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President's Message

Physician Participation in Executions: The Gordian Knot of the Medico-Legal Arena



H. Arthur McCulloch, MD

Like the legendary Gordian knot, the issue of physician involvement in judicial executions is an entanglement of administrative agencies, the courts, the legislature, and conflicting public policies within our state. For its part, the Board has attempted to solve this dilemma by harmonizing the ethics of the medical profession, the Board's disciplinary authority, and the statutory requirements for executions. Those considerations can

be summarized as follows.

- Two thousand years of medical principles and the AMA Code of Ethics state that physician participation in executions is unethical.
- North Carolina law authorizes the Board to discipline doctors for unethical behavior.
- The warden of Central Prison is required to have a physician present during executions.

Since the issue has been in the news occasionally in the past year, I thought some of you might be interested in learning how we arrived at the doorstep of this conundrum.

In April 2006, the Board received a complaint alleging that a physician was scheduled to participate in an execution. Upon investigation, it was determined, based on representations by the Department of Correction, that no physician had previously participated in an execution, nor was there any plan for physician participation in upcoming executions. Shortly following that complaint, the Board received several inquiries from physicians licensed by the Board, asking about the Board's position on physician involvement in executions.

Realizing that the issue of physician involvement in executions would recur, the Board decided it was appropriate to consider a Position Statement addressing the ethics and disciplinary consequences of such physician involvement. After deliberation by the Board, a public hearing, and the publishing of a draft statement in the *Forum*, a Position Statement was adopted this past January.*

Since we had been assured by authorities that the physician of the penitentiary was merely present and had no active role, the Board's Position Statement sought to enforce the ethics of the profession up to the point that the legislature limited our authority. Thus, we clarified our recognition of state law and the requirement for the presence of a physician but gave notice that active participation could result in discipline. The Position Statement does not express an opinion on the issue of capital punishment generally, nor was it intended as an in-

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Primum Non Nocere

forum

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

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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.

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strument for halting executions. Rather, it is targeted at the narrow issue of the ethical implications of physician involvement in executions.

After the Board issued the Position Statement, the pot continued to boil when lawyers for several condemned inmates filed for a temporary restraining order on grounds that their clients' constitutional rights to an execution free of undue pain and suffering were being violated. The resulting court action stayed several scheduled executions.

In response, the Department of Correction revised the Execution Protocol to include the requirement that a "doctor shall monitor the essential body functions of the condemned inmate and shall notify the Warden immediately upon his or her determination that the inmate shows signs of undue pain or suffering." The use of a processed EEG monitor (BIS) is also included. This revision was done without consultation with the Medical Board, the Medical Society, or the physicians of the penitentiary.

As the issue developed, the Department of Correction filed a lawsuit against the Board, alleging that executions are not medical procedures and, thus, the Board cannot discipline a physician for participating. However, the Medical Practice Act authorizes the Board to discipline its licensees for misconduct regardless of whether or not it involves a medical procedure. Indeed, the Board frequently disciplines physicians for non-medical conduct, eg, boundary violations, violations of patient confidentiality, and disruptive behavior. The authority of the Board to enforce the ethics of the medical profession is imperative for protection of the public safety and well-being and for maintaining the integrity of, and public trust in, the medical profession.

Significantly, the Department of Correction has not challenged the Board's conclusion that active physician participation in executions is unethical. Rather, the judge has made an initial determination that the Board does not have the authority to discipline a physician for active involvement in executions. At the time of this writing, the Board is filing an appeal from that decision. Meanwhile, in a separate proceeding, another judge has ordered that the Council of State reconsider the Execution Protocol.

It is difficult at this time to forecast whether this entanglement will ultimately be resolved by the judicial or legislative sword. However, whether the courts or the legislature agree with the Board or decide to limit the Board's disciplinary authority in some manner, the fact will remain that physician participation in executions is unethical.

*The Board has 30 Position Statements that serve as interpretive guides on a variety of topics important to physicians. These typically come about as a response to complicated questions of conduct brought to the Board's attention through complaints and inquiries. They are intended to provide a safe harbor for licensees from disciplinary action by the Board.

Improving Your Practice Management Through Outsourcing: Part I—Managed Care Contracting and Billing and Collections

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President, Satinsky Consulting, LLC



Ms Satinsky

If you are like most physicians in private practice, you know that running your business can sometimes seem as challenging as practicing medicine. Even if you have supplemented your clinical training with a business degree, you realize that you are dealing with a wide variety of issues that include quality of care, patient satisfaction, financial management, people, and supporting information technology.

My clients tell me that the longer they practice, the more complicated practice management becomes. Managed care companies and government payers continue to impact your revenue in unpredictable and usually negative ways. Patients expect more from their physicians and don't hesitate to say so. You keep operating expenses at a reasonable level by asking your staff to assume more responsibilities. If you are a small practice with 10 or fewer physicians, your practice manager, if you have one, may be deluged with the details of day-to-day operations. The very thought of taking responsibility for special projects that require a new knowledge base may be overwhelming.

You may be able to improve the management of your practice by outsourcing one or more functions that require specialized expertise that you don't have and are unlikely to hire. In this two-part article, I review five functions that you may be able to outsource to your advantage: managed care contracting, billing and collections, information technology, human resources, and financial planning. For each of these areas, I identify the problems that outsourcing may help you address, review the advantages and disadvantages of outsourcing, and offer helpful hints for selecting a vendor or consultant to help you. In this first part of the article, I deal with managed care and billing and collections. In the second part, which will appear in the next number of the *Forum*, I'll cover information technology, human resources, and financial planning.

Managed Care

Let's face it—physicians would be happy if managed care would go away. For the time being, however, managed care is here to stay, and for most practices, it accounts for a very large proportion of practice revenue. Although revenue from managed care contracts is very

important for most physician practices, ask any group of practice managers how they handle managed care and you'll get a similar response. Most managers hate it, avoid it, and rarely give it the attention that it warrants given its place as the financial foundation of the practice. Here's what I see on a regular basis.

- Many practices don't know which managed care contracts they have in place, when they last negotiated these agreements, the contract terms, and the financial obligation of the payers. It goes without saying that if you don't know what you have, you can't determine whether or not your situation is good or bad.
- Although North Carolina requires payers to give providers CPT-code-specific reimbursement for the most frequent 30 codes annually (and for the full list of codes upon request), many practices don't ask for this information. If I ask about their reimbursement level, physicians and practice managers tell me they'll check a recent sample of payments by the plans. Unfortunately, that type of check won't tell me if the actual payment matches the expected payment as stated in the contract between the plan and the practice.
- Although many practice management systems have features that compare actual with expected reimbursement, many practices don't recognize the importance of using this function. Well-run practices make this comparison regularly by automatically checking each remittance when it comes in or by running a regular report.
- As one managed care representative said to me, "We generally don't go out and offer to pay physicians more money. If you want an increase, you have to ask for it." There are occasional across-the-board fee increases, but in most cases, physicians must take the initiative.
- Each managed care plan has a unique method of reimbursement. Some plans pay a fixed percentage of Medicare, but not all plans relate this percentage to the same Medicare year. Other plans use proprietary fee schedules. It's difficult to compare reimbursement across plans—unless you know what information you need and how to make the comparison.
- Although one might think that all physicians receive the same amount of money for the same services, that's not how it works. The size of your practice, your location, and your importance to the network in which you participate are all contributing factors.

Outsourcing your managed care to a consultant who looks at both rates and contract language makes sense for the following reasons.

- Consultants that represent multiple clients have working relationships with the managed care plans. They know whom to call at each plan and how to frame the

"You may be able to improve the management of your practice by outsourcing one or more functions that require specialized expertise"

request for a rate increase in a way that is most likely to get a favorable result.

- Contract language review is a tedious task. You must review not only the legal agreement, but also information that is contained in detailed administrative manuals and extensive Web sites. Consultants with experience in reviewing and organizing this information into an easily understandable format can save you hours of reading and analysis.
- Depending on your selection of a managed care consultant, you can pick someone who will teach your staff what to do. Once you learn the steps, you can decide whether or not you want to ask the consultant to do all your contracts or teach your staff how to do the work.

I see only one disadvantage with outsourcing managed care contracting. If you engage a consultant that insists on doing all the work for you without teaching you how to do it yourself, you'll set up a dependency relationship that you may not need or want in the future.

If you want to outsource your managed care contracting, here are questions you should ask potential consultants.

1. What is your experience with managed care contract review and rate negotiations? Consultants vary in their experience. Some have been doing managed care work for many years, and others are relatively new at the game.
2. What kind of practices has the consultant represented? Every practice is different, so look for a seasoned consultant who has worked with practices in your specialty.
3. Is the consultant willing to work with you on some but not all of your managed care contracts? It is important to know what all the plans are paying you, but in some instances, the reimbursement is fine as it is. Some consultants insist that they work on each and every managed care contract that a practice has in place; others are amenable to working on those that the practice believes are the most important.
4. How will the consultant work with your practice? Consultants come in three varieties. "Messiahs" do the work for you; they save the day. Other consultants convince you that you can't get along without them—ever. You are best off with a consultant who fosters a collaborative relationship with your practice. Let the consultant teach you what he/she is doing, and then decide if you want to farm out all of the work or do some of it yourself.
5. How will the consultant charge you for the service? The most common methods for pricing managed care consultation are on an hourly basis or by the project. In my experience as a consultant, it is hard to predict how many hours each project will take. I know the average number of hours I spend reviewing contracts, administrative manuals, and Web sites, but I don't know when I begin a project for a new client how long it will take me to organize baseline information. I also can't predict how many rounds of negotiations will be required to reach a mutually acceptable conclusion.
6. What do references say about the consultant? You

can't ask other practices about reimbursement rates, but you can ask about overall results, accessibility, and timely response to your needs. You don't want a consultant who has so many other clients that you don't get the attention for which you have paid. You can also ask the North Carolina Medical Society or your state professional organization for suggestions.

Billing and Collections

You've probably heard the term "revenue cycle management." You need to set your fees at an appropriate level, negotiate your managed care contracts to bring in reasonable reimbursement, and make sure that your billing and collections processes support your efforts. Even if you regularly reevaluate your fee schedules and renegotiate your managed care contracts, the billing and collections portion of the revenue cycle process may malfunction, causing receivables to skyrocket. Here are the problems that I commonly see.

- In many practices, billing and collections is accountable to a practice manager who lacks the experience to supervise the function. Many practice managers began their careers in clinical positions and worked their way up the ranks. If their previous responsibilities never included billing and collections, they may lack the expertise to supervise the billing and collections staff.
 - High staff turnover is another common problem. Let's face it; asking for money all day long, primarily over the telephone, can be a frustrating experience. In my years as a practice management consultant, I've met only one collections person who loved what she was doing. In dealing with patients, as opposed to payers, she actually functioned somewhat as a social worker. If burnout in your billing and collections staff is common, it is costly to your practice to repeatedly recruit, hire, and train—over and over again.
 - Inability to focus is a common problem. In many small practices, the billing and collections staff multi-task, and they may not focus on the billing and collections aspect of their job with the concentration needed to get the job done. I've seen practices where the billing and collections people are not methodical in the way in which they organize their work. Rather than batch the unpaid claims for a single payer, they call or e-mail about individual claims, dragging out the resolution process.
 - Billing and collections staff may lack good working relationships with payers. Payers are more responsive to problems if they are consistently dealing with a single individual from your practice rather than with multiple people.
 - Self-pay by patients is becoming more and more important for several reasons. Employers are shifting the burden of health insurance to employees, and some are now opting for health savings accounts. People who are between jobs or are self-employed may have no health insurance at all. Many practices have a long-standing tradition of not asking patients for money, and staff may have trouble transitioning to a different *modus operandi* that requires payment at time of service.
- Outsourcing billing and collections has both advan-

"In many practices, billing and collections is accountable to a practice manager who lacks the experience to supervise the function"

tages and disadvantages. The following are the advantages.

- You may reduce your accounts receivable and bring more revenue into your practice sooner than you are doing now.
- Within your practice, you can focus on clinical care, not billing and collections.
- You'll have access to experts in coding, management, and insurance who will focus on these tasks and not be diverted by other pressing needs.
- Staff turnover and the accompanying costs of recruiting, hiring, and training new staff may decrease.
- As physician owners of your practice, you'll have more, not less control over billing and collections processes than you would if these are dependent on your in-house personnel—who keep leaving.
- You free up space previously taken up by billing hardware.
- You can reduce the number of phone calls about billing and collections that come directly into your practice. Billing and collections companies answer the phone with your practice name, so patients do not think their calls are being diverted.
- You increase the hours of coverage for questions related to billing and collections.

Outsourcing billing and collections can have three disadvantages. You can anticipate and address all of them.

- Your practice manager may be very threatened by the outsourcing of billing and collections. If, however, the decision to outsource allows more time to concentrate on other projects, he/she may welcome the approach.
- Your practice may feel as if it has lost control over its receivables. Indeed you do give up the responsibility for day-to-day aspects of billing and collections, but you don't give away your responsibility to direct your vendor in how the work is done. Here's an example: the vendor sends letters to patients who don't pay, and your practice, not the vendor, should write those letters and decide when to send them..
- As you plan the information technology support for your practice (ie, practice management system, electronic health records—EHR, and/or functional Web site), you should be looking at a practice management system and an EHR system that are integrated (ie, built off the same operating platform). If the vendor that you select for outsourcing your billing and collections uses a practice management system that does not have EHR or that has an EHR system that you do not like, you will limit your choice of information technology applications that appropriately support your practice.

If you would like to explore outsourcing billing and collections, here are questions you can ask potential vendors.

1. Is the vendor independently owned or a subsidiary of another organization? One of my clients that had previously been managed by a hospital and that had bought the practice back ruled out a potential vendor because that vendor was owned by a hospital.

