Primum Non Nocere

No. 3, 2005

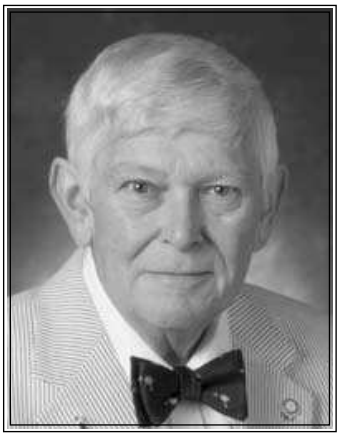
forum

NC MEDICAL BOARD

Santiago Atitlan: Pages 3 and 6

President's Message

"Don't Cry for Me, Argentina"



Charles L. Garrett, Jr, MD

My how time flies when you are having fun with friends. It is hard for me to believe that I have served on your Medical Board for the past five years and that it is now time for my service to come to an end. Service on this Board has been the most rewarding endeavor in my professional career. I have thoroughly enjoyed my time on the Board serving the public and the profession. It is humbling to think of the hundreds of physicians who have served before me, all the way back to the first Board members in 1859.

When I look back through the archives of the Board, I find that not a lot changes. Licensees are still abusing ethanol, diverting controlled substances, and committing what we now refer to as boundary violations. But our licensees get innovative. As new technologies develop, new ways to violate the Medical Practice Act are invented. The Internet has been a fertile source for violations. As I think about the Board members that will follow me, I wonder what sorts of violations and miscreant behavior they will have to deal with. Some of the discipline will be for things that our licensees haven't even dreamed up yet, but I predict that many sanctions will be for abusing ethanol, diverting controlled substances, and committing boundary violations.

I believe that the Board will position itself to more thoroughly investigate quality of care issues in the future. Plans are already being formulated to review the way that the Board handles the professional liability awards and settlements that are reported to it. A system of in-depth investigation of quality of care issues will require many expert reviewers. This is where you, the Board's licensees, can help your Board and help protect the public by being willing to review cases for the Board. I hope that you will assist the Board in this activity. The Board cannot move forward on these cases unless it has competent experts practicing in the same area as a licensee accused of delivering sub-standard care. These are the cases that the public really cares about, and rightfully so.

Thank you for the opportunity to serve you these past five years. I wish Godspeed to the remaining Board members and the new, incoming members.

Dr Garrett was appointed to the Board in January 2001 by Governor James B. Hunt, Jr. He served as the Board's secretary/treasurer from February to October 2002, and became president elect in November that same year. In February 2003, he assumed the office of president of the Board on the death of Dr John T. Dees. He served in this position until November 2003, and again became president in November 2004 for a term ending October 31, 2005.

In This Issue of the FORUM

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Fondly, Carolyn: Letters to a Young Physician Featured on Web Site

On its Web site, the North Carolina Medical Board proudly offers *Fondly, Carolyn: Letters to a Young Physician*, by Carolyn E. Hart, MD, of Charlotte, NC, as a service to all medical students, residents, faculty, mentors, and other physicians and health care professionals concerned about the humanity essential to professionalism and the practice of medicine.

To access *Fondly, Carolyn*, simply go to the Board's Web site: *www.ncmedboard.org*. The text can be downloaded and printed out in the free Adobe format.

We owe special thanks to Dr Hart for preparing a revised version of the *Letters to a Young Physician* series, which appeared in its original form in the Mecklenburg County Medical Society's publication, *Mecklenburg Medicine*, in 2002.

We also thank her and *Mecklenburg Medicine* for graciously permitting publication of the revised version in the *Forum* in 2002 and its publication on the NCMB's Web site.

NCMB Amends Administrative Rules

The North Carolina Medical Board has amended subchapter 32F, Annual Registration, and 32S, Physician Assistant Regulations, of the North Carolina Administrative Code. A copy of the rules is posted on the North Carolina Medical Board's Web site at *www.ncmedboard.org*, or you may access a copy through the Rules Division of the North Carolina Office of Administrative Hearing's Web site at *http://www.oah.state.nc.us*.

The amended rules include the following. *21 NCAC 32F .0103, Fee*, which requires each physician pay an annual registration fee in accordance with G.S. 90-15.1; except that every physician who holds a limited volunteer license shall pay an annual registration fee of $25. *21 NCAC 32S .0105*, *Annual Registration*, which requires each person holding a PA license in North Carolina to register his/her PA license each year no later than 30 days after his/her birthday. The license of any PA who fails to register and who remains unregistered for 30 days after certified notice of failure is automatically inactive. *21 NCAC 32S .0117, Fees*, which states the PA license fee is $200, except that an applicant for a PA limited volunteer license need not submit an application fee. The annual registration fee is $100.00 if you register within 30 days of your birthday. If you register later than 30 days after your birthday, the fee is $120.00. Any PA who holds a limited volunteer license or who submits a statement to the Board confirming that the PA is currently exclusively engaged in volunteer practice and has engaged exclusively in volunteer practice during the preceding year shall submit a reduced registration fee of $25.

Santiago Atitlan: The Call of Something Different—Part 2

Drs Bernadette and Jack Page

Dr Bernadette (Bernie) Page

Dr John (Jack) Page

What was the most humbling experience in your life? For Jack's father, it might have been when he jumped off the floating platform in a lake near Durham, North Carolina, to impress a girl (Jack's future mother). Trouble was, it was deeper on the other side of the platform and he couldn't swim. The current boyfriend of that young girl had to help pull him to safety. For Bernadette and Jack, it might be trying to set up a hospital almost from scratch. After all, they are well educated health professionals, but oh, what they didn't and still don't know! In no particular order, they want to share here some of the experiences they have had as they prepared for the April 1 opening of the *hospitalito.*

Drugs

The *comite* of laypersons in charge of the *hopitalito* wanted to know what drugs the doctors wanted stocked. So the docs scanned the suggested treatment protocols for common illnesses of children published by the Pan American Health Organization and teased out the drugs. They reviewed the suggested essential drug list by the World Health Organization. They also thought of the essential drugs for their respective disciplines. And they were proud of a list of some 50 items, mostly inexpensive, that they came up with. Then it got complicated. Guatemala has two cheap ways to buy drugs, both through government sponsored programs. One, called PROAM, offers drugs like Rocephin® for $1.50 for a one-gram dose and similar great prices for many others. But. . .they were told if they signed up with that program they could not buy drugs from anyone else. The agreement had to be exclusive and PROAM did not stock very many meds for inpatient care. The other program is called *Contrato Abierto*, or Open Contract, which uses the buying power of government agencies and not-for-profits to very aggressively negotiate directly with the drug companies. But like some governmental programs in the U.S., the government made the rules and negotiated too aggressively, so the manufacturers sued in the Guatemalan Supreme Court. They lost, but, in the process, rules were changed that added three additional months to the time it takes to get drugs under Open Contract. So one month before the *hospitalito* was due to open, the docs found out it would be three months before they got any drugs. Scramble, scramble, compromise, and make do. It is a way of life in Guatemala.

Newly hired enfermera auxilares *during employee orientation (one nurse is missing due to conflict with current work location).*

Equipment

They have received donations from all over the U.S. and many places in the world. Most of the donations are perfectly functional, with only some cosmetic problems, if any. Some, however, are deader than a doornail. A Hewlett-Packard monitor-defibrillator, destined for the ER, was plugged in but would not work. A little surgery, after disconnecting from the wall and the battery, revealed the capacitor had burned up. Parts are not available in Guatemala and servicing requires a return trip to the U.S. In the U.S., a small piece breaks and, rather than replacing that piece, a new panel or board is frequently put in. In Guatemala, where even skilled labor is inexpensive, repairs, not replacements, are the order of the day. The doctors are looking for an Ohio bed on which to stabilize and examine newborns, especially after C-sections. So they are using an old crib, raising the mattress, welding an O_2 tank-holder to one leg, a surge protector strip to the top, and chick warming lights to an IV pole welded to another leg. An Ohio bed from Mad Max, but perfectly functional—they hope.

"One month before the* hospitalito *was due to open, the docs found out it would be three months before they got any drugs"

Staff

Four nurses, a pharmacist, and two guards/groundskeepers/janitors have been hired, and all went through various stages of being oriented to what the *hospitalito* will do and how. All four nurses are

enfermeras auxiliares, three wonderful women and one man. But these nurses are like our nurse aids in the U.S. They all have at least a sixth-grade education and six weeks of nursing training. Because the nurses are really very sharp people, the doctors initially overestimated their current skills and knowledge, and some of the orientation was really over their heads. But part of the mission of the *hospitalito* is to not only give good care to its patients but to enable the indigenous people to learn how to take care of their own medical problems, so giving more training and knowledge to these *enfermeras auxiliares* will be an important part of that goal. Again, flexibility and creativity are necessary for staying on track. And the orientation has been a godsend to the doctors as they struggle to learn the local customs to avoid being their own worst enemy in relating to the patients. What do they expect? How is it usually done? What are they insulted by? What won't they do no matter how often they are asked? It is a clear example of how all learning in life is really a two way street.

Employee orientation being conducted in the conference room/administration/doctors' sleep room in the hospitalito.

"Part of the mission of the* hospitalito *is to. . .enable the indigenous people to learn how to take care of their own medical problems"

Standards

Many of the things we take for granted in the U.S. as standards of care or routine medical practice have to be reevaluated in an underdeveloped country. The doctors have been told all the Mayan descendants are Rh-positive. What implications does that have for prenatal screening for blood group and Rh incompatibility? What are the costs of that screening and the costs of stocking and administering RHO immune globulin to patients at risk; or, if no patients are Rh-negative, the cost of the expiring gamma globulin? And what of HIV-positive mothers? Do we treat for months or weeks, like in the developed world, or settle for the single-shot labor and newborn treatment to maximize efficiency for the dollar? How do the doctors make these kinds of decisions and live comfortably with the inevitable consequences over time. There are less onerous questions, of course. What is the normal hemoglobin for a one-year-old, healthy Mayan child? What are the normal height and weight standards for indigenous children in Guatemala? Does a guaiac for occult blood serve any purpose in a population where parasite and worm infestations are the norm? Several of these questions sound like the makings of some good, basic clinical research and might well be addressed in the near future with the help of medical and nursing students.

Comite K'aslimaal*, de facto board of trustees, planning the opening ceremony in a public school classroom.*

Lab

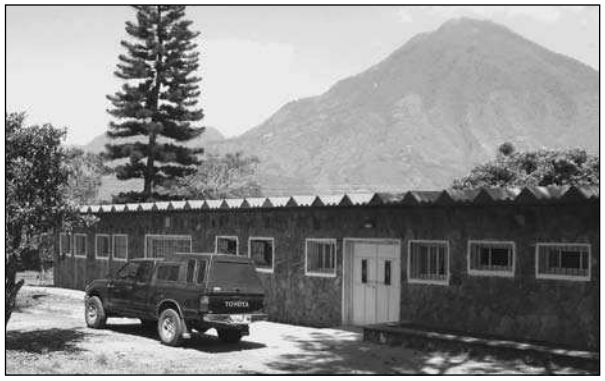
Setting up a laboratory is another lesson in humility. What tests do they want to do? How many of them will be done in a week or month or year? Tests using one process are cheap, per test, but cost a whole lot for the equipment to set them up. Other processes for the same test are very expensive, per test, but cost almost nothing to set up. How do you predict the volume so you can solve this kind of a fixed-cost/variable-cost problem? And what tests are really needed? And do they want to do the test if there is no reasonably available treatment for the disease if it is diagnosed, such as HIV? What does not testing do to some opportunities for prevention? What does testing without available treatment do to those diagnosed and to those making the diagnosis?

In the end, the initial lab will be able to do stool examinations for ova and parasites, hematocrits, rapid tests for pregnancy, HIV, diphtheria, cholera, rotavirus, and urine test strips. No cultures, gram stains, or CBCs, much less liver, kidney, and thyroid panels. All the decisions are best guesses by the doctors. They are made recognizing that in this, too, flexibility and the expectation of future change are necessary to maximize positive impact.

