, news items, and disciplinary reports in an attractive and well designed format.

- ◆ In 1998, the Board elected its first public member president, Mr Paul Saperstein, Greensboro.

In closing, it should be pointed out that the form, words, and size of the license certificate first adopted by the Board in 1859 are still used today, though in 1976 it was decided that pronouns indicating gender should appropriately reflect the sex of the licensee. ◆

REVIEW

Save the Money

James A. Wilson, JD

Director, NCMB Legal Department

Let me save you \$24.95. *Bad Medicine*, a new book by Lawrence J. O'Brien, blames physicians and, to a lesser extent, the federal government for the financial problems of health care in the United States. Physicians' narrow-mindedness and greed have led this nation to the brink of bankruptcy, and the Congress has willingly taken us there, intoxicated by the lobbying money of the medical establishment. The only things that will save us are enrolling everyone in an HMO that

requires selection of a primary care physician, cutting the total physician population in half (keeping most of the generalists), and employing modern scientific and information-systems methods in patient management. In essence, the book is a diatribe promoting managed care.

O'Brien begins with the proposition that the supply of medical care drives demand for medical care since physicians determine the

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Review

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need for their own services. He cites examples of regional variations in the rate of performance of certain surgeries and from there asserts that "widespread and irrefutable patterns of unnecessary and inappropriate testing and treatment" exist because physicians care more about their own income than their patients' needs. As it is, he charges, a license to practice medicine is "a license to steal."

Bad Medicine: How the American Medical Establishment

Is Ruining Our Healthcare System

Lawrence J. O'Brien

Prometheus Books, Amherst, NY, 1999
283 pages (notes, index), \$24.95 cloth
(ISBN 1-57392-260-9)

Medical science is mired in a world view analogous to a Copernican (outdated, in his judgment) conception of cosmology, O'Brien argues, leaving physicians with a remarkable resistance to new scientific developments. Supporting this, he uses the

example of the resistance of nineteenth- and early twentieth-century physicians to hand washing and the continuing doubt that *helicobacter pylori* causes ulcers. O'Brien's solution is for physicians to draw on the example of modern physics: general relativity and quantum mechanics. This brings a new epistemology, in his view, one that values experimental and experiential results over untested theories. Modern clinical science then becomes the collected and compiled observations of legions of generalist primary care physicians.

HMOs are O'Brien's vehicle for this change. He begins defending HMOs, asserting they make only coverage and not medical decisions, only contract interpretations and not clinical judgments. Organized medicine's statements to the contrary are lies, he says; after all, physicians could treat patients without regard to the patients' abilities to pay, or, at least, could worry about that later.

O'Brien thinks everyone should be required to enroll in an HMO. The cost would be \$12 per patient per month, plus some amount for surgical care, though sicker people might have to pay more. HMOs would improve health outcomes by ensuring

that gatekeeper primary care physicians form and maintain longitudinal relationships with patients. Modern management and information systems would usher in the new era of medical science.

O'Brien makes a few good points but exaggerates them until the reader will wonder whether even O'Brien believes what he is saying. One hopes that he does not, but from the vitriol one assumes he does. His constant reference to physicians as "free barons" is boorish. Most outlandish of all, he says that residency programs intentionally do a poor job with their residents so the alumni will have no choice but to refer cases back to the alma mater.

O'Brien's presentation is as tiresome as is his argument. The writing is stilted while both jargonistic and vernacular. Lengthy quotes from just a few sources reappear throughout the chapters. To this O'Brien adds a little invective and pretends to have analyzed the issues. Other debatable points he labels irrefutable facts, always without citation.

Only those with the dimmest possible view of physicians will find ideas that resonate in this book. Save the money. ♦

North Carolina Medical Board Meeting Calendar, Application Deadlines, Examinations July 1999 -- May 2000

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

North Carolina Medical Board **July 21-24, 1999**
July Meeting Deadlines:
Nurse Practitioner Approval Applications June 7, 1999
Physician Assistant Applications June 8, 1999
Physician Licensure Applications July 6, 1999

North Carolina Medical Board **September 15-18, 1999**
September Meeting Deadlines:
Nurse Practitioner Approval Applications August 2, 1999
Physician Assistant Applications August 3, 1999
Physician Licensure Applications August 31, 1999

North Carolina Medical Board **November 17-20, 1999**
November Meeting Deadlines:
Nurse Practitioner Approval Applications October 4, 1999
Physician Assistant Applications October 6, 1999
Physician Licensure Applications November 2, 1999

North Carolina Medical Board **January 19-22, 2000**
January Meeting Deadlines:
Nurse Practitioner Approval Applications December 6, 1999
Physician Assistant Applications November 24, 1999
Physician Licensure Applications January 4, 2000

North Carolina Medical Board **March 15-18, 2000**
March Meeting Deadlines:
Nurse Practitioner Approval Applications January 31, 2000
Physician Assistant Applications January 28, 2000
Physician Licensure Applications February 29, 2000

North Carolina Medical Board **May 24-27, 2000**
May Meeting Deadlines:
Nurse Practitioner Approval Applications April 10, 2000
Physician Assistant Applications March 24, 2000
Physician Licensure Applications May 9, 2000

👉 Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)

The May 1999 administration of the USMLE Step 3 was the last pencil and paper administration. Computer-based testing for Step 3 is expected to be available on a daily basis in November 1999. *Applications may be obtained from the office of the North Carolina Medical Board by telephoning (919) 326-1100.* Details on administration of the examination will be included in the application packet.

Special Purpose Examination (SPEX)

The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at 400 Fuller Wiser Road, Suite 300, Euless, TX 76039 or telephone (817) 868-4000.

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

February, March, April 1999

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

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

Consent Order:

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

Denial:

Final decision denying an application for practice

authorization or a motion/request for reconsideration/modification of a previous Board action.

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

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

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

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

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

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

ANNULMENTS

NONE

REVOCATIONS

de los HEROS, Reinaldo Orlando, MD

Location: North Andover, MA

DOB: 4/21/51

License #: 00-36170

Specialty: P (as reported by physician)

Medical Ed: University of Puerto Rico, San Juan (1975)

Cause: Dr de los Heros was convicted of a felony in Massachusetts, which is grounds for the automatic revocation of the license unless a hearing is requested within 60 days of notice by the Board. No hearing was requested.