2. What are the vendor's history and future plans?
3. How does the vendor service new clients? Does it add new staff or assign additional clients to current staff?
4. What is the vendor's attitude toward practices of your size and specialty? Some vendors are only interested in large practices, so make sure you ask this question early in your discussions so you can rule out vendors that won't meet your needs.
5. What practice management system does the vendor use? Most vendors will ask you to use the particular practice management software that they use. Some will give you options. One of my clients selected a billing and collections vendor that used the same practice management system that was already in place and found the transition relatively easy.
6. Can you check vendor references and make a site visit to client sites to see how the system works from the client's perspective?
7. Can you visit the vendor's site and meet the staff that will handle your account? I accompanied one client on two vendor site visits. The experience level and professionalism of one vendor clearly outshone that of the other and contributed to the final selection.
8. Check on staffing. Who will handle your account, and what is the staff turnover? Is there a certified coder on site?
9. How does the vendor charge? Some vendors charge a percentage of net collections and others charge a flat monthly fee. What is the fee for software licensing and set-up? What will you spend on hardware and connectivity?
10. Is staff training included in the start-up fee or is it extra? How does the vendor charge for ongoing training?
11. Will the vendor help you clean up past claims, and if so, will this service be included or will there be an extra charge?
12. What is the vendor's target for accounts receivable? You should be able to get targets for percentage of claims over 90 days old and for average days in receivables.
13. Given your particular situation, what financial savings does the vendor expect to produce for your practice?
14. What are the details of the transition process and how long will it take?
15. How frequently will the vendor meet with your practice?
16. What reports will you get on a regular basis? If the practice management system that the vendor uses does not produce clear reports that can help your practice, you may find yourself struggling to understand the financial health of your practice.

“Outsourcing billing and collections can have three disadvantages. You can anticipate and address all of them”

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Karen Diamond, CFP, CIMA, and Ed Barber, CFM, formerly with Merrill Lynch; and Jean Bailiff, Physician Discoveries.

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sylvania. She is the author of three books: *Medical Practice Management in the 21st Century* (Radcliffe Publishing, 2007), *The Foundation of Integrated Care: Facing the Challenges of Change* (American Hospital Publishing, 1997), and *An Executive Guide to Case Management Strategies* (American Hospital Publishing, 1995). The *Forum* has published several articles by Ms Satinsky, including *Managing the Implementation of HIPAA and the Privacy Rule*, in #4, 2002; *How to Determine If Your Practice Could Use a Professional Practice Administrator*, in #2, 2003; *Using Information Technology to Improve Patient Care and Communication: A Practical Guide – Part I*, in #1, 2004; *Using Information Technology to Improve Patient Care and*

Communication: A Practical Guide – Part 2, in #2, 2004; *Electronic Medical Records and the Development of Electronic Health Records and Electronic Patient Records*, in #3, 2004; *Implementation of the HIPAA Security Rule* in #4, 2004; *What Are You Doing About Health Care Quality in Your Practice, Part I*, #1, 2006 and *Part II*, #2, 2006. An adjunct faculty member at the University of North Carolina School of Public Health, Ms Satinsky is a member of the North Carolina Medical Society Quality of Care and Performance Improvement Committee, Medical Group Management Association, and North Carolina Medical Group Managers. She may be reached at (919) 383-5998 or margie@satinskyconsulting.com.

Physician, Protect Thyself!

A North Carolina Physician

I am a physician in North Carolina, board certified in anesthesiology and pain management. I trained at one of the best medical schools in the country and completed an excellent residency program. I served honorably as an officer in the armed services. After coming to North Carolina, I built a successful practice and found a great deal of satisfaction in helping patients with severe pain.

The physician who offers pain management care to his/her patients discovers very quickly that the patients being seen are generally extremely ill. These patients suffer chronic, debilitating pain, and in many cases palliative care is offered where there is no other meaningful care or cure available. The “symptom” of severe pain, which often accompanies trauma or disease like cancer, finally becomes the primary disease, at least in terms of what may be treatable.

We all became physicians in order to help others, to offer care and solace to our patients. Our patients in pain come to us for that help, and they often demand much from their physicians. Often, it becomes difficult for the physician to maintain the clear, definitive boundaries that are so necessary to keep both the patient and the physician healthy and productive.

Neglecting My Own Well-Being

In the area where I practiced, there were few pain management physicians; this is, unfortunately, the case in many counties in North Carolina. Patients, driven by the agony and frustration of unrelenting pain, often seek relief from nonphysicians, or from foreign markets. Most of the time, these “treatments” don’t work—the treatment may actually exacerbate the pain—and the patient is forced once again to try another remedy. There is an overwhelming need in these people’s lives for some—any—relief from pain.

As a “workaholic,” I put no limitations on the demands I made of myself or the demands I allowed others to make of me. I saw patients long into the evening, resulting in excessively long workdays. If there had been 36 hours in the day instead of 24, I could have filled that time with more patients. I had medical staff privileges at two hospitals and saw walk-in patients at both hospitals. I was willing to drive hundreds of

miles each week to visit patients; back and forth, between the two facilities daily. In addition, I took call (much of it involving my post-surgical patients) and attended to my busy office practice. I played the role of Superman. When other physicians had cases that no one else could or would handle, I was the “go-to” pain management specialist. The more difficult the challenge, the more quickly I accepted it. I wanted above all to make a difference in my patients’ lives; unwittingly, I was setting myself up for a fall.

It was impossible to schedule my days and nights in this way without ignoring my own well-being. Gradually, I lost sight of those necessary and appropriate boundaries between my personal life and professional life. My entire life was out of control, but I was so busy, so tired, so stretched that I wasn’t even aware of it. As events continued to spiral more and more out of control, I thought, of course, everything remained under *my* control.

Eventually, my hectic lifestyle resulted in behavior that was erratic enough to attract the attention of a person who, erroneously, reported me to the administration of one of the hospitals as being on drugs. When approached by a North Carolina Physicians Health Program (NCPHP) member, I not only denied the charge but was quite upset that I had been turned in; I certainly was not a user or abuser of drugs! Thank you, NCPHP, but I can handle this myself, I thought. Unfortunately, my way of handling the situation was not to cut my work load or take care of myself personally.

Of course, the fact that I knew I wasn’t on drugs didn’t keep the gossipers from continuing to talk: my lifestyle was as chaotic as ever, my demeanor just as frenetic, and I’m sure, in hindsight, that I was missing cues right and left that I was being watched. If some of the folks watching me were waiting for me to prove I was taking drugs, it didn’t happen. But if they were waiting for me to prove I was in trouble, I gave them all the proof they needed.

In what was an out of the blue scenario for me, I was notified that my staff privileges at one of the two hospitals where I practiced had been summarily suspended. It was felt that I was a serious danger to pa-

“Gradually, I lost sight of those necessary and appropriate boundaries between my personal life and professional life”

tients, they said. Me? A danger to patients? I took great care of my patients and they cared for me. I didn't understand; surely there must be some mistake. Charges were levied that were biased, based on gossip, and untrue! To add insult to injury, the hospital notified the North Carolina Medical Board and the National Physicians Data Bank within two hours of notifying me. Almost immediately, the Medical Board requested that I voluntarily surrender my medical license. I had not yet realized the consequences of years of neglect of my own well-being. My chaotic personal life and unrealistic professional demands had caught up with me. But at that time I felt my life was crashing down around me. I had never been so angry, so frustrated, so alone, and so afraid. How could this be happening to me?

Learning to Concentrate on Me

Thankfully, at a time I felt I couldn't fall any further, a miraculous new experience presented itself and lifted me up. Through my attorney, I reestablished contact with the NCPHP. As I mentioned, I had an earlier encounter with the NCPHP, when I was sure I didn't need any help! I am deeply grateful that they still had faith in me. With the encouragement of the NCPHP, I entered an inpatient treatment facility, and there began the miracle. For the first time in years, I was able and encouraged to concentrate on ME.

I came to understand and accept what I had been doing to myself. By not keeping myself healthy and making sure I was enjoying a full and satisfying personal life, I could not have a productive professional life. And only by remaining attentive to keeping my professional life healthy could I offer meaningful care to my patients. I eagerly embraced the knowledge and experience of my care providers. I learned more about what was driving me and recognized that I wasn't Superman after all. But I could continue being the excellent physician I knew I had been. By paying attention to my physical health, my emotional health, and my spiritual health (not always in that order!), my demeanor changed without effort. I lost the frantic, over-extended personality and found the calm, reassuring one that instilled, for my staff, my peers and my patients, a sense of confidence in me. I learned to properly schedule my work day, keeping in mind how many hours it actually contains and how much call I've taken.

The charges and claims made against me were, for the most part, unfounded; but the problem was definitely there, and even though I wasn't yet a danger to patients, it might have been only a matter of time. Too many patients, too little sleep, a missing report: experiences we have all shared, but in different contexts, different places.

Betrayal of Trust

Eventually, I regained my North Carolina medical

license with some hourly and surgical limitations that were gradually lifted. My license is now full and unrestricted. I opened a new medical practice, and although I was working a much lighter schedule than before, I soon realized that I needed another employee to work in the clinical area. In the past, I had several unsuccessful contract experiences with medical assistants from temporary hiring services, and I finally decided I had to bite the bullet and hire the best clinical assistant I could afford. I thought a registered nurse was out of the question, simply too expensive. One applicant, however, Christine (not her name), was a former registered nurse who had lost her license due to substance abuse. Christine led me to believe that she had completed treatment and was in recovery. She came highly recommended. I was extremely impressed with her credentials, and when I met her I found her to be pleasant, thoughtful, and articulate. I immediately considered hiring her.

Before hiring Christine, I discussed with her our practice environment and the safety parameters we had set up. I was completely frank about my prior difficulties and I wanted to make sure she understood the importance of strictly following our practice policies and procedures. We also talked about her desire to work in a safe and supportive environment and how that could assist her in her own recovery. Wanting to make sure I handled this prudently, and to demonstrate due diligence, I contacted the Drug Court, which was in charge of Christine's rehabilitation program. I talked to the Judge who was involved in her case to determine whether he felt Christine would be a good candidate for the position in my practice. He thought she'd be a perfect fit. I also sought the opinion of my Caduceus peers and my local contact with the NCPHP. Certainly, if anyone I approached had advised me not to hire Christine, I would have honored that advice. But, since all parties agreed, Christine's hire seemed beneficial for both of us. I hired her with every expectation that would be the case.

My DEA license had not been restricted when I voluntarily surrendered my medical license because there were no issues regarding use or distribution of pharmaceuticals. Even though my office practice is pain management, the only controlled drugs kept on the premises were alprazolam and hydromorphone. Both were in pill form and sealed in numbered blister packs. Both medications were kept in the front office, secured in a double-locked safe. No injectable narcotics were kept on the premises. This was all explained to Christine. Christine was never permitted to medicate patients. She had access to only one prescription book with numbered prescriptions, for which she was solely accountable. Each written prescription produced a carbon copy. No discrepancies occurred. Christine appeared to adjust quickly to her new job.

After a few months, Christine's performance, which had been excellent, began to decline. Her attention

“Christine led me to believe that she had completed treatment and was in recovery. She came highly recommended”

to detail was failing. This was a gradual process; she continued to arrive promptly and appeared to have no problem performing her professional duties. Two months into her employment, Christine tested positive on a urine screen required by the Drug Court. With my office manager, I immediately met with her to discuss the test results. Christine explained she had gained weight over Thanksgiving and had been taking diet pills. She assured us she had absolutely no idea an over-the-counter diet pill would produce a positive reading on her urine screen. We both counseled Christine about avoiding any substance that could test positive. I also reminded her that it was critical nothing happen that could jeopardize my career and damage my new practice. We told Christine in no uncertain terms that her employment would be immediately terminated if there were another positive urine screen.

She remained an enrollee of Drug Court Phase 3, and she was continued on a more stringent outpatient recovery plan as a result of the positive test. To the best of my knowledge, Christine adhered to all the requirements of her treatment plan, including random urine toxicology screens.

A month later, Christine had her regular drug screen. The next day, Christine's housemate called the office to report Christine would not be coming in because she was not feeling well. Later that morning, I received a call from an emergency room physician. He explained that he was taking care of Christine and he needed to know if I was missing any injectable narcotics from the office. The physician said it was vital to have this information to properly treat her for an overdose. I assured him that no injectable narcotics were kept in the office and that our daily controlled substance inventory showed no discrepancies. The ER physician told me Christine had been given dopamine to support her blood pressure and Narcan to reverse narcotic overdose symptoms. After stabilizing, she was transferred to a ward bed at the hospital for further monitoring.

A Gap in the System

My office manager and I immediately investigated possible sources in our office for Christine's drug access. I telephoned the North Carolina Medical Board to report this incident, as well as the local DEA agency. An investigator from the local agency visited the office that same day to evaluate the situation. After meeting with him, my office manager and I continued to investigate the possibility of drug diversion from the office. The local investigator agreed to notify all nearby pharmacies and ask them to fax me a list of patients that had been prescribed controlled substances under my name. I reviewed those but was unable to identify any unauthorized or fraudulent prescriptions.

It was not until four days later that we discovered Christine's source during a routine delivery of office supplies. Unknown to me or my staff, the delivery also included six vials of nalbuphine (Nubain). When

my office manager and I reviewed delivery invoices for existing supplies, we discovered there were six 10 mg vials of Nubain that had been ordered in previous weeks. These were ordered under the auspices of my practice. No such orders of Nubain had been authorized. Despite an extensive search, there remained no accounting for the additional six vials of Nubain.