Security

Guatemala is an impoverished country. Some World Bank studies identify it as having the largest gulf in the western hemisphere between the highest echelons of wealth and the lowest echelons of poverty. With poverty comes desperation and with desperation comes increases in crime. The *hospitalito* is located just outside town in an area of concrete block and adobe brick dirt-floor housing. No sanitation, no potable water by U.S. standards, and most homes without electric-

ity. The care is going to be available where the people who need it the most can access it. But what reasonable steps must be taken to protect the resources and personnel of the *hospitalito*? What risks are reasonable and which are just downright stupid? And how do you tell the difference? Most businesses, many delivery trucks, and large private homes in Guatemala have full time guards, many equipped with firearms. The *hopitalito* will be guarded by two men walking the grounds with machetes and loud voices in rotating shifts. A fence is being built around the facility but won't be completed before the doors open and care begins. The doctors and the *comite* of laypersons with which they work hope that the drugs and equipment in the *hopitalito* will not be so attractive to the unruly as to damage the benefits being offered to the overwhelming majority of the people.



Front entrance to hospitalito *for walking patients and their families. San Pedro volcano is standing behind* hospitalito.

The Children

Now for some of the good parts. Figures vary and data are always suspect, but various sources say that 49% of Guatemalan children are malnourished. Most don't starve to death but succumb easily when they catch "non-lethal" illnesses like measles, chicken pox, rotavirus diarrhea, and pneumonia. The *hospitalito* will have well-child care as an initial part of its services and it will monitor in various ways the nutritional status of its patients, referring when necessary to an already in place (and stressed) food supplementation program. On average, 80% of Guatemalan children get their immunizations (which, incidentally, are only those required in the U.S. in the early 1970s). But averages ignore the gulf between rich and poor, Spanish descent and indigenous. Therefore, aggressive immunization programs in the *hospitalito*, in complete collaboration with the local *Centro de Salud*, are planned. Eventually, the *hospitalito* hopes to help train community health promoters who will take the vaccination programs to the villages where the most medically neglected live.

Death rates for children under five in Guatemala average 40 per 1,000 in the "lower middle" income group. Most of these deaths are due to diseases mentioned above, like diarrhea and pneumonia. Programs are being put in place to feed, vaccinate, and, when needed, treat these children in the *hospitalito*, while at the same time showing the family how to treat many of these problems properly in the home. Local customs sometimes cause a cessation of breast-feeding just when it might be the most help. Having food preparers wash their hands can do wonders in limiting the spread within families of diseases that take their greatest toll on the elderly and young.

Childbirth

In Guatemala, less than a half of births are attended by a trained health professional. In rural indigenous areas, this percentage is far lower. The maternal mortality rate is about 200 per 100,000 live births. With the average woman being pregnant some 8 to 10 times, this is a lifetime childbirth mortality rate of slightly less than 2%. Most women deliver in their homes, attended by a native midwife called a *comadrona*. There is no training or certifying organization, and many of these people, usually women, feel "called" to this work in dreams. Mayan culture believes many of them receive their training in dreams as well. Many have sought more traditional training and experience, but most indigenous women are still attended without the benefit of the last 200 years or so of medical experience and knowledge. Relations are frequently strained between western care givers and the indigenous midwives, with neither side appearing to value or learn from the other. The *hospitalito* hopes from the first day to find ways to work collaboratively with the indigenous health care providers and to make everyone more effective in meeting the health care needs of the Mayan population. All the doctors are dedicated to this principle.

"The* hospitalito *hopes from the first day to find ways to work collaboratively with the indigenous health care providers"

Conclusion

So now the plumbing, painting, and stocking are done. Most of the equipment is in and the staff is trained. On April 1, 2005, the *hospitalito* opened for business and saw its first patients. It opened as a clinic and 24/7 emergency room and labor facility. When funding is available, a second stage is planned to open as a full, 20-bed community hospital. Future articles in this series will continue the story of the Pages, the *hospitalito*, the people of Santiago Atitlan—and the continuing education of everyone involved.

This is the second in a series of articles about the Pages and their work as they continue their planned two-year stay in Santiago Atitlan, Guatemala. If you would like to contact them, they can be reached at *brpage@yahoo.com* or *jackpage45@yahoo.com*. If you would like to give of your time or resources to support the *hospitalito* and their efforts, please visit the Web site of Pueblo a Pueblo at *www.puebloapueblo.org*.

FROM SANTIAGO ATITLAN

Juracan: A Message from Bernadette Page, MD, on the Guatemalan Disaster of October 6

(Presented exactly as received by e-mail at the *Forum* office on October 7.)

Juracan is the Mayan God of wind. His brother of course is rain. He had been giving us steady rain for days, sometimes heavy, almost all day and all night. By two days ago I was regretting that I had agreed to pick Jack up at the airport on Wed morning. We knew that Stan was affecting us, though he was supposed to touch land far away, in Mexico. But before he ever touched land, he had drenched us. As often in heavy rains some streets were flooded to the tops of the curbs. Others (cardiac hill, for those of you who have visited) looked like waterfalls. More than anything else, we were just tired of the rain. But as the night progressed, I didn't sleep well, dreading the drive, down narrow twisty roads, with multiple vehicles with poor brakes and drivers with more hurry than sense. It would be awful visibility to judge by the sound of the heavy rains.

"The mud is 6 feet high to the wall of the hospital. The front doors have been broken in"

At 6AM I decided it was time I could call Aclax, the local driver and see if he would pick up Jack and take Mark down. No answer. I called Mark, who was at the hospital so I could get a good night sleep and be fresh for the trip. "Muy pelligrosa aqui," Jacinto answered. I thought my Spanish was getting worse. Very dangerous there? His voice was really distressed. Mark took the phone. "Don't try to come out," he said. "There's been a mudslide. The mud is 6 feet high to the wall of the hospital. The front doors have been broken in." "Get out," I said. "We can't," he said. "It's impassable. We're ok for now." His voice sounded strained. We both were thinking the same thing. It was continuing to rain hard. What if there was another slide? "Can you call the bomberos?" "It's impassable," he repeated patiently. "Call my parents and tell them I can't make the flight and not to worry."

His parent's number didn't go through. I called my daughter. "Would you email Dad that I can't pick him up? And call Mark's parents and tell them he can't make his flight." "You sound so worried Mom. Are you all right?" "I am just worried about Mark." As I said it, a noise started. It didn't sound like the freight train of a tornado. More like a very heavy sustained wind. Or a freight train. It went on and on. I would have said it was 15 minutes. But perhaps it was 3. Then only the rain.

What to do? Kathy Roach called. "I'm at Rxin Tnamit. A woman is in labor, can you come in?" I thought about it. It was raining hard. Tornado, volcano eruption, landslide all ran through my mind. I decided to just stay put. Doctor Irene was in town, as was Dr Juan Manuel. Both much closer than I. My phone went out of service. Ken, who had arrived the day before, knocked at my door. We had oatmeal, about the only breakfast I could come up with that did not involve opening the refrigerator, for the electricity was of course out. We decided to try to walk into town, since I was too worried about the road to drive. I walked him down the hill. Large boulders had fallen, but the outside lane was still passable. No large landslide. We got to the football field. The road in front, always muddy after heavy rains, was a sea of mud, a crowd of people on either side looking across. A few were trying to cross. Ken said he would go over. I started out, but as the water swirled around my ankles, and the mud sucked my boots partly off with each step, I decided to stop. Ken went on. I returned to my house, moved my computer and printer away from the windows. Moved the files up off the ground. Warm and dry, I felt increasingly like I should go into town. But too worried about the road to try to drive. Finally I decided to visit Violeta and Serunda and Roberto, only a couple of small coffee fields away. They showed me where the landslide had occurred. John, from the Hotel Bambu, knocked at their door. "Is the doctor here?" he asked. (I had put a sign on my door). They are looking for a doctor at the colegio. We packed up all the medicines in the house and headed out in the still pouring rain. Last time to feel warm or dry for a while. Actually, when we got there, a local doctor had already set up for treatment. Jose Ataz Reanda, the local shaman whose Dad broke the first stone for the hospital in the 60s, came by. He offered to guide us into town. "Everyone says it is impassable. We can get through." For some reason we all believed him and followed his path through the mud and waters to Rxin Tnamit.

Others from the hospitalito staff were already there working, along with their staff. There was a 10 year old whose parents had died. He had a broken femur, a 3 inch v shaped in his scalp. It didn't bleed because it was packed with mud. He sang songs throughout our cleaning (we couldn't get out the mud) and reducing his leg. We were too afraid of hypothermia to clean him properly. When he was transferred out today, he was still covered in mud.

Two sisters, multiple deep dirty cuts, broken clavicle, wrist, clavicle, mud in eyes. Both their parents and 4 other sibs reportedly killed also. But the vast majority of people were just cold. Garbage bags of at least partly dry clothing arrived. We would strip the newcomers as soon as they came in, put on semi dry clothes, give them hot coffee to drink, send them off to a shelter.

Slowly, we began to piece together that there had been big mudslides near the hospital and above the town and above the football field. Also in Panajachel across the lake.

Irene, Juan Manuel, Ken and I decided to do shifts, 2 doctors to a shift. I got to go home for the night. Actually, I went to Mercedes' house. She is the sister of Chonita, where Kathy lives. They fed us hot rice and

beans and hot tea. Kathy and I went straight to bed. The comforting sound of female singing came from the front of the house. I thankfully pulled out a pair of dry socks I had put in a plastic bag. Heavenly!

Today we waited for patients to come, but they were few. Finally word came through that there was a passable way to Solola and that the hospital was open. We shipped out all our patients from Rxin Tnamit. The bomberos made it to the hospital and took out the 5 patients from there. Leah and Mark went to the Posada. We met them there. Mark said he wasn't going to split any more shifts with me. He told how he had been wakened up by screaming to find the mud filling the reception room and inches deep for much of the hall. How they had finally decided to move to the second story of the police building next door. We had lunch together at the Posada. I got out an email to my family. I think I probably had worried Sara to death. I had a hot fudge sundae. We met again as a doctor group. Decided to set up a temporary hospital at the Centro de Salud. We needed cots. Or at least mattresses. After much discussion, we decided to try to get them from the hospitalito.

We got Freddy, one of our guardians, and his teenage son Israel and headed out. We did cross some mud, but boards or lamina had been laid down and ropes had been strung up. It sounds dangerous, but by this time, the danger was just of falling off and getting muddy. We collected all the mattresses and supplies we could think of, left Ken there to spend the night, headed back to the Centro de Salud (detouring around the fire truck that was putting water in the reserve of a church), unloaded the stuff. I came home, found I have electricity but no water, and made the closest thing I could to Bisquick Coffee Cake and am ready for bed. I have the shift tomorrow at the Health Center "hospital" so it is early to bed.

"The comforting sound of female singing came from the front of the house"

"Seek peace and pursue it"

(Photos of the *hospitalito* after the mudslide can be found at *www.puebloapueblo.org.)*

NCMB Replaces Position Statement on Management of Chronic Non-Malignant Pain

At meetings in late 2004 and early 2005, the North Carolina Medical Board's Policy Committee undertook and completed study of the Board's position statement on the "Management of Chronic Non-Malignant Pain," which was originally adopted in September 1996. At its meeting in July 2005, the Committee recommended and the Board then adopted an updated and more inclusive statement titled "Policy for the Use of Controlled Substances for the Treatment of Pain." This new statement is a slightly modified version of a document developed by the Federation of State Medical Boards of the United States and revised by the FSMB in 2004.

The new statement reflects the Board's view that appropriate treatment of chronic pain may include both pharmacologic and non-pharmacologic modalities and that controlled substances, including opioid analgesics, may be an essential part of the treatment regimen. At the same time, it makes clear that all prescribing of controlled substances must comply with applicable state and federal law and that the guidelines for treatment include: (a) complete patient evaluation, (b) establishment of a treatment plan/contract, (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate. (Deviation from the guidelines will be considered on an individual basis for appropriateness.)

The text of the new statement is presented below.

Policy for the Use of Controlled Substances for the Treatment of Pain

- Appropriate treatment of chronic pain may include both pharmacologic and non-pharmacologic modalities. The Board realizes that controlled substances, including opioid analgesics, may be an essential part of the treatment regimen.
- All prescribing of controlled substances must comply with applicable state and federal law.
- Guidelines for treatment include: (a) complete patient evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate.
- Deviation from these guidelines will be considered on an individual basis for appropriateness.