Action: 2/17/99. Entry of Revocation issued: Dr de los Heros' medical license was revoked by the operation of law on June 23, 1998.

SIDLER, Leonard Oscar, Jr, MD

Location: High Point, NC (Guilford Co)

DOB: 3/08/49

License #: 00-23972

Specialty: ESM/IM (as reported by physician)

Medical Ed: Emory University (1974)

Cause: Hearing following Summary Suspension of 8/10/98, based on Notice of Charges and Allegations dated 8/07/98. On 6/29/98, Dr Sidler entered into a Stipulation with the Board that stated he would refrain from the use of all controlled substances, including, but not limited to, marijuana. On 7/22/98, a Board investigator collected a urine sample from Dr Sidler. Analysis indicated the presence of opiates (Lorcet, which Dr Sidler disclosed he was taking for dental pain) and cocaine. By ingesting cocaine, he failed to comply with his Stipulation and engaged in unprofessional conduct.

Action: 2/9/99. Order of Discipline issued: Dr Sidler's medical license is revoked effective 8/10/98, the date of his Summary Suspension.

SULLIVAN, Kevin Paul, MD

Location: Puyallup, WA

DOB: 10/21/51

License #: 00-32178

Specialty: FP/OBE (as reported by physician)

Medical Ed: University of Illinois (1976)

Cause: By an order of 10/18/97, the Board of Medical Examiners of Colorado revoked Dr Sullivan's medical license upon findings that included grossly negligent medical practice.

Action: 3/10/99. Order issued revoking Dr Sullivan's North Carolina medical license.

See Consent Orders:

GEE, Steven Hong Nee, MD

SUSPENSIONS

SAWYER, Horace Kimbrell, Jr, MD

Location: Tucker, GA

DOB: 9/04/30

License #: 00-13906

Specialty: GP/AM (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1963)

Cause: On 7/06/95, the Composite State Board of Medical Examiners of Georgia suspended Dr Sawyer's license for two years, to be followed by probation for ten years, for making untrue representations on his application for privileges at several hospitals in Georgia and for treatment and documentation that fell below the minimum standard of acceptable and prevailing practice in Georgia. Notice of Charges and Allegations issued by the North Carolina Board 9/14/98, hearing held 11/19/98.

Action: 2/17/99. Order issued: Dr Sawyer's medical license is suspended indefinitely.

Suvillaga, Victor Ivan, MD

Location: Wilmington, NC (New Hanover Co)

DOB: 10/19/48

License #: 00-26877

Specialty: GP/EM (as reported by physician)

Medical Ed: Universidad El Salvador (1979)

Cause: Dr Suvillaga engaged in unprofessional conduct by failing to comply with his 1997 and 1998 Consent Orders. He violated the 1997 order by applying to the DEA for registration to administer, prescribe, dispense, or order controlled substances. He violated the 1998 order by practicing at the Wallace Urgent Care Clinic without obtaining approval from the president of the Board and without notifying his employer of his Consent Order. Notice of Charges and Allegations issued 11/27/98, hearing held 1/21/99.

Action: 2/17/99. Findings of Fact, Conclusions of Law, and Order issued: Dr Suvillaga's medical license is suspended indefinitely.

See Consent Orders:

BRYSON, Gary Keith, MD

WHITT, John Alan, MD

SUMMARY SUSPENSIONS

NONE

CONSENT ORDERS

BRYSON, Gary Keith, MD

Location: Bowling Green, KY

DOB: 11/12/51

License #: 00-25482

Specialty: OBG (as reported by physician)

Medical Ed: Bowman Gray School of Medicine (1979)

Cause: In the U.S. District Court for the Western District of Kentucky in March 1994, Dr Bryson pled guilty to one count of mail

fraud, a felony, for submitting claims to Blue Cross/Shield of Kentucky for a surgical assistant when no surgical assistant was present and he knew he was not entitled to make the claims; he was sentenced to three years supervised probation with a fine of \$9,341.60; in response to this, the Kentucky Board of Medical Licensure, through an Agreed Order of Probation, placed Dr Bryson's medical license on probation for five years; in 1995, following a hearing on his criminal conduct and conviction, the Tennessee Board of Medical Examiners ordered Dr Bryson's license suspended, with the suspension stayed and a period of five years of probation imposed.

Action: 3/17/99. Consent Order executed: Dr Bryson's North Carolina medical license is suspended for three years; that suspension is stayed on condition that Dr Bryson abide by the terms of his Kentucky and Tennessee probations, that he not bill, charge, or in any way ask or receive monetary payment from any person for any medical services or goods provided in North Carolina until his license probations in Tennessee and Kentucky are terminated, and that he maintain a current AMA PRA; must comply with other conditions.

BURSON, Jana Kaye, MD

Location: Mooresville, NC (Iredell Co)

DOB: 5/14/61

License #: 00-39164

Specialty: IM (as reported by physician)

Medical Ed: Ohio State University (1987)

Cause: To amend the Consent Order of 1/23/99. After discussing Dr Burson's status and health with her, the Board agrees to making certain changes in her Consent Order allowing her to purchase, administer, prescribe, dispense, or order controlled substances and to apply for DEA registration.

Action: 4/14/99. Consent Order executed: the Board extends Dr Burson's license to expire on the date shown on the license; she shall practice only in settings approved in writing by the president of the Board; she shall present a copy of this Consent Order to all prospective employers and have confirmation of this fact sent to the Board before beginning such new employment; she shall refrain from the use of all mind or mood altering substances and all controlled substances unless lawfully prescribed by someone other than herself and refrain from the use of alcohol; she shall, at the Board's request, supply bodily fluids or tissue for screening to determine if she has consumed any of these substances; she shall maintain and abide by a contract with NCPHP; she shall obtain 50 hours of relevant Category I CME each year; must comply with other conditions. The numbered paragraphs of this Consent Order supersede and replace those of the 1/23/99 Consent Order.

GEE, Steven Hong Nee, MD

Location: San Leandro, CA

DOB: 1/28/30

License #: 00-11160

Specialty: GP/A (as reported by physician)

Medical Ed: Bowman Gray School of Medicine (1958)

Cause: Action by the California Medical Board 2/10/98. Dr Gee's California license was revoked, the revocation was stayed, and he was placed on probation for five years with terms and conditions. He admitted he failed a competency examination and engaged in repeated negligent acts in connection with two patients.