In due course, it became clear that Christine had been secretly ordering the Nubain vials. It is equally clear that no one else was aware that the orders had been placed, let alone that they had been diverted. Because Nubain is not a controlled substance, no DEA number or prescription is required. We discovered that Christine did not even require my medical license

number to place orders for Nubain; the fact that the order came from a medical office was sufficient authorization for the supplier to ship the vials. As a former RN, Christine was aware of this loophole. She was also aware that she could time her injections of Nubain to avoid positive urine test results.

A printed form was routinely used to fax the orders for supplies. All supplies were ordered by noting the number requested. Evidently, Christine penciled in orders for Nubain and then erased the hand-written entry after receiving the order. After unpacking and counting the supplies to assure the order was complete, Christine destroyed the accompanying invoices. We had no reason to believe that her reconciliation of items ordered to those received differed at all.

Having determined the source of Nubain diversion, I again contacted the local DEA agent to further investigate this matter. It seemed incredible to me that Nubain could be so easily acquired. Nalbuphine is a synthetic opioid agonist/antagonist and is a potent analgesic; its analgesic potency is essentially equivalent to that of morphine on a milligram basis. It impairs physical and mental abilities, and physicians are advised to use extreme caution when prescribing for patients with former opioid dependencies/addictions.

In addition, Nubain is extremely inexpensive. A 10 mg vial of Nubain costs a mere 79 cents. Therefore, in the context of invoice payments totaling hundreds to thousands of dollars, the nominal additional charges for Nubain could easily escape detection. In hindsight, this harrowing scenario lends support to the concern that this drug may be a very popular "drug of choice"

"Evidently, Christine penciled in orders for Nubain and then erased the hand-written entry after receiving the order"

for those who are in a position to order it, as Christine did, in any clinical setting. Based on the results of the narcotics investigation with which my staff and I fully cooperated, no charges were brought against the practice, my staff, or me. I kept the Medical Board fully apprised of the situation as it developed. Nevertheless, with the continuing advancement, and ease, of electronic communications and the invitation this presents to those who would use it to their own advantage, it becomes even more imperative that the physician protect herself/himself.

Protecting Precious Gifts

I am very concerned about Christine's well-being. However, she endangered others and she placed my practice and my career at risk, even though I am sure that was not her intent. In addition, I put myself at risk without meaning to. While I remain fiercely supportive of other health care providers in recovery, and I will continue to offer encouragement and assistance to others in recovery, I simply cannot afford to hire a colleague in recovery. This isn't my preference; however, in weighing the potential risk versus benefit involved

in such a situation, I have determined that I simply cannot take the risk, primarily because I am a sole practitioner. Despite a great support system, I have no "safety net" for my practice; no partners to bridge the gap in the event I am unable to work for even a very short time. The financial and emotional toll of again closing my practice doors is more than I can even consider. The years after my hospitalization were not easy. I lost my former medical practice, my patients, my staff. My home and my financial security were lost almost as quickly.

Nevertheless, I am a much happier, healthier, well-balanced physician today. I am a much more careful person; I manage my private practice in such a way that it benefits my patients, my staff, and myself. I am a happy man, a rare commodity these days. I take time to engage in hobbies and to seek support from, and offer it to, others. I recognize my health and my career as precious gifts that I enjoy and protect daily.

"I simply cannot afford to hire a colleague in recovery"

The author wishes to thank Donna Turner Eyster, JD, of Raleigh, for her assistance in preparation of this article.

Tamper-Proof Prescription Pads Mandate Postponed until April 1, 2008

*Nancy H. Hemphill, JD
NCMB Special Projects Coordinator*



Ms Hemphill

Three days before the tamper-resistant prescription pad requirement was to go into effect, Congress passed legislation pushing back the implementation date until April 1, 2008. The new mandate had been included in a federal budget bill (Section 7002(B) of P.L. 110-28, the US Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq

Accountability Appropriations Act of 2007) enacted in May 2007. Federal guidelines were issued August 17, while the North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA), published theirs on September 6, 2007. Federal law initially set the effective date as October 1, 2007.

Given the extremely short time frame for educating those affected by it and implementing the act, many professional associations, health care providers, state Medicaid directors, and others protested, and apparently Congress listened, delaying the effective date by six months.

The measure will apply to all handwritten prescrip-

tions for recipients of North Carolina Medicaid. The purpose of the law is to prevent alterations and forgeries of prescriptions and to protect the public health by reducing drug diversion and illegal sales.

The requirement applies to all outpatient drugs, including over-the-counter medications, for which state Medicaid programs provide reimbursement. Exceptions include: drugs administered in hospitals, long term care facilities, medical offices, and other inpatient health care settings. *Prescriptions that are transmitted by e-mail, fax, or telephone will be acceptable.* Refills presented prior to April 1 do not have to be resubmitted on the new form. Neither does the law apply when a managed care facility pays for the prescription. An emergency prescription written on a non-compliant form may be filled as long as a compliant prescription is filed within 72 hours after the prescription is filled. Out-of-state prescriptions must also meet the requirement.

From April 1, 2008, until October 1, 2008, prescription pads must only contain one out of three elements of tamper resistance (although they can, of course, fulfill more). If a prescription pad meets any one of the following requirements, its use is acceptable: (1) one or more industry-recognized features designed to prevent unauthorized copying of a complete or blank prescription form; (2) one or more industry-recognized

features designed to prevent erasure or modification of information written on the prescription by the prescriber; or (3) one or more industry-recognized features designed to prevent the use of counterfeit prescription forms. Beginning October 1, 2008, prescription pads must contain all three characteristics.

Under each of the three standards, a number of different anti-tampering features are listed in a DMA guidance letter. For example, the appearance of the word "VOID" across the entire front of the prescription blank when the prescription is photocopied or scanned would satisfy the first provision. The second provision might be met by using chemically treated ink or paper that resists washing, erasure, and reproduction. The third would be met by inserting a one-

inch square logo of the individual, professional practice, professional association, or hospital on the upper left corner of the prescription blank.

It is the duty of dispensing pharmacies to ensure that prescriptions are in compliance with Section 7002(b). North Carolina pharmacists will not be able to fill non-compliant paper prescriptions because the Center for Medical Assistance states: "Prescriptions reimbursed by NC Medicaid on noncompliant prescription pads are subject to recoupment." It is likely that pharmacists will be calling physicians asking them to resubmit prescriptions by phone, fax, or e-mail.

For more information, go to: www.dhhs.state.nc.us/dma/prov.htm, and look under "What's New."

The Controlled Substances Reporting System: A Useful Tool for Practitioners

Nancy H. Hemphill, JD
Special Projects Coordinator, NCMB

The North Carolina *Controlled Substances Reporting System* (CSRS) went into operation on July 1, 2007. Enacted by the state legislature in August 2005, the CSRS requires the North Carolina Department of Health and Human Services to establish and maintain a reporting system for all prescriptions for Schedule II, III, IV, and V controlled substances. It is hoped that the reporting system will stem the epidemic of deaths from unintentional drug overdoses from licit drugs, mostly narcotics. NCGS 90-113.71 states that the bill was ". . .intended to improve the State's ability to identify controlled substance abusers and refer them for treatment, and to identify and stop diversion of prescription drugs in an efficient and cost-effective manner that will not impede the appropriate medical utilization of licit controlled substances."

Dispensing pharmacies must now report all of the following to the DHHS: the patient's name, address, phone number, and date of birth; the date of the prescription; the prescription number; whether it's a new prescription or a refill; the metric quantity; estimated days of supply; its National Drug Code; and both the prescriber's and dispenser's DEA numbers. Pharmacies must report the dispensing of controlled substances at least monthly until July, 2008; thereafter, the data must be transmitted twice a month. Physicians, physician assistants, nurse practitioners, and others authorized to administer controlled substances under NCGS Chapter 90 are not required to report, even if they dispense these drugs. Other exemptions apply to licensed hospitals or long-term care facilities dispensing for inpatient use, and to wholesale distributors of controlled substances.

Access to the state's electronic data storehouse will be limited. Those who can write and fill prescriptions will be allowed access, as will individual patients; the SBI; the courts (under a court order in a criminal action); the

Division of Medical Assistance; and monitoring authorities from other states pursuant to an ongoing investigation. The North Carolina Medical Board (and other health care licensing boards) also can obtain the data, but only if the Board is already conducting an investigation of a licensee for prescribing irregularities. Note that the law provides both civil and criminal immunity to licensed health care providers who, in good faith, report or transmit data pursuant to this law. The law also includes civil penalties for those who breach its confidentiality provisions or use the information for improper purposes.

Prescribers who wish to receive information from the CSRS will have to file a one-time application for admission to the system and will receive a secure password. While the application is not currently available on line, it ultimately will be found at www.ncdhhs.gov/mhddsas. Until then, contact Johnny.Womble@ncmail.net, or (919) 715-2771, ext 248. Once a physician is registered and approved for access to the database, he or she can check a patient's prescription history on line. Physicians who suspect that a patient is abusing and/or diverting narcotics will finally have an easy and definitive way to verify narcotic use and curb abuse. Here's an example of how this might work. A patient may go to her primary care practitioner and request a refill for a one-time narcotic prescription originally provided by her orthopedist. With the patient still in the office, the physician can go to his computer, access the CSRS database, and check the patient's controlled substance information. If what the patient reports is true, the physician can write a refill. The pharmacy will then relay the details of that prescription to the database, so if the patient's orthopedist chooses to check on the patient, he or she can learn that a refill was issued.

The physician also can discover whether the patient

"Once a physician is registered and approved for access to the database, he or she can check a patient's prescription history on line"

has received narcotic prescriptions from other practitioners. After checking the history of the patient's narcotic drug use, the primary care practitioner can choose whether to counsel her about substance abuse or take other action. It is hoped that immediate access to a patient's narcotic prescription history will be used

to assist in proper prescribing and prevent abuse of controlled substances by individuals who should not receive them.

See also NCGS 90-113.71 through 90-113.76; 10A NCAC 26E .0601 through 10A NCAC 26E .0603.

Candidates Sought for Membership on Medicaid Drug Utilization Review Board

Glenda Adams, PharmD, RPh*

The North Carolina Division of Medical Assistance (DMA) is looking for candidates who would like to be considered for a North Carolina Medicaid Drug Utilization Review (DUR) Board member position.

In accord with the Social Security Act of 1927 and OBRA of 1990, the DUR program for outpatient drugs assures that prescriptions to Medicaid recipients are appropriate, medically necessary, and not likely to result in adverse medical events.

The DUR Board consists of the DMA DUR coordinator, five licensed and actively practicing physicians, five licensed and actively practicing pharmacists, and two at-large members with knowledge and expertise in one or more of the following: prescribing of Medicaid covered outpatient drugs; dispensing and monitoring of Medicaid covered outpatient drugs; drug use review, evaluation, and intervention; or medical quality assurance. Excluding the at-large members, *candidates must actively provide medical*

care to Medicaid patients.

The DUR Board meets quarterly in Raleigh, NC (1:00-3:00 PM, usually on the fourth Thursday of January, April, July, and October). In meeting months, two hours are compensated for attending the meeting and up to an additional two hours for preparing for the meeting. The preparation for the meeting involves reviewing reports/articles that will be discussed at the meeting. In the months when no meetings are scheduled, there is minimal time involvement. Mileage is compensated in accordance with State Budget Regulations (usually current IRS rate).

If you are interested in being notified when there is a vacancy on the DUR Board or would like additional information, please send an e-mail to Glenda Adams at glenda.adams@ncmail.net.

*Clinical Pharmacist, Clinical Policy Pharmacy Section, NC Division of Medical Assistance.

NCMB Policy Committee Continues Study of Position Statements

The Policy Committee of the North Carolina Medical Board regularly reviews the Board's Position Statements and considers new statements. The Board's licensees and others interested are invited to offer comments on any statement in writing to the chair of the Policy Committee, by e-mail (info@ncmedboard.org) or post (PO Box 20007, Raleigh, NC 27619). Comments are collected over time and considered when the relevant statement is reviewed or considered.

The Policy Committee discusses the Position Statements in public sessions during regularly scheduled meetings of the Board. The results are published on the Board's Web site and in the *Forum* before consideration by the Board, allowing for further written comments to assist the Committee in preparing a final version for Board action.

Recently, the following statement was proposed for consideration and comment.

End-of- Life Responsibilities and Palliative Care

Assuring Patients

Death is part of life. When appropriate processes have determined that the use of life-sustaining life-prolonging measures or

invasive interventions will only prolong the dying process, it is incumbent on physicians to accept death "not as a failure, but the natural culmination of our lives."^{*}

It is the position of the North Carolina Medical Board that patients and their families should be assured of competent, comprehensive palliative care at the end of the patient's life. Physicians should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided.

Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, an impeccable assessment and treatment of pain, and other physical, psychosocial, and spiritual problems. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;

- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- [may be] applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.**

There is no one definition of palliative care, but the Board accepts that found in the Oxford Textbook of Palliative Medicine: "The study and management of patients with active, progressive, far advanced disease for whom the prognosis is limited and the focus of care is the quality of life." This is not intended to exclude remissions and requires that the management of patients be comprehensive, embracing the efforts of medical clinicians and of those who provide psychosocial services, spiritual support, and hospice care.

A physician who provides palliative care, encompassing the full range of comfort care, should assess his or her patient's physical, psychological, and spiritual conditions. Because of the overwhelming concern of patients about pain relief, special attention should be given the effective assessment of pain. It is particularly important that the physician frankly but sensitively discuss with the patient and the family their concerns and choices at the end of life. As part of this discussion, the physician should make clear that, in some cases, there are inherent risks associated with effective pain relief in such situations:

Opioid Use

The Board will assume opioid use in such patients is appropri-

ate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan. (See the Board's Position Statement on the Management of Chronic Non-Malignant Pain Policy for the Use of Controlled Substances for the Treatment of Pain for an outline of what the Board expects of physicians in the management of pain.) Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.

