Volume 15, Issue 2

April 2011
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June 2011

West Virginia Board of Medicine Quarterly Newsletter

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Opiate Addiction and Prescription Drug Abuse: A Pragmatic Approach

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(Reprinted from the Journal of the
Islamic Medical Association,
Volume 43, 2011, with the authors' permission)

Abstract

In the United States, the abuse of prescription medications, and especially opiates, has significantly impacted escalating health-care costs, increased patient hospitalizations, and has led to a growing number of untimely deaths. Approximately 14% of American adults are using pain medications for nonmedical purposes; therefore, the recreational use of opioids is steadily on the rise. Contributing to the problem is a small number of physicians who indiscriminately prescribe opiates without proper assessment and a lack of use of nonaddictive adjunctive medications. The result has created a culture of iatrogenic drug addiction, and the offending providers are described as being "legalized drug pushers." There are several pragmatic changes to physician practices that are proposed that address this ever-growing problem. This includes limiting narcotic prescriptions for noncancer pain management. In addition, physicians must monitor the dosage, quantity, and treatment duration of narcotic usage. In the treatment of opioid dependence, physicians must properly control the use of agonist replacement treatments as these have developed a street value. Without adequate support measures and follow-up, the prescribing of narcotics will have addictive consequences. Additionally, certain treatment guidelines are recommended. These include restricting the patient to one pharmacy of his or her choice, expecting the patient to attend regular treatment support groups, requiring the patient to pay copayments in advance and other measures. These, along with changes in public policy and educational programs, will limit the growing trend of prescription drug abuse in the United States.

Key words: Prescription drug abuse, pain management, addiction, health policy.

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Impact and Statistics

A decade into the 21st century, the United States is in the midst of a major public health problem. The abuse of prescription drugs, especially opiates, is at near-epidemic proportions and has significantly contributed to escalating care costs, increasing patient hospitalizations, and a growing number of untimely deaths. An estimated 14% of American adults are using pain medications for nonmedical purposes, and the recreational use of opiates has steadily risen during the past decade. From 2002 to 2006, the percentage of young adults from the age of 18 to 25 abusing prescription opiates jumped from 4.1% to 4.6%. These figures suggest that approximately 1.5 million young adults are readily abusing these medications.[1] Additionally, opiate-related emergency room visits increased 126% from 2004 to 2008. Treatment admissions for nonheroin opioid abuse and dependence are also on the rise. From 1996 to 2006, the number of these treatments nearly quadrupled nationally from 16,605 to 74,750. In West Virginia, this trend has been especially severe.[2,3] During the same 10-year period, nonheroin opioid treatment soared in this state from two treatments per 100,000 to 78 per 100,000. Currently, West Virginia has the third largest nonheroin opioid abuse rate in the nation.

Although tobacco, alcohol, and marijuana previously have represented the drugs of choice for adolescents, recreational use of pharmaceuticals has the potential to become as prevalent. This is due to the relatively low cost, ready availability, and accepted medical use of prescription medications. In addition, the problem is enhanced by a small percentage of unscrupulous providers, who for financial reasons, play a major role in this epidemic. It is our opinion that pain assessment, psychosocial history, and patient behavior are not adequately assessed before opiates are prescribed.

A culture of iatrogenic drug addiction and legalized drug prescriptions has been created. The offending providers are described as being “legalized drug pushers.” The lack of standardized pain assessment instruments and protocols seems to be common. Psychosocial and behavioral techniques as well as nonaddictive adjunctive medication as alternatives to opioid prescriptions are not adequately explored.

Pain Management

Narcotics use for noncancer pain should be time limited and used as a last resort, not as a first line of treatment. Before the institution of pain management, a full assessment of pain should be performed, and nonnarcotic medication with psychosocial intervention should be tried initially before narcotics are used.

Even when legitimately used, narcotic prescriptions should include dosage, quantity, and treatment duration that is adequate to treat the pain. Monitoring the use of these medications reduces the risk of patient abuse and dependence, and decreases the likelihood of diversion through the drug’s sale or theft.

