Primum Non Nocere

No. 3 1998

forum

NC MEDICAL BOARD

President's Message

Charles E. Trado, MD

Phone Home!

E.T. couldn't, but you can. And at no charge, to boot!

Recent decisions of the North Carolina Medical Board, both budgetary and administrative, have made it possible to offer the public, physicians, applicants, and other interested parties in North Carolina the use of an 800 number for telephone calls to the Board. We have reason to believe that offering this service can be accomplished without overloading our switchboard or causing budget problems for the Board. Time will tell, of course.

We offer this service to the public and physicians in an honest effort to facilitate the licensing, complaint, and credentialing processes that are essential to the Board's work. Our telephone system has been upgraded several times over the past five years I have served on the Board and each time we hoped that we were improving our ability to communicate with our constituency. The offering of an 800 number is the best improvement we have made to date.

So please take advantage of our 800 number. We trust that in some way this might not only encourage communication with us but also help us carry out the mission of the Board more effectively and efficiently. Above all, we hope it will help us serve and protect the public better.

The new 800 number is: (800) 253-9653.

A Parting Word

Since this is my last message as president of the Board, I would like to take this opportunity to thank the staff of the Board and my colleagues on the Board for making this year an enjoyable experience. The responsibility has been nearly overwhelming at times and, at those times, each of you has been there to offer encouragement, expertise, and support. I thank you with all my heart.

The changes taking place in the practice of medicine and in the systems by which we receive medical care in this country are

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In This Issue of the FORUM

From the Executive Director

Andrew W. Watry

A Regulatory Perspective on Alternative Medicine

A recent *Los Angeles Times* article, one of a four part series, labels alternative medicine "The 18 Billion Dollar Experiment." The authors, Monmaney and Roan, write: "Although it is gaining fast in popularity, alternative medicine is still very much an experiment — one that huge numbers of Americans are conducting with themselves as the guinea pigs." We have in this country what is generally regarded as one of the best health care systems in the world, yet there is a strong market for alternative medicine and this market is increasing each year.

Edging into the Mainstream

According to the *Los Angeles Times* report, the alternative medicine industry is no longer a counter culture; it is edging into the mainstream. There is no doubt that at least part of the demand for alternative medicine results from a certain level of consumer dissatisfaction with so-called "traditional" scientific medicine, and those of us who provide administrative support for medical licensing boards need to take a hard look at this growing consumer demand. Like a business, we need to understand what is happening in the health care marketplace in order to do a better job of recommending improved public protection mechanisms to our licensing boards.

The following are some markers indicative of the shift in consumer interest, again published in the above mentioned *Los Angeles*

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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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Phone Home

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legion. Physicians struggle to adapt their practices to this changing environment while trying to keep pace with the most recent medical advances. Patients worry about their coverage, whether or not they can choose their physician, and whether or not they will receive optimum care for their illnesses. In this environment, the work of the Board becomes ever more important to the public and the profession.

In doing its work, the Board makes every effort to be fair to both patients and physicians alike. But more importantly, it is dedicated to safeguarding the public and enhancing, where permitted, the quality of medicine offered to the citizens of our state. May it always be so.

Thank you for allowing me to serve as your president. It has been an honor and a privilege I shall always cherish. ♦

1-800-253-9653

Regulatory Perspective

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Times article:

- herbal supplement sales in the U.S.: 2.09 billion in 1994 – 3.65 billion in 1997;
- number of homeopaths: 200 in 1970 – 3,000 in 1998;
- massage schools: 15 in 1969 – 800 in 1998;
- drugstore shelve space per store for vitamin, mineral and herbal supplements at Rite Aide Pharmacies: 8 feet in 1995 – 22 feet in 1998.

Use of over the counter herbal remedies further demonstrates this trend. In a 1997 mail survey of more than 29,000 U.S. households for the market research firm Hartman & New Hope, of Bellevue, Washington, these were the most commonly used herbal supplements:

Herb	% of U.S. Households
garlic	11%
ginseng	10%
ginkgo biloba	9%
echinacea	7%
St. John's wort	5%

These people are showing up in offices of licensed physicians as well. A cautionary note was sounded by B. Clair Eliason, MD, associate professor of family and community medicine at the Medical College of Wisconsin, in a recent issue of *American Medical News*: "Doctors need to be open-minded, but it's important to be skeptical because people are making a lot of money [selling herbal supplements] and patients aren't always benefiting."

Also, there are physicians suggesting that licensed physicians should learn more about alternative approaches to better help and advise patients who are seeking these treatments. A recent anecdote from a North Carolina physician brings this point home. She was treating a patient who had been to another physician for severe menorrhagia. The other physician had been unable to resolve a problem with elevated blood pressure, but when asking the patient about other medications, he didn't ask about herbs. It turns out the patient was taking ginseng and there are studies linking this herb to elevated blood pressure. So a sensitivity to alternative therapies by another physician helped resolve the problem. Also, the physician who started asking patients about alternative therapies was pleased to observe how patients opened up to her and sought her advice.

An Important Message

This burgeoning market presents a regulatory dilemma for medical boards. The challenge is to strike a balance, providing public protection from quackery while not interfering with alternative medical practices that benefit and serve consumers. The North Carolina Medical Board is meeting this challenge through a special Alternative Medicine Committee appointed by its president, Charles E. Trado, MD. The committee is pouring through considerable research material to help the Board make informed decisions on the complaints and concerns that will inevitably accompany the widening use of alternative medicine.

The purpose of this article is not to speak to what works and what doesn't work in this rapidly growing field. The jury is still out and there is a paucity of scientific study concerning many of these therapies, which is why, in most cases, they are labeled "alternative." The purpose of this article is to recognize the emerging role of alternative medicine, to look at factors that might precipitate increased consumer interest, and to suggest, from a regulatory perspective, what many medical consumers may be saying

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through their choices of health care to those who practice scientific medicine. Their message is also important to those of us involved in medical licensure.

The Burden of Proof

The people of this state, as represented in the General Assembly, have said they want a relatively open marketplace for alternative medicine. There is language in the North Carolina General Statutes (NCGS 90-14(a)(6)) that provides something of a safe harbor for licensed physicians practicing alternative medicine: "The Board shall not revoke the license of or deny a license to a person solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by competent evidence, the Board can establish that the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective." This puts a difficult burden on the Board in addressing complaints where a medical practice may involve a so-called "alternative therapy."

In order for the Board to resolve a complaint about practice below minimum standards, it would have the burden of proof to establish a safety risk that is greater than the prevailing treatment or that the therapy is not effective. The problem with alternative therapies is that, unlike more conventional treatments where there are double blind studies about efficacy printed in journals such as the *New England Journal of Medicine* and the *Journal of the American Medical Association*, few such scientific data exist about them. The Board is receiving increasing numbers of complaints about alternative therapies as that market expands.

The Paradox

It is paradoxical that as medicine becomes more and more sophisticated there seems to be a tendency to return to earlier health care practices, such as homeopathy, naturopathy, reflexology, and other alternative systems. When individuals are asked what drives them away from scientific health care, they almost universally report a frustration with scientific practitioners and the high cost of modern health care. Fee issues are difficult to prosecute unless there is flagrant exploitation or fraud. However, the medical boards are the focal point of consumer complaints about traditional health care rendered by physicians.

A look at the complaint and investigation activities of medical licensing boards will yield some important clues on this market shift. After many years in the field of medical licensing and regulation, my observations have led me to several conclusions, which I summarize in what follows.

1. Improving Communication

The largest number of complaints submitted to the Board, and, paradoxically, the complaints we are least capable of resolving, are those involving poor communication between physicians and patients. Many physicians can go through an entire career and not generate so much as one complaint to a medical board. Other physicians, equally competent, generate complaints monthly. This has a lot to do with interpersonal communication skills. Although this observation is anecdotal, it comes from looking at 500 to 600 complaints a year over many years. The specialty of obstetrics is high risk; insurance premiums reflect this. Yet, plenty of obstetricians make it through their entire careers without ever being sued. Their practices are not free of bad outcomes but they seem to have good rapport with their patients.

Risk managers suggest that people skills may have more to do with tort exposure than bad outcomes. Physicians who are short or abrupt with patients are sure to generate a stream of complaints to the Board. This leads to the issue of what drives some people to alternative practitioners. Find a patient who goes to an herbalist and you will probably find that patient has a horror story about a much exaggerated and failed doctor-patient relationship. It is a recurring theme in complaints before the Board, where we hear from people who are not only unhappy with outcome but are quite angry with their health care practitioner. These patients are prime candidates for alternative therapists.

2. Educating Consumers

Patients who believe in iridology (the study of the iris of the eye to diagnose health and disease) pay good money to have an eye examined for gallbladder disease. You might think the average high school or college anatomy course would give one pause in accepting this approach, but numbers of people seek this kind of health care. To the extent it is practical, I think medical providers at every level should generously supply patients with readable, easily understood health care information, such as pamphlets, references to further reading, journal articles, and other material, to help them understand modern scientific medicine.

3. Applying Basic Business Principles

We need to analyze the medical marketplace and determine what is driving the shift in the preferences of some consumers. What is it about alternative practitioners that patients find appealing? It might include: (1) less time spent sitting in the waiting room; (2) more personal contact with the practitioner; (3) a caring and compassionate attitude; (4) lower fees for routine services; (5) more community involvement of the practitioner; (6) good business practices, such as routine patient contact and follow-up outside the office; (7) friendly staff; and (8) good accessibility, including availability one or two nights a week after hours to accommodate people on different work schedules.

4. Spreading the Good Word

The good and positive things in medicine need to be brought to the public's attention. We need to work particularly on the perception that physicians are part of a closed club, more interested in shielding substandard medical practice than in doing the right thing. Many patients aren't aware of the quality assurance, peer review, and credentialing activities that go on in hospitals, medical associations, and other health care organizations. Nor are they aware of the work of the medical boards. This publication, the *Forum*, is but one example of an effort to help consumers appreciate what is going on in medicine to protect them.

Although it is uncomfortable for some physicians, publishing the names of disciplined physicians and the actions taken against them by the Board helps increase public confidence in medicine. It may also help obviate the need for more radical legislation, such as national licensure, or dissemination of less useful and perhaps harmful information, such as the number of complaints filed against a physician. We have seen situations where angry patients can abuse the system by loading up a practitioner's file with a number of complaints about the same thing. In my opinion, the disadvantages of making this information public, from a regulatory perspective, outweigh the advantages.

By increasing public awareness of all the mechanisms available to minimize substandard medical care or other breaches of trust by physicians, patients may feel more comfortable and will recognize they do have recourse. This, in turn, can inspire a more positive view of scientific medicine.

To the physicians reading this article: if you involve yourself more actively in peer

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review, and if you report significant violations to the Medical Board, you will help counter the impression that physicians tolerate substandard care at the expense of patients.

5. Avoiding Impropriety

It goes without saying that physicians need to take special care to avoid any appearance of impropriety. At the federal level, the Stark legislation (regarding self-referral) is one example of a response to a public perception that physicians, more than other professionals, need to be barred from engaging in business activities that appear to be a conflict of interest. Incestuous business practices by physicians are making a regular circuit on network news programs, and all physicians tend to be painted with the same broad stroke as being greedy. Physicians who are abusing Medicaid or Medicare, or some third party insurance carrier, are contributing to this public perception. So even though there may be a tendency to dismiss these kinds of violations as less significant than those that actually cause patient harm, they need to be taken seriously.

6. Becoming a Physician Resource About Alternative Care

Many physicians who are experts on alternative medicine suggest physicians learn more about alternative practices so they can be more responsive to their patients who have questions about those practices. Also, talking to patients and responding to questions about alternative therapies could help improve patient outcomes. In a recent *JAMA* article, Wetzel, et al, established that 64% of U.S. medical schools offer course work in alternative medicine.

Identifying Abuses

Alternative medicine does not equate with patient abuse. It simply presents more fertile ground for abuses because, in general, there is little or no science supporting many alternative medical practices. The FDA doesn't check to see what is in a bottle of St. Johns wort and no one is checking on labeling of this herb. A recent study, published in the *Los Angeles Times*, identified one St. Johns wort product of the nation's number one distributor of dietary supplements as having about 20% of labeled potency. You don't find credible scientific literature to support the practice of iridology or reflexology, and you will find very little science, if any, supporting colonic therapy. Yet the market for these and other alternative medical practices is strong.

The Board has taken direction from the General Assembly and is not prosecuting any physicians for engaging in alternative medical practices *solely* because they are "alternative." Some of these practices can be dangerous to patients, however. For the Board to successfully prosecute a practitioner for exposing patients to danger by use of an alternative therapy, the Board needs credible expert testimony to establish that the therapy in question "...has a safety risk greater than the prevailing treatment or the treatment is generally not effective." When asked to do so, qualified physicians should be willing to assist the Board in assessing such matters impartially.