Action: 2/08/99. Consent Order executed: Dr Gee's North Carolina medical license is revoked and the revocation is stayed for five years so long as he complies with the Order of the California Medical Board of 2/10/98; he shall obtain and document to the Board at least 50 hours of relevant Category I CME each year; must comply with other conditions.

GUTHRIE, John Robert, II, DO

Location: Mt Pleasant, SC

DOB: 3/08/42

License #: 00-24770

Specialty: FP (as reported by physician)

Medical Ed: Chicago College of Osteopathy (1979)

Cause: In the U.S. District Court for the District of South Carolina (in U.S.A. v. John Robert Guthrie), Dr Guthrie pled guilty to 100 felony counts related to distribution of controlled substances for other than legitimate medical purposes and was subsequently convicted on these felony charges. Dr Guthrie has retired from practice.

Action: 4/14/99. Consent Order executed: Dr Guthrie voluntarily surrenders his North Carolina medical license and the Board accepts that surrender.

HENDRICKS, David Martin, MD

Location: Chapel Hill, NC (Orange Co)

Durham, NC (Durham Co)

DOB: 5/20/51

License: Resident Training

Specialty: AN (as reported by physician)

Medical Ed: Medical University of South Carolina (1988)

Cause: On the application of Dr Hendricks for a license. He admits that while practicing as an anesthesiologist in South Carolina he diverted fentanyl for his personal use; by an order dated October 28, 1998, the South Carolina Board of Medical Examiners indefinitely suspended his license but stayed the suspension so long as he complies with a number of conditions. He completed an inpatient substance abuse program in March 1998 and signed a contract with the NCPHP in February 1998; he is in compliance with his NCPHP contract and reports he has been involved in an active recovery program with AA and Caduceus since February 1998; he has been offered a fellowship by a department of the Duke University Medical Center and Health System.

Action: 4/14/99. Consent Order executed: Dr Hendricks is issued a resident's training license to Duke University Medical Center and Health System; he shall not register with the DEA to prescribe Schedule II or II N controlled substances and shall not purchase, administer, prescribe, dispense, or order such substances; he shall refrain from the use of all mind or mood altering substances and all controlled substances unless lawfully prescribed by someone other than himself and refrain from the use of alcohol; he shall notify the Board within two weeks of his use of such medication or alcohol, identifying the prescriber and the pharmacy filling the prescription; he shall, at the Board's request, supply bodily fluids or tissue for screening to determine if he has consumed any of these substances; he shall maintain and abide by a contract with NCPHP; he shall not prescribe any drug for his own use; he shall obtain and document to the Board 50 hours of relevant Category I CME each year; must comply with other conditions.

KHOT, Prakash Nilkanth, MD

Location: King, NC (Stokes Co)

DOB: 5/10/44

License #: 00-19016

Specialty: FP/EM (as reported by physician)

Medical Ed: Nagpur Medical College, India (1967)

Cause: Concerning the Order of Summary Suspension and Notice of Charges of 12/23/98. Dr Khot admits and the Board finds that while there is reason to believe Dr Khot needs to take specific steps to improve his fund of knowledge and medical skill, it appears that if he does so, he can continue to practice medicine with a reasonable degree of skill and safety; he has undergone evaluation of what CME might be of use to him and has begun to implement a plan for such CME.

Action: 2/19/99. Consent Order executed: the Board lifts the Summary Suspension of Dr Khot's license; he shall exchange his current license for one issued to expire on the date shown on the license; he shall subscribe to and read Journal Watch and similar publications; he shall review a broad set of subjects in basic medical sciences in the diseases he sees commonly through the use of texts, review courses, and, at least once per week, attending a conference in internal or family medicine, auditing basic science courses with medical students, or attending grand rounds; by July 1, 1999, he shall complete a course in medical record keeping, if it is available by that time; he shall practice no more than 35 hours a week, except he may consult and treat beyond that limit in an emergency; he shall improve his knowledge of infectious diseases and antibiotic selection by October 1, 1999, through a one-month clinical fellowship or an intensive course of self-paced study approved by the president of the Board; he shall gather, review, and implement clinical practice guidelines; practice medicine only on persons 18 years old or older; he shall learn to access medical educational resources on the Internet; he shall secure the services of a practice monitor, approved by the president of the Board, who shall report on Dr Khot's performance to the Board every other month; he shall pass the certification examination of the American Board of Emergency Medicine by March 1, 2000; must comply with other conditions.

McCURDY, Donald Pittard, MD

Location: Birmingham, AL

DOB: 1/29/46

License #: 00-21824

Specialty: OPH (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1977)

Cause: Dr McCurdy executed a Stipulation and Consent Order with the

Alabama Board on 2/25/98; he admits he has a history of substance abuse, including treatment for addiction to heroin and abuse of cocaine and alcohol.

Action: 3/23/99. Consent Order executed: Dr McCurdy shall comply with the terms and conditions of the Alabama Stipulation and Consent Order; he shall have the Physician Recovery Network of Alabama send copies of all medical and other reports regarding him to the North Carolina Board at the same time they are sent to the Alabama Board; if he returns to North Carolina to practice medicine, he shall practice only in settings approved in writing by the Board's president, who may restrict the number of hours Dr McCurdy works, require evaluations by his colleagues or supervising physicians, and impose other restrictions; he shall refrain from the use of all mind or mood altering substances and all controlled substances unless lawfully prescribed by someone other than himself and refrain from the use of alcohol; he shall notify the Board within two weeks of his use of such medication or alcohol, identifying the prescriber and the pharmacy filling the prescription; he shall, at the Board's request, supply bodily fluids or tissue for screening to determine if he has consumed any of these substances; he shall maintain and abide by a contract with NCPHP; and he shall maintain a detailed log of all controlled substances he prescribes, orders, or administers and submit a copy to the Board on request; he shall obtain and document to the Board 50 hours of relevant Category I CME each year; must comply with other conditions.