Section I: Preamble

The North Carolina Medical Board recognizes that principles of quality medical practice dictate that the people of the State of North Carolina have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this policy, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The Board encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this policy has been developed to clarify the Board's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from physicians' lack of knowledge about pain management. Fears of investigation or sanction by federal, state, and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the Board will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The Board recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The Board will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The North Carolina Medical Board is obligated under the laws of the State of North Carolina to protect the public health and safety. The Board recognizes that the use of opioid analgesics for other than legitimate medical purposes pose a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the Board expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing, or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice. The Board will consider prescribing, ordering, dispensing, or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The Board will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

Allegations of inappropriate pain management will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for deviating from this policy when contemporaneous medical records document reasonable cause for deviation. The physician's conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life.

Section II: Guidelines

The Board has adopted the following criteria when evaluating the physician's treatment of pain, including the use of controlled substances:

Evaluation of the Patient—A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

Treatment Plan—The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment—The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (e.g., violation of agreement).

Periodic Review—The physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Consultation—The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance abuse or with a comor-

bid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

Medical Records—The physician should keep accurate and complete records to include:

1. the medical history and physical examination;
2. diagnostic, therapeutic, and laboratory results;
3. evaluations and consultations;
4. treatment objectives;
5. discussion of risks and benefits;
6. informed consent;
7. treatments;
8. medications (including date, type, dosage, and quantity prescribed);
9. instructions and agreements; and
10. periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

Compliance With Controlled Substances Laws and Regulations—To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and any relevant documents issued by the state of North Carolina for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute Pain—Acute pain is the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. It is generally time-limited.

Addiction—Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

Chronic Pain—Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

Pain—An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence—Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction—The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

Substance Abuse—Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance—Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

(Adopted September 1996 as "Management of Chronic Non-Malignant Pain.") (Redone July 2005 based on the Federation of State Medical Board's "Model Policy for the Use of Controlled Substances for the Treatment of Pain," as amended by the FSMB in 2004.)

D. Todd Brosius, JD, Joins NCMB Legal Staff

R. David Henderson, executive director of the North Carolina Medical Board, and Thomas W. Mansfield, JD, director of the Board's Legal Department, recently announced that D. Todd Brosius, JD, has joined the staff of the Board's Legal Department.

A native of Florida, Mr Brosius earned his BA in English from Tufts University and did graduate study in English literature at North Carolina State University, where he served as a teaching assistant for several years. He then took his JD from Duke University School of Law. While at Duke, he worked as a research assistant dealing with current issues in environmental law and conducting a study of citizen confidence in the U.S. political system. He was also an editor of the Duke Law Journal and was certified as a mediator through the Duke Private Adjudication and Mediation Center.

Immediately prior to joining the NCMB staff, Mr Brosius was associated with Smith Moore, LLP, in Raleigh. There he had significant litigation experience and represented numerous companies, hospitals, and individuals in the context of product liability, intellectual property, commercial disputes, and insurance defense. He also provided pro bono assistance to the Wake County District Attorney's Office in the prosecution of domestic violence cases.

Mr Brosius is an active member of the North Carolina State Bar Association, the Wake County Bar Association, and the Defense Research Institute. In his new role, he joins Mr Mansfield; Marcus B. Jimison, JD; Brian L. Blankenship, JD; and Katherine L. Carpenter, JD.

"We are delighted to have Mr Brosius joining our legal staff—a group of talented and dedicated attorneys," said Mr Henderson. "He brings still further strength to our efforts to serve the people of North Carolina."

GOVERNOR'S INSTITUTE ON ALCOHOL & SUBSTANCE ABUSE, INC.

Screening and Brief Intervention for Substance Abuse and Dependence in Adolescents

Sara B. McEwen, MD, MPH, and Jacob A. Lohr, MD

Dr McEwen

Dr Lohr

"Early hazardous alcohol use can have a dramatic negative impact on the many developmental transitions that take place during adolescence"

Adolescent substance abuse (SA) is a major preventable public health problem. Adolescent SA is common: children under 21 years of age drink 25% of the alcohol consumed in the U.S., and more than 5 million high school students (31.5%) admit to binge drinking at least once a month. Middle school students also are profoundly affected, as are college students. Despite the fact that successful interventions during this time period are likely to have long-term benefits across the lifespan, inadequacy of prevention, intervention, and treatment services for the adolescent is well documented. In a national sample of pediatricians and family practitioners, physicians reported providing alcohol-related screening to only 40.3% and education to 52% of their adolescent patients. Only 1 in 10 adolescents suffering from SA disorders receives treatment, and of those who do receive treatment, only 25% receive adequate therapy.

Many adolescents, adults, and even pediatricians surveyed by the American Academy of Pediatrics (AAP) in 1995 hold the perception that casual alcohol and other drug (AOD) use is not a significant concern. It is clear, however, that early hazardous alcohol use can have a dramatic negative impact on the many developmental transitions that take place during adolescence. Adolescent alcohol use is associated with a substantially increased risk of developing an alcohol use disorder in adulthood. In addition, adolescents who use alcohol are at increased risk of academic failure, motor vehicle accidents, other unintentional injuries, risky sexual behaviors, assault (including abuse and date rape), suicide attempts, and drowning. Early use of tobacco and alcohol is a predictive factor for the use of other drugs, use of a greater variety of drugs, and use of more potent agents. Intervention is required for any patient when substance use is having an effect on academic, social, or vocational functioning. Use of substances in association with other risk behaviors also warrants immediate intervention. Patients and their families should be advised that even casual use of substances, regardless of amount or frequency, is illegal and has potential adverse health consequences.

In addition, recent research has shown that heavy drinking is especially dangerous for teenagers because their brains are still developing. Heavy drinking during this period may have long-term negative effects on memory, learning, and other cognitive functions. It also appears that SA predisposes adolescents to experience elevated prevalence rates of psychopathology. Specifically, adolescents with substance use problems are at increased risk for symptoms of mood (girls) and disruptive behavior disorders (girls and boys). This is true for adolescents with less severe substance use problems as well as those with severe substance use problems. Identification of youth with less severe substance use problems may allow for intervention before either the substance use or any associated psychiatric problems progress to more severe levels.

An estimated 11 to 17.5 million children are being raised by a substance abusing parent or guardian. On occasion, therefore, physicians will need to interact with parents who have brought their child to the practice exhibiting symptoms of impaired judgment due to alcohol or drug use. Parents exhibiting signs of AOD impairment may be incapable of caring for a child properly. The child's best interests should guide the pediatrician's actions, especially when the parent's condition compromises his or her ability to share that interest. Reporting the situation to the appropriate authorities may be necessary. The AAP has issued a policy statement that addresses the array of professional, ethical, and legal obligations that the physician faces in this situation. See *http://aappolicy.aappublications.org*.

Research has shown that adolescent SA treatment is both medically effective and cost effective. Early identification of adolescents with AOD problems leading to assessment/intervention can improve the adolescent's quality of life, increase the adolescent's participation in society, reduce long-term care and costs, reduce the burden on the criminal justice system, and provide cost-effective referrals for needed services. Research indicates that adolescents and college students have responded well to brief interventions (defined as 1 to 5 sessions) and brief therapy (usually defined as 6 to 20 sessions).

Screening helps identify individuals who have begun

to develop or who are at risk for developing AOD related problems. Many screening tests are available. We recommend the CRAFFT, a brief, seven-question screen for AOD use in adolescents. (See *Figure One*.) The CRAFFT, easily administered and scored, has been shown to have good sensitivity and to be a valid screening tool for adolescents. Some questions in the CRAFFT are not perfectly suited for the lower and upper age limits of the target population (12-21), so adaptation for younger adolescents and college students is appropriate. The CRAFFT can be incorporated into virtually all clinical encounters with adolescents and young adults. Screening should occur at every routine visit unless the patient has undergone screening within the previous six months (and exhibits no "red flags") and at the time of sick visits as indicated and appropriate.

CRAFFT

- Have you ever ridden in a **C**ar driven by someone (including yourself) who was high or had been using alcohol or drugs?
- Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in?
- Do you ever use alcohol or drugs while you are by yourself **A**lone?
- Have you ever **F**orgotten things you did while using alcohol or drugs?
- Do your **F**amily or **F**riends ever tell you that you should cut down on your drinking or drug use?
- Have you ever gotten into **T**rouble while you were using alcohol or drugs?
- Does your alcohol or drug use ever make you do something that you would not normally do – like breaking rules, missing curfew, breaking the law or having sex with someone?

ADDN Question for younger adolescents:

- Do your parents or friends drink or use drugs in a way that causes problems for you?

SCORING: 2 or more positive items indicate the need for further assessment; one positive item warrants discussion

From: Knight JR, Sherritt L, Shrier LA, et al. Validity of the CRAFFT Substance Abuse Screening Test Among Adolescent Clinic Patients. Archives of Pediatrics and Adolescent Medicine 2002;156(6): 607-614.

Figure One

Brief interventions (BIs), short counseling sessions, lasting five minutes to one hour, are ideal for addressing the large group of mid-range adolescents and young adult substance users who have moderate and risky consumption patterns, are experiencing problems from use, and are involved in a high-risk peer group, but don't have other medical, interpersonal, or environmental stressors. BIs are also well suited to those who are unwilling to accept referral for more intensive treatment. There is good and increasing evidence for efficacy especially among those, based on motivational enhancement theory.

BIs are generally organized around six elements (mnemonic: FRAMES): (1) personalized **F**eedback or assessment; (2) emphasizing personal **R**esponsibility for change; (3) **A**dvice, or explicit direction to change; (4) a **M**enu offering a variety of change options; (5) **E**mpathy, emphasizing a warm, reflective, and understanding approach; and (6) **S**elf-efficacy, emphasizing optimism about the possibility of change. (See *Figure Two.*) The transtheoretical model of change is a useful organizing concept. According to this model, individuals progress through a series of identifiable stages as they address changing a problematic behavior. The stages include precontemplation (individual does not identify a behavior as problematic); contemplation (individual begins to consider behavior change but has no immediate plans to change); preparation (individual is ready to make a change and begins to take steps toward the healthier behavior); and action (individual has changed the behavior and maintained the change for a prolonged period of time).

Clinicians have been reluctant to screen because of both perceived and real barriers, including time constraints associated with high patient volume; inadequate reimbursement; physician fear of alienating or labeling patients and their families; inadequate education and training in SA; lack of dissemination to physicians of research supporting positive treatment outcomes; and lack of information about how to access referral and treatment resources. The AAP has issued policy statements that address alcohol, tobacco, and marijuana use as well as indications for management and referral of patients (see *www.aap.org*).

"The AAP recommends that pediatricians incorporate substance abuse prevention into daily practice"

Even when physicians recognize that an adolescent patient is using substances, the majority fails to realize the severity of the problem. In a recent study at the Center for Adolescent Substance Abuse Research in Boston, pediatricians correctly identified 75% of teens with a diagnosis of misuse or dependence, but underreported the level of use among half of these patients. Only a minority of pediatricians (16%) reported using a structured screening tool, often relying on their clinical impressions to determine severity. Researchers concluded that physicians would be more effective if they used a structured screening tool.

Adolescent SA may be the most commonly missed pediatric diagnosis. Clinicians taking care of adolescents should maintain a high index of suspicion and be aware of both the medical and behavioral presentations of substance use as well as its association with psychiatric comorbidity. The AAP has prepared guidelines for pediatric office assessment of SA.

Every clinical encounter is an opportunity for intervention. Through guidelines and policy statements, both the AAP and the American Medical Association have highlighted the importance of screening adolescent patients for alcohol and drug use. The AAP recommends that pediatricians incorporate substance abuse prevention into daily practice, acquire the skills necessary to identify young people at risk, and provide or facilitate assessment, intervention, and treatment as necessary. Pediatricians should include discussions of SA as a part of routine care, starting with the prenatal visit, and as part of ongoing anticipatory guidance.

PED DIRECT– Brief Intervention

A counseling strategy that incorporates feedback, responsibility, advice, a menu of strategies, empathy, and self-efficacy (FRAMES).