Because diverted prescription pain medications are the leading source of opioid access for adolescents, the importance of limiting quantities of prescribed narcotics cannot be overstated.[4]

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Opioid Treatment Dependence

Although methadone and Levaquin-acetylmethadol (LAAM) have been used as agonist replacement treatments for opioid dependence, the Substance Abuse and Mental Health Services Administration is now recommending buprenorphine (Subutex) and Suboxone, a combination of buprenorphine and naloxone, as office-based treatment alternatives for opioid addictions.[5] Physicians can be licensed to prescribe buprenorphine with minimal training and are required to refer patients only for adjunctive psychosocial treatments. Unfortunately, buprenorphine has developed a street value.

While using Suboxone to treat opiate addicts has been successful, the length of treatment and dosage are still being debated. We believe that the proper prescribing of newer agents will prevent these drugs from achieving the same fate and notoriety as methadone.

Motivation

Another factor that plays an important role in the prognosis and treatment of drug addiction is motivation. Assessing an individual's desire is subjective, hence problematic. Although psychosocial tools exist, consequences or losses associated with drug use and abuse are more accurate predictors of a patient's motivation. These consequences include being ostracized by social and/or religious groups; personal and professional losses in the form of income, jobs, professional licensures, and intimate relationships. As society becomes more tolerant of these issues, drug addiction and abuse become more pronounced. Often the patient's family and friends become tolerant of this behavior over time and enable the addiction.

Recommended Treatment Guidelines

While general guidelines for drug abuse treatment should be observed, we recommend the following:

a. Detoxification is not a cure for opiate addiction or any addiction for that matter.

b. Restricting the patient to one pharmacy of his or her choice throughout the treatment.

c. Requiring the patient to attend regular Narcotics Anonymous (NA), Alcoholics Anonymous (AA), or other treatment supportive groups. It is recommended that the patient with an addiction attend these sessions three times a week for the first three to four months and that their attendance is documented in a log and signed by their sponsors. The frequency of these sessions could be gradually reduced.

d. Obligating the patient to pay copayments to ensure compliance. Third parties can assist by keeping the copayments as low as possible ($10 to $20 per session). In addition, we recommend that Medicaid patients pay a small copayment ranging from $5 to $10 as a demonstration of the clients' commitment to treatment. If patients fail to attend designated treatment and counseling sessions, prescriptions should be withheld until the patients return to counseling sessions.

e. Reporting to the appropriate state agencies any excessive charges by physicians and counselors.

f. Using standardized tests such as pain assessment tools as a minimum requirement for opiate drug therapy is absolutely necessary. Documenting the use of adjunctive treatment modalities remains important.

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g. Administering goal-directed therapy with gradual tapering of medication as patients progress through treatment.

h. Licensure renewal may be tied to the successful completion of training. For example, some states, such as California, require pain-management certification as part of licensure and maintenance of licensure.

i. Monitoring and documenting objective factors in detoxification include blood pressure, pulse, respirations, diarrhea, rhinorrhea, and lacrimation. Both subjective and objective symptoms should be used and individualized for treatment.

j. Collaborating between physicians and addiction specialists is critical.

k. Limiting the Suboxone treatment dosage, in most cases, to not exceed 16 mg per day. This treatment should also be time-limited with gradual tapering ranging from six months to two years, depending on the patient's needs. It should be supplemented with a biopsychosocial approach (attendance at NA/AA and counseling sessions) and performed by professionals trained in addiction medicine (psychiatrists, American Society of Addiction Medicine [ASAM]-certified physicians or physicians undergoing special periodic addiction training).