Selected Guides

To assist physicians in meeting these responsibilities, the Board recommends *Cancer Pain Relief: With a Guide to Opioid Availability*, 2nd ed (1996), *Cancer Pain Relief and Palliative Care* (1990), *Cancer Pain Relief and Palliative Care in Children* (1999), and *Symptom Relief in Terminal Illness* (1998), (World Health Organization, Geneva); *Management of Cancer Pain* (1994), (Agency for Health Care Policy and Research, Rockville, MD); *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain*, 4th Edition (1999) (American Pain Society, Glenview, IL); *Hospice Care: A Physician's Guide* (1998) (Hospice for the Carolinas, Raleigh); and the *Oxford Textbook of Palliative Medicine* (1993) (Oxford Medical, Oxford).

(Adopted 10/1999; amendment proposed 5/2007)

*Steven A. Schroeder, MD, President, Robert Wood Johnson Foundation.

** Taken from the world Health Organization definition of Palliative Care (2002): (<http://www.who.int/cancer/palliative/definition/en>)

General Assembly Makes Historic Changes to Medical Practice Act

Thomas W. Mansfield, JD
Director, Legal Department
Legislative Liaison



Mr Mansfield

"There was a great deal of criticism from consumer advocacy groups, the media, and others regarding the appointment process"

The North Carolina General Assembly passed several bills this summer that make historic changes to the Medical Practice Act (MPA). These changes are the most comprehensive revision of the MPA since the Board's inception almost 150 years ago. These new laws resolve litigation regarding the Board member selection process, give consumers more access

to pertinent physician information, remove archaic language, reorganize/rewrite sections of the MPA that were disorganized and confusing, add a much-needed definitions section, specifically enumerate and also expand the powers of the Board (including the power to enact rules related to continued competence and the disposition of medical records), and improve the Board's ability to conduct hearings.

The following are highlights of new provisions. All changes went into effect October 1, 2007, except the

Board member selection process provisions, which go into effect January 1, 2008.

Board Member Selection Process

While the Governor has made the final decision regarding appointments of physician members to the Board, the North Carolina Medical Society (NCMS) provided the nominees from which the Governor was required by statute to choose. The Board and the people of North Carolina benefitted from the relationship between the Board and the NCMS, but there was a great deal of criticism from consumer advocacy groups, the media, and others regarding the appointment process.

House Bill 818¹ creates an independent Review Panel that will make recommendations to the Governor regarding appointments to seven physician seats and one seat held by a physician assistant or nurse practitioner.² The Review Panel will make at least two recommendations for each seat, and the Governor will pick from those recommendations. The Review Panel will consist of nine members. Eight of those members will be selected by the NCMS, Old North State Medical Society, NC Osteopathic Medical Association, NC Academy of Physician Assistants, and

NC Nurses Association Council of Nurse Practitioners.³ The ninth member will be one of the public members currently serving on the Board. Membership on the Board does not require membership in any of the organizations participating in the review and recommendation process.

House Bill 818 does establish other criteria for physician Board membership. Those criteria include having an active license in good standing with the Board, having an active clinical or teaching practice, having practiced clinically for five years preceding appointment, providing letters of recommendation, having no disciplinary history with any medical board in the preceding 10 years, and having no felony criminal convictions and no misdemeanor convictions involving the practice of medicine. Applicants must certify they understand that the Board's purpose is to protect the public, that they are willing to take disciplinary action against their peers when appropriate, and that they understand the significant time commitment required of Board members.

Consumer Access to Physician Information

House Bill 818 also authorizes the Board to collect certain information from physicians and make it available to the public. This will be in the form of a "physician profile" system. The Board currently publishes on its Web site significant information about its licensees in a user-friendly format. That information will be expanded to include area of practice, disciplinary actions by other medical boards and agencies, felony and certain misdemeanor criminal convictions, certain suspensions or revocations of hospital privileges, and some information about professional liability (so-called "malpractice") payments. Failure by the physician to provide the required information to the Board may result in disciplinary action.

The Board has spent much of the last year carefully studying the issue of publishing information about professional liability payments. The Board cannot begin publishing the payment information until it creates rules regarding how the information will be collected and published. The rulemaking process will take some months. Licensees should pay close attention to the *Forum* for updates.

Reorganization, Codification, and Licensing

House Bills 818 and 1381⁴ reorganize the licensing provisions of the MPA and codify in the statute many provisions previously covered specifically only by rule. Now, the reader of the MPA can more easily find the licensing provisions of the law. Archaic and outdated provisions are deleted.

There are only two entirely new concepts in the licensing laws. One is the requirement that all applicants for a license be able to communicate effectively in the English language. The other new concept is in the creation of a Special Purpose License, which may serve several purposes but was born of the need to facilitate bringing in excellent physicians practicing in other states to North Carolina on a temporary basis to consult with and teach our own licensees.

Definitions

Section 1 of House Bill 818 creates an expanded definition of the "practice of medicine or surgery." This new definition includes advertising or holding out that one is authorized to practice as a physician and using designations like "doctor." Broadly speaking, the use of a designation like "doctor" by someone not licensed by this Board is lawful only if the person using the designation has a doctorate degree, is licensed by another health care licensing agency, and makes it clear in which branch of the healing arts he or she is practicing.

Powers and Duties

Section 5 of House Bill 818 includes two major developments. The bill authorizes the Board to regulate the disposition and disposal of medical records and to appoint a custodian for abandoned medical records. This law does not apply to hospitals and other health care institutions, only individual Board licensees. Looking to long range changes, the bill authorizes the Board to develop and implement methods of assessing and improving physician practice and ensuring ongoing competence of licensees. This new authority fits in with the national trend regarding continued competence.

Conducting Hearings

The definitions section in House Bill 818 includes the term "hearing officer," which is defined as current and past Board members who are an MD, DO, PA, or NP, as well as current or retired members of the judiciary. Section 18 of the bill allows the Board to use these hearing officers to conduct disciplinary and licensing hearings. Historically, almost all hearings have been conducted by sitting Board members. This provision expands the pool of individuals who can hear Board cases and should permit the Board to conduct more hearings and in a more timely fashion.

Availability of Information to Complainants

Section 22 of House Bill 818 provides for greater access to information on the part of patients and certain other persons who complain to the Board about a licensee. The new law requires that the Board inform the complainant of the fact of and the basis for the Board's disposition of the complaint. For a number of years, the Board has informed complainants in a very timely fashion of the disposition of their complaints along with providing limited information about the nature or basis of the resolution of the complaint. The Board is currently studying how to strike the ideal balance between greater transparency to complainants in the disposition of cases not requiring formal disciplinary action and maintaining the effectiveness of such actions, which are critical to ensuring safe medical practice.

In addition, the new law gives the Board the discretion to supply to the complainant the licensee's written response to a complaint, which was protected as confidential under the previous law. The Board is in the process

"The bill authorizes the Board to regulate the disposition and disposal of medical records and to appoint a custodian for abandoned medical records"

of determining under what circumstances it will release to the complainant the licensee's written response. The Board will notify responding licensees of this possibility and point out that the new law prevents the written response provided by the Board from being admitted into evidence in any civil proceeding against the licensee.

Supervising Laser Hair Practitioners

House Bill 726⁵ does not make changes to the MPA, but it permits the NC Board of Electrolysis Examiners to license laser hair practitioners (LHPs) to use laser devices to remove or reduce unwanted hair. The licensees of that board were previously limited to electrolysis. The new law, in Section 6, requires that LHPs be supervised by a physician licensed by the Medical Board and that the physician be on site or readily available. While the statute is silent as to the need for a history and physical examination for each patient receiving laser hair removal, this Board has made clear in its Position Statement and disciplinary actions that good medical practice requires such an examination prior

to initiating laser hair removal.

Conclusion

The preceding paragraphs do not cover every important aspect of the new legislation. There are numerous other provisions that may be relevant to a licensee of the Board and of interest to the public. As always, we suggest that licensees consult with their private legal counsel regarding any questions about whether and how new legislation affects their practice.

"The new law, in Section 6, requires that LHPs be supervised by a physician licensed by the Medical Board"

¹Now Session Law 2007-346 and available at www.ncleg.net.

²The Review Panel will not make recommendations regarding the eighth physician seat that must go to a DO, academic alternative medicine practitioner or member of the Old North State Medical Society.

³The NCMS will have four members on the Review Panel. The other organizations represented will have one each.

⁴Now Session Law 2007-418 and available at www.ncleg.net.

⁵Now Session Law 2007-489 and available at www.ncleg.net. The effective date is October 1, 2007. This law does *not* require that all persons performing laser hair removal under the supervision of a physician be licensed by the Electrolysis Examiners.

Governor Appoints Thelma C. Lennon, of Raleigh, to North Carolina Medical Board



Ms Lennon

R. David Henderson, executive director of the North Carolina Medical Board, has announced that Governor Easley recently appointed Thelma C. Lennon, of Raleigh, as a public member of the Board. She replaces E.K. Fretwell, PhD, of Charlotte. Mr Henderson said: "Ms Lennon is fully committed to the work of the Board and to the health and safety of the people of North Carolina. She brings a wealth of experience and talent to the Board and we are deeply pleased to welcome her."

Ms Lennon earned her bachelor of science degree from North Carolina Central University. She earned her master's degree from Boston University in guidance and counseling and did further study of the subject at Harvard University. She also completed graduate study in adult education at North Carolina State University.

During her professional career, Ms Lennon served in education as an instructor and dean of students at a number of academic institutions. Before retiring, she worked as director of guidance and counseling for the North Carolina Department of Education.

While working, Ms Lennon was actively involved in the College Entrance Examination Board, National Vocational Guidance Association (of which she was president), National Career Guidance Association (of which she was president and chairman of the Commission on Women),

the National Career Guidance Institute of the University of Southern California (of which she was chairman), and the Education Trust Advisory Council. To name only a few of her many community services, she was actively involved with the North Carolina Center for Public Policy Research, Wake County Health Services, Inc, and Raleigh Housing Authority.

Since her retirement, Ms Lennon has devoted much of her time to volunteer activities focusing on health and education. She is currently a counselor at the North Carolina Department of Insurance's Senior Health Insurance Information Program (SHIIP), a member of the Board of Directors of the Carolinas Center for Medical Excellence, and chairman for the Alliance for Medical Excellence. She is also a member of the Wake County Community Advisory Council for Nursing Homes and the Governor's Advisory Council on Aging.

From 1996 to 2000, Ms Lennon served as the first American Association of Retired Persons (AARP) North Carolina state president and was selected as an alternate delegate to the White House Conference on Aging. In 2000, she was recognized by former Governor James Hunt as one of twelve women to be named "Distinguished Women of North Carolina." She has received the Order of the Long Leaf Pine, the AARP Andrus Award for Community Service, and most recently, was named Health Care Hero by the Triangle Business Journal.

She coauthored a journal article on "Counseling the Culturally Different" in the *Ohio State University Educational Journal*, and chaired the committee on the publication of *Navigating the Course of Change in Guidance and Counseling in Public Schools*.

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

May-June-July 2007

DEFINITIONS:

Annulment:
Retrospective and prospective cancellation of the practitioner's authorization to practice.

Conditions:
A term used in this report to indicate restrictions, requirements, or limitations placed on the practitioner.

Consent Order:
An order of the Board stating an agreement between the Board and the practitioner regarding the annulment, revocation, suspension, or surrender of the authorization to practice, or the conditions placed on the authorization to practice, or other action taken by the Board relative to the practitioner. (A method for resolving a dispute without a formal hearing.)

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

Dismissal:
Board action dismissing a contested case.

Inactive Medical License:
To be "active," a medical license must be registered on or near the physician's birthday each year. By not registering his or her license, the physician allows the license to become "inactive." The holder of an inactive license may not practice medicine in North Carolina. Licensees will often elect this status when they

retire or do not intend to practice in the state. (Not related to the "voluntary surrender" noted below.)

NA:
Information not available or not applicable.

NCPHP:
North Carolina Physicians Health Program.

Public Letter of Concern:
A letter in the public record expressing the Board's concern about a practitioner's behavior or performance. Concern has not risen to the point of requiring a formal proceeding but should be known by the public. If the practitioner requests a formal disciplinary hearing regarding the conduct leading to the letter of concern, the letter will be vacated and a formal complaint and hearing initiated.

Reentry Agreement:
Arrangement between the Board and a practitioner in good standing who is "inactive" and has been out of clinical practice for two years or more. Permits the practitioner to resume active practice through a reentry program approved by the Board to assure the practitioner's competence.

RTL:
Resident Training License. (Issued to those in post-graduate medical training who have not yet qualified for a full medical license.)

Revocation:
Cancellation of the authorization to practice. Authorization may not be reissued for at least two years.

Stay:
The full or partial stopping or halting of a legal action, such as a suspension, on certain stipulated grounds.

Summary Suspension:
Immediate withdrawal of the authorization to practice prior to the initiation of further proceedings, which are to begin within a reasonable time. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)

Suspension:
Withdrawal of the authorization to practice for a stipulated period of time or indefinitely.

Temporary/Dated License:
License to practice 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 Surrender:
The practitioner's relinquishing of the authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner. (Not related to the "inactive" medical license noted above.)

For the full text version of each summary and for public documents, please visit the Board's Web site at www.ncmedboard.org

ANNULMENTS

NONE

REVOCATIONS

EATON, Hubert Arthur, Jr, MD

Location: Wilmington, NC (New Hanover Co) | DOB: 5/25/1943
 License #: 0000-17858 | Specialty: IM (as reported by physician)
 Medical Ed: Meharry Medical College (1969)
 Cause: Dr Eaton has a history of substance abuse. In June 2006, a urine sample showed Dr Eaton had consumed alcohol in violation of his March 2005 Consent Order and his NCPHP contract.