PATTERSON, Anthony Curtis, MD

Location: Concord, NC (Cabarrus Co)
 DOB: 5/12/58
 License #: 00-34429
 Specialty: P (as reported by physician)
 Medical Ed: Medical College of Georgia (1985)
 Cause: To amend Consent Order of 7/05/98 stemming from his admission that he engaged in improper verbal boundary violations with two patients, including inappropriate sexual discussions with two patients. The Board and Dr Patterson agree that he must continue with counseling, but he may now be counseled by others beside Dr Gene Abel.

Action: 2/17/99. Consent Order executed: Dr Patterson will maintain and abide by a contract with NCPHP; he will continue the treatment protocols established by Dr Abel; he will continue his counseling with Dr Norris or such other counselor as the Board's president may direct in writing; he shall arrange for quarterly counseling reports to the Board; the terms and conditions in this Consent Order supersede those in any prior consent order but have no effect on the public nature of that order or the suspension of Dr Patterson's license previously served and now completed; he shall complete 50 hours of Category I CME by 6/01/99, including at least 10 hours on boundary violations; must comply with other conditions.

STEWART-CABALLO, Charles Willy, MD

Location: Fayetteville, NC (Cumberland Co)
 DOB: 2/24/57
 License #: 00-38215
 Specialty: OBG/OS (as reported by physician)
 Medical Ed: University of Minnesota (1985)
 Cause: To amend his Consent Order of 7/22/98.

Action: 2/17/99. Consent Order executed: Dr Stewart-Carballo's license shall be issued to expire on the date shown on the license (5/31/99); unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of mind or mood altering substances and all controlled substances and from the use of alcohol; he shall inform the Board within two weeks of his use of such substances or alcohol, identifying the prescriber and the dispensing pharmacy; at the Board's request, he shall supply bodily fluids or tissue for screening to determine if he has consumed any of these substances; he shall maintain and abide by his contract with NCPHP; he shall attend AA and NA meetings as recommended by NCPHP; he shall continue to participate in the Pavilion aftercare program; he shall obtain annual neuropsychological and medical evaluations, reports by practitioners approved in writing by the president of the Board to be sent to the Board by June 1 of each year; he shall not practice surgery other than minor surgical procedures; he shall obtain and document to the Board 50 Category I hours of relevant CME each year; he shall provide a copy of this Consent Order to all prospective employers; must comply with other conditions; the numbered paragraphs of this Consent Order supersede those in the prior consent orders, except those paragraphs related to the surrender of Dr Stewart-Carballo's license and the public nature of those orders.

SUVILLAGA, Victor Ivan, MD

Location: Wilmington, NC (New Hanover Co)
 DOB: 10/19/48
 License #: 00-26877
 Specialty: GP/EM (as reported by physician)
 Medical Ed: Universidad El Salvador (1979)
 Cause: Request to restore Dr Suvillaga's license, which was summarily suspended in November 1998 and, following a hearing, indefinitely suspended in February 1999 due to the violation of two earlier Consent Orders. In March 1998, Dr Suvillaga met with the Board and expressed his commitment to abide by the Board's directives and his agreements with the Board.

Action: 4/14/99. Consent Order executed: Dr Suvillaga is issued a license to expire on the date shown on the license (7/31/99); he shall practice only in a structured setting approved in writing by the Board through its president; he shall not practice in a solo, unsupervised setting under any circumstances; he shall practice no more than 45 hours a week; he shall not administer, prescribe, dispense, or order any controlled substances nor apply to the DEA for registration to do so; he shall continue his treatment and therapy with his current therapist or one approved by the Board's president and shall have that therapist report to the Board each year; he shall notify each of his employers of this Consent Order by certified mail; he shall obtain and document 50 hours of relevant Category I CME each year; must comply with other conditions.

WANGELIN, Robert Lester, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 5/21/45
 License #: 00-28370
 Specialty: P (as reported by physician)
 Medical Ed: West Virginia University (1972)
 Cause: To modify the Consent Order of 11/07/97. Dr Wangelin's license was suspended for one year under a Consent Order of 11/18/96. Under the Consent Order of 11/07/97, that suspension was extended until 1/31/99, after which his license was restored under conditions related to his having had improper relationships with female patients. Modification entails surrender of his license, with issuance of a temporary license subject to periodic review and possible renewal.

Action: 4/26/99. Consent Order executed: Dr Wangelin surrenders his license; he is issued a license to expire on the date shown on the license (7/31/99); he shall meet with the Board at its meeting in July; he shall continue treatment and supervision by his psychiatrist or another approved in writing by the president of the Board; he shall have his psychiatrist report to the Board monthly; he shall limit his practice to male patients; must comply with other conditions. The terms in the numbered paragraphs of this Consent Order supersede those in the prior Consent Orders, except those terms regarding the public nature of those Consent Orders; this Consent Order does not change any aspect of Dr Wangelin's license status during any prior period.

WARD, David Townsend, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 4/07/60
 License #: 95-00473
 Specialty: ORS (as reported by physician)
 Medical Ed: West Virginia University (1986)
 Cause: On application for reissuance of Dr Ward's license, surrendered on 8/26/97 as a result of a problem with substance abuse, specifically alcohol and cocaine. He has been unable to practice with reasonable skill and safety due to his impairment. He now reports to the Board that he successfully completed treatment, has been clean and sober since February 1998, and is doing well in his recovery program.

Action: 2/17/99. Consent Order executed: Dr Ward's license shall be issued to expire on the date shown on the license (7/31/99); unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of mind or mood altering substances and all controlled substances and from the use of alcohol; he shall inform the Board within two weeks of his use of such substances or alcohol, identifying the prescriber and the dispensing pharmacy; at the Board's request, he shall supply bodily fluids or tissue for screening to determine if he has consumed any of these substances; he shall maintain and abide by his contract with NCPHP; he shall obtain and document to the Board 50 hours of relevant CME each year; must comply with other conditions.

WHITT, John Alan, MD

Location: Wilson, NC (Wilson Co)
 DOB: 10/21/58
 License #: 00-31692
 Specialty: P (as reported by physician)
 Medical Ed: East Carolina School of Medicine (1985)
 Cause: On 27 occasions from January 1996 to September 1997, Dr Whitt prescribed a Schedule II controlled substance to a child without examining the child in his professional capacity; he failed to maintain an appropriate record for written prescriptions of Schedule II controlled substances issued in the name of that child; though he has received treatment related to abuse of a controlled substance and has been an anonymous participant in the North Carolina Physicians Health Program, on several occasions between January 1996 and September 1997 he self-medicated with a Schedule II controlled substance. He signed a contract with NCPHP on 2/23/99.