Another concept that needs to be explored is the opening of a methadone detoxification clinic to be run by nonprofit agencies with the stipulation of getting motivated patients off methadone instead of the trend of keeping patients on methadone indefinitely, as practiced currently by some for-profit agencies. A small percentage of patients on methadone who are undergoing severe emotional, financial, and behavioral problems and fail other treatments may need to be on methadone longer. Physicians should be aware that if they are not able to provide such treatment, they can and should refer some patients to methadone maintenance clinics.[6]

While the above-mentioned treatment recommendations represent a practical approach employed by physicians, these are only part of the equation. We believe that these steps alone are insufficient, and additional action at the public policy level is needed. These include the following:

Public Policy Recommendations

First, the Drug Enforcement Agency's (DEA's) regulation for Schedule II drugs with a high likelihood for abuse needs to be seriously evaluated. Such drug dispensing should be restricted and time-limited. In addition, triple prescription copies are warranted. One copy should be kept on file with the prescribing physician, one with the dispensing pharmacist, and one submitted to the DEA in that geographic area in order to review and verify that drugs are being dispensed properly.

Second, medical boards should be authorized to conduct periodic audits of patients' charts and other physician records for compliance with good clinical practice guidelines. This is especially critical with regard to cases where physicians are prescribing a large amount of narcotics. Changes in laws may be needed to address that scenario.

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Third, increased public awareness and an opiate education program addressing inherent dangers need to be promoted at the national and local levels via the media. Patients must be educated on the proper disposal of leftover portions of opioid prescriptions. This will contribute to a decrease in the amount of diverted pain medications sold on the street.

Fourth, there should be a great enforcement of providers accepting private or government insurance (Medicaid and Medicare). Physicians engaged in abusive charges in exchange for prescribing narcotics need to be reported to state professional boards and licensure agencies. Conversely, authorities should investigate patients who "doctor shop" or "pharmacy shop," and appropriate charges should be filed against the patient.

Finally, controlled prospective studies need to be conducted to determine treatment effectiveness of Suboxone across multiple social and economic domains. Post-treatment follow-up needs to be conducted through interviews and random drug testing for an additional year. Success would be determined upon the patient's ability to resume, maintain, and fulfill social and life-related obligations. These results would be verified by additional means such as random drug testing.

While prescription drug abuse exists in epidemic proportions, it has the potential to spiral out of control to conditions not yet seen in modern society.[5,6] The implementation of more stringent guidelines and broad-reaching educational programs are imperative to stop the potentially dangerous trend.*

*The authors also believe that prohibiting cash as an option to pay for abused prescription drugs would benefit in cutting down drug abuse, especially the supply side. Outrageous and outlandish charges should be reported to the respective licensing boards through education. Fees should be limited to median charges such as private insurance, Medicare and Medicaid.

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BOARD ACTIONS
April 2011—June 2011

BANDAK, ABDALLA ZACKARIA, M.D. – Charleston, WV (06/08/2011)
WV License No. 21839
Board Conclusion: Relating to unprofessional conduct and to the renewal of a license to practice medicine and surgery by making a false statement in connection with a licensure application.
Board Action: Dr. Bandak completed two (2) hours of continuing medical education ("CME") coursework in the subject of end-of-life care, including pain management, to meet the fifty (50) hours required. Dr. Bandak shall pay to the Board a $200 civil fine and a $100 administrative fee for his deficiency of two (2) hours of CME in the subject of end-of-life care, including pain management.

BEAVER, AMY LYNN, P.A.-C. – Wheeling, WV (05/04/2011)
WV License No. 00630
Board Conclusion: Relating to performing other than at the direction and under the supervision of a supervising physician; failure to comply with a rule of the Board; unprofessional conduct, including commission of an offense against any provision of state law related to the practice of physician assistants, or any rule promulgated under the law; commission of any act involving moral turpitude, dishonesty or corruption and/or a crime; performing tasks beyond her authorized scope of practice; prescribing a controlled substance other than in good faith; and prescribing controlled substances under state or federal law, to or for herself, or to or for any member of her immediate family.
Board Action: PUBLICLY REPRIMANDED for her unprofessional conduct; shall actively participate in the West Virginia Medical Professionals Health Program for a period of twelve (12) months immediately preceding any request for reinstatement of her West Virginia physician assistant license and shall comply with any and all of its requirements; shall fully comply with all agreed conditions set forth in the December 2010 Consent Agreement entered into with the State Medical Board of Ohio; and shall continue to attend and successfully complete the Northern Panhandle Drug Court Program she was accepted into on January 3, 2011, for the duration specified by the Court.