Conclusion

I believe the work of the state medical boards is essential to countering the potential risks involved in the practice of untested and unproven alternative therapies. By taking deliberate action to assure the qualifications, professionalism, and competence of those we license, the boards will contribute measurably to the public's confidence in modern scientific medicine, which will discourage the growing demand for unproven, unscientific remedies. While this result is not the purpose of vigorous board action, it will be a byproduct of the board's constant effort to improve one of the best health care systems in the world. ♦

New Board Officers Elected

At its meeting in July, the North Carolina Medical Board elected its officers for the year beginning November 1, 1998. Mr Paul Saperstein, of Greensboro, who is currently vice president of the Board, was chosen president. He is the first public member of the Board to be elected to that position. Wayne W. VonSeggen, PA, a physician assistant from Winston-Salem, was chosen vice president of the Board, and Elizabeth P. Kanof, MD, a physician from Raleigh, was chosen secretary-treasurer. An article concerning the Board's new officers and a message from Mr Saperstein will appear in the next number of the *Forum*.

Impaired Physician Treatment Programs: A Study

Daniel M. Avery, MD, President, American Society of Forensic Obstetricians & Gynecologists

Abstract: There are only a few treatment centers in the United States able to address the specific recovery needs of addicted health care professionals. These have significant differences in their treatment programs and costs.

Dr Avery

Chemical dependency is characterized by the compulsive use of mood altering substances, which, in addicted health care professionals, leads to impairment or the inability to practice medicine with reasonable skill and safety.[1] It is a chronic, progressive, and potentially fatal disease when untreated.

Addiction exists when the use of chemicals consequently causes increasingly severe complications in a person's life. Most addicts require professional help to arrest this disease, usually involving a number of treatment modalities and support.[2]

The Issue

Chemical dependency treatment programs of all varieties have been established throughout the United States since 1983, but there are only a few that are able to address the specific recovery needs of addicted health care professionals.[3] Treatment of the addicted physician almost always must be approved by his or her state medical licensing board and/or its impaired physician program. Most physician addicts require residential or extended care treatment, and most programs are incapable of meeting these special needs due to time limitations or an insufficient patient volume to justify staffing needs.[1]

The Study

Four large treatment centers specializing in addicted health care professionals were selected for this study. Data for analysis were acquired via voluntary patient and staff interviews, published information, personal

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correspondence, and the centers' marketing brochures and patient handbooks. The selected treatment centers are approved by all state licensing boards and impaired physician programs. Data were gathered, studied, and categorized according to administration, cost, staff, addictions treated, medical treatment plans, therapies, meetings, contracts, and discharge planning. Identification of treatment centers is alphanumeric. The accompanying table summarizes the study data according to the above categories.

Results

Cost & Staff

The administration data show that residential treatment can be very expensive. Cost for the average length of stay ranges from $15,600 to $31,000. All are approved by the JCAHO and act as advocates for their recovering physicians after treatment. Three are Twelve Step oriented and two will negotiate costs with insurance carriers.

Each treatment center's program is headed by a medical director and is staffed by addictionologists. Each uses psychiatrists, primary therapists, and family therapists. Center A has only one family therapist compared to the others' six or seven, but it is the only one with medical specialists available for consultation.

Problems Treated

Conditions usually treated in residential programs include chemical addictions, sexual addictions, eating disorders such as bulimia and anorexia nervosa, gambling addictions, and multiple diagnoses. Only treatment center A's program treats all five. Medical treatment in all centers is provided physicians, with three offering initial assessment by a physician and one by a nurse with later assessment by a physician. Histories and physical examinations are performed by staff physicians in all treatment centers except one, which uses physicians in treatment. Only treatment center A's program provides detoxification and stabilization. Brief physician hospital visits are usually monthly, except for center A, which provides visits approximately three times a week. All programs use urine drug screening from once or twice a week to as often as needed.

Therapies

Therapies consist of group therapy, professional group therapy, individual therapy, family therapy, and individual and group

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Comparison of Residential Treatment Programs for Healthcare Professionals. Therapies and Meetings in hour units unless otherwise noted.

TREATMENT CENTER	A	B	C	D
ADMINISTRATION				
JCAHO Approved	Yes	Yes	Yes	Yes
Twelve Step Oriented	Yes	Yes	Yes	No
Insurance Negotiable	Yes	No	No	Yes
Advocacy	Yes	Yes	Yes	Yes
Average Length of Stay, Weeks	10	18	16	12
Average Cost, Total	$15,750	$31,000	$15,600	$17,000
Weekly	1,575	1,720	970	1,471
Daily	225	328	195	294
PROFESSIONAL STAFF				
Medical Directors	1	2	1	1
Addictionologists	1	5	3	2
Psychiatrists	30	3	3	2
Psychologists	3	2	1	2
Primary Therapists	6	8	6	7
Family Therapists	1	7	6	7
Other Medical Specialists	Yes	No	No	No
Medical Consultants	Yes	No	No	No
ADDICTIONS TREATED				
Chemical	Yes	Yes	Yes	Yes
Sexual	Yes	Yes	Yes	Yes
Gambling	Yes	No	Yes	Yes
Eating Disorders (Women/Men)	Yes/Yes	Yes/Yes	Yes/No	Yes/Yes
Coexisting Psychiatric Diagnoses	Yes	Yes	No	Yes
MEDICAL TREATMENT PLANS				
Initial Physician assessment	Yes	Yes	Yes	Yes
History and Physical	Yes	Yes	Yes*	Yes
Detoxification	Yes	No	No	No
Stabilization	Yes	No	No	No
Physician Visits per month	15	1	1	1
Drug Screens per Week	1	PRN	1	PRN
THERAPY				
Group, Weekly	10	4	13	5
Professional	4	1	1	0
Individual, Monthly	4	1	4	0
Total Individual Hours per Stay	10	5	16	0
Professional Group Number	8	80	10	40
First Step, Weekly	0	9	3	0
Lecture, Weekly	5	1	0	5
Exercise, Weekly	3	5	5	2
Couples Therapy, Monthly	PRN	2	2	PRN
Occupational. Monthly	12	20	2	11
Family Weeks per Two Months	4	1	4	2
Relapse Prevention	Yes	Yes	Yes	Yes
MEETINGS				
AA/NA/CA/, Weekly	2	8	7	7
Caduceus, Weekly	1	1	1	1
Men's	No	Yes	Yes	Yes
Women's	No	Yes	Yes	Yes
House	No	Yes	Yes	Yes
CONTRACTS				
Initial	Yes	Yes	Yes	No
Orientation	Yes	No	No	Yes
Relaps	Yes	Yes	Yes	No
Discharge/Aftercare	Yes	Yes	Yes	Yes
Conjoint With Licensing Boards, PRNs	Yes	Yes	Yes	Yes
Advocacy With Licensing Boards	Yes	Yes	Yes	Yes
DISCHARGE PLANNING				
Aftercare Program	Yes	No	No	Yes
Quarterly Reports	No	Yes	No	No
Revisits	Yes	Yes	No	No
Reunions	No	Yes	No	No

*By Physician Patients

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couples therapy, as well as First Step groups, occupational therapy, lectures, relapse prevention groups, and vigorous exercise programs. Total group therapy ranges from four to thirteen hours. Treatment center A's program offers four hours of professional therapy per week while most offer only one. Center D's offers none. The number of health care professionals under treatment in each program ranges from eight to eighty. Individual counseling ranges from none to four hours per month, while family therapy ranges from twice a month to once every two months. Two programs have First Step meetings three to nine times a week, while the other two have none. All have occupational therapy, relapse prevention programs, and strenuous exercise programs. Lectures range from none to five per week.

Treatment Programs

Addiction treatment programs are by tradition Twelve Step oriented and include regular Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA) meetings. Three of the study programs require one meeting per day, while treatment center A's program only requires two meetings a week plus a weekly Caduceus meeting. All programs except center A's offer men's, women's, and combined groups. All offer different contracts during and after treatment.[4]

Discharge

Discharge planning begins on admission and only two programs offer aftercare. One collects patient-generated quarterly reports, signed and verified by the recovering physician's local physician monitor, documenting results of drug screens, Caduceus and AA attendance, and overall quality of life. The same center offers revisits and reunions while the other has monthly alumni meetings.

Summary

In summary, treatment Center A appears to offer the most the quickest for the least. The average length of stay is less and all conditions are treated. It is the only treatment center that offers medical stabilization and detoxification plus availability of all medical specialties for consultation. There is more time for group therapy, individual therapy, and family therapy, and there are more lectures. It also offers two years of monthly alumni meetings for long-term support. Center A's disadvantages are having only one family therapist on staff, requiring only two AA meetings a week, having no First Step groups, no separate groups for males and females, no quarterly reports, and no reunions.

As we said at the beginning, there are only a few treatment programs that specialize in the addictions and unusual needs of recovering health care professionals. The data are very interesting, informative, and educational. Most physicians learn very little about addiction in medical school, residency, or practice unless they themselves become addicts. While the treatment programs described above require significant time and money, treatment for health care professionals is lifesaving for physician addicts and their patients.[4]

References

1. *COPAC Residential and Extended Treatment for Chemical Dependency: Nationally Recognized for Providing Quality Extended Care Since 1979.* Brandon, Mississippi.

2. *The University of Alabama in Birmingham Professional Resource Program: A New Vision: Our Vision for the Healthcare Professional.* Birmingham: the University of Alabama in Birmingham Center for Psychiatric Medicine.

3. *Yes, There is a Happier Healthier Life in Recovery from Addiction.* Chicago: The Rush Institute for Mental Well Being, Rush Presbyterian Saint Luke's Medical Center.

4. Avery, DM. The Impaired Physician: Intervention. *The Medicolegal OB/GYN Newsletter,* 1996, 5:1-13.

Reprinted with permission from the October 1997 number of the American Society of Forensic Obstetricians and Gynecologists publication *The Medicolegal OB/GYN Newsletter.* For further information on contacting the treatment centers discussed in this article or on the ASFOG, write William D. Daniel, MD, at the ASFOG: PO Box 536, Buckhannon, WV 26201, or telephone (304) 472-8594.

Editor's Note: As he notes, Dr Avery deals with only four treatment centers in his study. There are quite a few others, of course, and their costs begin under $15,600 and average approximately $22,000. ♦

NOTICE

NCMB Introduces New Telephone Numbers and 800 Number, Has New Street Address

The North Carolina Medical Board has improved its telephone system over the past several months. This process has required new telephone and fax numbers. However, to facilitate a smooth transition to the new numbers, the Board's old numbers will remain usable throughout the rest of 1998. The new numbers, which are now fully active, are:

BOARD OFFICE: (919) 326-1100
FAX: (919) 326-1130 or (919) 326-1131

All the Board's extension numbers have also been modified by having a 2 added as a prefix. For example, extension 10 is now extension 210. When callers know the extension they want and do not need to speak to the receptionist, they may call **(919) 326-1109.**

The Board has also introduced a statewide 800 number, allowing callers to telephone the Board from anywhere in the state without a long-distance charge: **(800) 253-9653.**

Office renovation has created a new entry to the Board, which has caused the physical address to change to **1201 Front Street, Raleigh, NC 27609.** (The address was previously 1203 Front Street.) The mailing address, PO Box 20007, Raleigh, NC 27619, has not changed.

Guidelines for Chronic Pain Management in Older Persons Now Available

Clinical practice guidelines for the management of chronic pain in older persons have been developed and written under the auspices of the American Geriatrics Society (AGS) Panel on Chronic Pain in Older Persons. The guidelines were approved by the AGS Board of Directors on March 6, 1998.

The guidelines document was published in the *Journal of the American Geriatric Society* of May 1998 (Vol 46, No 5, pages 635-651). Among other things, it deals with assessment of chronic pain in older persons, pharmacologic treatment of chronic pain in older persons, non-pharmacologic strategies for pain management in older persons, and recommendations for health systems that care for older persons.

Reprints of the document as published in the *JAGS* may be gotten by writing Patricia Connelly, Senior Director, Special Projects and Education, American Geriatrics Society, 770 Lexington Avenue, Suite 300, New York, NY 10021.

NCMB Adopts/Amends Several Position Statements

The North Carolina Medical Board has recently adopted and/or amended position statements related to the physician-patient relationship, retention of medical records, and the prescribing of legend or controlled substances for other than valid therapeutic reasons.

● *NCMB Position Statement*

THE PHYSICIAN-PATIENT RELATIONSHIP

[The following section is added to the existing Position Statement on The Physician-Patient Relationship.]

Termination of the Physician-Patient Relationship

The Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in compliance with the physician's obligation to support continuity of care for the patient. It must be done by appropriate written notice given to the patient, the relatives, or the legally responsible parties sufficiently far in advance (at least 30 days) to allow other medical care to be secured. Should the physician be a member of a group, the notice of termination must state clearly whether the termination involves only the individual physician or all members of the group.

● *NCMB Position Statement*

RETENTION OF MEDICAL RECORDS

The North Carolina Medical Board supports and adopts the following language of Section 7.05 of the American Medical Association's current *Code of Medical Ethics* regarding the retention of medical records by physicians.

7.05: Retention of Medical Records

Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations:

(1) Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.

(2) If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.

(3) In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.

(4) Whatever the statute of limitations, a physician should measure time from the last professional contact with the patient.

(5) If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority.