Action: 3/18/99. Consent Order executed: the Board suspends Dr Whitt's medical license for 45 days, beginning June 1, 1999, allowing him time to transition his patients to other medical providers; prior to the end of the 45-day suspension, he shall be interviewed by the Board and if that interview is satisfactory he shall be issued a license dated to expire on the date shown thereon. The following terms and conditions shall apply to any license issued to Dr Whitt under this Consent Order: he shall improve his keeping of medical records, following the applicable Board Position Statements; he shall maintain a detailed log of all controlled substances he prescribes, orders, or administers and submit a copy to the Board on request; he shall duplicate all prescriptions he writes for controlled substances; he shall obtain and document to the Board 50 hours of relevant Category I CME each year from 1999 through 2003; he shall refrain from the use of all mind or mood altering substances and all controlled substances unless lawfully prescribed by someone other than himself and refrain from the use of alcohol; he shall notify the Board within two weeks of his use of such medication or alcohol, identifying the prescriber and the pharmacy filling the prescription; he shall, at the Board's request, supply bodily fluids or tissue for screening to determine if he has consumed any of these substances; he shall maintain and abide by his contract with NCPHP; he shall have his physician send reports of his mental health to the Board on request; must comply with other conditions.

MISCELLANEOUS BOARD ORDERS

NONE

DENIALS OF LICENSE/APPROVAL

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

SURRENDERS**GARTRELL, Douglas Mervyn, MD**

Location: Smithfield, NC (Johnston Co)
 DOB: 6/17/59
 License #: 93-00471
 Specialty: P/CHP (as reported by physician)
 Medical Ed: Duke University School of Medicine (1987)
 Action: 4/19/99. Voluntary surrender of medical license.

JACOBS, Kenneth Lee, MD

Location: Kinston, NC (Lenoir Co)
 Wilkesboro, NC (Wilkes Co)
 DOB: 7/26/59
 License #: 95-00953
 Specialty: OBG (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1992)
 Action: 3/26/99. Voluntary surrender of medical license.

WHITTIER, Stephen Allen, MD

Location: Williamston, NC (Martin Co)
 Kitty Hawk, NC (Dare Co)
 DOB: 2/19/60
 License #: 97-00424
 Specialty: IM/EM (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1994)
 Action: 3/19/99. Voluntary surrender of medical license.

See Consent Orders:

**GUTHRIE, John Robert, II, DO
WANGELIN, Robert Lester, MD**CONSENT ORDERS LIFTED**ALEXANDER, John Eugene, MD**

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 4/09/38
 License #: 00-18385
 Specialty: ORS (as reported by physician)
 Medical Ed: Meharry Medical College (1965)
 Action: 2/01/99. Order issued lifting Consent Order of 10/15/96.

CARMACK, Keith Keenan Kilauea, MD

Location: Goldsboro, NC (Wayne Co)
 DOB: 11/24/49
 License #: 00-30306
 Specialty: FP (as reported by physician)
 Medical Ed: University of Hawaii (1983)
 Action: 2/01/99. Order issued lifting Consent Order of 2/27/97.

FELDMAN, Rhonda Glen, Physician Assistant

Location: Ferguson, NC (Wilkes Co)
 Boone, NC (Watauga Co)
 DOB: 10/26/63
 License #: -01966
 Education: Duke University (1995)
 Action: 2/01/99. Order issued lifting Consent Order of 3/02/98.

HUBBARD, Karl Winsor, MD

Location: Elizabeth City, NC (Pasquotank Co)
 DOB: 10/15/54
 License #: 95-00291
 Specialty: ORS/OSM (as reported by physician)
 Medical Ed: University of Louisville (1982)
 Action: 2/01/99. Order issued lifting Consent Order of 3/09/95.

MARSHALL, John Everett, MD

Location: Lincolnton, NC (Lincoln Co)
 DOB: 7/13/54
 License #: 00-39646
 Specialty: OBG (as reported by physician)
 Medical Ed: Universidad Del Noreste, Mexico (1981)
 Action: 2/01/99. Order issued lifting Consent Order of 12/31/97.

NELSON, Mark Theodore, MD

Location: Sanford, NC (Lee Co)
 DOB: 11/24/61
 License #: 93-00251
 Specialty: EM/AN (as reported by physician)
 Medical Ed: University of Kansas (1989)
 Action: 2/01/99. Order issued lifting Consent Order of 2/08/96.

SCHEUTZOW, Mark Howard, MD

Location: Charlotte, NC (Mecklenburg Co)
 Matthews, NC (Mecklenburg Co)
 DOB: 8/19/57
 License #: 97-00166
 Specialty: PM (as reported by physician)
 Medical Ed: Ohio State University (1993)
 Action: 2/01/99. Order issued lifting Consent Orders of 2/19/97 and 9/04/97.

TEMPORARY/DATED LICENSES:ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES**BENTLEY, Steven Edmunds, MD**

Location: Raleigh, NC (Wake Co)
 DOB: 9/01/53
 License #: 00-23676
 Specialty: EM (as reported by physician)
 Medical Ed: Medical College of Georgia (1978)
 Action: 3/19/99. Temporary/dated license extended to expire 9/30/99.

BURSON, Jana Kaye, MD

Location: Davidson, NC (Mecklenburg Co)
 Mooresville, NC (Iredell Co)
 DOB: 5/14/61
 License #: 00-39164
 Specialty: IM (as reported by physician)
 Medical Ed: Ohio State University (1987)

Action: 3/19/99. Temporary/dated license extended to expire 7/31/99.

COYNE, Mark Dennis, MD

Location: Stoney Creek, NC (Guilford Co)

DOB: 8/12/49

License #: 00-33493

Specialty: EM/OS (as reported by physician)

Medical Ed: Chicago Medical School (1983)

Action: 3/19/99. Temporary/dated license allowed to expire.