BOWMAN, CHRISTOPHER EDWARD, M.D. – Hurricane, WV (06/03/2011)
WV License No. 19283
Board Conclusion: Relating to unprofessional conduct and to the renewal of a license to practice medicine and surgery by making a false statement in connection with a licensure application.
Board Action: Dr. Bowman shall complete, and provide certification of his completion to the Board, four (4) hours of approved continuing medical education ("CME") coursework, within ninety (90) days of the entry date of the Consent Order. Dr. Bowman shall pay to the Board a $400 civil fine and a $100 one-time administrative fee for his deficiency of four (4) hours of CME.

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BOARD ACTIONS
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CLARKE, KEVIN MICHAEL, M.D. – Fairmont, WV (05/16/2011)
WV License No. 15547
Board Conclusion: Relating to inability to practice medicine competently; unprofessional conduct; unqualified to practice medicine and surgery in the State of West Virginia.
Board Action: Effective June 1, 2011, Dr. Clarke's medical license was SUSPENDED for a period of five (5) years. During the first eight (8) months of the suspension, he shall successfully complete an Anger Management Treatment Program. After successful completion, he shall undergo a complete forensic psychiatric evaluation. Upon notification from the forensic psychiatrist that Dr. Clarke is ready to return to the practice of medicine, the Complaint Committee shall meet with Dr. Clarke and shall prepare a Consent Order establishing the expected conduct and any limitations on his practice. The Complaint Committee shall report on this matter to the Board who may then vote to suspend enforcement of the suspension penalty and place Dr. Clarke on probation for the remainder of the five (5) year period.
Court Action: Dr. Clarke filed an appeal of the Board's Order in the Logan County Circuit Court, West Virginia, but no stay of the Board's Order was granted by the Court during the pendency of the appeal (May 31, 2011). In June 2011, Dr. Clarke dismissed his appeal.

FREDERICK, LIZA A., M.D. – Charleston, WV (04/11/2011)
WV License No. 17975
Board Conclusion: Relating to presenting a false statement in connection with a license application.
Board Action: Effective April 11, 2011, license suspended for a period of three (3) years, the suspension was immediately stayed, and the license was placed on PROBATION for a period of three (3) years, subject to compliance with conditions. Dr. Frederick was PUBLICLY REPRIMANDED for her false answer on her renewal application.

ICZKOWSKI, KENNETH ALAN, M.D. – Centennial, CO (04/11/2011)
WV License No. 24404
Board Conclusion: Relating to having his license acted against in another state.
Board Action: License GRANTED effective April 11, 2011; paid to the Board a fine of $3,000 for his failure to comply with the requirements of the Florida Board of Medicine.

MELDON, STEPHEN WILLIAM, M.D. – Cleveland, OH (05/06/2011)
WV License No. 22810
Board Conclusion: Relating to unprofessional conduct and to the renewal of a license to practice medicine and surgery by making a false statement in connection with a licensure application.
Board Action: Dr. Meldon shall complete two (2) hours of continuing medical education ("CME") coursework in the subject of end-of-life care, including pain management, within thirty (30) days of the entry date of the Consent Order, and shall provide proof of the same to the Board. Dr. Meldon shall pay to the Board a $200 civil fine for his deficiency of two (2) hours of CME in the subject of end-of-life care, including pain management.