Action: 6/08/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/18/2007: Dr Eaton's North Carolina medical license is revoked.

MILLER, Shelly Ann, MD

Location: Raleigh, NC (Wake Co) | DOB: 7/13/1965
 License #: 0095-01008 | Specialty: FP (as reported by physician)
 Medical Ed: University of Connecticut (1991)
 Cause: The NCPHP determined that Dr Miller, who had an NCPHP contract, was not able to maintain control of her abuse of mood-altering substances. In May 2006, the NCPHP recommended she surrender her medical license, which she did on 6/13/2006. Dr Pendergast testified Dr Miller did not appear to be clinically stable.

Action: 6/20/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 6/20/2007 to consider the recommendation of a hearing panel held on 2/21/2007: Dr Miller's North Carolina medical license is revoked.

TROGDON, James Clifford, Nurse Practitioner

Location: Chapel Hill, NC (Orange Co) | DOB: 10/19/1957
 Approval #: 0002-01033
 NP Education: NA
 Cause: The Board received information that during 2005 and 2006, Mr Trogdon forged a physician's signature on mul-

iple prescriptions for a controlled substance and gave the medication to one or more family members. When confronted, he admitted the conduct and surrendered his approval as an NP on April 5, 2006. He later admitted he had taken the medications himself.

Action: 6/20/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 6/20/2007: Mr Trogdon's North Carolina NP approval is revoked.

See Consent Orders:

BRYDON, Kim Marie, MD

SUSPENSIONS

HARRIS-CHIN, Cheryl Jacqueline, MD

Location: Charlotte, NC (Mecklenburg Co) | DOB: 3/25/1963
 License #: 2002-00914 | Specialty: PD (as reported by physician)
 Medical Ed: University of the West Indies (1988)
 Cause: The Maryland Board suspended Dr Harris-Chin's license for six months in April 2006. It had determined she improperly accessed medical records, requested a consultation on a fictitious patient, and failed to notify the Board of her change of address. It also concluded her denial to the Board concerning the issues was unprofessional.

Action: 6/06/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/18/2007: Dr Harris-Chin's North Carolina medical license is suspended for six months.

TERRY, Sandra Louise, Nurse Practitioner

Location: Hope Mills, NC (Sampson Co) : DOB: 3/20/1971
 Approval #: 0002-01963
 NP Education: NA
 Cause: The Nursing Board summarily suspended Ms Terry's nursing license in July 2006 based on a history of several convictions for DUI and for eluding arrest in a motor vehicle. On July 21, 2006, the Nursing Board confirmed its suspension decision. In April 2007, the Medical Board filed charges

Action: based on the actions of the Nursing Board.
7/10/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 6/20/2007: Ms Terry's North Carolina nurse practitioner approval is suspended indefinitely.

See Consent Orders:

BASAMANIA, Beth P, MD
BLAKE, John Alder, Physician Assistant
CARBONE, Dominick J., Jr, MD
GUARINO, Clinton Toms Andrews, MD
HILL, Monica Rae, DO
HOPE, Shelly-Ann Violet, MD
JOHANSEN, James Richard, MD
MARTIN, Michele I., MD
McKEEL, Cameron Roberts, Physician Assistant
MOCLOCK, Michael Anthony, MD
MORTER, Gregory Alan, MD
NG, Chun-Ho Patrick, MD
STEINER, Drew John, MD
REYNOLDS, Robert Jack, MD

SUMMARY SUSPENSIONS

NONE

CONSENT ORDERS

BASAMANIA, Beth P, MD

Location: Chapel Hill, NC (Orange Co) | DOB: 3/31/1963
 License #: 0099-00323 | Specialty: FP (as reported by physician)
 Medical Ed: George Washington University (1990)
 Cause: Dr Basamania prescribed numerous prescriptions for non-controlled substances to herself and kept no record of those prescriptions. She also abused Ultram®. During this time she did not practice clinical medicine. In June 2006, she surrendered her medical license.

Action: 7/19/2007. Consent Order executed: Dr Basamania's North Carolina medical license is indefinitely suspended.

BENTLEY, Susan Warren, Nurse Practitioner

Location: Huntersville, ND (Mecklenburg Co) | DOB: 7/19/1954
 Approval #: 0009-40101
 NP Education: NA
 Cause: Ms Bentley was asked for a copy of her collaborative practice agreement with Dr Joseph Jemsek in July 2006. She provided a document titled "2005 Collaborative Practice Agreement for Nurse Practitioners at Jemsek Clinic" that indicated it was created in October 2005. The document was not properly signed or dated by Ms Bentley or Dr Jemsek. Another nurse practitioner at the clinic indicated no such agreement was in place in 2004. Earlier documents, called "protocols" did not comply with the spirit and letter of the law at that time.

Action: 5/23/2007. Consent Order executed: Ms Bentley is reprimanded.

BLAKE, John Alder, Physician Assistant

Location: Wilmington, NC (New Hanover Co) | DOB: 3/05/1971
 License #: 0001-03290
 PA Education: The College of West Virginia (2001)
 Cause: Mr Blake, operating his own medical practice without a physician on site to supervise, mismanaged the care of four patients. Proper consultation with his supervising physician would most likely have prevented the problems of mismanagement of his patients. He has no previous disciplinary history and has taken significant CME. His supervising physician has developed a remediation plan concerning the issues in the case and Mr Blake has implemented an electronic medical records system for all his patients. All but one of the patients involved continue treatment by Mr Blake.

Action: 6/18/2007. Consent Order executed: Mr Blake's PA license is suspended for one year; suspension is stayed and he is placed on probation on terms and conditions; he shall have on-site supervision and meet with his primary supervising physician on a weekly basis for six months; he shall submit himself to the Center for Personalized Education for Physicians by July 31, 2007, for assessment and provide resulting reports to the Board; must comply with other requirements related to the issues of the case.

BRYDON, Kim Marie, MD

Location: Raleigh, NC (Wake Co) | DOB: 11/06/1957
 License #: 0000-33795 | Specialty: P (as reported by physician)
 Medical Ed: University of Kansas (1987)
 Cause: Dr Brydon had a sexual relationship with a patient. When working for the North Carolina Correctional Institute for Women, Dr Brydon began treating an inmate for mental problems in 2001. A year after being released from NC-CIW, the patient moved in with Dr Brydon and they began a sexual relationship. The patient was later reincarcerated based on her obtaining prescription drugs by forging Dr Brydon's name on prescription blanks from one of Dr Brydon's old prescription pads. Dr Brydon saw the patient again after the patient was readmitted to NCCIW. Dr Brydon has admitted this was inappropriate but she did it in an effort to conceal the relationship they had. Dr Brydon voluntarily surrendered her license in April 2007.

Action: 6/26/2007. Consent Order executed: Dr Brydon's North Carolina medical license is revoked.

CARBONE, Dominick J., Jr, MD

Location: Winston-Salem, NC (Forsyth Co) | DOB: 8/09/1965
 License #: 0097-00498 | Specialty: US (as reported by physician)
 Medical Ed: University of Michigan Medical School (1990)
 Cause: Application for reinstatement of license. From December 2005 to March 2006, Dr Carbone had a consensual sexual relationship with a patient. He ceased practice in December 2006 and surrendered his license in January 2007. His license was indefinitely suspended in 2007 via Consent Order. He has completed an in-depth evaluation at the Professional Renewal Center in Kansas and has a contract with the NCPHP.

Action: 7/01/2007. Consent Order executed: Dr Carbone is issued a license; that license is suspended and suspension is stayed on probationary terms; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

COLLINS, Paul Dwayne, MD

Location: Pembroke, NC (Robeson Co) | DOB: 2/08/1973
 License #: 2005-00139 | Specialty: FP (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (2001)
 Cause: On application to reinstate license. Because of his history of alcohol and substance abuse, Dr Collins entered a Consent Order with the Board in 2005 to obtain a license. In February 2006, he tested positive for alcohol, violating his Consent Order and his contract with the NCPHP. He surrendered his license in March. Since July 2006, he has undergone weekly therapy and attends AA. He reports he has abstained from alcohol and mind-altering substances since that time. He has a five-year contract with the NCPHP and the NCPHP reports he is in compliance.

Action: 5/25/2007. Consent Order executed: Dr Collins is issued a license to expire on the date shown on the license [6/30/2007]; he shall be on probation for 12 months; he shall maintain and abide by a contract with the NCPHP; he shall attend AA and/or NA meetings weekly; he shall work no more than 40 hours per week and shall not take call, he shall abide by all recommendations of his treatment program and therapist; unless lawfully prescribed by another person, he shall refrain from use of all mind- or mood-altering substances and alcohol; he shall submit to drug/alcohol

screenings as requested by the Board; must comply with other conditions.

COOPER, Armah Jamale, MD

Location: Butner, NC (Granville Co) | DOB: 5/28/1956
 License #: 0000-29096 | Specialty: P/FRY (as reported by physician)
 Medical Ed: Meharry Medical College (1981)
 Cause: Dr Cooper has, on occasion, prescribed for himself for his epilepsy when prescriptions from his physician in Maryland were delayed. To do this, he wrote prescriptions in the name of a friend, taking the drug himself. He has been evaluated by the NCPHP and does not appear to have an abuse problem. He has also enrolled in a prescribing course and has been referred to appropriate physicians for his care.
 Action: 7/09/2007. Consent Order executed: Dr Cooper is reprimanded.

COULSON, Alan Stewart, MD

Location: Hamlet, NC (Richmond Co) | DOB: 6/21/1941
 License #: 2000-01476 | Specialty: VS (as reported by physician)
 Medical Ed: Guy's Hospital Medical School, UK (1970)
 Cause: Dr Coulson's cardiac surgical privileges were suspended at his hospital. Review of the charts of four of his patients for the Board by an outside expert noted Dr Coulson failed to meet acceptable standards in three of the cases. Review of the charts of five vascular surgical patients by an outside expert indicated appropriate care.
 Action: 6/20/2007. Consent Order executed: Dr Coulson's license is limited: he shall not perform cardiac surgery in North Carolina; he agrees to periodic chart review; must comply with other conditions.

DASSO, Edwin Joseph, MD

Location: Greensboro, NC (Guilford Co) | DOB: 6/26/1955
 License #: 2007-01165 | Specialty: AN (as reported by physician)
 Medical Ed: University of Texas Southwestern Med Center, Dallas (1983)
 Cause: Dr Dasso holds licenses in several states and has not practiced clinical medicine since 1994. He works as a medical director for insurance companies. He has no plans to practice clinical medicine in North Carolina.
 Action: 7/11/2007. Consent Order executed: Dr Dasso is issued a limited administrative license that requires he not practice clinical medicine; should he decide to resume clinical practice, the Board president must approve a plan for updating his skills and his practice site.

DAVIDSON, Arthur Turner, Jr, MD

Location: New York, NY | DOB: 8/30/1947
 License #: 2007-00917 | Specialty: NA
 Medical Ed: Howard College of Medicine (1975)
 Cause: Dr Davidson signed a Consent Order with the New York Board accepting a censure and reprimand, agreeing to take a targeted CME course, and agreeing to a two-year probation as a result of prescribing for his wife during her pregnancy. He has completed the terms of his agreement with New York and holds a medical license there. This North Carolina Consent Order is intended only to make Dr Davidson's New York record a matter of public record in North Carolina.
 Action: 6/05/2007. Non-Disciplinary Consent Order executed: Dr Davidson is issued a North Carolina medical license.

DAUITO, Ralph, MD

Location: Vineland, NJ | DOB: 3/31/1956
 License #: 2007-01012 | Specialty: R (as reported by physician)
 Medical Ed: Georgetown University School of Medicine (1984)
 Cause: On appeal of a license denial. Dr Dauito signed a Consent Order with the New Jersey Board in December 2001 admitting to certain findings regarding his treatment of a patient. He failed to diagnose a pseudoaneurysm because he did not view all of the X-rays. Later, he made the diagnosis but failed to inform the patients physician. He was reprimanded and required to take ethics course and an angiography

course, and pay a fine. His license was suspended with a stay based on his compliance with conditions placed on him. He agrees to abide by the conditions set in New Jersey in North Carolina. A North Carolina license is granted on conditions set forth in the following Consent Order.

Action: 6/18/2007. Consent Order executed: Dr Dauito is reprimanded as a reciprocal action to the New Jersey reprimand; he shall have an audit of his practice to determine the hours he works, the number of patients he sees per week, and the types of radiology he performs; the North Carolina Board president will review the audit results to determine if any limits should be put on Dr Dauito's practice; he must comply with other conditions.

GREER, Gary Wayne, MD

Location: Hickory, NC (Catawba Co) | DOB: 9/17/1953
 License #: 0096-01621 | Specialty: EM (as reported by physician)
 Medical Ed: Harvard Medical School (1979)
 Cause: Dr Greer wrote prescriptions for himself and a patient with whom he had a close family relationship. He made no medical record in either case. It does not appear that the drugs prescribed were inappropriate for his or his relative's medical conditions. He was not aware of the restrictions on such prescribing and has placed himself under the care of a personal physician. The relative has also been placed under the care of a personal physician. Dr Greer has practiced for 27 years without any other Board action against him. He will take remedial training related to the prescribing issue.
 Action: 6/20/2007. Consent Order executed: Dr Greer's license is cited with a Public Letter of Concern; he shall comply with the relevant Board position statements and shall attend a prescribing course within 12 months; must comply with other conditions.