ENGLEMAN, James Donald, Jr, MD

Location: Greenville, NC (Pitt Co)

Vanceboro, NC (Craven Co)

DOB: 4/05/60

License #: 00-32696

Specialty: FP (as reported by physician)

Medical Ed: University of Louisville (1985)

Action: 3/19/99. Temporary/dated license extended to 9/30/99.

FORD, Stephen Mitchell, MD

Location: Durham, NC (Durham Co)

DOB: 12/05/52

License #: 00-29570

Specialty: P (as reported by physician)

Medical Ed: East Tennessee State (1984)

Action: 3/19/99. Temporary/dated license extended to expire 9/30/99.

FULGHUM, Thomas Grady, MD

Location: Sanford, NC (Lee Co)

Erwin, NC (Harnett Co)

DOB: 6/29/57

License #: 00-31987

Specialty: EM/IM (as reported by physician)

Medical Ed: Duke University School of Medicine (1983)

Action: 3/19/99. Temporary/dated license extended to expire 3/31/00.

GLENN, Robert Alan, Physician Assistant

Location: Asheville, NC (Buncombe Co)

DOB: 3/13/59

License #: 1-01972

Education: George Washington University (1989)

Action: 3/19/99. Temporary/dated license extended to expire 9/30/99.

GORSKI, Karen, Physician Assistant

Location: Huntersville, NC (Mecklenburg Co)

DOB: 1/08/57

License #: 1-02145

Education: State University of New York, Stonybrook (1982)

Action: 3/19/99. Temporary/dated license extended to expire 3/31/00.

GREGORY, Ginger Dobbins, Physician Assistant

Location: Angier, NC (Harnett Co)

DOB: 8/30/63

License #: 1-01410

Education: Bowman Gray School of Medicine (1991)

Action: 3/19/99. Temporary/dated license extended to expire 9/30/99.

McCALL, Michael Alvin, MD

Location: Atlanta, GA

DOB: 11/04/61

License #: 00-36569

Specialty: OBG (as reported by physician)

Medical Ed: University of Florida College of Medicine (1989)

Action: 3/19/99. Temporary/dated license extended to expire 9/30/99.

MORRIS, Robert Harry, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)

Lumberton, NC (Robeson Co)

DOB: 11/18/50

License #: 1-00110

Education: Howard University (1975)

Action: 3/19/99. Temporary/dated license extended to expire 3/31/00.

PAINE, Karen Nicholson, MD

Location: Raleigh, NC (Wake Co)

Garner, NC (Wake Co)

DOB: 7/07/46

License #: 00-20834

Specialty: FP/OM (as reported by physician)

Medical Ed: New York University (1971)

Action: 3/19/99. Temporary/dated license extended to expire 3/31/00.

POWELL, Thomas Edward, MD

Location: Durham, NC (Durham Co)

DOB: 7/11/64

License #: 98-00439

Specialty: GP (as reported by physician)

Medical Ed: University of Texas, San Antonio (1995)

Action: 3/19/99. Temporary/dated license extended to expire 3/31/00.

RIDDLE, William Mark, MD

Location: Greenville, NC (Pitt Co)

DOB: 3/20/56

License #: 00-39871

Specialty: FP/EM (as reported by physician)

Medical Ed: East Carolina University School of Medicine (1985)

Action: 3/19/99. Temporary/dated license extended to expire 9/30/99.

SCONTSAS, George John, MD

Location: Kinston, NC (Lenoir Co)

DOB: 12/17/48

License #: 00-32852

Specialty: ADD/N (as reported by physician)

Medical Ed: University of Virginia (1977)

Action: 3/19/99. Temporary/dated license extended to expire 3/31/00.

SHIVE, Robert Macgregor, MD

Location: Charlotte, NC (Mecklenburg Co)

DOB: 11/02/33

License #: 00-13226

Specialty: P (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1961)

Action: 3/19/99. Temporary/dated license extended to expire 3/31/00.

DISMISSALS

NONE

“END-OF-LIFE DECISIONS” AUDIO TAPE AVAILABLE

Order Directly from the North Carolina Medical Board

End-of-Life Decisions Forum [4 hours; 1998]:

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

(See article How We Die in North Carolina on page 4 of this number of the Forum.)

LICENSES RECENTLY MADE INACTIVE (Results from Failure to Register)