(6) Immunization records always must be kept.

(7) The records of any patient covered by Medicare or Medicaid must be kept at least five years.

(8) In order to preserve confidentiality when discarding old records, all documents should be destroyed.

(9) Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

Please Note:

a. North Carolina has no statute relating specifically to the retention of medical records.

b. Several North Carolina statutes relate to time limitations for the filing of malpractice actions. Legal advice should be sought regarding such limitations.

● *NCMB Position Statement*

PRESCRIBING LEGEND OR CONTROLLED SUBSTANCES FOR OTHER THAN VALID MEDICAL OR THERAPEUTIC PURPOSES, WITH PARTICULAR REFERENCE TO SUBSTANCES OR PREPARATIONS WITH ANABOLIC PROPERTIES

General

It is the position of the North Carolina Medical Board that prescribing any controlled or legend substance for other than a valid medical or therapeutic purpose is unprofessional conduct.

The physician shall complete and maintain a medical record that establishes the diagnosis, the basis for that diagnosis, the purpose and expected response to therapeutic medications, and the plan for the use of medications in treatment of the diagnosis.

The Board is not opposed to the use of innovative, creative therapeutics; however, treatments not having a scientifically valid basis for use should be studied under investigational protocols so as to assist in the establishment of evidence-based, scientific validity for such treatments.

Substances/Preparations with Anabolic Properties

The use of anabolic steroids, testosterone and its analogs, human growth hormone, human chorionic gonadotrophin, other preparations with anabolic properties, or autotransfusion in any form, to enhance athletic performance or muscle development for cosmetic, nontherapeutic reasons, in the absence of an established disease or deficiency state, is not a medically valid use of these medications.

The use of these medications under these conditions will subject the person licensed by the Board to investigation and potential sanctions.

The Board recognizes that most anabolic steroid abuse occurs outside the medical system. It wishes to emphasize the physician's role as educator in providing information to individual patients and the community, and specifically to high school and college athletes, as to the dangers inherent in the use of these medications. ♦

Never Take Your Medical License for Granted!

A North Carolina Physician

I never thought an innocent and unintentional mistake could potentially put my practice at risk.

I had just returned from my yearly vacation. I was overloaded with patients and reviewing charts that were three deep when my office manager stopped me and said: "We have an urgent problem. Medicare has stopped payment because you do not have a license."

"Are you sure?"

"I faxed your license but the answer was the same."

I quickly called the North Carolina Medical Board. The attorney for the Board said: "You have been practicing medicine without a license and must stop."

Only then did I realize my mistake. For seven years, I was a solo proprietor; then, the year before, when my practice changed to an S corporation, I became responsible for paying two registration fees. I innocently and ignorantly paid only the corporate fee. I responded to that notice and soon afterwards my verification of payment came. Thinking I had satisfied my obligations, I failed to respond to the other registration notices that started arriving. I had a registration in my hands – I didn't need anything else. The other notices moved to a lower priority and I failed to delegate the matter to my office manager. I became enmeshed with two new medical students who popped onto the scene. Soon, the notices were out of sight and mind.

When I heard "you have been practicing medicine without a license," my anxiety level heightened. I struggled with a few more patients and then stopped.

I barely slept that night. The magnitude of this problem was beginning to eat at me. I began to worry about providing 24-hour, 7-day a week coverage for my patients and the potential negative impact on managed care contracts and nonpayment. Worse yet, I worried about a gap in malpractice insurance and even about bankruptcy.

I was in Raleigh the next morning, trusting that understanding minds would prevail. The situation was finally worked out, but it wasn't easy and it wasn't fun.

Never take your medical license for granted! Remember that if your practice is incorporated, you need to pay registration fees for both your corporation and your personal license. ♦

LETTERS TO THE EDITOR

Reflections on CME

To the Editor: I read with interest [Dr Trado's] message [To CME or Not to CME] in the recent issue of the NCMB's *Forum* [Vol III, No 1]. In response to [Dr Trado's] questions:

1. A specific 150 hour per 3 years requirement is onerous and not proven to be beneficial to the education of the physician. It does line the pockets of the CME industry, which largely is underpaid academicians. Something like the legal profession's 10-15 hours per year would be more appropriate. At present, physicians sign up for extended 3 to 5-day meetings, then either sleep through lectures or skip them entirely, only to receive their certificate of attendance. How about recognizing what we learn every day in our practice of medicine through our patient encounters, chart reviews, reference reviews for management, and following the recommendations of our consultants? This seems inherently more beneficial.
2. Allowing for more "worldly information" to qualify for CME will make us more rounded as individuals and happier as practitioners. What about ethics or philosophical pursuits? This perhaps would aid in our judgment as much as purely medical information.
3. CME offerings by academicians may help us in objective testing, but is of limited usefulness in daily practice. In many instances, those who actually practice medicine see more cases than those who lecture. We do not report our experiences and observations by which we learn the art of medicine, which would be of great benefit to our younger colleagues.
4. Hospital credentialing requirements will assist the Board in monitoring physician CME hours. A simple attestation form to the Board should suffice and, of course, be subject to the honor system requirements.
5. Recertification is not required of all specialties. If done, I would presume that CME requirements would be more stringent than the Board would require.
6. Quality assurance activities by third-party payers will serve to measure to some extent the value of CME in the practice setting. I'm not sure the monitoring by the Board will be beneficial. The positive effect will be the personal satisfaction gained in future patient management.
7. The AMA Physician's Recognition Award should play no role as a model, as it is built on sustaining the financial survival of the CME industry.
8. Enforcement should not be an issue if CME is made relevant and reasonable in its demands (ie, time requirements). Simply make it reportable with registration.

James A. Villier, MD
Charlotte, NC

"Mind Altering Drugs"

To the Editor: Through the years as I have read your publication, I have found repeated references to "mind altering drugs." The last time was in regard to the article Ultram Is Not For Addicts. In this instance, of course, it is referring to an oral analgesic, but in most instances it seems to be reserved for use of psychotrophic medications. The very idea that psychiatrists dispense medication that "alters the mind" has been a bias that we have had to work hard to dispel throughout the years.

I would appreciate hearing your explanation as to what constitutes your definition of "mind altering." Is it a category of drugs, or is it a drug that works on the central nervous system, or is it a drug that produces certain side effects or alleviates specific symptoms?

William R. Bodner, Jr, MD
Greensboro, NC

Response to Dr Bodner

To the Editor: Most references in the *Forum* to "mind altering drugs" have been my authorship, nearly always as part of a Board Order or Consent Order. The language used is "mind or mood altering drugs," meaning potentially impairing drugs subject to abuse, as in: "Dr X shall refrain from the use of all mind or mood altering substances and all controlled substances, including but not limited to, sedatives, stimulants, pain medications, and he shall likewise refrain from the use of alcohol." It is a term of some imprecision, used for its inclusiveness. I cannot recall ever using the term to refer to psychotropic medications.

I welcome suggestions for improvement in this and any other language used by the Board, particularly in its legal documents.

James A. Wilson, JD
Director, Legal Department
North Carolina Medical Board ♦

NCMB Report to the People of North Carolina: A Review of 1997

On March 4, 1998, Charles E. Trado, MD, of Hickory, president of the North Carolina Medical Board, released to the public the following report on the Board's work over the past year. This is the third year in which such a complete and detailed report on the actions of the Board has been offered the people of the state.

1. Andrew W. Watry Becomes Executive Director

Andrew W. Watry, the former executive director of the Georgia Composite State Board of Medical Examiners assumed the post of executive director of the NCMB on March 1, 1998. Mr Watry was selected in January to replace Bryant D. Paris, Jr, who is now to be the Board's executive director emeritus. He and Mr Paris will work closely together to guide a smooth transition.

Mr Watry was executive director of the Georgia board for 17 years. He has extensive experience at both the state and national levels, having served as president of the Administrators in Medicine and as a member of the Board of Directors of the Federation of State Medical Boards. A native of Wisconsin, he received his Bachelor of Science and Master of Public Administration degrees from Georgia State University and spent 10 years in various state management positions in Georgia before becoming executive director of the Georgia board.

Over the years, Mr Watry's efforts and the quality of his leadership of the Georgia board won widespread national recognition. In an editorial on December 9, 1997, *The Atlanta Journal*, characterized Mr Watry as "the longtime, lauded director" of the board. It went on to describe his work as remarkably effective.

Mr Watry has said that he looks forward to this new opportunity. "Bryant Paris is a distinguished leader and it's an honor to be asked to succeed him as executive director and to work with the outstanding staff he has assembled. Needless to say, I expect to draw heavily on his wisdom and experience in his new role as executive director emeritus of the Board."

"I believe it is fair to say," said Dr Charles E. Trado, president of the Board, "that Georgia's loss is definitely North Carolina's gain."

2. Other Key Activities

a. Medical Coordinator Joins Staff: In June 1997, the Board added a full time medical coordinator, Jesse E. Roberts, Jr, MD, to its staff. His tasks include evaluating medical care issues, reviewing complaints relating to medical care, and acting as a medical advisor to the Board. A native of Louisiana, Dr Roberts took his medical degree from Louisiana State University and is board certified in internal medicine, with a subspecialty in rheumatology. Among other things, he has served on the faculties of Bowman Gray, Duke, and UNC schools of medicine. From 1992 to 1997, he was medical director of the Rehabilitation Medicine Centers of Forsyth Memorial Hospital in Winston-Salem.

b. Complaints System Reorganized: Throughout late 1996 and early 1997, an extensive evaluation was conducted of all aspects of the Board's system for handling complaints from the public and professionals. That evaluation led to the conclusion that the approach to processing and dealing with complaints was far too slow and lacked consistency. It was also clear that a much improved method of tracking complaints through the system was needed to prevent neglecting specific items: it was found that some complaints were stalled for inordinate periods for lack of such an effective approach to tracking. As a result, a significant reorganization was instituted and new resources added to the effort.

Complaints, previously an office in the Investigative Department with one staff member, was made a full Board department. Three experienced staff members were brought in to structure an efficient and more responsive system. The director of the new Complaints Department is a professional in the field of medical records. Her two assistants in the the Department also have significant skill and experience for the task. The operations of the Board's Complaints Committee were also enhanced to speed the review of complaints and the Board's computer system is undergoing further refinement to maintain control of the system.

The skill and expertise of the Board's new medical coordinator was essential to implementing these changes in the Board's system for handling complaints. As a result of this effort, the Board now has a much stronger and more efficient complaint system that can be responsive to the public's concerns in ways not possible just a year ago. Needless to say, improvements will continue to be made over the coming year.

c. Expansion and Restructuring of Investigative Staff: During 1997, it was decided to restructure control of the Investigative Department by naming an overall director and a separate supervisor of field investigations. Don Pittman, for many years director of the Department, was designated supervisor of field investigations, and John W. Jargstorf, following 29 years of service in the U.S. Air Force, became director of the Investigative Department in January 1998. In the Air Force, Mr Jargstorf was in charge of providing support services to 31 intelligence agencies around the Pacific rim. The field staff was increased from six to seven persons and the office support group from two to three persons. This increase in personnel (three persons, in all) and improvement in structure will significantly enhance the Board's ability to investigate the medical care and other issues that are presented to it.

d. Informational Efforts: The Board's information and communication program continued to expand throughout 1997 and included the second full news conference, held in March 1997. Activities included further efforts to increase widespread public and media outreach: producing the quarterly *Forum*, sent to all licensees, the media, and others; distributing a Board brochure for the public; appearing on statewide radio and television programs; providing a bimonthly news release to all the state's media; distributing a detailed bimonthly disciplinary report, which also appears in the *Forum*. This approach keeps the public and profession better informed and has a distinct educational impact on licensees.

The Board also published a new item titled *North Carolina Medical Board Documents* that contains the Medical Practice Act, the Administrative Code relating to medicine, and the Position Statements of the Board.

The Board continued to offer and regularly update its web page, working through a system set up in cooperation with the Administrators in Medicine (AIM) organization. The AIM web address is **www.docboard.org**, and the Board's page can be found there.

The Board also continued operating its electronic mailbox. The address is **ncmed-**

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NCMB Report

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brd@interpath.com. Requests for complaint forms may be sent to the Board by e-mail (mailing addresses should be included in the request) and comments for the Board's consideration are welcome. However, the Board cannot respond to all comments and questions received.

e. Educational Programs: In 1997, the Board presented over 30 educational outreach programs to medical schools, public groups, and civic and professional organizations. Of particular interest was the Board's presentation of a special seminar on sexual misconduct. Barbara S. Schneidman, MD, MPH, associate vice president of the American Board of Medical Specialties, led the seminar in the Board's offices on July 16. Attending were representatives of specialty societies, medical education programs, and other medical groups. The Board produced a video program of this seminar and is making it available to medical schools and residency programs across the state. It is also being requested by state medical boards throughout the country.

During 1997, the Board produced or participated in developing three educational videos:

The Magic Kiss: Sexual Misconduct and Boundary Issues in Medicine

Produced by the Board: A two hour seminar and Q&A session on boundary issues presented to the NCMB and others by Barbara S. Schneidman, MD. (Available from the North Carolina Medical Board: telephone (919) 828-1212, ext 230.)