GUARINO, Clinton Toms Andrews, MD

Location: Hickory, NC (Catawba Co) | DOB: 2/04/1966
 License #: 0099-00062 | Specialty: IM (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (1996)
 Cause: In 2005, Dr Guarino voluntarily surrendered his North Carolina medical license as a result of his arrest for traffic offenses and evidence that he suffered a substance abuse/dependency condition. In January 2006, he entered into a Consent Order with the Board suspending his medical license. In September 2006, he pled guilty to DUI, driving on a restricted license, and felony eluding arrest stemming from the 2005 incident. In October 2006, he entered a second Consent Order with the Board reinstating his license on a temporary basis with conditions related to his situation. In November, Dr Guarino tested positive for drug use on screenings by the Board and the NCPHP. On December 7, 2006, he surrendered his license.
 Action: 6/18/2007. Consent Order executed: Dr Guarino's North Carolina medical license is indefinitely suspended; he may not apply for reinstatement for at least one year.

HARRELL, Raymond Martin, MD

Location: Chapel Hill, NC (Orange Co) | DOB: 7/13/1975
 License #: RTL | Specialty: AN (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (2007)
 Cause: Dr Harrell has a history of substance and alcohol abuse. He sought help at an inpatient facility and has been sober since 2000. He has a monitoring contract with the NCPHP.
 Action: 6/21/2007. Consent Order executed: Dr Harrell is issued a resident training license for UNC Hospital; he shall maintain and abide by a contract with the NCPHP; he shall meet with the Board as requested and shall provide a letter from his program director evaluating his performance; he shall submit to drug/alcohol screenings as requested by the Board; unless lawfully prescribed by another person, he shall refrain from the use or possession of all mind- or mood-altering substances and controlled substances; must comply with other conditions.

HILL, Monica Rae, DO

Location: Lumberton, NC (Robeson Co) | DOB: 1/18/1968
 License #: 2003-00805 | Specialty: IM (as reported by physician)
 Medical Ed: Des Moines University Osteopathic Medical Center (1998)
 Cause: Dr Hill attempted to gain payment for acquired time off for a friend and former co-worker who had been fired for cause by the hospital in which Dr Hill worked as a hospitalist. The hospital did not offer such payments in those situations. She called the vice president and COO of the hospital, asked the payment be made as a favor to her, and offered to provide an expert review that would make the hospital look good if payment were made. In fact, she had no case in which she was providing an expert review. She was, in essence, bluffing to assist her former co-worker.

Action: 6/20/2007. Consent Order executed: Dr Hill's North Carolina medical license is suspended for 30 days; suspension is stayed; she shall obey all laws and regulations related to the practice of medicine.

HOPE, Shelly-Ann Violet, MD

Location: Lenoir, NC (Caldwell Co) | DOB: 9/23/1963
 License #: 2003-00157 | Specialty: OB/GYN (as reported by physician)
 Medical Ed: Howard University (1990)
 Cause: Dr Hope issued prescriptions to patients without first performing a physical examination. From May to September 2006, she provided medical services for one John Garcia through Inetmedic.com, a business that renders medical services via the Internet. He told her as long as she was licensed in North Carolina she need not be licensed elsewhere. She issued numerous prescriptions without physical examinations and allowed Inetmedic to bill patients for her services. She was paid \$25 per patient. From October 2006 to March 2007, she contracted with Juan Ibanez, MD, to provide medical services through online companies owned by him. Again, she authorized numerous prescriptions without examining patients. She allowed Ibanez to bill patients for her services and she was paid \$5,000 per month. She admits that she was assisting in the unlicensed practice of medicine in North Carolina by Ibanez and his group, and by Garcia and his group.

Action: 6/20/2007. Consent Order executed: Dr Hope's North Carolina medical license is suspended for 90 days; suspension is stayed on probationary terms and conditions; she shall comply with the Board's position statements on prescribing and within 12 months she shall take and complete a course on prescribing; she shall not prescribe without performing a physical examination and she shall not assist any person or entity in the unlicensed practice of medicine in North Carolina; must comply with other conditions.

HUMBLE, Scott David, MD

Location: Raleigh, NC (Wake Co) | DOB: 9/28/1970
 License #: 2007-00897 | Specialty: PTH (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (1998)
 Cause: Dr Humble recognized he was abusing alcohol during postgraduate training in Florida and voluntarily entered the Florida Professionals Resource Network with a five-year monitoring contract. In October 2006, he entered a contract with the NCPHP, which did not express reservations about his ability to practice safely.

Action: 5/30/2007. Consent Order executed: Dr Humble is issued a medical license [to expire 11/30/2007]; he shall maintain and abide by his NCPHP contract; he shall submit to drug/alcohol screenings as requested by the Board; unless lawfully prescribed by another person, he shall refrain from the use or possession of all mind- or mood-altering substances and controlled substances, including alcohol; must comply with other conditions.

JOHANSEN, James Richard, MD

Location: Shelby, NC (Cleveland Co) | DOB: 9/12/1959

License #: 0096-00957 | Specialty: FP (as reported by physician)

Medical Ed: University of California, Irvine (1986)

Cause: In February 2007, Dr Johansen abruptly and without notice to patients closed his practice. He told his staff to stay at the practice for several days so they could inform patients with appointments that the practice was closed. He informed the Board that a domestic situation had caused him to close his practice and asked guidance. He did not mail notices to patients nor provide his patients information on how to obtain their records. A Board investigator visited the office location and found no contact information or instructions for patients, though there were 10 notes from patients stuck in the door asking for their records. Complaints were received by the Board as late as March 16, 2007, about being unable to obtain records. The Board contacted Dr Johansen and told him to facilitate informing all patients about obtaining records. He reports he did as requested. Investigation found this to be true. Dr Johansen has kept the Board informed of his efforts to meet his ethical responsibilities since that time. A new group has taken over the practice and it has reopened.

Action: 6/20/2007. Consent Order executed: Dr Johansen's North Carolina medical license is suspended for two years as of 5/01/2007; suspension will be stayed as of 6/15/2007 and he is placed on probation on terms and conditions; he shall obey all laws and regulations related to medical practice and comply with all ethical responsibilities regarding closing of his practice; must comply with other conditions.

JONES, Robert Glen, MD

Location: Raleigh, NC (Wake Co) | DOB: 4/06/1959

License #: 0094-00536 | Specialty: OSM/SM (as reported by physician)

Medical Ed: Emory University School of Medicine (1988)

Cause: On application for license reinstatement. Dr Jones surrendered his license in June 2006 and his license was suspended by consent order in September 2006 as a result of his alcohol abuse. The NCPHP reported he has been in compliance with his NCPHP contract and there is no evidence patient care was compromised by his use of alcohol.

Action: 7/26/2007. Consent Order executed: Dr Jones' is issued a temporary/dated license to expire on the date shown on the license [11/30/2007]; he shall maintain and abide by a contract with the NCPHP; unless lawfully prescribed by someone else, he shall not use mind- or mood-altering substances, controlled substances, or alcohol and shall notify the Board if and when such are prescribed; he shall supply hair and/or bodily fluids for screening as requested by the Board; he shall attend AA or Caduceus meetings; must comply with other conditions.

MARTIN, Michele I., MD

Location: Statesville, NC (Iredell Co) | DOB: 5/20/1965

License #: 0096-01667 | Specialty: GP/P (as reported by physician)

Medical Ed: Loma Linda University (1994)

Cause: Between April 2003 and July 2006, Dr Martin had an intimate relationship with Patient A but did not end their existing patient-physician relationship. She continued to give treatment, including prescribing controlled medications, to Patient A. From early 1999 to early 2002, she also wrote prescriptions for Patient B, a family member.

Action: 6/19/2007. Consent Order executed: Dr Martin's North Carolina medical license is suspended for six months; suspension is stayed on probationary terms; she shall attend the Vanderbilt courses on prescribing controlled substances and on maintaining proper boundaries within 12 months; she shall maintain and abide by a contract with the NCPHP; she shall perform 100 hours of community service approved by the Board president; must comply with other conditions.

McKEEL, Cameron Roberts, Physician Assistant

Location: Asheville, NC (Buncombe Co) | DOB: 1/09/1968

License #: 0001-03586
 PA Education: NA
 Cause: Mr McKeel has a significant criminal history with previous convictions for DUI, possession of drug paraphernalia, and breaking and/or entering. In October 2006, he was arrested in South Carolina and charged with illegal possession of prescription medication, which he later admitted to Board investigators. He also admitted possession of marijuana and chronic alcohol use. A urine sample in December 2006 was positive for amphetamine, marijuana, and alcohol. In October 2006, Mr McKeel was also arrested in Buncombe County for felony assault by strangulation and misdemeanor assault on a female. He later admitted to Board investigators that he did touch the alleged female victim's neck and head.

Action: 5/30/2007. Consent Order executed: Mr McKeel's PA license is suspended indefinitely.

MOCLOCK, Michael Anthony, MD

Location: Dubois, PA | DOB: 11/18/1951
 License #: 2007-01013 | Specialty: FP (as reported by physician)
 Medical Ed: Medical College of Pennsylvania (1990)
 Cause: On application for a North Carolina license. Dr Moclock entered into a Consent Agreement with the Pennsylvania Board in 2006 in which he admitted he abused alcohol and suffered active alcohol dependency from 1999 to 2001 and self-prescribed cough syrup with hydrocodone in 2001. He voluntarily sought treatment in 2004 and later in 2004 relapsed. He is now participating in the PHMP monitoring program. In 2006, he was assessed by the NCPHP, which has no reservations about his ability to practice safely.

Action: 6/14/2007. Consent Order executed: Dr Moclock is issued a North Carolina medical license; his license is suspended indefinitely, suspension is stayed on terms and conditions, he is placed on probation for three years; he shall abide by the terms of the Pennsylvania Consent Order and shall enter a five-year contract with the NCPHP and abide by its terms; he shall submit to drug/alcohol screenings as requested by the Board; unless lawfully prescribed by another person, he shall refrain from the use of all mind- or mood-altering substances, controlled substances, and alcohol; must comply with other conditions, must comply with other conditions.

MORTER, Gregory Alan, MD

Location: Wilmington, NC (New Hanover Co) | DOB: 12/03/1959
 License #: 0000-36401 | Specialty: PD (as reported by physician)
 Medical Ed: University of Pittsburgh (1986)
 Cause: Dr Morter has a history of substance abuse. In 2005, he entered a Consent Order with the Board requiring he report to the Board and the NCPHP any prescription he might receive for mind- or mood-altering substances, but he did not notify the Board or the NCPHP when a hydrocodone-containing cough syrup was prescribed by his physician. He did not disclose his use of this prescription when asked about drug use recently and when a routine drug screen was done.

In February 2007, he admitted to a Board investigator that he abused hydrocodone after a difficult court date involving a domestic situation. He surrendered his medical license in April 2007.

Action: 7/17/2007. Consent Order executed: Dr Morter's North Carolina medical license is suspended indefinitely.

NG, Chun-Ho Patrick, MD

Location: Kannapolis, NC (Cabarrus Co) | DOB: 4/06/1959
 License #: 0000-32813 | Specialty: FP (as reported by physician)
 Medical Ed: Medical College of Georgia (1985)
 Cause: Expert review of five patient charts revealed Dr Ng's documentation of care and ongoing treatment and management of medications was below the standard of care. The expert indicated this failing was in part a symptom of Dr Ng's reliance on electronic recordkeeping. The expert also concluded Dr Ng's failure to use pain contracts in treatment of chronic

pain patients was below the standard of care. Kannapolis police charged him with unlawfully dispensing a controlled substance without finding a medical reason. The Board summarily suspended his medical license on 2/22/2007. Many of his colleagues have written the Board attesting to his competence and professionalism.

Action: 7/20/2007. Consent Order executed: Dr Ng's medical license is suspended for five months, running retroactively from 2/22/2007; at the end of the five months, he may return to practice under probationary terms related to record-keeping and proper prescribing; must comply with other conditions.

PUSEY, Tanya Terese, Nurse Practitioner

Location: Huntersville, NC (Mecklenburg Co) | DOB: 4/27/1970
 Approval #: 0002-01713
 NP Education: Clemson University (2002)
 Cause: Ms Pusey worked for Dr Joseph Jemsek between 2003 and 2005. The Board asked her for a copy of her collaborative practice agreement with Dr Jemsek in July 2006. She provided what she termed a protocol agreement because collaborative agreements were not in place at the time of her employment. The "protocol" was not properly signed or dated by Ms Pusey or Dr Jemsek and did not comply with the spirit and letter of the law at that time.

Action: 5/21/2007. Consent Order executed: Ms Pusey is reprimanded.

REYNOLDS, Robert Jack, MD

Location: Knoxville, TN | DOB: 12/09/1953
 License #: 0000-27968 | Specialty: AM/IM (as reported by physician)

Medical Ed: University of Tennessee (1980)
 Cause: In April 2005, Dr Reynolds pled guilty to DUI in Colorado and the next year he pled guilty to DUI in Buncombe County, NC. Following these convictions, he entered a contract with the NCPHP. In March 2006, Dr Reynolds tested positive for alcohol, having failed to call the NCPHP to check on the need for urine screens earlier as required. He says his failure to call the NCPHP was an oversight. Dr Reynolds has not practiced clinical medicine since 2000. He admits that when abusing alcohol he is unable to practice appropriately.

Action: 6/05/2007. Consent Order executed: Dr Reynolds' North Carolina medical license is suspended for four months; suspension is stayed on terms and conditions; he shall maintain and abide by his NCPHP contract; he shall submit to drug/alcohol screenings as requested by the Board; he shall provide a copy of this Consent Order to all current and prospective employers; unless lawfully prescribed by another person, he shall refrain from the use or possession of all mind- or mood-altering substances and controlled substances; must comply with other conditions.