Privacy
Discussion of AOD use should take place in private, without parents or others present.

Empathy
Adopt a warm, reflective, and understanding style. Avoid a blaming, confrontational, or coercive style.

Directness
Maintain eye contact and raise the subject, "I would like to take a few minutes to talk about your alcohol and/or other drug use."

Data
Feedback: "I am concerned about your drinking and/or drug use. Our screening indicates that you are participating in risky drinking that could be harmful to you." Alternately: "I am concerned that you are at-risk because of the drinking behavior of your parents/family/friends."
Give consequences of adolescent/young adult AOD misuse. Offer comparison to national norms.

Identify willingness to change
"On a scale of 1-10 (1 low, 10 high) how ready are you to change your alcohol/drug use patterns?"
If the response is 6 or less, then ask, "Why not more?"
If greater than or equal to 7, then the patient is ready; move on to recommendations.
The response will help the physician to identify discrepancies and assist the patient to move along the continuum from ambivalence to change.

Recommend action/advice
All adolescents/ young adults: "We strongly recommend that you abstain from AOD. It is especially important that you never drive after drinking (or using drugs)."
Screen positive, but unsure if dependent drinker/ drug user: abstain from AOD, and refer for further assessment to specialized substance abuse treatment provider.
Dependent drinkers and/or drug users: abstain from drinking and refer to a detoxification center or specialized treatment facility.

Elicit response
"How does this sound to you?" or "Where does this leave you?"

Clarify and confirm action
Possible clarification/confirmation: "We have just completed a screening test for AOD use that indicates that your AOD use puts you at increased risk for a whole spectrum of problems (medical, social, academic, job related, financial, legal). I am very concerned about your drinking and/or drug use (or the influence of AOD use of your parents/peer group). In the interest of your health (and family), I recommend immediate referral for further assessment and treatment. We know that cutting back or abstaining from alcohol and other drugs is very difficult to do on your own. We would like to offer you help."

Telephone referral
"Would you be willing to speak with a counselor, social worker, etc, now?"
"I'd like to call right now for an appointment or referral. What do you think?"

Figure Two

Sara B. McEwen, MD, MPH, is consultant to the Governor's Institute on Alcohol and Substance Abuse and the Division of Mental Health, Development Disabilities, and Substance Abuse Services. Jacob A. Lohr, MD, is executive director of the Governor's Institute on Alcohol and Substance Abuse. This is the third in a series of articles addressing substance abuse/dependence issues. Other articles in the series will address fetal alcohol syndrome/effects, prescription drug dependence, SA in physicians, and the Alcohol/Drug Council of North Carolina's Action Plan.

NCMB Announces Increase in Certain Fees

R. David Henderson, Executive Director, NCMB

At the request of the North Carolina Medical Board, the General Assembly recently approved changes to certain medical licensing and registration fees. Effective November 1, 2005, the following fees will be assessed.

- The physician application fee for license by endorsement will now be $388 (was $288) and includes a $38 fee for criminal background record check.
- The resident training license application fee will now be $138 (was $25) and includes a $38 fee for criminal background record check.
- The annual registration fee for physicians will now be $175 (was $125).
- The late registration fee will now be $50 (was $20).

Mr Henderson

In April 2005, the following fees were increased by rule.

- The physician limited volunteer license registration fee was set at $25.
- The resident training license registration fee was raised to $125 (was $15).

Most of our licensees will be affected by the annual registration fee increase from $125 to $175. In this regard, it is important to note that, other than a modest increase five years ago ($25), the Board has not had an annual registration fee increase in almost 15 years. Also, even with an increase to $175, North Carolina physicians, ranked tenth by population in the U.S., will pay less than physicians in 22 other states (Connecticut's annual registration fee is $450) and less than many other North Carolina licensees (NC optometrists pay $300 per year).

Although no one likes a fee increase, the NCMB must periodically seek additional funds in order to properly regulate the practice of medicine for the benefit and protection of the people of North Carolina. However, barring the unexpected, the increased revenue generated by the above fees should permit the NCMB to fulfill its public protection mandate for several more years without further fee increases.

NCMB Modifies Position Statement Relating to Hair Removal by Use of Laser

At its meeting in July 2005, the North Carolina Medical Board revised that section of its Position Statement on Laser Surgery that deals with the removal of hair by use of lasers and other devices that manipulate and/or pulse light causing it to penetrate human tissue. The revision stemmed from an extensive evaluation of the process conducted by the NCMB's Policy Committee in public meetings held over the previous year and involving testimony and comments offered by a wide variety of interested persons and groups.

The changes in the wording of the Laser Hair Removal section of the statement are underlined in the text of that section appearing below.

Laser Hair Removal

Lasers are employed in certain hair-removal procedures, as are various devices that (1) manipulate and/or pulse light causing it to penetrate human tissue and (2) are classified as "prescription" by the U.S. Food and Drug Administration. Hair-removal procedures using such technologies should be performed only by a physician or by an individual designated as having adequate training and experience by a physician who bears full responsibility for the procedure. The physician who provides medical supervision is expected to provide adequate oversight of licensed and non-licensed personnel both before and after the procedure is performed. The Board believes that the guidelines set forth in this Position Statement are applicable to every licensee of the Board involved in laser hair removal, whether as an owner, medical director, consultant or otherwise.

It is the position of the Board that good medical practice requires that each patient be examined by a physician, physician assistant or nurse practitioner licensed or approved by this Board prior to receiving the first laser hair removal treatment and at other times as medically indicated. The examination should include a history and a focused physical examination. Where prescription medication such as topical anesthetics are used, the Board expects physicians to follow the guidelines set forth in the Board's Position Statement titled "Contact with Patients Before Prescribing." When medication is prescribed or dispensed in connection with laser hair removal, the supervising physician shall assure the patient receives thorough instructions on the safe use or application of said medication.

The responsible supervising physician should be on site or readily available to the person actually performing the procedure. What constitutes "readily available" will depend on a variety of factors. Those factors include the specific types of procedures and equipment used; the level of training of the persons performing the procedure; the level and type of licensure, if any, of the persons performing the procedure; the use of topical anesthetics; the quality of written protocols for the performance of the procedure; the frequency, quality and type of ongoing education of those performing the procedures; and any other quality assurance measures in place. In all cases, the Board expects the physician to be able to respond quickly to patient emergencies and questions by those performing the procedures.

Professional Corporations: Two Important Requirements

Thomas W. Mansfield, JD, Director
NCMB Legal Department

The staff of the North Carolina Medical Board (Board) frequently receives questions regarding the formation and maintenance of professional corporations (PCs) that practice medicine. The purpose of this article is to address two issues that are often discussed: the requirement that all shareholders be certified as licensees of the Board who are permitted to practice medicine, and the requirement that a PC notify the Board when a shareholder dies. For the purpose of this article, the principles asserted regarding PC's apply to professional limited liability companies (PLLCs), as well.

In North Carolina, the only entities permitted by law to practice medicine are individuals licensed or approved by the Board, professional corporations certified by the Board, hospitals, and HMO's. Professional corporations formed under Chapter 55B of the North Carolina General Statutes are permitted to practice medicine because all the owners are licensed by the Board, which is responsible for regulatory oversight.

The Professional Corporation Act in N.C. Gen. Stat. § 55B-6 provides that "[n]o share or shares of any stock of a professional corporation shall be transferred upon the books of the corporation unless the corporation has received a certification of the appropriate licensing board that the transferee is a licensee." The Act also provides that the term " '[l]icensee' means any natural person who is duly licensed by the appropriate licensing board to render the same professional services which will be rendered by the professional corporation of which he is, or intends to become, an officer, director, shareholder or employee." The instructions for obtaining the certification from the Board are available on the Board's Web site: *www.ncmedboard.org*. The Board's legal staff interprets the above requirements to mean that every shareholder in the PC must have an active license to practice medicine.

A licensee of the Board who passes away no longer has an active license and cannot continue indefinitely to hold shares in the corporation. In fact, N.C. Gen. Stat. § 55B-7 requires that a PC practicing medicine report to the Board the death of any of its shareholders within 30 days thereafter. The same statutory section also states that, "[w]ithin one year of the date of such death, all of the shares owned by such deceased shareholder shall be transferred to and acquired by the professional corporation or persons qualified to own such shares."

As always, the Board's Legal Department recommends that the Board's licensees consult with their private legal counsel whenever they have questions regarding laws enforced by the Board.

Speaking Personally

Pharmacists and the Dispensing of Emergency Contraceptives

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

Mr Work

There have been some rare but highly publicized events recently when pharmacists have refused to dispense prescription orders for emergency contraception, claiming that this therapy is tantamount to abortion.

In February 2004, the North Carolina Board of Pharmacy received a consumer complaint about a pharmacist who declined to dispense a prescription for Preven®, a product then used for emergency contraception, citing his religious beliefs. (Preven® is no longer on the market.) The Board initiated an investigation; however, the complaint was later withdrawn.

Much publicity has occurred in both the general circulation and medical press on this kind of conduct. As a result, the North Carolina Board of Pharmacy adopted the following policy during its meeting in April 2005.

"It is unacceptable, however, for pharmacists to impose their moral or ethical beliefs on the patients they serve"

Conscience Concerns in Pharmacist Decisions

A pharmacist should function by serving the individual, community and societal needs while respecting the autonomy and dignity of each patient. The best practice by a pharmacist is to promote the good for every patient in a caring, compassionate, and confidential manner. Pharmacists should discuss and resolve any questions about emergency contraception prior to employment. Compassionate care and conscientious objection are not mutually exclusive.

A pharmacist has the right to avoid being complicit in behavior that is inconsistent with his or her morals or ethics. It is unacceptable, however, for pharmacists to impose their moral or ethical beliefs on the patients they serve. Pharmacists who object to providing a medication for a patient on this basis alone, therefore, should take proactive measures so as not to obstruct a patient's right to obtain such medication.

The Board notes that although pharmacists have a right to avoid moral or ethical conflict, they do not have a right to obstruct otherwise legitimate prescription dispensing or delivery solely on the basis of conscientious objection.

Board of Pharmacy staff interprets this policy to mean that if a pharmacist refuses to fill a prescription for emergency contraception then that pharmacist has an obligation to get the patient and the prescription to a pharmacist who will dispense that prescription in a timely manner.

Phrases and Concepts From: American Pharmacist Association Code of Ethics;
"May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?" Cantor & Baum. New England Journal of Medicine, November 4, 2004, p 2008.

Rev 4/05

It's not unusual for laymen to commingle contraception and abortion as if these words were interchangeable, and they are not. Television networks, including CNN and FOX, seem to be attracted to this issue. Emotions run high on the topic with a volatile mix of pharmaceuticals, sex, and at least two kinds of morality. Some civil reflection on this matter is in order, hence this article.

First of all, we need to settle on a standard definition of terms. Conception occurs and pregnancy begins when a fertilized egg attaches to the wall of a woman's uterus. Preventing the fertilization or the attachment is standard contraception. Recent research indicates that some products operate to suppress ovulation when the chance of conception is highest or obstruct penetration of the egg by sperm. In the normal life of a sexually active female, there are many instances where a fertilized egg fails to attach to the uterine wall and is expelled as a part of the menstrual cycle.

Dislodging and expelling the fertilized egg from the uterine wall is abortion. By definition, contraception is not abortion.

Emergency contraceptive products such as Plan B® act by preventing a fertilized egg from attaching to the uterine wall. A woman can effectively avoid a pregnancy by consuming this product after intercourse but prior to attachment of the egg to the uterine wall. Missed birth control pills or rape can produce an urgent need for emergency contraception. Time is of the essence in this situation because the drug should be administered within 72 hours of intercourse to be effective.

Consuming a large dose of a standard oral contraceptive after intercourse can also prevent attachment to the uterine wall. The only drug used in contemporary medical practice that causes an abortion is RU 486® (mifepristone). Federal rules require this product to be provided only by a physician; pharmacists do not dispense

this drug.