DECEMBER 1998

Name (alphabetical)	License #	Name (alphabetical)	License #	Name (alphabetical)	License #	Name (alphabetical)	License #
Abbott, Martin Keith	93-00002	Flood, William Augustus, Jr.	00-36349	Latham, William Carson	00-13485	Reid, Charles Hamilton, Jr.	00-07087
Adams, William Wesley	00-09742	Floro, Teresita	93-00698	Lee, Daniel Chong-Moo	00-21066	Rindani, Arun Bhaskerrao	00-21858
Adjare-Sefa, Akwasi	93-00642	Fork, Heather Elizabeth	00-36098	Leigh, Ralph Jeffrey	00-29135	Roman, Richard Michael	00-36416
Agbogou, Bob Nwachukwu	96-05147	Foushee, John Caldwell	00-06081	Lester, Mitchell Norman	97-00318	Rookstool, Douglas Wayne	96-00103
Alexander, Jamile Yasmin	94-00187	Francis, Gail Joan	96-01315	Letendre, Scott Lee	94-00895	Roque, Augustine L.	00-15751
Amatya, Sudha Shrestha	94-00700	Fry, Richard Joseph	00-24650	Levy, Susan Rae	00-26949	Rose, William Chandler	00-36813
Amin, Mayank S.	97-01217	Gallemore, Ron Paul	96-00539	Linatoc, Cheryl Ann	00-32263	Ruenes, Albert, Jr.	00-34149
Amling, Christopher Lee	94-00011	Garabedian, Vicken	94-00500	Lyday, William Davie, II	96-01389	Saglik, Metin	00-20194
Ammons-King, Valeria	00-34647	Gilbert, Brian Wayne	00-20725	Madani, Mohamad Ali	00-21421	Sallee, Donald Eugene	00-38839
Atkinson, Sharon Joy	97-00456	Giuffra, Loretta Joan	00-33367	Malin, Jonathan Adam	95-01321	Sams, Mary Couch	93-00580
Baig, Nighat Mughal	95-01484	Glasgow, Sandra Rozanna	96-01324	Mammino, Jere Joseph	00-34671	Savoca, Paul Eugene	00-35743
Ballenger, Claude Newton, Jr.	00-11633	Gold, Herman Kalman	00-14664	Marchuk, Jerome Michael	00-18800	Schmieg, Anthony Luke	00-39882
Ballentine, Noel Hudson	00-24573	Goldwasser, Harry David	00-38954	Markham, Juliet Kirwan		Sellers, Gladstone Arnold	00-32572
Barton, John Homer, Jr.	00-32625	Goodwin, Timothy Brian	00-39943	Maur, Gurpreet Singh	97-00325	Sen, Sreeroop	96-00155
Bell, Robert Matthew	00-23005	Gornet, Michael Kenneth	00-35128	May, Dean Francis	95-00139	Shafai, Mandana	96-00725
Betsill, William Lafayette, Jr.	00-29826	Gray, David Maxwell	00-28037	May, Philip Bessom, Jr.	00-16908	Shealy, Clyde Norman	00-10579
Biggers, Robert David	00-18847	Green, Bruce Quinton	00-14453	McAlvany, William Price	00-33866	Shesley, Daniel Patrick	94-01031
Bingham, Marcel Daniel	94-00723	Grice, Kathryn Ashton	00-30277	McCarthy, James Andrew	00-31173	Sheth, Lalit Ratilal	00-22878
Borowitz, Michael Joseph	00-24892	Groat, Richard Arnold	00-09082	McNair, Hal Harris	00-15829	Sigman, Ira Lowell	94-01335
Boss, Nathan Craig	00-35272	Gulley, Margaret Lynn	00-34985	McPhail, Althea Hill	00-36571	Singer, Jeffrey Harris	00-36269
Boutos, Rafik Helmy	00-32198	Hainsworth, Dean Parrish	94-00261	Merrell, Dale Ernest	00-24464	Sinopoli, Walter Anthony	93-00813
Bowen, William Jarvis	00-39764	Hall, Frenesa Kaye	00-35081	Merrell, Matthew McDonald	96-00821	Skovron, Elizabeth Horan	00-32041
Bressler, Rubin	00-13062	Hardee, Michael Shaun	96-01625	Migliani, Jasjeet Kaur	98-01717	Snow, David Michael	00-32963
Brinton, Eliot Ashby	00-24744	Healy, Grant Fletcher	00-20914	Miller, Debra Rose	94-01271	Solomon, Morton	98-01066
Burger, Peter Corson	00-19674	Hearne, Steven Edward	00-35364	Min, John Ki-Ho	94-00586	Soriano, Ariel Fernando	95-01666
Burgess, John Buchanan, Jr.	00-38020	Hedgepeth, Bruce Llewellyn	94-00833	Mitchell, Edmund Mansfield	95-01607	Speckman, Jerry Michael	00-25441
Butler, Larry Stephen	00-26736	Hildebrand, Stephen Ward	00-35921	Moore, Curtis Alan	00-31179	Spivak, Kitty Shimoni	00-20576
Calton, Thomas Farrell	95-00530	Hill, Matthew Richard	00-35662	Moreau, Christina Lynn	96-00163	Starling, Charles Ray	00-09144
Camrud, Marissa Ann	96-00476	Hill, Trafford, Jr.	00-19607	Morton, Jeffery Douglas	94-01276	Stickel, Delford Lefew	00-11271
Caple, Phillip Maurice, Sr.	00-22898	Himmelwright, Gabel G.	00-05571	Muthusamy, V. Raman	97-00112	Stoner, Bradley Philip	00-39108
Carbone, Anthony Joseph	95-00317	Hood, Bold Robin, III	00-31147	Nayer, Muhammad Abu Saleh	94-01459	Stose, Willis Gilson	00-30738
Chantry, Caroline Jean	00-27578	Hood, William Plexico, Jr.	00-15244	Niehus, Douglas Richard	94-01282	Talangkabayang, Reuel Vergara	00-28702
Chen, Richard Wumin	96-01265	Howell, Howard Scott	00-38779	Novak, Joseph Stephen, Jr.	97-00686	Tannahill, Robert Bruce	00-13392
Cherry, Ronald Robert	98-01204	Howell, Scott Thomas	00-31726	Oakley, Anne Dennison	00-39657	Taylor, William Joseph	00-35056
Churchill, Carol Ann	00-39508	Hrehorovich, Victor R.	94-00529	Orandi, Yasmin Anne	00-35031	Theis, James Oliphant	96-01748
Cox, Raymond Lorenzo, Jr.	00-33491	Hutchins, Earl Curtis	00-35927	Ortiz, Donald Joseph	00-35178	Titus, Anthony Forsythe	00-32588
CriddleVFrank Jefferson, Jr.	00-20253	Iglesias, Octavio E.	00-17872	Overtreet, Lathan Wyatt	94-00960	Todd, Nevins Woodcock, III	00-33760
Cross, Brian Gregory	95-01211	Jain, Mukesh	94-01222	Page, Edwin Leonard	00-35816	Via, Dan Forrest	96-00396
Cruz, Jose Rafael	95-01212	Jimenez, John Lawrence	95-01552	Pai, Sung-Yun	97-01839	Vigil, Kirk Samuel	00-39708
Curry, Charles Lorenza	00-11461	Kang, Joon	00-21667	Pastorelle, Dominic Joseph, Jr.	00-20057	Westerfield, Byron Thomas	00-24957
Davidson, James Joseph	96-00023	Kashuk, Jeffrey Lee	00-39835	Patterson, Lisa Fay Chancey	95-01473	White, Robert Lee Jr.	94-00672
De Trane, Frank Joseph	00-35319	Keller, Sarah Lynn	00-36370	Pearsal, Albert Washington, IV	95-01051	White, William Nichols II	94-00673
Desai, Sanjay Arvind	94-00776	Kellogg, Aurora Gozum	00-32002	Peeler, Robert George	00-10197	Wiggins, Mark Walton	96-01108
Diem, Susan Joanne	94-01400	Kirchner, Arthur Burtnett	93-00736	Pham, Khoi Duy	00-34704	Wilson, Carolyn Scott	00-32912
DinoffVArthur Addison	00-30325	Klein, Jonathan David	00-32750	Phillips, Paul Bruce		Wimbish, Kathryn Jo	00-28383
Dotters, Deborah Jean	00-28175	Koehler, Susan Lynn	96-00083	Platek, Lee Joseph	98-01014	Winer, Eric Paul	00-31697
Downer, Merry	95-01227	Kreegel, Drew Alan	00-38114	Pipkin, Nicky Lynn	00-32418	Wolff, Bryan Christopher	00-35553
Ellis, Scott Joseph	00-39416	Kurowski, Cameron John	96-01160	Pool, Robert Smithwick	00-10200	Woolfitt, Sandra Smith	00-31939
Ende, Michael Ephraim	00-21946	LaMonica, Debora Ann	00-00552	Porubsky, Gary Lee	00-27726	Woolcott, Philip, Jr.	00-09935
Erdman, John Paul	00-39937	Lafayatis, Robert Alan	00-28996	Quigley, Robert Lawrence	00-34133	Yasmin, Vida Rashidfarokhi	00-36020
Filly, Anthony Latham	96-01311	Laster, Dan Wayne	00-21065	Reddy, Jayapal Aragonda	94-00986	Yenal, Kem	95-00780