Pain Management

Produced by the NC Agency for Public Telecommunications: One hour conversation and Q&A session on the management of chronic pain and the Board's related position statement featuring Dr Trado and two other specialists. A Health Connections program broadcast on 2/06/97. (Available only from the Agency: telephone (919) 733-6341.)

Patient-Doctor Boundaries

Produced by the NC Agency for Public Telecommunications: One hour conversation and Q&A session on sexual misconduct and related subjects featuring Drs Barrett, Schneidman, Alexander, and Nussbaum. A Health Connections program broadcast on 7/17/97. (Available only from the Agency: telephone (919) 733-6341.)

f. Revised Position Statement on Medical Records, New Statement on the Retired Physician: During the year, the Board amended and expanded its Position Statement on Access to Physician Records, making clear the physician's duty to provide copies of records or summaries of records to patients or their designees in a timely manner. It also developed a Position Statement on The Retired Physician, making the point that a physician who is retired and does not maintain a registered license must not practice in any way or write prescriptions. It also reminds retired physicians who keep their licenses registered that they have the same obligations as any other licensed physician: they must maintain their skills and expertise and keep good medical records.

g. Legislative Changes: During 1997, the General Assembly amended the Medical Practice Act to change annual registration of medical licensees. Rather than all licensees registering in January, each will now register within 30 days of his/her birthday. This system has been implemented and is working well.

The General Assembly also permitted the Board to develop a mandatory continuing medical education requirement for medical licensees. The Board will develop rules for this purpose through a process set by law.

h. Special Projects: During the year, the Board continued to examine issues related to telemedicine and the evaluation of cognitive skills. It also continued to encourage physicians to become familiar with effective methods of pain management. Given recent changes in the law regarding continuing medical education (CME), the Board initiated a task force to study how a CME requirement should be established for North Carolina and what that requirement should be. The members of the Board's CME Task Force come from the most concerned elements of the medical community: medical schools, Area Health Education Centers, the North Carolina Medical Society and other medical groups, and practicing physicians. The state's leading CME specialists are being drawn on by the Board as it studies development of a CME requirement.

3. Looking Ahead

The Board intends to continue enhancement of its complaint and investigative processes. It will also be evaluating its overall operations to consistently improve all aspects of its work. Development of the CME requirement will move ahead, with the Board working intensively with the members of its CME Task Force. The evaluation of post-licensure competence, on which the Board has focused attention for some time, will remain a major interest.

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

NCMB 1997 BOARD ACTION REPORT:
[With 1996 Comparisons in Brackets]

Licenses Denied After Hearing =
1997: 4 Actions — 4 Persons (3 physicians, 1 NP)
[1996: 1 Action — 1 Person (1 PA)]

Annulments =
1997: 0
[1996: 0]

Revocations =
1997: 4 Actions — 4 Persons (4 physicians)
[1996: 5 Actions (1 by C/O) — 5 Persons (3 physicians, 2 PAs)]

Suspensions =
1997: 9 Actions (5 by C/O, 1 by Misc Order) (3 stayed) — 9 Persons (9 physicians)
[1996: 5 Actions (4 by C/O) (no stays) — 5 Persons (5 physicians)]

Summary Suspensions =
1997: 8 Actions — 8 Persons (7 physicians, 1 PA)
[1996: 6 Actions — 6 Persons (6 physicians)]

Consent Orders =
1997: 69 Actions — 61 Persons (51 physicians had 56 actions, 10 PAs had 13 actions)
[1996: 38 Actions — 34 Persons (29 physicians had 33 actions, 5 PAs had 5 actions)]

Miscellaneous Actions/Board Orders =
1997: 7 actions — 7 persons (5 physicians, 2 PAs)
[1996: 0]

Surrenders in Lieu of Action =
1997: 21 Actions (6 by C/O) — 21 Persons (19 physicians, 1 PA, 1 NP)
[1996: 12 Actions — 12 Persons (10 physicians, 2 PAs)]

Dated Licenses Allowed to Expire =
1997: 2 Actions — 2 Persons (1 physician, 1 PA)
[1996: 2 Actions — 2 Persons (2 physicians)]

Dismissals of Charges =
1997: 9 Actions [5 by C/O, 3 surrendered/expired, 1 after hearing] — 9 Persons (7 physicians, 2 PAs)
[1996: 1 Action — 1 Person (1 physician)]

Dated Licenses Extended =
1997: 73 Actions — 43 Persons (36 physicians had 62 actions, 7 PAs had 11 actions)
[1996: 66 Actions — 46 Persons (44 physicians had 64 actions, 2 PAs had 2 actions)]

Dated Licenses Returned to Full =
1997: 3 Actions — 3 Persons (3 physicians)
[1996: 6 Actions — 6 Persons (6 physicians)]

Consent Orders Lifted =
1997: 21 Actions — 21 Persons (21 physicians)
[1996: 9 Actions — 9 Persons (9 physicians)]

Revoked Licenses Restored =
1997: 0
[1996: 0]

From the North Carolina Board of Pharmacy

David R. Work, Executive Director, North Carolina Board of Pharmacy

Mr Work

• FDA Declares OTC Quinine Misbranded

In response to concerns about the use of over-the-counter (OTC) quinine for the treatment and/or prevention of malaria, the Food and Drug Administration (FDA) published a final rule in the March 20, 1998, *Federal Register* establishing that OTC drugs containing quinine for the treatment and/or prevention of malaria are not generally recognized as safe and are misbranded. This action reclassifies quinine as a new drug within the meaning of the federal Food, Drug and Cosmetic Act and requires that FDA approval be obtained for marketing.

The decision to classify OTC quinine as unsafe was based on data and information examined by the FDA while it was reviewing OTC quinine for the treatment and/or prevention of nocturnal leg cramps. Quinine was removed from the market for this indication due to the lack of substantial evidence of effectiveness, along with evidence of toxicity at the doses recommended. Additionally, the FDA expressed serious safety and efficacy concerns with regard to the continued OTC availability of quinine for the self-treatment of malaria without the care and supervision of a physician.

As a result, physicians may be requested to prescribe quinine for their patients who had been getting the drug OTC. There is nothing irregular about prescribing quinine if, in the physician's judgment, it would be appropriate therapy.

• Caffeine Count

Which has more caffeine, Coca Cola or tea? Physicians who get such questions can find the answer in a good reference: Bowes and Church's *Food Values of Portions Commonly Used*, J.B. Lippincott, 1994. It reveals that Coca Cola has 46 milligrams of caffeine in 12 ounces, while Pepsi has 38 milligrams for the same quantity. There are 103 milligrams in 6 ounces of brewed coffee. Various forms of cappuccino, vienna, chicory, etc, range down to about 25 milligrams. Black brewed tea has 36 milligrams for 6 ounces, and instant powdered tea has 31 milligrams for one teaspoonful.

Chocolate also has its share of caffeine, with 6 ounces of semi-sweet chocolate chips containing 105 milligrams of caffeine. The amount of caffeine in other forms of chocolate ranges down to Hershey's Mr. Goodbar at 5 milligrams per 1.75 ounce bar.

• Mexican Connection

Physicians may have heard stories about people who visit Mexico and easily purchase drugs over the counter that would have required a prescription in this country. In Mexico, these items are freely available in "pharmacies" that may not even have a pharmacist on duty. Generally, the focus of such a tale is the price, which is a fraction of the cost for the same drug in the United States.

Pharmacist James Robinson, from Macks Pharmacy in Stony Point, related a different experience from one of his customers. A woman that was consuming Levsin 0.125 milligram had visited Mexico and desired to take advantage of the lower prices in that country. She visited a pharmacy and requested Levsin but received Lanoxin 0.125 milligram. Upon return to the United States, she asked Pharmacist Robinson about the drug and he explained the error that occurred. The three-times per day dose of Lanoxin, rather than Levsin, could have resulted in a disaster.

When your patients tell you the common story about lower prescription drug prices in Mexico, you may wish to share the foregoing information.

• Narrow Therapeutic Index Drugs

Physicians may be receiving telephone calls from pharmacists to obtain their permission for using a different manufacturer's product for certain drugs. This provision requires that the pharmacist get the permission of both the prescriber and the patient before changing sources for certain products.

A 1997 revision in the Pharmacy Practice Act during the last session of the General Assembly provided for a list of narrow therapeutic index drugs. These are drugs that have less than a twofold difference in the minimum toxic concentration and minimum effective concentration in the blood, or those drug formulations that exhibit limited or erratic absorption, formulation dependent bioavailability, and wide intrapatient pharmacokinetic variability that requires blood level monitoring. The North Carolina Secretary of Health and Human Services, after receiving advice from the State Health Director, the North Carolina Board of Pharmacy, and the North Carolina Medical Board, has identified the following drug products as being narrow therapeutic index drugs. They are listed alphabetically.

carbamazepine (all dosage forms) [Tegretol, various others]

digoxin (all dosage forms) [Lanoxin]

levothyroxine sodium tablets [Levothroid, Levoxyl, Synthroid, various others]

lithium (all oral dosage forms, all salts) [Cibalith, Eskalith, Lithobid, Lithotabs, various others

phenytoin (all oral dosage forms, all salts) [Dilantin]

theophylline [Elixophyllin, Slo-Phyllin, Slo-bid Gyrocaps, Theochron, Theo-Dur, Theo-24, Uniphy]

warfarin sodium tablets [BMS Warfarin, Coumadin, Warfarin]

A prescription for a narrow therapeutic index drug shall be refilled using only the same drug product by the same manufacturer that the pharmacist last dispensed under the prescription, unless the prescriber is notified by the pharmacist prior to the dispensing of the other manufacturer's product and the prescriber and the patient give documented consent to the dispensing of the other manufacturer's product. The term "refilled" shall include a new prescription written at the expiration of a prescription that continues the patient's therapy on a narrow therapeutic index drug.

All other provisions of the State Product Selection Law, including the prescription format providing for "Dispense as Written" and "Product Selection Permitted" are still in effect. ♦

REVIEWS

Culture and Healing

James A. Wilson, JD
Director, NCMB Legal Department

Reports abound that North Carolina is becoming increasingly multicultural. In some communities, it is necessary to know more than one language to serve the population's needs. Medicine, too, is becoming increasingly multicultural in the sense that the culture of medicine is being complemented, some might say supplanted, by legal and business cultures. Such pressures bring different values to bear on what had been a much simpler transaction between individual physicians and their individual patients. Thus, an awareness of the effects of culture on medical practice is becoming increasingly important.

One new book on this subject is *The Cultural Context of Health, Illness, and Medicine* by Martha O. Loustaunau and Eilsa J. Sobo. Written at about the level of an undergraduate text, the book fulfills its stated purpose to motivate and enable the reader "to recognize and understand culturally related factors that influence our views and constructions of health, illness, and healing, as well as of science and medicine."

The Cultural Context of Health, Illness, and Medicine
Martha O. Loustaunau and Elisa J. Sobo
Bergin & Garvey, Westport, CT, 1998.
232 pages, $21.95 paper (ISBN 0-89789-548-7),
$59.95 cloth (ISBN 0-89789-487-1).

Introductory materials helpfully define terms and establish expectations for the remainder of the work. Opening chapters provide an appreciation for the role of culture and society in perceptions of illness and health and of the propriety of different approaches to healing. Chapter 1 shows each culture develops its own ideas about health and healing, the lenses through which each culture views the other's practices, and the consequences when patients and healers come from different cultures. Chapter 2 illuminates the effects of social structure on the healing encounter, including an examination of the role of family and of mistrust between patients and physicians. The third shows how cultural and societal expectations about the different life stages (pregnancy, infancy, adolescence, etc) affect care.

Later portions further develop these theories, with examples that become more fully developed and more important. Chapter 4 concerns different typologies used by medical anthropologists to classify various healing systems. Practitioners are described and analyzed, for example, as either professional (eg, physicians, nurses), adjunct (eg, technicians), limited (eg, dentists), marginal (eg, chiropractors), or quasi-medical (eg, quacks). The chapter continues with descriptions of traditional, culturally-based schools of thought, such as the importance of equilibrium in health. Discussion next turns to how one culture might see as disease what another sees as being within the range of normal or, at worst, slightly irritating. Finally, there is information on cultural values affecting the selection of various types of healers.

Chapter 5 is a cultural history of medicine in the United States describing the ascendency and modern predominance of the biomedical model. It advances the notion that biomedicine can be seen as a culture unto itself. It argues for a biopsychosocial model and the need for cultural understanding and respect in order to cure and care for members of all cultures. Chapter 6 shows how cultural difference can contribute to miscommunication. The final chapter attempts to apply the book's principles to the example of HIV/AIDS and the effects of society and culture on the development of appropriate public health strategies.

The book makes a fine introduction for the newly curious. Well-crafted, straightforward prose, reasonable and clear organization, and heavy use of section headings make this work quite accessible, though there are frequent ramblings and digressions. Clinical examples are well-chosen and illuminating, but are too few. Questions for discussion at the end of each chapter are overly pedantic and do not challenge the reader to greater understanding or further study.