A pregnancy could result when a pharmacist declines to dispense a prescription for an emergency contraceptive and fails to refer the patient to another source for the product. This pharmacist could have liability exposure for the tort of "Wrongful Conception," which is recognized in many states. In one published case from Michigan, a pharmacist negligently dispensed the wrong drug instead of an oral contraceptive and the patient became pregnant. Damages could include medical expenses, pain and suffering, loss of wages, emotional distress, and the husband's loss of consortium, but not the cost of raising the child. If the pregnant patient decides to have an abortion, it is possible that the pharmacist could also be liable for that expense. If the pharmacist intentionally refuses to dispense the prescription and such conduct is found to be willful and wanton misconduct, then punitive damages may be possible. This is a straight-forward malpractice case where a pharmacist has a duty established by the board of pharmacy or by expert testimony and fails or refuses to comply with that duty. Damages are a direct result of that conduct.

One large retail chain has publicly announced that emergency contraceptives will not be stocked in its stores. It has pharmacies in most of its locations and some are in very rural areas, far from alternative sources for the drug. It remains to be seen how much liability for wrongful conception would be shared between a pharmacist and an employer who intentionally excludes emergency contraceptives from its inventory with no actual market experience.

In summary, it is possible for pharmacists to decline to dispense prescriptions for contraception, but such an act may have unexpected and serious consequences.

David R. Work has been Executive Director of the North Carolina Board of Pharmacy for over 25 years. His words are his own and do not reflect a position or opinion of the Board of Pharmacy. The writer thanks Board counsel Bailey & Dixon, Raleigh, for providing the legal research for this opinion piece.

NCMB Policy Committee Continues Review of Position Statements

The Policy Committee of the North Carolina Medical Board is continuing its examination of the Board's various position statements first announced last year. The Board's licensees and others interested in the subjects dealt with by the statements are invited to offer comments in writing to the Board, by e-mail or post, for consideration as part of the review process. Comments should be addressed to the attention of the Policy Committee of the North Carolina Medical Board and posted to PO Box 20007, Raleigh, NC 27619, or e-mailed to *info@ncmedboard.org*.

The Policy Committee will discuss the statements scheduled for consideration in sessions open to the public during regularly scheduled meetings of the Board. Interested parties are invited to attend those sessions as observers. Should revision of a statement be proposed by the Committee and approved by the Board, a draft of the proposed revision will be published on the Board's Web site and in the *Forum*, and further written comments will be invited to assist the Policy Committee in preparing a final version of the statement for Board action.

The schedule currently set for statement evaluation is noted below, though those wishing to attend should check dates and times on the Board's agenda, which is posted on the Board's Web site several days before each meeting. They may also telephone the Board's office for information concerning meeting times.

November 16, 2005
- "Prescribing Legend or Controlled Substances for Other Than Validated Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties"
- "Sale of Goods from Physician Offices"
- "Availability of Physicians to Their Patients"
- "Fee Splitting"

January 18, 2006
- "Retention of Medical Records"
- "Medical Record Documentation"
- "The Retired Physician"

March 15, 2006
- "Sexual Exploitation of Patients"
- "The Physician-Patient Relationship"

NOTICE:
Position on Perfusion Advisory Committee Open

The North Carolina Medical Board periodically appoints physicians to various health care boards and committees. A position is now open with the North Carolina Perfusion Advisory Committee (NCPAC). The NCPAC regulates the practice of perfusion in North Carolina. It has five members: three perfusionists, one physician, and one public member. The physician member must be a cardiothoracic surgeon or a cardiovascular anesthesiologist. The initial term is for two years.

For further information, please see Article 40, Chapter 90 of the North Carolina General Statutes or contact R. David Henderson, Executive Director, at 1-800-253-9653, ext. 218 or *david.henderson@ncmedboard.org*.

If you are interested in serving in this position, please send your CV and a cover letter by January 1, 2005, to: R. David Henderson, Executive Director, PO Box 20007, Raleigh, NC 27619.

NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
May—June—July 2005

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 or subsequent to the expiration of a previously issued temporary license.

Voluntary Dismissal:
Board action dismissing a contested case.

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

ANNULMENTS
NONE

REVOCATIONS

BELFORD, Paul Douglas, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 9/02/1946
License #: 0093-00029
Specialty: FP (as reported by physician)
Medical Ed: University of Toronto (1972)
Cause: Dr Belford closed his medical practice without providing his patients sufficient advance notice to allow them to obtain continuing medical care and without informing them how to obtain copies of or request transfer of their medical records.
Action: 6/30/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 2/16/2005: Dr Belford's North Carolina medical license is revoked as of the date of this Order.

REESE, Perry, III, MD
Location: Roseboro, NC (Sampson Co)
DOB: 8/17/1958
License #: 0094-00988
Specialty: FP (as reported by physician)
Medical Ed: Wayne State University (1990)
Cause: The Board found that Dr Reese prescribed controlled substances to a patient on several occasions without performing an examination of the patient. He falsified the patient's medical record to indicate the patient reported she was in pain, when she had made no such statement, and that examinations were done at each visit. He prescribed a controlled substance to the patient without a legitimate medical purpose.
Action: 6/29/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 4/21/2005: Dr Reese's North Carolina medical license is revoked; he may not make application for reinstatement for at least two years from 4/21/2005.

See Consent Orders:
STOCK, Margot Therese, Nurse Practitioner

SUSPENSIONS

See Consent Orders:
ADKINS, Paula Clark, MD
ANDERSON, Joseph Robert, Jr, MD
CLARK, Edward Joseph, MD
COOPERMAN, Glenn Arthur, MD
EATON, Lynne Antoinette, MD
FARRELL, Edwin Gayle, MD
FLEISCHHAUER, Thomas Frazee, MD
HENDERSON, Paul Manning, MD
KNUTSON, Thomas Marvin, MD
PARIKH, Prashant Pramod,MD
WHITE, Anne Litton, MD
WHITMER, Gilbert Gomer, Jr, MD

SUMMARY SUSPENSIONS

TATE, Larry R., MD
Location: Worthington, OH
DOB: 3/28/1946
License #: 0000-23444
Specialty: Forensic Path/Anat Path (as reported by physician)
Medical Ed: University of Michigan (1971)
Cause: Dr Tate may have committed acts of unprofessional conduct and may be unable to practice medicine with reasonable skill and safety. The Board finds the public health, safety, or welfare requires emergency action.
Action: 5/24/2005. Order of Summary Suspension of License issued; Dr Tate's North Carolina medical license is summarily suspended.

CONSENT ORDERS

AARONS, Mark Gold, MD
Location: Southern Pines, NC (Moore Co)
DOB: 5/07/1958
License #: 0000-31233
Specialty: NEP/IM (as reported by physician)
Medical Ed: Baylor College of Medicine (1984)
Cause: Application for reinstatement of license. In 2003, Dr Aarons developed an addiction to cocaine. He attended residential treatment for chemical dependency in Atlanta from 2/03/2004 to 5/01/2004. In

November 2004, a urine screen collected from him tested positive for cocaine in violation of his NCPHP contract and he voluntarily surrendered his North Carolina medical license on 12/10/2004. He reports he successfully completed an inpatient treatment program that ran from 1/07/2005 to 2/19/2005 and the NCPHP reports he is in compliance with is contract.

Action: 7/26/2005. Consent Order executed: Dr Aarons is issued a license to expire on the date shown on the license [11/23/2005]; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, all controlled substances, and alcohol, and he shall inform the Board within two weeks of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; he shall attend AA and/or Caduceus meetings as recommended by the NCPHP; he shall practice only in a setting approved in writing by the Board's president; he shall provide a copy of this Consent Order to all current and prospective employers; must comply with other conditions.

ADKINS, Paula Clark, MD

Location: South Charleston, WV
DOB: 11/26/1965
License #: 0099-00745
Specialty: ER (as reported by physician)
Medical Ed: Marshall University School of Medicine (1996)
Cause: In June 2004, Dr Adkins was charged by Pinehurst, NC, law enforcement officials with one count of obtaining a controlled substance by false pretense and eight counts of attempting to do so. In August 2004, she surrendered her North Carolina medical license. In September 2004, she pled guilty to nine misdemeanor counts of common law forgery arising out of the previous charges. She received a suspended sentence and probation. Dr Adkins submitted herself to the NCPHP for assessment and it was recommended she undergo residential inpatient treatment for chemical dependency and opiate abuse. She has presented herself for treatment and has made application for reinstatement of her license, such application being held in abeyance until the disciplinary matter is resolved.
Action: 6/03/2005. Consent Order executed: Dr Adkins' North Carolina medical license is indefinitely suspended; her pending application for reinstatement of her license may now proceed.

ANDERSON, Joseph Robert, Jr, MD

Location: Asheville, NC (Buncombe Co)
DOB: 10/12/1965
License #: 0095-00807
Specialty: FP (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1991)
Cause: Relative to the Board's charges against Dr Anderson. Dr Anderson presented prescriptions made to himself for 60 tablets of Concerta® (half 18 and half 54 milligrams) to an Asheville pharmacy. The prescriptions bore the name of one of his former practice partners, the signature being stamped with a stamp he stole from his former partner. The former partner had never written prescriptions for Dr Anderson. Dr Anderson was convicted in Buncombe County of two misdemeanors for this conduct. He has legitimate need for the drug and it had been properly prescribed for him previously by his physician, who had since retired. Dr Anderson has a contract with the NCPHP, which reports he is in compliance with the contract. He has a physician now caring for him and is not prescribing for himself.
Action: 6/15/2005. Consent Order executed: Dr Anderson's North Carolina medical license is suspended indefinitely, that suspension being stayed; he is placed on probation on conditions; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; he shall cause his physician to provide the NCPHP with quarterly reports as the NCPHP require; must comply with other conditions.

BENTLEY, Steven Edmunds, MD

Location: Vilas, NC (Watauga Co)
DOB: 9/01/1953
License #: 0000-23676
Specialty: EM (as reported by physician)
Medical Ed: Medical College of Georgia (1978)
Cause: In July 2004, while on duty at Highsmith-Rainey Memorial Hospital, Dr Bentley became frustrated with a nurse and physically assaulted her by placing his hands on her neck and shoulders.
Action: 7/21/2005. Consent Order executed: Dr Bentley is reprimanded; he shall obtain an evaluation and, if recommended, enter, maintain, and abide by a contract with the NCPHP; he shall maintain a relationship with an NCPHP therapist, psychiatrist, or other clinician if recommended as a result of his evaluation; must comply with other conditions.

CLARK, Edward Joseph, MD

Location: Wilson, NC (Wilson Co)
DOB: 4/11/1968
License #: 2001-01028
Specialty: R/VIR (as reported by physician)
Medical Ed: University of Vermont (1995)
Cause: In July 2004, Dr Clark received medical care at Nash General Hospital in Rocky Mount, NC. The total bill for medical services was $4,840. When admitted to Nash General, Dr Clark gave a false name, address, and Social Security number. When the hospital attempted to collect the amount owed, it was unable to do so due to the false information Dr Clark provided. For several months, Dr Clark made no effort to contact the hospital to pay his bill. He was interviewed four times by the staff of the NCMB and three times claimed he was seen at Nash General's ER in July for pain caused by a kidney stone. Efforts were made to confirm he was seen at the hospital's ER but the hospital had no record of his being a patient. He later admitted he did not know the name he had used when he checked into Nash General. After reviewing a patient chart, he admitted the chart represented the care he had received. In April 2005, Dr Clark paid $4,480 for the care rendered at Nash General.
Action: 5/10/2005. Consent Order executed: Dr Clark's North Carolina medical license is suspended for one year, but such suspension is stayed; he shall notify the Board of any change of address within 10 days; must comply with other conditions.

COOPERMAN, Glenn Arthur, MD

Location: Atascardero, CA
DOB: 3/01/1954
License #: 0096-00150
Specialty: OB/GYN—REN (as reported by physician)
Medical Ed: University of Southern California (1985)
Cause: On action by another medical board. In November 2003, the medical board in California entered a decision adopting a proposed decision of October 2003 finding Dr Cooperman was dishonest when interviewed by an investigator. The November 2003 decision revoked Dr Cooperman's California medical license for two years, stayed that action and placed him on two years probation. It also ordered him to do 96 hours of community service, complete an ethics course, complete 40 CME hours for each year of probation, and fulfill other conditions.
Action: 6/13/2005. Consent Order executed: Dr Cooperman's North Carolina medical license is suspended for two years, said suspension being stayed.