JANUARY 1999

Amory, David William	94-01374	Eachempati, Soumitra Ramagopal	96-01295	Litwicki, Daniel Joseph	97-01808	Schactman, Brian Howard	96-01466
Baluyot, Noreen Ann	97-01239	Eckard, Donald Alan	97-01742	Matre, Jeffrey John	97-01051	Sekhon, Arjinderpal Singh	00-25078
Barton, Kari Lyn	97-00184	Eloi, Emmanuel	94-01180	McPherson, Samuel Dace, Jr.	00-07962	Shea, Richard Paul Jr.	93-00313
Bennett, John Arthur	00-32085	Evans, Eric Alan	96-00187	Merritt, James Milton	00-35986	Silber, Robert	00-36430
Benson, Elizabeth Wray	96-01226	Findeiss, James Clifford	00-22566	Miller, Raymond Nicholas	00-21589	Soulsby, David Leon	00-31205
Berend, Michael Edward	94-00020	Gleason, William Lounsbury	00-11492	Munson, Barbara Jean	00-31601	Theodoridis, Dimitrios	00-19412
Bowens, Clifford, Jr.	94-00728	Glover, John Snow	00-11493	Nasir, Ma'an Aziz	94-00593	Thompson, James Carol Jr.	97-01174
Boyle, James Edward	00-35278	Gruber, Michael Paul	00-34336	O'Brien, Mark Edward	00-36788	Tomski, Steven Michael	97-00409
Chartier, Stanley Earl	00-17096	Hamilton, Bonnie Carol	00-34027	Patterson, Harold Calvin	00-07181	Trantham, Joey Lee	00-26605
Christensen, Christian Paul	96-00885	Hatt, Jeannine	00-23030	Patton, Robert Gray	00-09866	Webb, Michael David	00-29050
Citron, David Sanford	00-08899	Iselin-Chaves, Irene Anne	97-01210	Perez-Limonte, Leonel	00-35722	Williams, Linda Morgan	97-00810
Cohan, Robert Henry	00-17326	Kanj, Souha Sami	00-34523	Puckett, James Dean	00-15997	Wuest, Julie Ann	94-00678
Cousar, George Richard, Jr.	00-11820	King, Daniel Denoon, Jr.	00-11397	Reddy, Radha Thiruvengadam	94-00987	Young, William Daniel	00-17054
Cummings, James Francis	98-00034	Lane, Carl Edward	00-21486	Richard, Mark Steven	93-00295		
Doshi, Vasant Narottam	00-29736	Lasswell, William Lonzo, Jr.	94-01435	Rizwan, Syed Ali	97-00379		

FEBRUARY 1999

Allison, Adolphus Reid, Jr.	00-10752	Dennis, Robert Glenn	00-09408	McKillion, Patrick Charles	97-00663	Scowcroft, James Andrew	97-01587
Attkisson, Sallie Ann	95-01478	Diaz, Lazaro Andres	96-01291	McLean, Malcolm	00-10539	Shane, Lois Bryna	00-26055
Bates, Brian Anthony	95-00015	Farrell, Stella Bridget	97-00944	Meares, Ben Miller	00-14838	Skansi, Viviana Karlovac	00-38559
Batra, Rajnish Kumar	00-34248	Fillia, Rebecca Dawn	94-00790	Melvin, James Henry, III	00-39855	Smith, Jerry Edward	00-13233
Becknell, George Franklin	00-08971	Finch, Derel	97-00241	Moskal, Michael Joseph	98-00336	Templeton, David Wesley	94-00158
Bringace, Virginia Anne	94-00733	Harrington, George David	94-00826	Mushet, George Richmond	94-00109	Tomassoni, Gery Foster	95-01442
Buchanan, John Terrance	98-00202	Hilton, Amy Beth Renee	93-00489	Olson, Craig Byron	00-32411	Ward, James Singleton	00-19899
Byrd, William Carey, Jr.	00-08474	Johnson, Richard Eric	00-36744	Patel, Alpa Ashok	97-01099	Wilson, Mary Calanthe	00-32599
Chandler, Gilbert Sewell, III	00-34273	Johnson, Thomas Gary	00-27699	Philp, Lorraine Barbrea	96-00056	Yow, Daniel Eugene,	00-46249
Cory, John Ward	98-01624	Johnston, Paul Edward	00-34638	Powell, John Gary	00-14750	Zimmer, Christopher A.	94-01369
Crouch, Fred Michael	00-32353	Jones, Jason Daniel	98-01324	Rainer, Robert Oscar	93-00286		
D'Agnes, Gerard Saverio	00-39782	Larson, Lawrence Oliver	00-32132	Rich, Alan Martin, Jr.	00-15166		
Dalton, James David	00-17943	Levy, Louis Ira	00-18120	Rowan, Patrick Jerome	00-19281		
Davis, David Albert	96-01586	Lou, Lily Joan	96-00988	Sandell, Sharon Rae	93-00307		

CHANGE OF ADDRESS FORM

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

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IMPORTANT

ATTENTION PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS Registration Information

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

PAs

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

NPs

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

North Carolina Medical Board
P.O. Box 20007
Raleigh, NC 27619