Deeper development of ideas is available in *The Anthropology of Medicine*, edited by Romanucci-Ross, Moerman, and Tancredi. Apparently intended as a graduate level text, this work shows the duality of humans, both patients and healers, as both biological and cultural beings. The book is a collection of essays or reports of field work in 19 chapters organized into four parts, each part with a brief introduction by the editors.

The Anthropology of Medicine: From Culture to Method
(Third Edition)
Lola Romanucci-Ross, Daniel E. Moerman, and
Laurence R. Tancredi, Editors
Bergin & Garvey, Westport, CT, 1997.
400 pages, $29.95 paper (ISBN 0-89789-516-9),
$79.50 cloth (ISBN 0-89789-490-1).

Part I focuses on how different cultures make different decisions about using modern scientific medicine, traditional medicine, or both. The editors posit that the blending of systems will depend upon the impact of each system on the culture. Supporting this notion are chapters showing examples of where divergent systems peacefully coexist, where there has been an exchange or absorption of ideas when the systems intersect (herbals, in the example), and where medicine acts as a metaphor for ethnic identity and social status.

Part II analyzes non-Western practices with the example of how plants become medicine. Recognizing that there is not a clear demarcation between using a plant as food or as medicine, this part discusses instances of plants being used in a non-random, non-placebo way as drugs. Chapters include lists of the botanical characteristics influencing the likelihood a plant will be useful as a drug, a merely descriptive exploration of the role of taste in choosing medicinal plants, and a description of cultural influences on the transmissibility of infectious agents and, specifically, the impacts of proximity to and domestication of animals. The best chapter, and it is absolutely fascinating, sets forth the evolution of nutrition. It explains the large number of essential nutrients in human diet, the natural omnivorousness of human beings, and how agriculture and the development of food processing technology has led humans to obtain most of their sustenance from a very few sources. The final chapter of this part puts forth malaria as an example of diet as medicine, but it mostly bores with a description of study methodology.

Part III collects works on the sociocultural aspects of mind-body interaction and the effects of stress on pain and the use of placebo in controlling it. Chapters concern the role of the shaman as intellectual leader of a community and an interesting argument that the placebo effect may be the predominant factor in any therapy's effectiveness for pain control. One chapter shows the importance of the psychological history of the pain experience to the patient and examines chronic pain as a social status in search of validation. Most interesting is the chapter describing a study showing that while physicians give members of minority groups less pain medication, when using patient controlled analgesia (PCA) there is no difference in the amount of medicine taken or subjective pain experienced across different minority groups. The second chapter of this part is said to concern "metaphoric medicine," but is absolutely incomprehensible.

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Culture and Healing

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Part IV outlines modern practices and the imprinting that practitioner training has on medical practice. It begins with an unbearable, ridiculous allegory to the effect that "Stress is for people what blood is for vampires." Other chapters include a history of modern psychiatry, a plodding argument that "madness" is cultural and negotiable, and an interesting and disturbing account of potential abuse of elders. The penultimate chapter, perhaps a suitable synopsis of the book as a whole, asserts somewhat insultingly that physicians are poor scientists, particularly in that they do not recognize that the sociocultural cannot be divorced from the biological. The book closes stating that physicians must recognize that all people live within cultures and the culture should be expected to affect health and healing.

The book's best segments are the prefatory and introductory materials prepared jointly by the editors. Organization is thematic, but coherence is not what it could be, leaving too much to the reader, especially the uninitiated, to integrate the ideas of the various chapters. In taking a considerable amount of effort, the novice to medical anthropology will find several provocative ideas. Whether these are worth slogging through the poorly written or extraordinarily contrived pieces is a close question. ♦

ANNOUNCEMENT

The End-of-Life Decisions Forum

October 23, 1998
8:30 AM to 4:00 PM
Brownstone Hotel
1707 Hillsborough Street
Raleigh, North Carolina 27605

Organized by the Staffs of the North Carolina Medical Board, North Carolina Board of Nursing, and North Carolina Board of Pharmacy

PURPOSE:

To provide a forum for health care regulators, professionals, and policy makers to explore the issues surrounding end-of-life decisions and to initiate a continuing process for addressing such issues in North Carolina.

OBJECTIVES:

1. To educate regulatory board members and staff about the legal, ethical, and moral issues surrounding end-of-life decisions.
2. To evaluate how changing technology and advances in medical treatment affect end-of-life decisions.
3. To explore the dynamics of patient participation and self-determination in making end-of-life decisions in collaboration with health care professionals.
4. To initiate a process for further developing public policy related to patient choice and identifying appropriate standards for health care professionals dealing with end-of-life decisions.

NEED:

There is a dynamic at work in society that requires all those in the health care professions to communicate more sensitively with patients and to understand and respond to their values.

In this process, there must be an increased awareness of the importance of end-of-life decisions, which are the most significant to be made in the relationship between the patient and the health care professional. The health care professions must admit the limitations of their technology and of themselves. They must deal with the end of life with the same dedication they give to preserving it.

The end of life need not be viewed as a professional failure or a defeat when its approach is attended with genuine respect for the needs and concerns of the patient.

END-OF-LIFE DECISIONS FORUM:

In dealing with this subject, the End-of-Life Decisions Forum may raise more questions than it answers. By doing so, however, it will stimulate a necessary dialogue among the health care professions in North Carolina. This should lead to the development of a more appropriate framework for end-of-life decisions.

The Forum will address the significant moral, legal, and ethical issues involved in end-of-life decisions and the interaction between patients and health care professionals in the process of decision making.

The Forum will seek to identify critical topics and essential issues that demand further discussion and clarification, including policy questions related to patient choice and standards for health care professionals.

The Forum will feature a distinguished keynote lecturer, panel presentations, and small group discussions. At the close of the day, an attempt will be made to develop a consensus on the next steps to be taken – on "where we go from here."

BE A PART OF THE FORUM ON OCTOBER 23:

Be part of this necessary dialogue on the end of life and the many issues it raises. Join with other health care professionals at the End-of-Life Decisions Forum on October 23. The schedule promises a productive day for everyone involved.

Registrations will be taken on a first come, first serve basis. Don't miss this opportunity to participate! For information on available space and registration, write or telephone Pamela Trantham at the North Carolina Board of Nursing, PO Box 2129, Raleigh, NC 27602-2129 – (919) 782-3211. The registration fee for the day is $50.

SCHEDULE

End-of-Life Decisions Forum

8:30AM	REGISTRATION
8:45	Welcome and Introductions
9:00	Keynote Address/Q&A
	Lawrence O. Gostin, JD, LLD (Hon)
10:00	BREAK
10:35	Panel Presentation: Critical Topics
	Polly Johnson, RN, MSN, Facilitator
	North Carolina Laws/Legal Dilemmas
	Anne Dellinger, JD
	Bioethical Issues
	Nancy M.P. King, JD
	Medical Regulatory/Professional Issues
	George C. Barrett, MD
	Hospice Perspective
	Sharon Dixon, RN, MPH
	Academia
	Bill Campbell, PhD
	Hemlock Society Perspective
	Joseph A. Buckwalter, MD
	The Media
	Catherine Clabby, MA
	Consumer Protection Issues
	David A. Swankin, JD
12:15 PM	LUNCH ON YOUR OWN
1:30	Small Group Discussions
2:45	BREAK
3:00	Feedback from Small Groups
3:30	Preparing for the Future
4:00	ADJOURN

(Schedule subject to change without notice.)

PRESENTERS

George C. Barrett, MD
Member and Former President, North Carolina Medical Board; Vice President, Federation of State Medical Boards

Joseph A. Buckwalter, MD
Professor Emeritus of Surgery, University of North Carolina School of Medicine, Chapel Hill; President, North Carolina Hemlock Society

Bill Campbell, PhD
Dean, School of Pharmacy, University of North Carolina, Chapel Hill

Catherine Clabby, MA
Medical Reporter, Raleigh News and Observer

Anne Dellinger, JD
Professor of Public Law and Government, Institute of Government, University of North Carolina, Chapel Hill

Sharon Dixon, RN, MPH
Senior Vice President, Clinical Services, Hospice at Charlotte

Lawrence O. Gostin, JD, LLD (Hon)
Professor of Law, the Johns Hopkins University and Georgetown University; Co-Director of the Johns Hopkins University/Georgetown University Program on Law and Public Health

Polly Johnson, RN, MSN
Executive Director, North Carolina Board of Nursing

Nancy M.P. King, JD
Associate Professor of Social Medicine, University of North Carolina School of Medicine, Chapel Hill

David A. Swankin, JD
President, Citizen Advocacy Center, Washington, DC ♦

NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
May-June-July 1998

DEFINITIONS

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

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

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

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

NA:
Information not available.

NCPHP:
North Carolina Physicians Health Program

RTL:
Resident Training License.

Revocation:
Cancellation of the authorization to practice.

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

Suspension:
Temporary withdrawal of the authorization to practice.

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

Voluntary Dismissal:
Board action dismissing a contested case.

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

ANNULMENTS

NORRIS, Dolly Frances, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 10/03/66
License #: 96-01782
Specialty: GP (as reported by physician)
Medical Ed: Uniformed Services University of the Health Sciences (1992)
Cause: Dr Norris forged letters of recommendation and made false statements or representations to the Board or willfully concealed material information from the Board in connection with her application for a medical license in 1996.
Action: Hearing held 7/16/98. License annulled effective 7/27/98.

REVOCATIONS

RICKETSON, Greer Homer, MD
Location: Alexandria, LA
DOB: 11/08/44
License #: 00-32168
Specialty: RO (as reported by physician)
Medical Ed: Tulane University (1973)
Cause: Dr Ricketson's license to practice medicine in Louisiana was revoked by the Louisiana State Board of Medical Examiners for, among other things, issuing numerous prescriptions without any medical indication, physical examination, or therapeutic purpose. The Louisiana Board found him unfit to practice medicine. The action of the Louisiana Board is grounds for action by the North Carolina Medical Board.
Action: Hearing held 7/16/98. License revoked effective 7/16/98.

SCHER, Stephen Barry, MD
Location: Lincolnton, NC (Lincoln Co)
DOB: 5/10/40
License #: 00-36034
Specialty: FP/A (as reported by physician)
Education: University of Michigan (1965)
Cause: Conviction of a felony in the case of Commonwealth of Pennsylvania v. Stephen Barry Scher.
Action: 5/28/98. Entry of Revocation issued indicating revocation of license by operation of law on 5/25/98.

SUSPENSIONS

See Consent Orders:
PATTERSON, Anthony Curtis, MD
See Miscellaneous Board Orders:
PERKERSON, Ralph Benton, Jr, MD

SUMMARY SUSPENSIONS
NONE

CONSENT ORDERS

BROWN, David Houston, MD
Location: Lillington, NC (Harnett Co)
DOB: 12/11/45
License #: 00-28623
Specialty: IM/EM (as reported by physician)
Medical Ed: Universidad Autonoma Guadalajara (1976)
Cause: To make modifications of a Consent Order dated 4/29/97. Dr Brown surrendered his license on 9/20/96 to seek treatment for alcohol and other substance abuse. Following his successful treatment, license was reissued 4/29/97 pursuant to the Consent Order of the same date.
Action: 6/10/98. Consent Order executed: Dr Brown is issued a license to expire on the date shown (11/30/98); he shall practice in a setting that has first been approved in writing by the Board's president; he may not engage in solo practice; he shall not practice more than 45 hours a week; unless prescribed by someone else, he shall not use mind or mood altering substances or controlled substances or alcohol; he shall notify the Board in writing within two weeks of his use of such substances or alcohol and shall identify the prescriber and dispensing pharmacy; he shall supply bodily fluid or tissue samples as requested by the Board for screening purposes; he shall maintain and abide by his contract with the NCPHP; must comply with other conditions.

DOLIN, Michael Glen, MD
Location: Rockville Center, NY
DOB: 7/14/45
License #: 94-00779
Specialty: ORS/OAR (as reported by physician)
Medical Ed: New York Medical College (1970)
Cause: To resolve a case heard on 1/22/98 on charges filed against Dr Dolin on 7/16/97. Following its hearing, the Board concluded Dr Dolin had made a false statement or representation to the Board, or willfully concealed material information from the Board in connection with his application for a license, and by false representations obtained a thing of value, his license, from the Board, on 12/30/93, 5/5/94, and 6/10/94. On each occasion, he answered "No" to a question about his awareness of any investigations of him by a governmental agency or medical board when he was, in fact, aware of investigations of him by the Nassau County Police, BCS, and DEA. Dr Dolin's arrest and subsequent involvement with the courts and other agencies all arose from his wife's severe and documented illness; his prescriptions were written with the goal of treating his wife's medical condition and were limited in scope; he had no knowledge that his wife had obtained his blank prescription pads to procure more medication until 1/06/93. The application questions involved here all concern the consequences arising from the tragic situation in Dr Dolin's family.
Action: 5/15/98. Consent Order executed: Dr Dolin is reprimanded.