EATON, Lynne Antoinette, MD

Location: Worthington, OH
DOB: 9/08/1961
License #: 0094-00783
Specialty: OB/GYN (as reported by physician)
Medical Ed: Medical College of Pennsylvania (1988)
Cause: Dr Eaton has two Consent Orders filed in 2004 with the Ohio Board of Medicine, both based on her admitted seeking of treatment for chemical dependency. The first Consent Order suspended her license for not less than 60 days and the second established conditions to assure her compliance with the Consent Orders.
Action: 7/07/2005. Consent Order executed: Dr Eaton's North Carolina medical license is suspended for 12 months, suspension being stayed so long as she complies with the terms of her Ohio Consent Order.

FARRELL, Edwin Gayle, MD
Location: Mcleansville, NC (Guilford Co)
DOB: 3/13/1945
License #: 0000-17345
Specialty: Ped/Adol Med (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1971)
Cause: Dr Farrell prescribed oxycodone to Patient A on several occasions while he had a significant emotional relationship with Patient A. He thought at first the patient had a legitimate need for the drug. He later realized he should not be prescribing to the patient and informed the patient of that fact. He also called local pharmacies to tell them not to fill the prescriptions. The patient became upset with Dr Farrell and approached him to write a prescription for the drug to another person with whom Dr Farrell has no patient/physician relationship. Dr Farrell says he felt threatened and wrote the prescription. When the Board discovered this, it gave him the choice of surrendering his license or being summarily suspended. He surrendered his license on 12/07/2004.
Action: 4/07/2005. Consent Order executed: Dr Farrell's license is suspended indefinitely.

FLEISCHHAUER, Thomas Frazee, MD
Location: Fuquay-Varina, NC (Wake Co)
DOB: 2/07/1953
License #: 0000-33653
Specialty: NEP/IM (as reported by physician)
Medical Ed: University of Virginia (1979)
Cause: Relative to the Board's charges against Dr Fleischhauer. In January 2003, a person already on opioids became a patient of Dr Fleischhauer. The patient was diagnosed with fibromyalgia, migraines, and lupus. In an attempt to alleviate the patient's symptoms, he began a series of narcotics and other medications. Sometime later, Dr Fleischhauer began to see the patient socially. He denied any romantic relationship, though he sought to make the relationship romantic, which the patient refused. In June 2003, he wrote the patient a letter severing the patient/physician relationship because of a "conflict of interest." He advised her to find another physician within 30 days; however, he continued to treat her and prescribe narcotics even beyond the 30-day limit and around the time the personal relationship ended. In late July or August 2003, he and the patient entered a business venture together, which lasted just a few weeks. Expert review of Dr Fleischhauer's diagnosis, treatment, and record-keeping related to the patient found the standard of practice was below the minimum. The diagnosis of lupus had no objective evidence behind it and the prescribing of narcotics was inappropriate in several respects. Though Dr Fleischhauer sent the patient to a pain management specialist who approved his treatment, there was very little exploration of alternative approaches. His records for the patient fell below minimum standards of practice.
Action: 6/15/2005. Consent Order executed: Dr Fleischhauer's North Carolina medical license is suspended for two years, but said suspension is stayed for all but 60 days on terms and conditions; the 60-day period of active suspension shall begin 7/16/2005; he shall agree to be assessed by the NCPHP and follow the recommendations made by the NCPHP; he shall not treat chronic pain patients and shall not prescribe outpatient Schedule II, IIN, opioid narcotic substances unless the patient is terminally ill or on kidney dialysis; must comply with other conditions.

HARRIS, John Joel, Jr, MD
Location: Lumberton, NC (Robeson Co)
DOB: 6/30/1958
License #: 0000-32114
Specialty: AN (as reported by physician)
Medical Ed: University of Tennessee, Memphis College of Medicine (1984)
Cause: On application for reinstatement of license. Dr Harris has a substance abuse and bipolar disorder and surrendered his license in September 2003. He sought and obtained continuing treatment in Georgia for his mental health issues in October 2003 and was in an inpatient facility for 84 days. He was then transferred to a three-quarters facility where he remained for 14 months. He has participated in Georgia's Impaired Physicians Program and has contacted the NCPHP, with which he will enter a contract on his return to North Carolina.
Action: 4/05/2005. Consent Order executed: Dr Harris is issued a North Carolina medical license to expire on the date shown on the license [7/31/2005]; he shall meet with the Board when requested; unless lawfully prescribed by someone else, he shall refrain from the use or possession of all controlled and mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

HEINAN, Michelle Lynn, Physician Assistant
Location: Gilbert, AZ
DOB: 10/18/1961
License #: 0001-02732
PA Education: Alderson-Broaddus (1985)
Cause: In August 2004, while Ms Heinan was employed by the Methodist College PA Program, she practiced as a PA without submitting a Notice of Intent to Practice Form to the Board as required. Her only Notice of Intent Form on file with the Board was active from July 1999 to May 2001.
Action: 7/06/2005. Consent Order executed: Ms Heinan is reprimanded.

HENDERSON, Paul Manning, MD
Location: Fletcher, NC (Henderson Co)
DOB: 1/09/1970
License #: 0099-00871
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1998)
Cause: In 2003, Dr Henderson became a Big Brother to a young man and, after consulting with the young man's mother, proposed to give him a complete physical examination. The mother did not understand, however, that the physical examination would be done at the physician's home. She also did not know the time of the examination. Dr Henderson did the examination without a chaperone present. The mother was not aware the examination had taken place until told by her son. The Board's Position Statement titled "Guidelines for Avoiding Misunderstandings During Physical Examinations" strongly advises that a third party be present during an examination such as the complete physical given the boy. It also advises such examinations be conducted in appropriately maintained and equipped examination rooms.
Action: 5/06/2005. Consent Order executed: Dr Henderson's North Carolina medical license is suspended for six months, suspension being stayed on terms and conditions; Dr Henderson shall maintain and abide by a contract with the NCPHP; he shall maintain a relationship with a therapist, psychiatrist, or other clinician approved by the NCPHP; he shall complete a CME course on maintaining proper boundaries and provide the Board evidence of successful completion of that course by November 2005 (this he completed during March 2005); he shall comply with the guidelines of the Board regarding chaperones when performing examinations and specifically agrees a female chaperone shall be present anytime he examines a female and that a female or male chaperone, as appropriate, shall be present anytime he examines a patient under 18 years of age; must comply with other conditions.

INTINI, Ronald Samuel, MD
Location: Hubert, NC (Onslow Co)
DOB: 8/21/1952
License #: 2001-00706
Specialty: FP (as reported by physician)
Medical Ed: University CETEC (1983)
Cause: Dr Intini voluntarily submitted to an assessment at the Center for Personalized Education for Physicians in Aurora, Colorado. The CPEP identified areas in which Dr Intini could benefit from additional education and he has undertaken that education, following all the Board's recommendations to him. He has worked at the Womack Army Medical Center and at Camp Lejeune to the satisfaction of supervising staff. He now wishes to return to private practice and has told the Board he does not intend to practice OB or to provide prenatal care.
Action: 5/06/2005. Consent Order executed: Dr Intini shall not practice OB

or provide prenatal care; he shall have one of the other physicians with whom he practices provide the Board with quarterly reports evaluating his work.

JARRELL, Renaldo Andrew, MD
Location: Joliet, IL
DOB: 3/23/1962
License #: 2005-00953
Specialty: IM (as reported by physician)
Medical Ed: Southern Illinois University School of Medicine (1990)
Cause: On action by another state. In June 2004, the medical board in Illinois entered a Consent Order reprimanding Dr Jarrell based on allegations he had not ordered an X ray in a prompt fashion and for inadvertently neglecting to record a patient's refusal of care.
Action: 6/14/2005. Consent Order executed: Dr Jarrell is reprimanded.

KNUTSON, Thomas Marvin, MD
Location: Goldsboro, NC (Wayne Co)
DOB: 10/23/1952
License #: 0000-25610
Specialty: EM/FP (as reported by physician)
Medical Ed: University of Minnesota (1979)
Cause: From 2002 to 2004, Dr Knutson engaged in inappropriate prescribing of controlled substances to a patient, performing no physical examinations and preparing no related medical records. When pharmacists brought to his attention that the patient was "doctor shopping," he confronted the patient and stopped prescribing for the patient.
Action: 6/03/2005. Consent Order executed: Dr Knutson's North Carolina medical license is suspended for two months, suspension being stayed on condition he strictly comply with the Board's position statement titled "Contact with Patients Before Prescribing."

MORTER, Gregory Alan, MD
Location: Newport News, VA
DOB: 12/03/1959
License #: 0000-36401
Specialty: PD (as reported by physician)
Medical Ed: University of Pittsburgh (1986)
Cause: On application for restoration of his license. Dr Morter has a history of substance abuse. In December 2000, the medical board in Virginia entered a Consent Order reprimanding him for abusing controlled substances and related improper prescribing. Virginia allowed him to continue practice under certain terms and conditions. In October 2001, Dr Morter surrendered his Virginia medical license due to relapse. In February 2002, he pled guilty in U.S. District Court to a felony count of conspiracy to obtain a controlled substance. He has been a participant in the Virginia Health Practitioner's Intervention Program and that group reports he has been sober for three years and believes he is safe to return to practice as long as he complies with monitoring. Virginia reinstated Dr Morter's license in September 2003. Dr Morter and the North Carolina Medical Board entered a Consent Order in October 2004 indefinitely suspending his North Carolina medical license. Dr Morter has met with the NCPHP and that group advocates for a temporary license for him.
Action: 6/10/2005. Consent Order executed: Dr Morter is issued a license to expire on the date shown on the license [10/31/2005]; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

NGUYEN, Tuong Dai, MD
Location: Waxhaw, NC (Union Co)
DOB: 4/11/1967
License #: 2000-00566
Specialty: IM (as reported by physician)
Medical Ed: Temple University School of Medicine (1996)
Cause: On application for license reinstatement. In February 2004, Dr Nguyen surrendered his North Carolina medical license. Under a Consent Order of 10/21/2004, his license was indefinitely suspended for engaging in professional sexual misconduct. He accepts personal and professional responsibility for those boundary violations. From 3/22/2004 to 4/30/2004, he attended and successfully completed treatment from the Professional Renewal Center's Professional Sexual Misconduct Treatment team. He has received regular and continuing cognitive-behavioral treatment and monitoring on an outpatient basis with Eugenia Gullick, PhD. In July 2004, he attended and successfully completed a three-day course on maintaining proper boundaries sponsored by Vanderbilt School of Medicine and the Sante Center for Healing. He has been assessed by the NCPHP and the NCPHP has reported he is fully compliant and has made considerable progress. The NCPHP feels Dr Nguyen is safe to return to practice.
Action: 5/26/2005. Consent Order executed: Dr Nguyen is issued a North Carolina medical license to expire on the date shown on the license [9/30/2005]; he shall maintain and abide by a contract with the NCPHP; he shall continue therapy with Dr Gullick or another approved counselor and shall comply with recommendations of the counselor; the counselor shall be directed to provide quarterly reports on Dr Nguyen's progress to the Board; he shall post a copy of the Principles of Medical Practice in prominent places in his office; he shall ensure a chaperone who has read this Consent Order is present during patient examinations and that the chaperone records any misconduct that occurs; the chaperone's records shall be sent to the counselor on a quarterly basis; each month, a member of his staff who has read this Consent Order shall complete a Staff Surveillance Form and provide it to the counselor; one week each quarter his staff shall ask patients to complete a Patient Satisfaction Survey and those surveys shall be sent to the counselor; must comply with other conditions.