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BOARD ACTIONS
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RICE, JOHN F., P.A.-C. – Dunbar, WV (04/07/2011)
WV License No. 00678
Board Conclusion: Relating to unprofessional conduct.
Board Action: License again GRANTED effective April 1, 2011, to be supervised by Sue A. Westfall, M.D., at the Dawes facility of Cabin Creek Health Systems. Said license is extended and continued, under terms, for a period of sixteen (16) months, automatically expiring and terminating October 31, 2012, at 11:59 p.m.

RIDGEWAY, JOSEPH ALOYSIUS, IV, M.D. – Columbus, OH (06/03/2011)
WV License No. 24403
Board Conclusion: Relating to having his license acted against in another jurisdiction, and excessive use of alcohol.
Board Action: License GRANTED June 3, 2011, and placed on PROBATION for a period of two (2) years, subject to terms.

ROBERTS, SAMUEL KUMP, M.D. – Elkins, WV (04/11/2011)
WV License No.10846
Board Conclusion: Relating to unprofessional and unethical conduct.
Board Action: PUBLICLY REPRIMANDED for his actions resulting in the warrant for his arrest for battery.

SCOTT, THOMAS FRANCIS, M.D. – Huntington, WV (06/13/2011)
WV License No. 8379
Board Conclusion: Relating to unprofessional conduct, violating an Order of the Board, and failing to perform a legal obligation.
Board Action: PUBLICLY REPRIMANDED for his unprofessional conduct, violating an Order of the Board, and failing to perform a legal obligation. Dr. Scott shall pay a CIVIL FINE in the amount of $300.

SHARMA, RASHMI, M.D. – Vienna, WV (04/07/2011)
WV License No. 24402
Board Conclusion: Relating to unprofessional conduct.
Board Action: GRANTED licensure effective April 7, 2011. Dr. Sharma was PUBLICLY REPRIMANDED and paid to the Board a FINE of $1,000 for not taking appropriate steps and responsibility for completing probation in a timely manner in the State of California. Within thirty (30) days of entry of the Consent Order, Dr. Sharma is to present herself for an assessment by the West Virginia Medical Professionals Health Program and abide by its recommendations, if any.

SHIELDS, DOUGLAS ALLEN, M.D. – Jonas Ridge, NC (05/05/2011)
WV License No. 21270
Board Conclusion: Relating to unprofessional and unethical conduct and the inability to practice medicine with reasonable skill and safety to patients by reason of illness or excessive use of alcohol.
Board Action: License SURRENDERED effective May 5, 2011.

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BOARD ACTIONS
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SPEILMAN, DANIEL EDGAR, M.D. – Lewisburg, WV (04/04/2011)
WV License No. 17740
Board Conclusion: Relating to failure to practice medicine with reasonable skill and safety to patients by reason of illness.
Board Action: Effective April 4, 2011, license SURRENDERED to the Board, and his drug dispensing registration issued by the Board is TERMINATED the same day.

STINEHOUR, SETH J., D.P.M. – Rochester, NY (05/16/2011)
License No. 10383
Board Conclusion: Relating to unprofessional conduct and the inability to practice podiatry with reasonable skill and safety due to mental impairment.
Board Action: License summarily suspended effective May 17, 2011, at 12:01 a.m. and notified that on June 1, 2011, at 3:00 p.m., the Board would convene a hearing for the purpose of hearing evidence regarding the contents of the Board's May 17, 2011, Order. On May 16, 2011, Dr. Stinehour signed a Consent Order, in order to eliminate the need for a hearing in this matter, and the Board voted to accept the signed Consent Order and to enter into it to resolve the charges in a Complaint and Notice of Hearing entered October 12, 2010. The Board, with a quorum present and voting, voted at a special meeting on June 1, 2011, to terminate and dismiss this matter and strike it from the docket of the Board. The Consent Order entered by the Board on June 3, 2011, accepts the SURRENDER of Dr. Stinehour's license effective May 7, 2011. Dr. Stinehour will not apply to the Board for licensure until he proves by medical and psychiatric evidence to the Board's satisfaction that he is competent to return to the practice of podiatry.