PATTERSON, Anthony Curtis, MD
Location: Concord, NC (Cabarrus Co)
DOB: 5/21/58
License #: 00-34429
Specialty: Psychiatry (as reported by physician)
Medical Ed: Medical College of Georgia (1985)
Cause: Dr Patterson admits he engaged in improper verbal boundary violations with two patients, including sexual discussions with two patients. He is an active participant in the NCPHP and has been evaluated by the Behavioral Medicine Institute of Atlanta, which says he can practice without threat to the safety of patients.
Action: 6/02/98. Consent Order executed: Dr Patterson's license to practice medicine is suspended for six months beginning on the effective date of this Consent Order; suspension will be stayed after 90 days on conditions stated in this Consent Order; he shall maintain and abide by a contract with NCPHP; he shall continue counseling with Dr Gene Abel, with quarterly reports from Dr Abel to the Board and to NCPHP; he shall continue the treatment protocols established with Dr Abel; he shall meet with the Board when requested; he shall complete 50 hours of CME in the next year, including at least 10 on boundary violations; must comply with other conditions.

SCONTSAS, George John, MD
Location: Kinston, NC (Lenoir Co)
DOB: 12/17/48
License #: 00-32852
Specialty: N (as reported by physician)
Medical Ed: University of Virginia (1977)
Cause: Application for reissuance of license. Originally licensed in 1988, Dr Scontsas surrendered his license on 11/22/94 because of problems with alcohol and other chemical dependence; his license was reissued under a Consent Order in 1995 after he underwent treatment; he again surrendered his license in August 1996 due to a relapse in his recovery.
Action: 6/08/98. Consent Order executed: Dr Scontsas is issued a dated license to expire on the date shown (12/31/98); except as prescribed for him by someone else, he shall refrain from the use of all mind or mood altering substances, controlled substances, and alcohol; he shall notify the Board within two weeks of his use of such substances or alcohol, including the name of the prescriber and the dispensing pharmacy; he shall supply bodily fluid or tissue samples as requested by the Board for screening purposes; he shall maintain and abide by a contract with the NCPHP; he shall not prescribe, order, administer, dispense, or otherwise deal with controlled substances as defined by the Federal Controlled Substances Act and shall not apply for ADE controlled substance registration; he shall obtain 50 hours of Category I CME relevant to his practice each year; must comply with other condition.

STEWART-CARBALLO, Charles Willy, MD
Location: Fayetteville, NC (Cumberland Co)
DOB: 2/24/57
License #: 00-38215
Specialty: OBG/Other (as reported by physician)
Medical Ed: University of Minnesota (1985)
Cause: In a Consent Order of 12/18/97, Dr Stewart -Carballo admitted unprofessional conduct when he violated previous Consent Orders with the Board and contracts with the NCPHP by consuming alcohol; and he admitted engaging in conduct contrary to honesty by failing to disclose to the Board prior arrests for alcohol related driving offenses. He surrendered his license pursuant to the Consent Order of 12/18/98. He signed a new NCPHP contract and reports he has fully complied with it and regularly attends AA and NA meetings; he voluntarily obtained treatment at a treatment center from April 12 to May 10, 1998, and has participated in the center's aftercare program.
Action: 7/22/98. Consent Order executed: Dr Stewart-Carballo is issued a dated license to expire on the date shown on the license (11/30/98); unless lawfully prescribed by someone else, he shall refrain from the use of all mind or mood altering or controlled substances and from the use of alcohol; he shall notify the Board within two weeks of his use of such medications or alcohol, identifying the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluid or tissue samples for drug and alcohol screening; he shall maintain and abide by a contract with the NCPHP and attend AA and NA meetings as recommended by the NCPHP; he shall continue to participate in his aftercare program; he shall obtain annual neuropsychological and medical evaluations to be done by practitioners approved by the Board, with results to be reported to the Board; he shall not perform any invasive procedures; he shall have a third person present during all patient encounters; he shall comply with all CDC guidelines; he shall obtain and document 50 hours of Category I CME directly relevant to his practice each year; he shall provide a copy of this Consent Order to all prospective employers; must comply with other conditions. The terms and conditions in the numbered paragraphs of this Consent Order replace those in the prior Consent Orders, save for those paragraphs related to the surrender of his license and the public nature of the prior orders.

MISCELLANEOUS BOARD ORDERS

PERKERSON, Ralph Benton, Jr, MD
Location: Jacksonville, FL
DOB: 9/18/48
License #: 00-18285
Specialty: DR/NM (as reported by physician)
Medical Ed: Medical College of Georgia (1971)
Cause: Hearing on charges in the Notice of Charges dated 8/09/96. Dr Perkerson's license was summarily suspended by an order of the same date that was served on 8/28/96. As part of his treatment for a broken nose in 1980, Dr Perkerson was administered cocaine; in the following days and weeks, he began to abuse cocaine; though he stopped on his own after three months, he relapsed in 1990, abusing both cocaine and alcohol; he then entered a treatment program and stayed clean and sober until relapsing again in September 1995; he again went to treatment and remained clean and sober until using cocaine in June 1996; he again entered treatment; his license was summarily suspended by the Georgia Composite State Board of Medical Examiners in June 1996 on evidence of his resumed use of cocaine; by Consent Order, he agreed not to practice in Georgia until permitted by the Georgia Board. He has signed a recovery contract with the impaired physicians program of Georgia; he regularly attends Caduceus meetings, sees a therapist weekly, and sees an addictionologist and psychiatrist monthly; in February 1998, the Georgia Board, by Consent Order, restored his license on terms related to his recovery from substance abuse.
Action: 6/09/98. Findings of Fact, Conclusions of Law, and Order issued: Dr Perkerson's license is suspended indefinitely, but that suspension is stayed on the following conditions: except as prescribed for him by someone else, he shall refrain from the use of all mind or mood altering substances, controlled substances, and alcohol; he shall notify the Board within two weeks of his use of such substances or alcohol, including the name of the prescriber and the dispensing pharmacy; he shall supply bodily fluid or tissue samples as requested by the Board for screening purposes; he shall maintain and abide by a contract with the impaired physicians program of Georgia; should he practice in North Carolina, he shall maintain and abide by a contract with the NCPHP; he shall not prescribe, order, administer, procure, or otherwise deal as a practitioner with any substances controlled under the Federal Controlled Substances Act and shall not apply for DEA controlled substance registration; must comply with other condition.

VERELL, Karen Lea, MD
Location: Jacksonville, NC (Onslow Co)
DOB: 3/05/53
License #: 00-26608
Specialty: PD/ADL (as reported by physician)
Medical Ed: University of Mississippi (1978)
Cause: On 11/18/96, the Board preferred charges against Dr Verell alleging she had engaged in unprofessional conduct. On 12/16/97, following a hearing on 11/20/97, the Board entered a Findings of Fact, Conclusions of Law, and Order of Discipline in which it found Dr Verell had engaged in unprofessional conduct. The Board suspended her license and stayed the suspension on condition that she be reprimanded. On 12/23/97, Dr Verell filed a motion to re-open her case for further hearing. Because the Board could not consider her motion before the time to appeal expired, she acted to preserve her right to appeal by filing a notice of appeal on or about 1/09/98. The appeal notice being filed, the Board no longer had jurisdiction to consider the motion to re-open. On 2/11/98, the Board and Dr Verell filed a Request to Remand, asking the Wake County Superior Court to remand the matter to the Board. This was done by an order dated 2/11/98. On 3/18/98, the president of the Board granted the Motion to Re-Open and the hearing was held 4/16/98. As a result of that hearing, the Board found that Dr Verell's conduct

constitutes grounds for discipline because of her response to another staff physician's urgent request for her assistance to attend a pediatric patient during and after a significant medical crisis, her lack of appropriate follow-up with the staff physician who requested her help to verify that pediatric assistance during and after the crisis was actually obtained, and her toleration of inaccurate and erroneous information being included in her response when she settled for a similar sounding name and an approximate date of birth at a time when she had the patient's true name and birth date, an act that alone could have endangered the life of the patient and subjected a fellow clinician to increased jeopardy both professionally and personally. Her conduct is mitigated by her good clinical reputation and a history of proven responsiveness to pediatric emergencies, by her attempt to assess the situation, develop an appropriate response, and alert another physician to respond, and by other issues pertaining to professional communications.
Action: 5/18/98, nunc pro tunc to 12/16/97. Board Order executed: Dr Verell is publicly reprimanded for unprofessional conduct.

DENIALS OF LICENSE/APPROVAL
NONE

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

SURRENDERS

FORD, Stephen Mitchell, MD
Location: Durham, NC (Durham Co)
DOB: 12/05/52
License #: 00-29570
Specialty: P (as reported by physician)
Medical Ed: East Tennessee State University (1984)
Action: 6/11/98. Voluntary surrender of license.

TEICHNER, Ronald, MD
Location: Miami, FL
DOB: NA
License #: 00-18914
Specialty: GYN/OB (as reported by physician)
Medical Ed: University of Illinois (1953)
Action: 1/20/98. Voluntary surrender of license.

CONSENT ORDERS LIFTED

DONAU, Charles Robert, Physician Assistant
Location: Fayetteville, NC (Cumberland Co)
DOB: 10/18/42
License #: 1-00016
Education: University of Washington (1972)
Action: 5/26/98. Order issued lifting Consent Orders of 11/16/95 and 4/23/97.

MARTIN, Gerald Randall, MD
Location: Brevard, NC (Transylvania Co)
DOB: 6/04/56
License #: 00-32949
Specialty: IM (as reported by physician)
Medical Ed: University of Texas Medical Branch, Galveston (1987)
Action: 5/26/98. Order issued lifting Consent Order of 11/15/95.

MEYER, Graham Scott, MD
Location: Fayetteville, NC (Cumberland Co)
DOB: 11/11/58
License #: 95-00405
Specialty: EM/PD (as reported by physician)
Medical Ed: University of Ontario (1986)
Action: 5/26/98. Order issued lifting Consent Orders of 10/08/96 and 3/22/97.

SHANKS, David Edward, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 6/02/41
License #: 00-20440
Specialty: PUD/HO (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1966)
Action: 5/26/98. Order issued lifting Consent Orders of 8/02/96 and 7/16/97.

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

ADAMS, Beverly Jean S., MD
Location: Durham, NC (Durham Co)
DOB: 11/11/45
License #: 00-25974
Specialty: OTO (as reported by physician)
Medical Ed: Duke University School of Medicine (1976)
Action: 5/15/98. Temporary/dated license extended to expire 11/30/98.

BLAKE, Daniel Jackson, MD
Location: Winston-Salem, NC (Forsyth Co)
Black Mountain, NC (Buncombe Co)
Asheville, NC (Buncombe Co)
DOB: 4/12/48
License #: 00-23830
Specialty: P/ADD (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1978)
Action: 5/15/98. Full and unrestricted license reinstated.

BLEMINGS, Ginger Dobbins, Physician Assistant
Location: Fayetteville, NC (Cumberland Co)
DOB: 8/30/63
License #: 1-01410
Education: Bowman Gray University (1991)
Action: 5/15/98. Temporary/dated license extended to expire 9/30/98.

BRANCH, Robert Donald, Physician Assistant
Location: Kinston, NC (Lenoir Co)
DOB: 7/07/58
License #: 1-02026
Education: University of Texas (1995)
Action: 5/15/98. Temporary/dated license extended to expire 5/31/99.

BROWN, David Houston, MD
Location: Lillington, NC (Harnett Co)
DOB: 12/11/45
License #: 00-28623
Specialty: IM/EM (as reported by physician)
Medical Ed: Universidad Autonoma Guadalajara, Mexico (1976)
Action: 5/15/98. Temporary/dated license extended to expire 7/31/98.

CHEEK, John Christopher, MD
Location: New Bern, NC (Craven Co)
DOB: 3/03/57
License #: 97-01906
Specialty: N/CN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1984)
Action: 5/15/98. Temporary/dated license extended to expire 11/30/98.

COLLINS, Natalear Rolline, MD
Location: Franklinton, NC (Franklin Co)
DOB: 10/22/55
License #: 00-27108
Specialty: GP/OM (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1981)
Action: 5/15/98. Temporary/dated license extended to expire 5/31/99.

COYNE, Mark Dennis, MD
Location: Stoney Creek, NC (Guilford Co)
DOB: 8/12/49
License #: 00-33493
Specialty: EM/FP (as reported by physician)
Medical Ed: Chicago Medical School (1983)
Action: 5/15/98. Temporary/dated license extended to expire 7/31/98.

COYNE, Mark Dennis, MD
Location: Stoney Creek, NC (Guilford Co)
DOB: 8/12/49
License #: 00-33493
Specialty: EM/FP (as reported by physician)
Medical Ed: Chicago Medical School (1983)
Action: 7/17/98. Temporary/dated license exended to expire 11/30/98.

FOERCH, Jeffry Scott, MD
Location: Blowing Rock, NC (Watauga Co)
DOB: 10/10/52
License #: 96-00806
Specialty: None reported by physician
Medical Ed: Chicago Medical School (1977)
Action: 7/17/98. Temporary/dated license extended to expire 1/31/99.