OSTMAN, David Lee, MD
Location: Hampton, VA
DOB: 8/26/1956
License #: 0000-30221
Specialty: OB/GYN (as reported by physician)
Medical Ed: Wayne State University (1982)
Cause: On action by another medical board. In October 2004, the medical board in Virginia entered a Consent Order that found Dr Ostman had twice prescribed phentermine for weight loss to a patient without performing or recording a comprehensive history or physical examination and without informing the patient of the benefits and risks of the drug. He also failed to document any diet or exercise program. Similar failures affected his treatment of several other weight-loss patients. He also authorized 225 prescriptions via his Web site to various persons for "Libido Lotion," a topical preparation containing testosterone. One "customer" was an investigator for the Virginia Department of Health Professions. Dr Ostman processed the orders and forwarded them to Bellevue Pharmacy in St Louis, MO, requesting it compound and mail the product directly to those who requested and paid for it via the Web site. From December 2001 to May 2003, he sold or dispensed prescription medications to patients without holding a license from the Board of Pharmacy. A drug audit of his office, conducted at his request in May 2003, found shortages of controlled substances from stock. He closed his private practice in Virginia in May 2003 and since June 2003 has been employed by the VA Medical Center in Hampton, VA, as a full-time physician and Director of Women's Services. He no longer prescribes Libido Lotion or any other prescription medication via the Internet.
Action: 6/10/2005. Consent Order executed: Dr Ostman is reprimanded.

PARIKH, Prashant Pramod, MD
Location: Lansdale, PA
DOB: 4/19/1962
License #: 2005-00796
Specialty: FP (as reported by physician)
Medical Ed: Grant Medical College, University of Mumbai (1984)
Cause: In May 2004, Dr Parikh submitted a letter of recommendation to the Baord from a fellow physician, but the Board discovered he had written the letter himself and had signed the fellow physician's name. In fact, the Board had previously received an authentic letter of recommendation from the physician in question. The Board received evidence that Dr Parikh's record of service is otherwise unblemished.

Action: 5/09/2005. Consent Order executed: Dr Parikh is issued a license; his license is suspended for one year, that suspension being stayed on condition he be evaluated by the NCPHP and comply with any treatment recommendations made by the NCPHP; he shall receive written approval of his future practice setting from the president of the Board, which the president is under no obligation to give; must comply with other conditions.

RAMPULLA, Elliot John, MD
Location: Tuscaloosa, AL
DOB: 11/17/1943
License #: 0000-18046
Specialty: APN (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1972)
Cause: On action by another medical board. In August 2004, the medical board in Alabama found Dr Rampulla had conducted his practice in a manner dangerous to Patients A-K, committing unprofessional conduct, distributing controlled substances for other than legitimate medical reasons, committing gross negligence, and failing to maintain patient records. He was fined $20,000 and reprimanded, had his prescribing restricted until his medical records procedure was implemented in accord with direction of a consultant, and was required to complete CME on medical record keeping and controlled substance management.
Action: 5/24/2005. Consent Order executed: Dr Rampulla is reprimanded.

RAPPAPORT, Daniel Shapiro, MD
Location: Salisbury, NC (Rowan Co)
DOB: 7/25/1948
License #: 2001-00185
Specialty: IM (as reported by physician)
Medical Ed: University of Minnesota (1987)
Cause: On action by another medical board. In October 2004, the medical board in Florida reprimanded Dr Rappaport relative to his prescribing to a single patient.
Action: 5/06/2005. Consent Order executed: Dr Rappaport is reprimanded.

STOCK, Margot Therese, Nurse Practitioner
Location: Greenville, NC (Pitt Co)
DOB: 8/10/1936
Approval #: 0002-01145
NP Education: NA
Cause: Relative to the Board's charges against Ms Stock. During 2003 and 2004, Ms Stock prescribed controlled substances to four patients. They were her friends or children of neighbors that were her friends. In each case, she prescribed controlled substances without proper documentation and/or the knowledge of her supervising physician. She kept no documentation explaining or justifying the prescriptions. She also post-dated a prescription for Percocet® and issued refills for Schedule III controlled substances. These actions were outside the scope of her collaborative practice agreement with her supervising physician. She has also been prescribed phentermine for her own use by two different health care providers with whom she works—an NP and a physician. Five times she called in refills for phentermine for her own use as if the refills were authorized by the prescribers, which they were not.
Action: 6/15/2005. Consent Order executed: Ms Stock's approval to perform acts permitted to nurse practitioners is terminated. She must reapply for approval, and the Board may consider these matters when deciding to grant or deny her application.

TURPIN, Payton Duke, MD
Location: Asheville, NC (Buncombe Co)
DOB: 8/27/1952
License #: 2005-01114
Specialty: EM/IM (as reported by physician)
Medical Ed: Emory University School of Medicine (1978)
Cause: Dr Turpin has a history of alcohol abuse but has abstained from alcohol since July 2003. He is licensed in five states. He has a contract with the Connecticut Physician Health Program for treatment and monitoring. In preparing to move to North Carolina, he entered into a contract with the NCPHP, which has advocated on his behalf.
Action: 6/20/2005. Non-Disciplinary Consent Order executed: Dr Turpin shall comply with his NCPHP contract; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; must comply with other conditions.

WHITE, Anne Litton, MD
Location: Winston-Salem, NC (Forsyth Co)
DOB: 11/23/1954
License #: 0000-29552
Specialty: FP/D (as reported by physician)
Medical Ed: Indiana University (1980)
Cause: On 5/04/2005, the Board issued Charges and Allegations against Dr White alleging she violated a Consent Order between her and the Board dated 2/16/2005. A hearing was held on the Charges and Allegations on 6/15-16/2005. The Board found that Dr White committed one count of unprofessional conduct by prescribing treatment for a patient without seeing or examining the patient and by maintaining an inaccurate and inadequate chart for that patient. On all other charges, the Board found in Dr White's favor. It found she did not commit acts alleged in the Notice that would have constituted obstructing an inspection of her practice and would have violated her 2/16/2005 Consent Order; it found she did not misrepresent to the Board that she had not ordered a cosmetic substance not approved by the FDA (Tri-Botox) as alleged in paragraphs 10-13 of the Notice; it found she did not aid and abet the unlicensed practice of medicine; and it found she did not commit other acts of unprofessional conduct as alleged in the Notice.
Action: 7/22/2005. Consent Order executed: Dr White's North Carolina medical license is suspended for two years beginning 6/16/2005; said suspension is stayed for all but 30 days on certain terms and conditions; Dr White shall devise a system to better organize her office records; she shall participate in chart review for any potential deficiencies in the system so the Board may recommend corrective measures; random inspections of her practice shall occur from time to time during the period of suspension; she shall not treat any family member or herself; she shall obtain 10 hours of CME on ethics within six months; must comply with other conditions.

WHITMER, Gilbert Gomer, Jr, MD
Location: Rocky Mount, NC (Nash Co)
DOB: 9/04/1961
License #: 0000-36854
Specialty: ORS (as reported by physician)
Medical Ed: The Johns Hopkins University (1987)
Cause: Dr Whitmer has a history of self-prescribing medications, the details of which are set forth in the Consent Order between him and the Board dated 1/30/2003. That Order required he refrain from use or possession of all mind- or mood-altering substances and all controlled substances unless lawfully prescribed for him by someone other than himself. In June 2003, Dr Whitmer supplied the Board a urine sample that tested positive for marijuana. Use of marijuana was a violation of his Consent Order and he admitted such conduct. Dr Whitmer surrendered his North Carolina medical license in July 2004.
Action: 2/08/2005. Consent Order executed: Dr Whitmer's North Carolina medical license is suspended indefinitely.

MISCELLANEOUS ACTIONS
NONE

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

DENIALS OF LICENSE/APPROVAL

DIAMOND, Patrick Francis, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 5/15/1946
License #: 0098-00042
Specialty: FP (as reported by physician)

Medical Ed: Autonomous University Tamaulipas (1987)
Cause: Dr Diamond failed to satisfy the Board of his qualifications for a medical license because he is unable to practice with reasonable skill and safety. The Board also cited the reasons set out in Dr Diamond's Consent Order of 2/19/2004 and his answering "no" on his application form when asked if he were aware of any investigation of him by governmental agencies or licensing boards. He was, in fact, investigated and disciplined on his nursing license by Texas, was investigated by the DEA, and had his medical license suspended by Utah.
Action: 4/20/2005. Denial of application for medical license in North Carolina.

SURRENDERS

ALEXANDER, John Eugene, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 4/09/1938
License #: 0000-18385
Specialty: OR (as reported by physician)
Medical Ed: Meharry Medical College (1965)
Action: 6/30/2005. Voluntary surrender of North Carolina medical license.

CONNINE, Tad Robert, MD
Location: Hawkinsville, GA
DOB: 1/19/1964
License #: 0099-00193
Specialty: RO (as reported by physician)
Medical Ed: University of Southern Florida (1992)
Action: 7/01/2005. Voluntary surrender of North Carolina medical license.

EGIDIO, Robert John, DO
Location: Banner Elk, NC (Avery Co)
DOB: 12/31/1955
License #: 0093-00092
Specialty: FP (as reported by physician)
Medical Ed: University of Osteopathic Medicine and Health Sciences (1983)
Action: 7/21/2005. Voluntary surrender of North Carolina medical license.

GLOVER, William James, MD
Location: Bath, NC (Beaufort Co)
DOB: 3/21/1926
License #: 0000-32370
Specialty: GS (as reported by physician)
Medical Ed: Loyola University—Stritch School of Medicine (1949)
Action: 5/25/2005. Voluntary surrender of North Carolina medical license.

MOSSBURG, William Lee, MD
Location: Lewisburg, WV
DOB: 8/23/1938
License #: 0000-32021
Specialty: GS/VS (as reported by physician)
Medical Ed: West Virginia University (1969)
Action: 6/13/2005. Voluntary surrender of North Carolina medical license.

RITTER, Joseph George, MD
Location: North Myrtle Beach, SC
DOB: 11/19/1930
License #: 0000-33292
Specialty: APN/AN (as reported by physician)
Medical Ed: University of Pittsburgh (1956)
Action: 7/14/2005. Voluntary surrender of North Carolina medical license.

COURT APPEALS/STAYS
NONE

CONSENT ORDERS LIFTED

CORNWALL, Richard Orran, Physician Assistant
Location: Winston-Salem, NC (Forsyth Co)
DOB: 5/19/1948
License #: 0001-00031
PA Education: Bowman Gray (1972)
Action: 7/14/2005. Order issued lifting Consent Order of 5/22/2003.

DUNCAN, John David, MD
Location: San Antonio, TX
DOB: 11/05/1942
License #: 0000-24901
Specialty: R (as reported by physician)
Medical Ed: University of Texas, Galveston (1968)
Action: 6/06/2005. Order issued lifting Consent Order of 6/19/1995.

GAFFNEY, Mary Elizabeth, DO
Location: Charlotte, NC (Mecklenburg Co)
DOB: 6/08/1965
License #: 0096-01319
Specialty: FP/EM (as reported by physician)
Medical Ed: Michigan State University (1991)
Action: 5/25/2005. Order issued lifting Consent Order of 3/19/2004.

MARINO, Baptiste Steven, MD
Location: Lexington, NC (Davidson Co)
DOB: 2/10/1960
License #: 0000-34079
Specialty: AN (as reported by physician)
Medical Ed: Medical College of Ohio (1986)
Action: 5/25/2005. Order issued lifting Consent Order of 9/22/2000.

PHILIPS, Sherif Antoun, MD
Location: Greenville, NC (Pitt Co)
DOB: 6/24/1958
License #: 0095-01056
Specialty: NEP/IM (as reported by physician)
Medical Ed: Ain Shams Medical School (1981)
Action: 6/22/2005. Order issued lifting Consent Order of 5/21/2004.

WRIGHT, Brent Dean, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 5/07/1957
License #: 0000-28448
Specialty: OB/GYN (as reported by physician)
Medical Ed: University of Missouri, Columbia (1983)
Action: 7/19/2005. Order issued lifting Consent Order of 6/19/2003.

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

BARBER, Robert Anthony, DO
Location: Morehead City, NC (Carteret Co)
DOB: 9/30/1954
License #: 2003-00222
Specialty: FP (as reported by physician)
Medical Ed: University of Health Sciences College of Osteopathic Medicine (1989)
Action: 5/20/2005. Temporary/dated license extended to expire 11/30/2005.

BREWER, Thomas Edmund, MD
Location: Denton, NC (Davidson Co)
DOB: 11/04/1956
License #: 0000-28141
Specialty: GP/EM (as reported by physician)
Medical Ed: Wake Forest University School of Medicine (1983)
Action: 7/21/2005. Temporary/dated license extended to expire 1/31/2006.