WEHBE-HIJAZI, NAJLA ADNAN, M.D. – Riyadh, Saudi Arabia (04/19/2011)
WV License No. 19097
Board Conclusion: Relating to presenting a false statement in connection with a renewal application.
Board Action: Dr. Wehbe-Hijazi's expired license is reactivated to ACTIVE status effective April 19, 2011. She paid to the Board $300 for providing false information to the Board on applications submitted to the Board, $200 of which is designated a fine for her deficiency of two (2) hours of continuing education in end-of-life care, including pain management, during the required periods and $100 of which is designated administrative costs.

WEST VIRGINIA BOARD OF MEDICINE
COMPLIANT WITH NPDB REPORTING

The U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), has undertaken efforts to improve the completeness and accuracy of data reported to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB).

On April 1, 2011, the NPDB updated its Compliance Status page to include medical licensing board actions taken against physicians. The audit done by the NPDB of the West Virginia Board of Medicine showed that the Board is in compliance with reporting disciplinary actions on medical doctors, podiatrists, and physician assistants.

BOARD NEWS

Effective June 7, 2011, Governor Tomblin appointed **Cathy M. Funk, M.D.,** to serve as a member of the Board. Dr. Funk is an internal medicine specialist who practices in Martinsburg, West Virginia, and will serve on the Board with a term expiring September 30, 2014.

Heather L. Olcott is now the Board's Disciplinary Counsel, after the departure of John A. W. Lohmann in January 2011. Heather is a West Virginian who was raised on a Jane Lew dairy farm, with both an undergraduate degree in social work and a law degree from West Virginia University. She is a licensed social worker in West Virginia as well as an attorney, and she came to us from the Attorney General's Office, first in the Civil Rights Division, where she represented both the Human Rights Commission and complainants in employment discrimination and fair hearing cases, then from the Employment Unit of the DHHR division, defending DHHR in employment grievances.

Terri Westfall, who began work at the Board offices in 2009, has been promoted from Receptionist/Certification and Verification Coordinator to the new West Virginia Board of Medicine position of Records Management Assistant.

Kimberly Jett is now the Board's Receptionist/Certification and Verification Coordinator. She comes to us with eighteen years of experience in the medical field: eight years with Thoracic and Cardiovascular Associates in Charleston and then ten years with James A. Pollack, M.D., until he left his Charleston medical practice for California.

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Badshah J. Wazir, M.D.
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Kenneth Dean Wright, P.A.-C.
Huntington

WEST VIRGINIA HEALTH ADVISORIES

West Virginia's Division of Infectious Disease Epidemiology has posted West Virginia Health Advisories #46 and #47 on its website, http://www.wvidep.org. The link to this website and to other websites of interest may be found on the Board of Medicine's website on our "Related Links" page: http://www.wvbom.wv.gov/links.asp.

LICENSE RENEWAL - 2011

As of June 30th, the West Virginia Board of Medicine completed its annual license renewal for all medical doctors whose last name began with the letters M through Z and all podiatrists. A total of 3,116 medical doctors and 125 podiatrists were eligible to renew their licenses this year. From this total, 2,511 medical doctors and 100 podiatrists renewed their licenses in ACTIVE status. An additional 277 medical doctors and 15 podiatrists renewed in INACTIVE status. Further, 328 medical doctors and 10 podiatrists chose to no longer hold a license in West Virginia.

Of those medical doctors and podiatrists who did renew their licenses, 89% renewed online. The Board of Medicine will continue to increase its efforts to improve the online renewal system with the ongoing goal of this system serving as the primary vehicle for the renewal process.

In order for the Board to communicate to you important notices and relevant information, it is essential that you notify the Board of any change of address. Please note that there is a change of address form on Page 12 of this Newsletter which must be used for a change of address.