HALE, Phillip Douglas, MD
Location: Danville, VA
DOB: 2/05/55
License #: 96-00826
Specialty: FP (as reported by physician)
Medical Ed: Uniformed Services University (1982)
Action: 5/15/98. Full and unrestricted license reinstated.

HARRIS, Donald Philip, MD
Location: Greensboro, NC (Guilford Co)
DOB: 4/9/34
License #: 00-13127
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine, Chapel Hill (1961)
Action: 7/17/98. Temporary/dated license extended to expire 1/31/99.

HOLTKAMP, John Harry, MD
Location: Raleigh, NC (Wake Co)
DOB: 11/20/54
License #: 00-28045
Specialty: CHN/PD (as reported by physician)
Medical Ed: New York University (1980)
Action: 5/15/98. Temporary/dated license extended to expire 7/31/98.

HOLTKAMP, John Harry, MD
Location: Raleigh, NC (Wake Co)
DOB: 11/20/54
License #: 00-28045
Specialty: CHN/PD (as reported by physician)
Medical Ed: New York University (1980)
Action: 7/17/98. Temporary/dated license extended to expire 1/31/99.

KEEVER, Richard Alan, MD
Location: High Point, NC (Guilford Co)
DOB: 6/11/41
License #: 00-16400
Specialty: OTO (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1969)
Action: 5/15/98. Temporary/dated license extended to expire 11/30/98.

LESTER, Allan John, MD
Location: Cary, NC (Wake Co)
DOB: 9/19/44
License #: 00-20159
Specialty: FP/OM (as reported by physician)
Medical Ed: University of Otago, New Zealand (1970)
Action: 7/17/98. Temporary/dated license extended to expire 1/31/99.

LOWE, James Edward, Jr, MD
Location: Briarcliff Manor, NY
DOB: 12/05/50
License #: 00-37887
Specialty: PS/GS (as reported by physician)
Medical Ed: Meharry Medical College (1975)
Action: 5/15/98. Temporary/dated license extended to expire 11/30/98.

LUTZ, Robert Paul, MD
Location: Boone, NC (Watauga Co)
Chapel Hill, NC (Organge Co)
DOB: 5/05/48
License #: 00-27387
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1982)
Action: 7/17/98. Allow license to expire as of 7/31/98.

MARSHALL, John Everett, MD
Location: Lincolnton, NC (Lincoln Co)
DOB: 7/13/54
License #: 00-39646
Specialty: OBG (as reported by physician)
Medical Ed: Universidad Del Noreste, Mexico (1981)
Action: 5/15/98. Temporary/dated license extended to expire 1/31/99.

MARTIN, Gerald Randall, MD
Location: Brevard, NC (Transylvania Co)
DOB: 6/04/56
License #: 00-32949
Specialty: IM (as reported by physician)
Medical Ed: University of Texas Medical Branch, Galveston (1987)
Action: 5/15/98. Full and unrestricted license reinstated.

MEAD, Robert J., MD
Location: Asheboro, NC (Randolph Co)
DOB: 12/13/45
License #: 00-32790
Specialty: AN/PD (as reported by physician)
Medical Ed: Jefferson Medical College (1978)
Action: 5/15/98. Temporary/dated license extended to expire 11/30/98.

MINARD, John Lawrence, MD
Location: Morganton, NC (Burke Co)
DOB: 1/12/35
License #: 00-29347
Specialty: CHP/P (as reported by physician)
Medical Ed: University of Pittsburgh (1961)
Action: 7/17/98. Temporary/dated license extended to expire 1/31/99.

NELSON, Mark Theodore, MD
Location: Sanford, NC (Lee Co)
DOB: 11/24/61
License #: 93-00251
Specialty: ELY/AN (as reported by physician)
Medical Ed: University of Kansas (1989)
Action: 7/17/98. Temporary/dated license extended to expire 1/31/99.

PRESSLY, Margaret Rose, MD
Location: Sylva, NC (Jackson Co)
DOB: 5/05/56
License #: 00-34548
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1990)
Action: 5/15/98. Temporary/dated license extended to expire 11/30/98.

PULEO, Joel Gregg, MD
Location: Pinehurst, NC (Moore Co)
DOB: 9/15/53
License #: 00-27965
Specialty: OBG (as reported by physician)
Medical Ed: Duke University School of Medicine (1979)
Action: 5/15/98. Temporary/dated license extended to expire 9/30/98.

PULEO, Joel Gregg, MD
Location: Pinehurst, NC (Moore Co)
DOB: 9/15/53
License #: 00-27965
Specialty: OBG (as reported by physician)
Medical Ed: Duke University School of Medicine (1979)
Action: 7/17/98. Full and unrestricted license reinstated.

QURESHI, Aftab Ahmad, MD
Location: Ahoskie, NC (Hertford Co)
DOB: 9/29/40
License #: 00-24494
Specialty: GS/VS (as reported by physician)
Medical Ed: King Edward, Pakistan (1962)
Action: 7/17/98. Full and unrestricted license reinstated.

REESE, Perry, III, MD
Location: Cary, NC (Wake Co)
DOB: 8/17/58
License #: 94-00988
Specialty: FP (as reported by physician)
Medical Ed: Wayne State University (1990)
Action: 6/01/98. Temporary/dated license, limited to male patients, issued to expire 12/31/98.

RUDISILL, Elbert Andrew, Jr, MD
Location: Hickory, NC (Catawba Co)
DOB: 1/14/47
License #: 00-21863
Specialty: FP (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1977)
Action: 5/15/98. Temporary/dated license extended to expire 11/30/98.

SCHEUTZOW, Mark Howard, MD
Location: Matthews, NC (Mecklenburg Co)
DOB: 8/19/57
License #: 97-00166
Specialty: PM (as reported by physician)
Medical Ed: Ohio State College of Medicine (1993)
Action: 5/15/98. Temporary/dated license extended to expire 1/31/99.

SHANKS, David Edward, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 6/02/41
License #: 00-20440
Specialty: PUD/HO (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1966)
Action: 5/15/98. Full and unrestricted license reinstated.

SUVILLAGA, Victor Ivan, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 10/19/48
License #: 00-26877
Specialty: FP/EM (as reported by physician)
Medical Ed: University of El Salvador (1979)
Action: 7/17/98. Temporary/dated license extended to expire 1/31/99.

SYKES, Larry Justain, Jr, Physician Assistant
Location: Fayetteville, NC (Cumberland Co)
DOB: 9/11/46
License #: 1-00388
Education: Fort Sam Houston, TX (1976)
Action: 7/17/98. Full and unrestricted license reinstated.

WEST, Harold Kenneth, MD
Location: Apopka, FL
Maitland, FL
DOB: 4/21/54
License #: 98-00437
Specialty: FP/EM (as reported by physician)
Medical Ed: Loma Linda University (1979)
Action: 5/15/98. Temporary/dated license extended to expire 7/31/98.

WEST, Harold Kenneth, Jr, MD
Location: Apopka, FL
Maitland, FL
DOB: 4/21/54
License #: 98-00437
Specialty: FP/EM (as reported by physician)
Medical Ed: Loma Linda (1979)
Action: 7/17/98. Extend temporary license to expire 7/31/99.

DISMISSALS

SONI, Chandrakanta Anantku, MD
Location: Raleigh, NC (Wake Co)
Cary, NC (Wake Co)
DOB: 1/15/51
License #: 00-39093
Specialty: IM (as reported by physician)
Medical Ed: MGM Medical College, India (1976)
Action: 5/13/98. Notice of Dismissal issued in case initiated by Notice of Charges dated 1/08/98. [License surrender acknowledged 1/28/98.]

TEICHNER, Ronald, MD
Location: Miami, FL
DOB: NA
License #: 00-18914
Specialty: GYN/OB (as reported by physician)
Medical Ed: University of Illinois (1953)
Action: 5/28/98. Notice of Dismissal issued in case initiated by Notice of Charges dated 1/08/98. [License surrender dated 1/20/98.]

North Carolina Medical Board
Meeting Calendar, Application Deadlines, Examinations
October 1998 -- September 1999

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

North Carolina Medical Board	**November 18-21, 1998**
November Meeting Deadlines:	
Nurse Practitioner Approval Applications	October 5,1998
Physician Assistant Applications	October 6, 1998
Physician Licensure Applications	November 3, 1998
North Carolina Medical Board	**January 20-23, 1999**
January Meeting Deadlines:	
Nurse Practitioner Approval Applications	December 7,1998
Physician Assistant Applications	December 2, 1998
Physician Licensure Applications	January 5, 1999
North Carolina Medical Board	**March 17-20, 1999**
March Meeting Deadlines:	
Nurse Practitioner Approval Applications	February 1,1999
Physician Assistant Applications	February 3, 1999
Physician Licensure Applications	March 2, 1999
North Carolina Medical Board	**May19-22, 1999**
May Meeting Deadlines:	
Nurse Practitioner Approval Applications	April 5, 1999
Physician Assistant Applications	April 1, 1999
Physician Licensure Applications	May 4, 1999
North Carolina Medical Board	**July 21-24, 1999**
July Meeting Deadlines:	
Nurse Practitioner Approval Applications	June 7, 1999
Physician Assistant Applications	June 8, 1999
Physician Licensure Applications	July 6, 1999
North Carolina Medical Board	**September 15-18, 1999**
September Meeting Deadlines:	
Nurse Practitioner Approval Applications	August 2, 1999
Physician Assistant Applications	August 3, 1999
Physician Licensure Applications	August 31, 1999

☞ **Residents Please Note USMLE Schedule**

Examinations Schedule

United States Medical Licensing Examination (USMLE) Step 3

May 11-12, 1999 Sitting
Deadline for receipt of application: February 10, 1999
December 7-8, 1999 Sitting
Deadline for receipt of application: September 7, 1999

Special Purpose Examination (SPEX)

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

LICENSES RECENTLY MADE INACTIVE
(Results from Failure to Register)