ROESKE, Christie Furr, Nurse Practitioner

Location: Belmont, NC (Gaston Co) | DOB: 9/28/1971
 Approval #: 0002-01176
 NA Education: NA
 Cause: Ms Roeske was employed by the Jemsek Clinic and was supervised by Dr Joseph G. Jemsek from 2002 to 2007. In July 2006, she was asked to provide the Board a copy of her Collaborative Practice Agreement with Dr Jemsek. She provided a document that noted it was created in October 2005. It was neither signed nor dated. Another nurse practitioner at the clinic indicated no such document existed in 2004 when she began work. The Board found that documents that did exist did not meet the requirements of the rules and regulations.

Action: 5/23/2007. Consent Order executed: Ms Roeske is reprimanded.

SKELTON, Henry Grady, III, MD

Location: Tucker, GA | DOB: 6/09/1951
 License #: 2004-00265 | Specialty: PTH/DMPD (as reported by physician)
 Medical Ed: Medical College of Georgia (1979)
 Cause: In September 2006, the Georgia Board reinstated Dr Skelton's Georgia license, issuing a fine and a reprimand as a result of his practicing without a valid license because he failed to renew his license on the appropriate date.
 Action: 5/17/2007. Consent Order executed: Dr Skelton is reprimanded.

SMILEY, Margaret Lynn, MD

Location: Durham, NC (Durham Co) | DOB: 7/11/1952
 License #: 0000-28347 | Specialty: ID/IM (as reported by physician)
 Medical Ed: Duke University School of Medicine (1978)
 Cause: Dr Smiley has not practiced clinical medicine since 1988 and her position with a pharmaceutical company does not involve clinical practice. She has had an inactive license and now applies for a limited administrative license.
 Action: 7/13/2007. Non-Disciplinary Consent Order executed: Dr Smiley is granted a limited administrative license that requires she not practice clinical medicine in North Carolina.

SMITH, Kathleen Jeanne, MD

Location: Tucker, GA | DOB: 3/06/1951
 License #: 2004-00601 | Specialty: D/DMP (as reported by physician)
 Medical Ed: University of Iowa College of Medicine (1975)
 Cause: Dr Smith's Georgia license was reinstated in 2006 via a Consent Order. She was fined and reprimanded for practicing without a license because she failed to renew her license on the appropriate date.
 Action: 5/22/2007. Consent Order executed: Dr Smith is reprimanded.

STEINER, Drew John, MD

Location: Elkin, NC (Surry Co) | DOB: 12/03/1962
 License #: 0099-01479 | Specialty: FP/EM (as reported by physician)
 Medical Ed: Georgetown University (1989)
 Cause: Dr Steiner has an alcohol abuse problem. He surrendered his medical license in January 2007 and entered an inpatient treatment program, which he completed successfully in May 2007. He has a five-year contract with the NCPHP. There is no evidence his care of patients was ever compromised by his use of alcohol.
 Action: 7/30/2007. Consent Order executed: Dr Steiner's medical license is indefinitely suspended as of 1/10/ 2007; must comply with certain conditions.

WALDMAN, Richard Alan, MD

Location: Whiteville, NC (Columbus Co) | DOB: 4/07/1942
 License #: 0000-39134 | Specialty: PD (as reported by physician)
 Medical Ed: New York University (1968)
 Cause: A review of the medical records of seven of Dr Waldman's patients showed he failed to maintain coherent and accurate records. He also failed to meet the Board's CME requirement for the three-year period 2002-2004.
 Action: 6/05/2007. Consent Order executed: Dr Waldman is reprimanded; he shall comply with the Board's Position Statement on Medical Record Documentation; he shall attend and satisfactorily complete an intensive course on record keeping; he shall complete 20 hours of Category I CME within one year; must comply with other requirements.

WEED, Barry Christopher, MD

Location: Raleigh, NC (Wake Co) | DOB: 7/06/1969
 License #: 2002-00625 | Specialty: P (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1998)
 Cause: Dr Weed has a history of alcohol and substance abuse. As a result, he entered a contract with the NCPHP after graduation from medical school. Although the Board received favorable reports from the NCPHP regarding Dr Weed, he began to think he could drink safely in moderation. In 2005, he had a single-vehicle accident and was charged with

DUI. He disclosed this incident to the Board, but a criminal record check revealed certain misdemeanor convictions he did not disclose on his application for a license in 2002. He believed those incidents, happening when he was a teenager, did not have to be noted. In June 2006, he entered inpatient treatment for his substance abuse, which he successfully completed. He voluntarily surrendered his North Carolina medical license in November 2006. He has now applied for reinstatement.

Action: 6/08/2007. Consent Order executed: Dr Weed's license is reinstated subject to conditions and said license will expire on the date shown on the license [12/08/2007]; he shall maintain and abide by his NCPHP contract; he shall submit to drug/alcohol screenings as requested by the Board; he shall provide a copy of this Consent Order to all current and prospective employers; unless lawfully prescribed by another person, he shall refrain from the use or possession of all mind- or mood-altering substances and controlled substances; must comply with other conditions.

WILLIAMS, Jason Anthony, Physician Assistant

Location: Wake Forest, NC (Wake Co) | DOB: 3/11/1974
 License #: 0001-02539
 PA Education: Methodist College (1998)
 Cause: The Board found Mr Williams had prescribed controlled substances to a patient his supervising physician had discharged and to another his supervising physician had directed was to get no narcotics. It also found he did not, on one occasion, have a statement of supervisory arrangement and, on one occasion, practiced before submitting his Notice of Intent to Practice. He promptly corrected the deficiencies in his compliance when these were called to his attention.
 Action: 5/18/2007. Consent Order executed: Mr Williams is reprimanded.

YOUNG, Jordon Terrell, MD

Location: Winterville, NC (Pitt Co) | DOB: 3/06/1972
 License #: 2007-01009 | Specialty: IM (as reported by physician)
 Medical Ed: Medical University of the Americas, Nevis, West Indies (2003)
 Cause: On application for a license. Dr Young has a history of alcohol and drug use. He did not include convictions for possession of controlled substances and probation violation on his application because he believed it was not necessary since he received a pardon for the offenses from the Governor of Florida. He is under contract with the NCPHP and has undergone residential inpatient treatment. He is in compliance with his NCPHP contract.
 Action: 6/15/2007. Consent Order executed: Dr Young is issued a license to expire on the date shown on the license [12/15/2007]; he is reprimanded; he shall maintain and abide by his NCPHP contract; he shall submit to drug/alcohol screenings as requested by the Board; unless lawfully prescribed by another person, he shall refrain from the use of all mind- or mood-altering substances, controlled substances, and alcohol; the Board endorses issuance of DEA prescribing privileges to him; he must comply with other conditions.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

BOWMAN, James Thomas, MD

Location: North Wilkesboro, NC (Wilkes Co) | DOB: 11/16/1951
 License #: 0000-21742 | Specialty: FP (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1977)

Cause: Dr Bowman's application is denied on the basis of his past history with the Board, his criminal history, and his probation violation in 2003.

Action: 6/04/2007. Letter issued denying Dr Bowman's application for reinstatement of his North Carolina medical license. [Hearing is scheduled on this action for 8/15/2007.]

VINCENT, Robert Allen, MD

Location: Fitchburg, WI | DOB: 5/15/1944

License #: NA | Specialty: R (as reported by physician)

Medical Ed: University of Wisconsin Medical School (1970)

Cause: An appeal of the Board's earlier decision to deny a license to Dr Vincent. The Board found the Boards of California, North Dakota, and Wisconsin had all taken action against Dr Vincent's license.

Action: 6/07/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 4/18/2007: Denial of Dr Vincent's application for a North Carolina medical license was proper and shall remain in effect.

SURRENDERS

AUGUSTINE, Santhosh, MD

Location: Lumberton, NC (Robeson Co) | DOB: 5/30/1960

License #: 0096-00445 | Specialty: NA

Medical Ed: Trivandrum Medical College, India (1985)

Action: 7/24/2007. Voluntary surrender of North Carolina medical license.

BLISS, Laura Katherine, MD

Location: Mebane, NC (Alamance Co) | DOB: 4/25/1958

License #: 0095-00018 | Specialty: FP (as reported by physician)

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

Action: 6/01/2007. Voluntary surrender of North Carolina medical license.

COLLINS, Paul Dwayne, MD

Location: Pembroke, NC (Robeson Co) | DOB: 2/08/1973

License #: 2005-00139 | Specialty: FP (as reported by physician)

Medical Ed: Wake Forest University School of Medicine (2001)

Action: 7/13/2007. Voluntary surrender of North Carolina medical license.

McGHEE, James Ernest, MD

Location: Charlotte, NC (Mecklenburg Co) | DOB: 4/25/1953

License #: 0094-00578 | Specialty: FP (as reported by physician)

Medical Ed: Emory University (1988)

Action: 7/23/2007. Voluntary surrender of North Carolina medical license.

O'DELL, Kevin Bruce, MD

Location: Shelby, NC (Cleveland Co) | DOB: 6/04/1957

License #: 0000-39312 | Specialty: EM (as reported by physician)

Medical Ed: University of Nebraska (1983)

Action: 7/25/2007. Voluntary surrender of North Carolina medical license.

PYKE, George Albert, MD

Location: Anna Maria, FL | DOB: 9/24/1948

License #: 0096-00690 | Specialty: FP (as reported by physician)

Medical Ed: University of Miami (1975)

Action: 5/09/2007. Voluntary surrender of North Carolina medical license.

RAPPAPORT, Richard Alan, Physician Assistant

Location: Marion, NC (McDowell Co) | DOB: 4/30/1974

License #: 0001-03970

PA Education: Emory University PA Program (2003)

Action: 5/22/2007. Voluntary surrender of North Carolina PA license.

RATHBURN, Stephen Don, MD

Location: Asheville, NC (Buncombe Co) | DOB: 7/26/1958

License #: 2002-01516 | Specialty: AN (as reported by physician)

Medical Ed: Northeastern Ohio University (1982)

Action: 4/10/2007. Voluntary surrender of North Carolina medical license.

PUBLIC LETTERS OF CONCERN

BOOKER, James Judson, IV, MD

Location: Forest, VA | DOB: 11/11/1970

License #: 2002-00089 | Specialty: OB/GYN (as reported by physician)

Medical Ed: Medical College of Virginia (1998)

Cause: A Letter of Concern was issued by the Florida Board regarding Dr Booker. He was also fined and required to attend CME courses in risk management and to perform community service. The North Carolina Board is concerned that Dr Booker left a foreign body in a patient during a surgical procedure.

Action: 5/09/2007. Public Letter of Concern issued: Dr Booker is admonished and cautioned that a repetition of such an incident may lead to disciplinary proceedings.

CABELL, Kyle Lawrence, MD

Location: Greensboro, NC (Guilford Co) | DOB: 11/05/1964

License #: 0098-00482 | Specialty: NS (as reported by physician)

Medical Ed: Stanford University (1986)

Cause: The Board is concerned that Dr Cabbell performed an anterior cervical discectomy, arthrodesis and anterior instrumentation at the wrong point.

Action: 6/14/2007. Public Letter of Concern issued: Dr Cabbell is informed of the Board's concern about issues of quality of care and cautions him that a repetition of such an incident may lead to disciplinary proceedings.

ENNEVER, Peter Robert, MD

Location: Greensboro, NC (Guilford Co) | DOB: 5/19/1960

License #: 0095-00567 | Specialty: HO/IM (as reported by physician)

Medical Ed: George Washington University (1988)

Cause: The Board is concerned that Dr Ennever treated and prescribed Oxycodone to a co-worker, a person with whom he had a significant emotional relationship.

Action: 5/21/2007. Public Letter of Concern issued: Dr Ennever is admonished and cautioned that a repetition of such an incident may lead to disciplinary proceedings.

GOUDARZI, Kamran, MD

Location: Wilmington, NC (New Hanover Co) | DOB: 11/29/1953

License #: 0000-25503 | Specialty: GS/VA (as reported by physician)

Medical Ed: University of London (1978)

Cause: The Board has been notified of a payment made on Dr Goudarzi's behalf in resolution of a claim rising out of a surgery in which he removed a patient's second rib rather than the intended first rib. The Board recognizes this is a known risk of such surgery but is concerned treatment of the patient may have fallen below the standard of care.

Action: 6/14/2007. Public Letter of Concern issued: Dr Goudarzi is cautioned that a repetition of such an incident may lead to disciplinary proceedings.

HINDS, David McDonald, Physician Assistant

Location: Goldsboro, NC (Wayne Co) | DOB: 3/05/1947

License #: 0001-00200

PA Education: University of North Carolina (1977)

Cause: Mr Hinds practice three years under supervision of Dr Charles Land without first filing an intent to practice form with the Board.

Action: 7/10/2007. Public Letter of Concern issued: The Board is concerned about such an extended violation of regulations and cautions Mr Hinds that a repetition of such an incident may lead to additional disciplinary proceedings; he is ordered to take CME in professional ethics approved by the Board president.

JACKSON, George Hagan, MD

Location: Signal Mountain, TN | DOB: 9/27/1960

License #: 0094-00848 | Specialty: N (as reported by physician)

Medical Ed: University of Louisville (1992)

Cause: Dr Jackson's Virginia license was summarily suspended due to substance abuse and illness in 2006. He admitted to a long history of alcohol and substance abuse.

Action: 7/11/2007: Public Letter of Concern issued: The North Carolina Medical Board notifies Dr Jackson that to reactivate his North Carolina license he must first make application to the Board, which is under no obligation to approve and will not approve unless by means of a public consent order reflecting what occurred in Virginia. He must also first be readmitted to practice in Virginia.