Ext #	Staff of the West Virginia Board of Medicine 304.558.2921	
227	**Robert C. Knittle, M.S.**	Executive Director
214	**Deborah Lewis Rodecker, J.D.**	General Counsel
215	**Heather L. Olcott, J.D.**	Disciplinary Counsel
211	**Lori Blaney**	Paralegal
212	**M. Ellen Briggs**	Executive Assistant
210	**Wendy L. Greene**	Physician Assistant Coordinator
222	**Leslie A. Inghram, CMBI**	Investigator
224	**Kimberly Jett**	Receptionist/Certification and Verification Coordinator
216	**Michael R. Lilly**	Information Systems Coordinator
213	**Charlotte Ann Pulliam**	Complaint Coordinator
220	**Deborah D. Scott**	Fiscal Officer
221	**Sheree J. Thompson**	Licensure Analyst
218	**Teresa L. Westfall**	Records Management Assistant

CHANGE OF ADDRESS FORM

NAME:____ **LICENSE#:**_______________
(Last) (First) (Middle) (Suffix)

By law, you must keep this office apprised of any and all address changes. **If not currently practicing, check here** ☐

PREFERRED MAILING ADDRESS (Required):
(This address is public information, except phone & email)

HOME ADDRESS:
☐ **Check here if same as preferred mailing address**

_______________ Address 1 _______________

_______________ Address 2 _______________

_______________ City, State, Zip, County _______________

_______________ Phone _______________

_______________ Email _______________

MAIN WORK ADDRESS:
☐ **Check here if same as preferred mailing address**

____
Address 1
____
Address 2
____
City, State, Zip, County
____
Phone Fax
____
Email

Enter average weekly on call hours for **ALL** locations:_____________

List **AVERAGE HOURS** worked per week (not on call) at this location:
Direct Patient Care:___________
Administration:____________
Formal Teaching:____________
Research:____________
Other Medical/Podiatric Activities:___________

SECOND WORK ADDRESS:

____
Address 1
____
Address 2
____
City, State, Zip, County
____
Phone

List **AVERAGE HOURS** worked per week (not on call) at this location:
Direct Patient Care:___________
Administration:____________
Formal Teaching:____________
Research:____________
Other Medical/Podiatric Activities:___________

THIRD WORK ADDRESS:

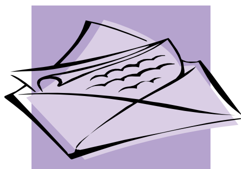
____
Address 1
____
Address 2
____
City, State, Zip, County
____
Phone

List **AVERAGE HOURS** worked per week (not on call) at this location:
Direct Patient Care:___________
Administration:____________
Formal Teaching:____________
Research:____________
Other Medical/Podiatric Activities:___________

Enter your self-designated primary and secondary SPECIALTY here: (M.D.'s and D.P.M.'s ONLY)
Primary Specialty: _______________ Secondary Specialty: _______________

LICENSEE'S ORIGINAL SIGNATURE:_______________________________ **DATE:**_______________

RETURN FORM TO: West Virginia Board of Medicine, 101 Dee Drive, Suite 103, Charleston, WV 25311



CHANGE OF ADDRESS INFORMATION

NOTE: There is a Change of Address Form located on Page 12 of this Newsletter. You may also visit the Board's website at www.wvbom.wv.gov for a Change of Address Form. By law, a licensee of the Board of Medicine must keep this office apprised of any and all address changes. The preferred mailing address of a licensee is the licensee's address of record, which is public information, with the exception of the telephone number and e-mail address.

E-MAIL ADDRESSES

Since the Board is no longer mailing paper copies of its newsletter, it is important that you keep us apprised of your current e-mail address. As licensees of this Board, you are charged with knowledge of the contents of each newsletter.

To provide a current e-mail address, please send an e-mail containing your name and license number to the Board at wvbomnewsletter@wv.gov.

REMEMBER, all newsletters may be accessed at our website at www.wvbom.wv.gov/newsletter.asp. Publication dates are: January, April, July, and October.

WEST VIRGINIA BOARD OF MEDICINE
2011 MEETINGS

July 11
September 12
November 14

All Board meetings begin at 9:00 a.m.