MARCH 1998

Name (alphabetical)	License #
Adams, John Sindos, Sr.	94-00005
Aleman, Micaela,	95-01474
Alexander, Stuart Kalman	00-18748
Alexander, William McKinley	00-08326
Anderson, David James Mearns	00-34539
Andrews, Randall Scott	00-30587
Appiah, Augustine	00-20588
Ashley, David Michael	95-00790
Ballenger, James Caudell	00-16822
Barnes, Craig Edwin	00-33608
Bellstrom, Laura Ann	00-35836
Bodily, Kurt Olsen	00-36147
Bowers, William Hampton	00-15023
Bradshaw, Elaine Allen	96-01535
Brendlinger, Dirck Lowe	00-33346
Broome, David Van	00-36660
Brown, Elisa Christine	00-36662
Brunson, Jack Wade, Jr.	00-24838
Campbell, Scott Eugene	00-35079
Chittchang, Amonrath	00-29087
Coates, Kimberly Willis	95-00864
Cohen, Betty Ann	00-33011
Coogan, Alice Clark	00-36678
Creque, Luritz Clergymann	00-09407
Crim, Julia Ruth	00-34966
Curtsinger, Luke James, III	00-36681
Davis, Craig Alan	96-00048
Davis, John Scott	00-35625
Dilley, Sharon Patricia	00-32488
Drake, Karen Lynn	00-36514
Durand, Andre Mark	00-30629
Eastman, Ann Rethy	95-00561
Ebbert, Paul James	00-25272
Ellinas, Herodotos	94-00243
Ellis, Richard Bruce	00-33591
Engel, Moshe David	96-01602
Fann, William Edwin	00-17625
Fenster, Michael Scott	00-34601
Finkel, Bruce Daniel	93-00111
Fisher, David Christopher	00-34001
Freeman, Lynne Michelle	95-00347
Galford, Roberta Elizabeth	00-31509
Gill, Kevin Joseph	00-38950
Glass, Jeffrey Peter	93-00383
Goldberg, Jeffrey Alan	00-35904
Gordon, Ronald S.	00-39272
Griffiths, Marian Folsom	00-28642
Grippo, Allen Edward	00-13984
Guthrie, John Robert	00-24770
Haddad, Reem Mariam	95-01266
Hale, David Benjamin	00-35910
Hannasch, James Donald	00-26258
Harbourne, Kevin Scott	94-01206
Harrison, Stephanie	98-00269
Harrity, Jane DeSisto	93-00143
Hawkins, Joseph Buchanan, Jr.	00-30167
Heath, Stacey Maurice	00-35919
Hellman, Fredric Neil	95-00091
Hicks, Howard Kenneth, Jr.	00-23290
Howard, Thomas Peter	96-01634
Hoyle, Robert Mark	00-34220
Imami, Emran Riaz	94-00082
Jeremiah, Michael Patrick	00-36742
Jewell, Thomas William	00-33847
Josephs, David Michael	00-38102
Joshi, Vijay Vinayak	00-32522
Joyner, Ronald Freeman	00-15951
Kalman, Anna	00-32001
Kanter, Robert Keene	00-39436
Kaplan, Andrew Howard	00-30378
Khan, Abdul Rahim	96-00968
Kim, Sang You	00-31555
Kirby, Jack Payton	00-15788
Knight, Kenneth Karl	00-35682
Knight, Robert M.	00-34373
Koontz, William Luther	00-19861
Kupfer, Stuart Roy	00-35952
Lamy-Monnot, Lianne	00-36469
Lang, Thomas John	96-00065
Langdell, Robert Dana	00-08687
Langeland, Rolf Heikki	96-00979
LeBleu, Todd Howle	00-35157
Levine, Rebecca Jane	97-01035
Macintosh, Victor Henry	00-25814
Mair, Scott Douglas	95-00991
Mannan, Arif	93-00526
Martin, Peter James	00-35424
McDaniel, William Jeffrey	00-35702
Micca, Joseph Louis	00-36475
Miller, Gregory Atwood	95-01007
Minzter, Ronald Marshall	00-34104
Moorjani, Harjasrai S.	93-00543
Moradian, Glenn Peter	00-39858
Morgan, Brent Wilson	94-00942
Morrison, James Edward	00-35172
Morrison, Sidney Emmett, Jr.	00-13507
Moyer, Joseph George	00-34414
Mythen, Michael Gerard	95-00001
Naguib, Sherif George	00-35995
Navoy, Joseph Francis	00-32546
Nelson, Claudia Kristelle	00-25630
Nguyen, Thuan Phuong	94-00598
Noetzel, Harry Albert	94-00599
Ogden, William Davidson	00-35998
Osborne, Ladd Bruce	00-38820
Panezai, Fazal Rehman	00-33879
Parham, Asa Richmond	00-05919
Paulk, Kirk Alan	96-00224
Perkins, Cheryl Elaine	00-36410
Phea, Theodora Yvette	00-39317
Porter, David Joel	95-01639
Quakenbush, Julie Ann	00-29376
Radovich, Catherine Marie	00-21850
Radwan, Hiba Muhammad	
Rifka, Mona Gabriel	94-01317
Rollie, Orris O.	00-23425
Rudolph, Alan Theodore	00-18225
Sahakian, Wiken	00-34151
Saul, Robert Anthony	00-22623
Scarlett, Hugh Henry, Jr.	00-38196
Schwartzburt, Elizabeth	94-00343
Schweers, Carl Amos	00-36824
Seningen, Ronald Perry	00-16201
Shefferly, James Robert	00-30094
Shellman-White, Sondra Ann	95-01416
Slagle, Steven James	00-38205
Slusher, Ernestine Marye	93-00814
Smith, Douglas Randall	00-33144
Smith, Hale Michael	00-35205
Smith, Lawrence Edward	95-00726
Smith, Stanley Lamar	00-31652
Sprance, Lee Anne	00-39094
Staton, Frederick	00-24617
Steele, George Horace, Jr.	00-29201
Stewart, Joseph Grier, Jr.	94-00365
Strickland, Robert Allen	00-24102
Swackhammer, Randy Lee	00-33315
Taylor, George Winston, Jr.	00-07038
Tuttle, Jay Robert	00-15601
Van Der Werken, Barbara Susan	00-34757
Van Steyn, Scott Jeffrey	00-35246
Villalobos, Linda Ann	00-35544
Vince, Steven Ward	00-34926
Vinson, David, Jr.	95-00261
Vuksta, Michael Joseph, Jr.	00-35067
Webster-Clair, Deborah C.	00-33575
Weed, Thomas Evans	00-40019
Welch, Bruce Charles	00-36853
Welch, William Calvin	00-20692
Wells, Brenda Austin	00-35548
Whisnant, John Keenan, Jr.	00-16042
Whitley, Thomas Harrison, Jr.	00-16046
Williams, Oliver Alfred	00-16310
Willis, Michael Delano	98-00422
Wolfe, Edwin Leonard	00-15812
Young, Josephine Chung C.	94-01101
Zapanta, Lydia Soriano	00-22440
Zimmerman, Aaron Harold	96-00794
Zoret, Carol Lynne	00-31225

APRIL 1998

Name (alphabetical)	License #
Affronti, John Paul	00-39914
Anggelis, Chris Nick	00-29208
Bart, Deborah Sue	00-33344
Baucom, Sandra Sasser	00-27554
Bell, Meredith Windham	00-38586
Benson, Telford Le Roy	00-15017
Berger, Adam Scott	93-00034
Bonyak, Edward Vincent	00-36655
Boulware, George Robert	00-14064
Bryer, Mark Philip	00-34568
Buhrman, William Currie	00-31455
Burns, Georgianna Tsekouras	00-34260
Burstain, Jennifer Morrow	96-01565
Carlson, Gregory Brian	00-34267
Catena, Thomas Gerard	93-00059
Cauthen, William Louis, Jr.	93-00664
Chambliss, John Randolph	00-06060
Clark, Margaret Anne	00-26644
Craven, Nicholas Scott	00-13425
Critelli, Virginia Lynn	95-00545
Crouch, Timothy Ellis	96-01584
Curtis, Thomas Christopher	94-01163
Dalton, Howell Barron, Jr.	00-33225
Daniel, Louie Samuel	00-05504
De Los Heros, R. Orlando	00-36170
Dhaliwal, Amarjit Singh	00-38261
Dharia, Tarun Manilal	00-36686
Dono, Patrick Anthony	00-38606
Downes, Thomas Robert	00-28176
Duncan, Joel Wesley	00-38508
Estes, John Eugene, Jr.	00-18632
Evans, Jean Carpenter	00-30803
Evans, Peter John	97-01338
Faber, Kenneth Alan	00-33648
Faehnrich, Jana Alexandra	95-00786
Ferraro, Frank James	94-00054
Fisher, Joseph Douglas	93-00695
Frick, Robert Burke	00-25288
Garland, Wesley Scott	00-12033
Giarve, Stanley Edward	00-28755
Gibbons, Gregory David	00-26928
Glanzman, Robert Louis	00-34325
Goldstein, Joel Michael	00-39177
Gorten, Ralph J.	00-11348
Gottfredsdottir, Maria Soffia	95-01256
Gregory, Hugh Hancock, Jr.	00-39427
Grover, Daniel Austin	95-00601
Harris, Randall Edward	00-28646
Hayes, Thomas Patrick	00-39613
Herman, James Gordon	00-33921
Hiken, James Nathan	94-00838
Hood, Thomas Ruffin	00-07880
Houghton, Raymond Curtis	00-10726
Howard, James Andrew	94-00842
Hurst, Emil Douglas	94-00079
Jacobs, Robert Joseph	00-28222
Johnson, George, Jr.	00-09099
Klein, Jeffrey Ira	94-00545
Koury, George Eli	00-07249
La Grange, Charles Rex	00-11739
Levy, Alan Merrill	00-31566
Lewis, Barton Lee	00-37885
Lewis, Mitchell Laine	95-01316
Lind, Philip Karl	93-00515
Llenza, Charles Federico	00-21070
Lopez, Raul Ignacio	00-15773
Lowry, Suzan Chuang	94-01441
Macias, Michelle Montalvo	00-39017
Mallory, Roger Lee	94-00296
Marconi, Mark Anthony	95-01325
Marini, Julius Richard, Jr.	00-13160
Marlow, Gary John	94-00099
McCombs, Ricky J.	00-34681
McKellar, David Loflin	00-34094
McLeod, John Frank, III	00-33095
McNair, Nancy Lynn	00-39033
Meyerson, Scott Michael	96-00642
Miller, Michael Thomas	94-01272
Millon, Angela Duncan	95-01341
Montgomery, Wayne Swope	00-10290
Moore, Jack Clark, II	00-38812
Moorman, Lemuel Talbott	00-08260
Moreno, Linda Beatriz	95-01612
Mosleth, Michael Bertram	00-35445
Mukherjee, Sanjoydeb	97-00341
Mushtaq, Ednan	96-00651
Muss, Hyman Bernard	00-19270
Mutch, David Gardner	00-28065
Ngo, Thuy Tuong	93-00254
Nichols, William Edward	94-00313
Nowoslawski, Joseph Felix	00-25171
Nugen , Richard Recher	00-18977
Nyquist, Steven Richard	00-31182
O'Neill, James Flemister	00-10194
Oaks, Howard Grady	96-00348
Oweida, Sami Joseph	00-28788
Palmgren, Einar Alexander	00-05664
Park, In Kyu	00-20326
Parker, Craig Philip	97-01531
Parker, Martha Elizabeth	00-16923
Parrish, Glenn Cade	00-18284
Patterson, Larry Todd	95-00684
Patterson, Mary Deffner	95-00685
Perez, Gerardo Marcelino	93-00272
Philip, Jeffrey Scott	00-34126
Pickens, Christopher James	
Plunkett, Mark Alan	95-01063
Proctor, Jeffrey Glen	95-00691
Quinn, Leo Francis	00-38676
Quinn, Peter Joseph, III	00-34896
Redding, Anne Denise	00-36250
Rehm, Jeffrey Ronald	00-38829
Reifman, Larisa Grigorevna	00-27844
Reimer, Curtis Daniel	95-01390
Reinstein, Leon Julio	00-39520
Ricks, David Kay	00-30851
Roberts, John Cranston	00-38184
Rugen, Rebecca Vander Veer	00-36817
Sanderson, Thomas Walter	00-29660
Sasanka, Jaroslaw Piotr	98-00688
Schmidt, Paul	94-01020
Schnell, James William	94-00340
Shannon, Matthew Brian	96-01066
Shields, Teresa Eve Miller	00-32861
Shin, David John	00-09563
Shirazi, Khalil K.	00-20443
Simmons, Rache Michele	00-34805
Simpson, Steve Lynn	94-01039
Sinis, Stamatios	00-18716
Slaker, Dirk Paul	95-00227
Smith, Gregory Craig	00-38691
Smith, Linnea Weblemoe	00-20966
Snedeker, Jeffrey David	00-30860
Solnit, Aaron Daniel	00-39480
Solovieff, Gregory Vladimir	00-19772
Sparacino, Michael Louis	00-39747
Steiner, Theodore Scott	94-01346
Strudwick, Bette Catoe	00-09145
Stuart, Frank Allan, III	00-11958
Sultan, Sultan Ahmad	00-36053
Suslavich, Frank John, Jr.	00-23441
Swanton, Caroline H. Buie	00-13067
Tahhan, Hassan Raymond	00-35528
Tarnasky, Paul Randall	93-00337
Thielman, Nathan Maclyn	00-35568
Thomas, David Raymond	00-38562
Thompson, Edward Monroe	00-33568
Thwing, Philip Tolleson	00-39493
Trow, Lorraine Johanna	00-31212
Van De Ven, C. Johan Marie	00-34185
Verro, Piero	95-00259
Wade, Patricia Ann	00-39347
Walden, Burt Marcus	00-08163
Walsh, Louisa Marcy	97-00415
Walters-Scherrer, Barbara Ann	00-31755
Warner, Douglas Keith	96-01514
Warning, William Joseph, II	00-34193
Weber, David Jay	00-29186
Weiss, Larry Lister	00-13396
West, Gregory Gillman	00-33170
Williamson, Charles Edward, Jr.	00-39500
Winfrey, Mae Millicent	00-35232
Woods, Roderick Dale	00-36295
Youyeunyong, Sunai	00-26887
Zaidi, Anita Kaniz Mehdi	93-00382

CHANGE OF ADDRESS FORM

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

Please print or type. Date:_____

Full Legal Name of Licensee:_____

Social Security #:_____License/Approval #:_____

(Check preferred mailing address)

❑ Business:_____

_____

Phone:(_____)_____Fax:(_____)_____

❑ Home: _____

_____

Phone:(_____)_____Fax:(_____)_____

The Board requests all 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.

Expert Reviewers Needed for NCMB Panel of Medical Advisors

The North Carolina Medical Board evaluates approximately 500 quality-of-care cases each year. These involve issues arising from patient complaints, malpractice claim outcomes, and hospital reports. To do this, the Board draws on the knowledge and experience of the expert reviewers on its Panel of Medical Advisors. They analyze medical records and report their conclusions to the Board for its consideration. On occasion, a reviewer may be asked to offer testimony at one of the Board's formal hearings, but generally evaluations are treated as confidential and are handled by mail. Because the issues involved must be dealt with in a timely manner, evaluation reports are due back from the reviewers within six weeks of their receipt of the case materials. Compensation is provided at the rate of $125 per hour.

The Board needs to increase the number of expert reviewers on its Panel of Medical Advisors. Physicians interested in considering assisting the Board as expert reviewers should mail the form below, accompanied by a full *curriculum vitae*, to the executive director of the Board at the address noted on the form.

Expert Reviewer Response Form

TO: Andrew W. Watry, Executive Director
North Carolina Medical Board
PO Box 20007
Raleigh, NC 27619

Yes, I am interested in the possibility of participating as an expert reviewer for the North Carolina Medical Board. I am under no obligation but would be willing to consider a request to evaluate medical records and attend a short seminar for expert reviewers. Enclosed find my full curriculum vitae.

NAME (Please Print)_____

ADDRESS: _____

_____

_____

NORTH CAROLINA MEDICAL LICENSE #:_____

TELEPHONE: (___) _____ — _____

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Raleigh, NC 27619
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