NJAPA, Anthony Kechante, DO

Location: Goldsboro, NC (Wayne Co) | **DOB:** 11/14/1963

License #: 2006-00122 | **Specialty:** OB-GYN/EM (as reported by physician)

Medical Ed: New York College of Osteopathic Medicine (1992)

Cause: A complaint to the Board resulted from Dr Njapa's interaction with a patient and involved inappropriate self-disclosure about his personal life to the patient. This action was inconsistent with the role of the physician.

Action: 6/06/2007. Public Letter of Concern issued: Dr Njapa is admonished and cautioned that a repetition of such an incident may lead to disciplinary proceedings.

NOVELL, Laura Ann, MD

Location: North Canton, OH | **DOB:** 5/20/1963

License #: 2005-01765 | **Specialty:** R (as reported by physician)

Medical Ed: St Louis University School of Medicine (1997)

Cause: Based on information in a malpractice claim paid on her behalf and on the corresponding medical record and explanation by Dr Novell, the Board is concerned her interpretation of a spinal x-ray was erroneous.

Action: 6/05/2007. Public Letter of Concern issued: Dr Novell is admonished and cautioned that a repetition of such an incident may lead to disciplinary proceedings.

ROLLER, Jeffrey Earl, MD

Location: Morganton, NC (Burke Co) | **DOB:** 4/08/1962

License #: 0000-38682 | **Specialty:** EM (as reported by physician)

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

Cause: The Board is concerned that Dr Roller failed to perform an appropriate evaluation of an elderly patient who presented with head and other injuries resulting from a motorcycle accident.

Action: 6/06/2007. Public Letter of Concern issued: Dr Roller is admonished and cautioned that a repetition of such an incident may lead to disciplinary proceedings.

ROSS, David Bruce, MD

Location: High Point NC (Guilford Co) | **DOB:** 4/18/1954

License #: 0000-30468 | **Specialty:** OS (as reported by physician)

Medical Ed: Vanderbilt University (1980)

Cause: Dr Ross provided medical treatment to a co-worker. Under conditions not in accord with the Board's guidelines, he aspirated and injected the knee of a female co-worker with whom he had a significant emotional relationship.

Action: 6/29/2007. Public Letter of Concern issued: Dr Ross is admonished and cautioned that a repetition of such an incident may lead to disciplinary proceedings.

ROWE, Kristina Dezielle, MD

Location: Pollocksville, NC (Craven Co) | **DOB:** 5/10/1956

License #: 2001-01438 | **Specialty:** IM (as reported by physician)

Medical Ed: University of Connecticut (1987)

Cause: The Board is concerned that Dr Rowe issued prescriptions to herself and family members. It also believes issuing prescriptions without documented examination and history is dangerous.

Action: 5/25/2007. Public Letter of Concern issued: Dr Rowe is admonished and cautioned that a repetition of such an incident may lead to disciplinary proceedings.

STAUBER, Marshall Ephraim, MD

Location: Hollywood, FL | **DOB:** 6/28/1960

License #: 2007-00848 | **Specialty:** OSS (as reported by physician)

Medical Ed: University of South Florida College of Medicine (1986)

Cause: A Letter of Concern was issued by the Florida Board regarding Dr Stauber. He was fined, required to attend CME courses on risk management, to perform community service, and present a lecture on wrong site surgery. The North Carolina Board is concerned Dr Stauber's treatment of the subject patient was below the standard of care based on his performance of surgery at the wrong site.

Action: 5/22/2007. Public Letter of Concern issued: Dr Stauber is admonished and cautioned that a repetition of such an incident may lead to disciplinary proceedings.

WACHOWIAK, Wilma Lynne, Nurse Practitioner

Location: Charlotte, NC (Mecklenburg Co) | **DOB:** 1/24/1944

Approval #: 0002-00144

NP Education: MAHEC (1977)

Cause: The Board is concerned that Ms Wachowiak prescribed outside the scope of her collaborative practice agreement by prescribing for two persons who were not patients of the clinic where she worked. She also failed to document the prescriptions and did not inform her supervising physician of her actions.

Action: 6/06/2007. Public Letter of Concern issued: Ms Wachowiak is admonished and cautioned that a repetition of such an incident may lead to disciplinary proceedings.

CONSENT ORDERS LIFTED

ANDERSON, Joseph Robert, MD

Location: Asheville, NC (Buncombe Co) | **DOB:** 10/12/1965

License #: 0095-00807 | **Specialty:** FP (as reported by physician)

Medical Ed: Bowman Gray School of Medicine (1991)

Action: 6/19/2007. Order issued lifting Consent Order of 6/15/2005.

CROSS, Harry Giles, Jr, Physician Assistant

Location: Southern Pines, NC (Moore Co) | **DOB:** 3/11/1960

License #: 0001-01139

PA Education: Wake Forest University PA Program (1989)

Action: 5/10/2007. Order issued lifting Consent Order of 6/17/2004.

DeVIRGILIIS, Juan Carlos, MD

Location: Boone, NC (Watauga Co) | **DOB:** 8/29/1957

License #: 0000-28719 | **Specialty:** FP-Ger/P (as reported by physician)

Medical Ed: Faculty of Med Sciences, National U of La Plata (1982)

Action: 6/14/2007. Order issued lifting Consent Order of 1/13/2005.

KINNALLY, Steven Joseph, Physician Assistant

Location: Wilmington, NC (New Hanover Co) | **DOB:** 11/11/1952

License #: 0010-00347

PA Education: University of Washington MEDEX NW PA Program (2001)

Action: 6/18/2007. Order issued lifting Consent Order of 11/30/2005.

MUNCHING, Aaron Albert, Physician Assistant

Location: Durham, NC (Durham Co) | **DOB:** 1/10/1961

License #: 0010-00016

PA Education: Alderson-Broadus (1990)

Action: 6/18/2007. Order issued lifting Consent Order of 3/10/2005.

SPEROS, Thomas Lee, MD

Location: Asheville, NC (Buncombe Co) | **DOB:** 10/26/1949

License #: 0000-20967 | **Specialty:** FP (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1976)

Action: 6/19/2007. Order issued lifting Consent Order of 8/31/2005.

**TEMPORARY/DATED LICENSES: ISSUED,
EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES**

BARBER, Robert Anthony, DO

Location: Morehead City, NC (Carteret Co) | DOB: 9/30/1954
License #: 2003-00222 | Specialty: FP (as reported by physician)
Medical Ed: University of Health Sciences Coll of Osteopathic Med, Kansas City (1989)
Action: 5/31/2007. Temporary/dated license extended to expire 11/30/2007.

CRUMP, Carolyn Faydene, MD

Location: Lexington, NC (Davidson Co) | DOB: 1/27/1950
License #: 2005-01115 | Specialty: GP (as reported by physician)
Medical Ed: George Washington University (1976)
Action: 7/19/2007. Temporary/dated license issued to expire 7/31/2008.

DeVIRGILIIS, Juan Carlos, MD

Location: Boone, NC (Watauga Co) | DOB: 8/29/1957
License #: 0000-28719 | Specialty: FP-Gen/P (as reported by physician)
Medical Ed: Faculty of Med Sciences, National U of La Plata (1982)
Action: 6/14/2007. Full and unrestricted license issued.

GARDNER, James Eric, MD

Location: Collierville, TN | DOB: 9/18/1970
License #: 2002-00116 | Specialty: VS/GS (as reported by physician)
Medical Ed: University of Tennessee (1996)
Action: 5/17/2007. Temporary/dated license extended to expire 5/31/2008.

HARDY, Stephen Carl, MD

Location: Waxhaw, NC (Mecklenburg Co) | DOB: 7/11/1957
License #: 0000-35911 | Specialty: NA
Medical Ed: University of Virginia (1985)
Action: 5/17/2007. Full and unrestricted license issued.

KINNALLY, Steven Joseph, Physician Assistant

Location: Wilmington, NC (New Hanover Co) | DOB: 11/11/1952
License #: 0010-00347
PA Education: University of Washington MEDEX NW PA Program (2001)
Action: 6/18/2007. Full and unrestricted license issued.

KPEGLO, Maurice Kobla, MD

Location: Greensboro, NC (Guilford Co) | DOB: 1/04/1949
License #: 0000-29314 | Specialty: GP/PD (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1983)
Action: 7/19/2007. Temporary/dated license issued to expire 1/31/2008

MUNCHING, Aaron Albert, Physician Assistant

Location: Durham, NC (Durham Co) | DOB: 1/10/1961
License #: 0010-00016
PA Education: Alderson-Broadbudds (1990)
Action: 6/18/2007. Full and unrestricted license issued.

ROBINSON, Lindwood Allen, MD

Location: Raleigh, NC (Wake Co) | DOB: 7/08/1971
License #: 2001-01126 | Specialty: EM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1997)
Action: 7/19/2007. Temporary/dated license issued to expire 1/31/2008.

ROGERS, Bruce William, MD

Location: Greensboro, NC (Guilford Co) | DOB: 8/11/1947
License #: 0000-32563 | Specialty: FP/EM (as reported by physician)
Medical Ed: Medical College of Pennsylvania (1982)
Action: 5/17/2007. Temporary/dated license extended to expire 11/30/2007.

SMITH, David Lewis, Physician Assistant

Location: Raleigh, NC (Wake Co) | DOB: 9/19/1951
License #: 0001-01503
PA Education: Alderson Broadbudds College (1992)
Action: 7/19/2007. Full and unrestricted PA license issued.

WHITE, Steven William, Physician Assistant

Location: Fayetteville, NC (Cumberland Co) | DOB: 12/19/1962

License #: 0001-02116
PA Education: Midwestern University (1996)
Action: 7/19/2007. Full and unrestricted PA license issued.

See Consent Orders:

**COLLINS, Paul Dwayne, MD
HUMBLE, Scott David, MD
WEED, Barry Christopher, MD
YOUNG, Jordon Terrell, MD**

DISMISSALS

NONE

REENTRY AGREEMENTS

BREITER, Katherine Lay, MD

Location: Morganton, NC (Burke Co) | DOB: 12/01/1966
License #: 2007-00776 | Specialty: P (as reported by physician)
Medical Ed: Medical University of South Carolina (1994)
Cause: Dr Breiter has not practiced clinical medicine since 2004.
Action: 5/16/2007. Reentry Agreement executed: Dr Breiter is issued a North Carolina medical license; her practice shall be observed by a physician colleague for six months; the observer must report to the Board following the observation period concerning Dr Breiter's skills.

CONNOR-RIDDICK, Tracy Nickol, Physician Assistant

Location: Charlotte, NC (Mecklenburg Co) | DOB: 6/14/1974
License #: 0001-02920
PA Education: Wake Forest University School of Medicine (1999)
Cause: Ms Connor-Riddick has not practiced as a PA since 2000, although she has continued to work in the medical field.
Action: 6/19/2007. Reentry Agreement executed: Ms Connor-Riddick is issued a PA license; she shall have her supervising physician observe her practice for one year and report on her skills to the Board on a quarterly basis; she shall inform the Director of Compliance when she begins work as a PA; she shall meet with the Board as requested.

GIRARD, Christina Marie, DO

Location: Rohnert Park, CA | DOB: 1/03/1966
License #: 0099-00229 | Specialty: GP (as reported by physician)
Medical Ed: Midwestern University, Downers Grove, IL (1997)
Cause: Dr Girard has not practiced clinical medicine since May 2003.
Action: 6/13/2007. Reentry Agreement executed: Dr Girard is issued a North Carolina medical license; her practice shall be observed by a colleague for four months; the observer must report to the Board following the observation period concerning Dr Girard's skills.

HAISLIP-RAMBO, Carole Lynn, Physician Assistant

Location: Mount Airy, NC (Surry Co) | DOB: 7/29/1948
License #: 0010-00895
PA Education: Emory University (1989)
Cause: Ms Haislip-Rambo has not practiced as a PA since 2005.
Action: 5/01/2007. Reentry Agreement executed: Ms Haislip-Rambo is issued a PA license; she shall have her supervising physician observe her practice for six months and report on her skills to the Board within 30 days after the six-month period; she shall meet with the Board as requested.

A change of address form is now available on the Board's Web site at www.ncmedboard.org.

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.

Compliance Reviews for Nurse Practitioners and Physician Assistants in North Carolina

Beginning January 1, 2008, the North Carolina Board of Nursing and the North Carolina Medical Board will begin a standardized approach to nurse practitioner and physician assistant Compliance Reviews. The purpose of the Compliance Reviews is to ensure that the physician assistant (PA) or nurse practitioner (NP) is complying with the Board's rules and regulations. As stated in both the PA and NP rules, certain information and records shall be maintained and made available to representatives from either Board upon request. Compliance Reviews will provide the opportunity for the state's PAs and NPs to refamiliarize themselves with the Board's rules and regulations governing their practice.

This means that NPs and PAs will be chosen at random for a review of their practice arrangements to assure they are in compliance with the laws and administrative rules governing NPs and PAs. These reviews will be conducted by mail or by site visits by the Medical Board, the Board of Nursing, or both agencies. For site visits, at least a twenty-four (24) hour notice will be given before the PA or NP is visited by a Board staff member, and every effort will be made to accommodate the schedule of the PA or NP.

The standardized review form that the staff from both Boards will be using to conduct the Compliance Reviews is available on each Board's Web site at www.ncbon.com or www.ncmedboard.org for your review.

Supervising physicians may choose to attend the on-site reviews and will be provided a copy of the results of the Compliance Review. Supervising physicians will also be expected to participate in meeting any physician-related deficiencies that may be noted in the review process.

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: November 14-16, 2007; December 14, 2007; January 16-18, 2008; February 20-21, 2008; March 26-28, 2008

Residents Please Note USMLE Information

United States Medical Licensing Examination

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at www.fsmb.org.

Special Purpose Examination (SPEX)

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

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