COLLINS, Paul Dwayne, MD
Location: Pembroke, NC (Robeson Co)
DOB: 2/08/1973
License #: 2005-00139
Specialty: FP (as reported by physician)
Medical Ed: Wake Forest University School of Medicine (2001)
Action: 5/20/2005. Temporary/dated license extended to expire 11/30/2005.

CORNWALL, Richard Orran, Physician Assistant
Location: Winston-Salem, NC (Forsyth Co)
DOB: 5/19/1948

License #: 0001-00031
PA Education: Bowman Gray (1972)
Action: 5/19/2005. Full and unrestricted PA license issued.

CROSS, Harry Giles, Jr, Physician Assistant
Location: Southern Pines, NC (Moore Co)
DOB: 3/11/1960
License #: 0001-01139
PA Education: Wake Forest University/Bowman Gray (1989)
Action: 5/19/2005. Full PA license issued.

DeVIRGILIIS, Juan Carlos, MD
Location: Boone, NC (Watauga Co)
DOB: 8/29/1957
License #: 0000-28719
Specialty: FP/P (as reported by physician)
Medical Ed: Faculty of Medical Sciences, National University of la Plata (1982)
Action: 5/20/2005. Temporary/dated medical license extended to expire 11/30/2005.

EATON, Hubert Arthur, Jr, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 5/25/1943
License #: 0000-17858
Specialty: IM (as reported by physician)
Medical Ed: Meharry Medical College School of Medicine (1969)
Action: 7/21/2005. Temporary/dated license extended to expire 1/31/2006.

FOLKERTS, AnnaMaria, Physician Assistant
Location: Elon, NC (Alamance Co)
DOB: 8/24/1961
License #: 0001-02206
PA Education: College of West Virginia (1996)
Action: 5/20/2005. Temporary/dated PA license extended to expire 11/30/2005

HARRIS, John Joel, Jr, MD
Location: Lumberton, NC (Robeson Co)
DOB: 6/30/1958
License #: 0000-32114
Specialty: AN (as reported by physician)
Medical Ed: University of Tennessee, Memphis, College of Medicine (1984)
Action: 7/21/2005. Temporary/dated license extended to expire 11/30/2005.

HOOPER, Jeffrey Curtis, MD
Location: Greensboro, NC (Guilford Co)
DOB: 9/21/1964
License #: 0097-00286
Specialty: FP (as reported by physician)
Medical Ed: Vanderbilt University School of Medicine (1995)
Action: 7/21/2005. Temporary/dated license extended to expire 11/30/2005.

[Typographical error in January 2005 Report is corrected below.]
LEMAIRE, Pierre-Arnaud Paul, MD
Location: Wilson, NC (Wilson Co)
DOB: 3/24/1960
License #: 0000-39440
Specialty: GS/VS (as reported by physician)
Medical Ed: U of Medicine and Dentistry of NJ, R.W. Johnson School of Medicine (1985)
Action: 11/18/2004. Full and unrestricted medical license issued.

MAYFIELD, Kelli Burgin, MD
Location: Ellenboro, NC (Rutherford Co)
DOB: 8/15/1963
License #: 0095-00998
Specialty: FP (as reported by physician)
Medical Ed: East Tennessee State University (1993)
Action: 7/21/2005. Full and unrestricted medical license issued.

MUNCHING, Aaron Albert, Physician Assistant
Location: Wilmington, NC (New Hanover Co)
DOB: 1/10/1961
License #: 0001-00016
PA Education: Alderson Broaddus (1990)
Action: 7/21/2005. Temporary/dated license extended to expire 11/30/2005.

NIEMEYER, Meindert Albert, MD
Location: Elon, NC (Alamance Co)
DOB: 6/16/1956
License #: 0000-30440
Specialty: FP (as reported by physician)
Medical Ed: Faculty of Medicine of National University of Utrecht (1987)
Action: 5/20/2005. Temporary/dated license extended to expire 5/31/2006.

PRESSLY, Margaret Rose, MD
Location: Boone, NC (Watauga Co)
DOB: 5/05/1956
License #: 0000-34548
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1990)
Action: 7/21/2005. Temporary/dated license extended to expire 7/31/2006.

SMITH, David Lewis, Physician Assistant
Location: Wilmington, NC (New Hanover Co)
DOB: 9/19/1951
License #: 0001-01503
PA Education: Alderson Broaddus College (1992)
Action: 7/21/2005. Temporary/dated license extended to expire 1/31/2006.

STROUD, Joan Marie, Physician Assistant
Location: Gastonia, NC (Gaston Co)
DOB: 4/24/1956
License #: 0001-01476
PA Education: Pennsylvania State University (1980)
Action: 7/21/2005. Temporary/dated license extended to expire 1/31/2006.

WADDELL, Roger Dale, MD
Location: Aberdeen, NC (Moore Co)
DOB: 11/17/1954
License #: 0000-30105
Specialty: GP (as reported by physician)
Medical Ed: University of Colorado School of Medicine (1981)
Action: 7/21/2005. Temporary/dated license extended to expire 1/31/2006.

WHITE, Steven William, Physician Assistant
Location: Cameron, NC (Harnett Co)
DOB: 12/19/1962
License #: 0001-02116
PA Education: Midwestern University (1996)
Action: 5/20/2005. Temporary/dated PA license extended to expire 9/30/2005.

See Consent Orders:
AARONS, Mark Gold, MD
HARRIS, John Joel, MD
MORTER, Gregory Alan, MD
NGUYEN, Tuong Dai, MD

REENTRY AGREEMENTS

BLACKMORE, Jonathan Charles, DO
Location: Wilmington, NC (New Hanover Co)
DOB: 7/15/1952
License #: 2005-00942
Specialty: FP (as reported by physician)
Medical Ed: Philadelphia College of Osteopathic Medicine (1992)
Cause: On application for a medical license. Dr Blackmore has not practiced medicine since 2002 due to his taking time off to care for an ill family member. He agrees this indicates a need for successful completion of a reentry program. His CME is current.
Action: 5/17/2005. Reentry Agreement and Order executed: the Board shall issue Dr Blackmore a full and unrestricted license; Dr Blackmore shall arrange to have a physician colleague observe his practice for six months and report on his work in a detailed letter to the Board;

he shall meet with the Board when requested to do so to discuss his transition back into practice.

BOZEMAN, Elizabeth Ribadeneyra, MD
Location: Winston-Salem, NC (Forsyth Co)
DOB: 1/01/1961
License #: 2005-00795
Specialty: FP (as reported by physician)
Medical Ed: University of South Carolina School of Medicine (1991)
Cause: On application for a medical license. Dr Bozeman has not practiced medicine actively since August 2002. She agrees this indicates a need for successful completion of a reentry program. Her CME is current.
Action: 5/02/2005. Reentry Agreement and Order executed: the Board shall issue Dr Bozeman a full and unrestricted license; Dr Bozeman shall arrange to have a physician colleague observe her practice for six months and report on her work in a detailed letter to the Board; she shall meet with the Board when requested to do so to discuss her transition back into practice.

COLEMAN, Elizabeth Anne, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 2/21/1951
License #: 0000-29062
Specialty: P (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1983)
Cause: On application for reissuance of Dr Coleman's license. In 1991, Dr Coleman asked her license be made inactive and she has not practiced since that time. She now wishes to practice under a volunteer license for a limited time each week under supervision of Dr Steve Bentsen. Dr Coleman has had a neuropsychological examination, a fact she wishes to make public. While she has kept her CME up to date, she admits that because of the length of time she has been out of practice supervision by another physician is needed.
Action: 6/08/2005. Reentry Agreement and Order executed: The Board shall reissue Dr Coleman's medical license; Dr Coleman shall practice under supervision; her practice setting must be approved by Board's president; she shall arrange to have her supervising physician report quarterly on her work in a detailed letter to the Board; she shall practice no more than 16 hours per calendar week; the results of her neuropsychological examination is incorporated in this Order; must comply with other conditions.

CRUMP, Carolyn Faydene, MD
Location: Lexington, NC (Davidson Co)
DOB: 1/27/1950
License #: 2005-01115
Specialty: GP (as reported by physician)
Medical Ed: George Washington University School of Medicine (1976)
Cause: Dr Crump has not practiced medicine since 1999. She has kept her CME requirements up to date.
Action: 6/24/2005. Consent Order executed for reentry: The Board issues Dr Crump a license to expire on the date shown on the license [9/30/2005]; she shall enter a contract with the NCPHP; she shall obtain approval of a practice site from the president of the Board; she shall arrange for a supervising physician approved by the Board to provide the Board quarterly letters for two years concerning Dr Crump's level of clinical skill; must comply with other conditions.

GREEN, Paul Edward, Physician Assistant
Location: Lewisville, NC (Forsyth Co)
DOB: 8/04/1947
License #: 0001-00123
PA Education: NA
Cause: Mr Green has not practiced as a physician assistant since June 2000.
Action: 6/30/2005. Reentry Agreement and Order executed: Mr Green is issued a full and unrestricted physician assistant license; he shall arrange to have a physician review and countersign his medical records for the first six months of his practice; he shall have the supervising physician deliver to the Board a letter at the end of the six-month observation period describing in detail the observations made and stating an opinion on the level of Mr Green's clinical skill; must comply with other conditions.

LABORE, Francis Walter, Physician Assistant
Location: New Bern, NC (Craven Co)
DOB: 12/26/1948
License #: 0001-00126
PA Education: NA
Cause: Mr Labore has not practiced since January 2003. His CME is not yet up to date.
Action: 6/24/2005. Reentry Agreement and Order executed: Mr Labore is issued a physician assistant license; he shall arrange to have his supervising physician observe his practice for the first six months following resumption of practice; he shall have that supervising physician deliver to the Board a letter at the end of the six-month observation period describing in detail the observations made and stating an opinion on the level of Mr Labore's clinical skill; Mr Labore shall obtain all required CME in a timely manner; must comply with other conditions.

LACKEY, Victoria Donovan, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 4/18/1966
License #: 0096-00226
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1992)
Cause: On application for a medical license. Dr Lackey has not practiced medicine since January 2002. Her CME is up to date.
Action: 7/12/2005. Reentry Agreement and Order executed: Dr Lackey is issued a full and unrestricted medical license; she shall arrange for a physician colleague to observe her practice for six months and, at the end of that time, have that physician report to the Board in detail on her practice and the level of her skill; must comply with other conditions.

SRINIVASAN, Saumini, MD
Location: Bangalore, India
DOB: 7/29/1962
License #: 2005-01116
Medical Ed: University College of Medical Sciences, Delhi, India (1987)
Cause: Dr Srinivasan has not practiced medicine since 2002. Her CME is up to date.
Action: 6/28/2005. Reentry Agreement and Order executed: Dr Srinivasan is issued a full and unrestricted medical license; she shall arrange to have a physician colleague observe her practice for the first six months of her practice; she shall have the observer physician provide the Board a letter at the end of the six-month observation period describing in detail the observations made and stating an opinion on the level of Dr Srinivasan's clinical skill; must comply with other conditions.

DISMISSALS

RAMMING, Kenneth Paul, MD
Location: Los Angeles, CA
DOB: 4/17/1939
License #: 0000-15562
Specialty: SO/TS (as reported by physician)
Medical Ed: Duke University School of Medicine (1965)
Action: 7/15/2005. Notice of Dismissal issued: Charges and Allegations issued against Dr Ramming on 5/17/2004 are dismissed with prejudice.

WARD, Bennie Brooks, MD
Location: Shallotte, NC (Brunswick Co)
DOB: 12/27/1927
License #: 0000-11609
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1959)
Action: 7/25/2005. Notice of Dismissal issued: Charges and Allegations issued against Dr Ward on 10/28/2004 are dismissed without prejudice.

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.

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North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: November 16-18, 2005; January 18-20, 2006; February 15-16, 2006; March 15-17, 2006; April 12-13, 2006

Residents Please Note USMLE Information

United States Medical Licensing Examination

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at *www.fsmb.org*. If you have additional questions, please e-mail Amy Ingram, the Board's GME Coordinator, at *amy.ingram@ncmedboard.org* or visit the Board's Web site at *http://www.ncmedboard.org*.

Special Purpose Examination (SPEX)

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

North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609