

forum

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

Fondly, Carolyn: Letters to a Young Physician, Part III - page 4



President's Message

Walter J. Pories, MD

Lessons from a Crow

They made a big deal about those two birds. Apparently Betty and her mate were the subjects of a test to determine whether crows could learn how to extract meat from a test tube with a wire. The birds were presented with two wires, one straight and the other bent into a hook. The experiment did not last long. As soon as the crows learned that only the bent wire was effective, the dominant male commandeered the tool. Betty's response was to bend the remaining wire by wedging it into a crack in the cage, adjusting it until she had a functional tool. The folks at Oxford University are normally quite reserved, but they were excited this time. The observation proved that birds not

only use tools but also can fabricate them. I didn't think it was such a big breakthrough because, at least on our farm, we have all sorts of livestock who keep outsmarting us.

The more interesting aspects to the story are that 1) Betty learned when and what she needed to know, 2) she improved with practice, 3) and her learning was measured by outcomes.

These basic principles of education, even applicable to crows, differ from our approach to the continuing education of physicians. Currently, we simply mandate the process. In North Carolina, physicians must document 150 hours of practice relevant CME every three years in order to stay up to date.

b) Each person licensed to practice medicine in the State of North Carolina shall complete no less than 150 hours of practice relevant CME every three years in order to enhance current medical competence, performance or patient care outcome. At least 60 hours shall be in the educational provider-initiated category as defined in Rule .0102 of this Section. The remaining hours, if any, shall be in the physician-initiated category as

continued on page 2



From the Executive Director

Andrew W. Watry

Our Ecosystem

To use an analogy with nature, a medical board is in a complex community of organizations instead of organisms. This community has a more profound impact on public protection and the profession of medicine than many may think. When we go out to speak to various community groups, people are often surprised to learn the breadth and scope of this Board's activities. For licensees, unless they have been on the receiving end of complaints or investigations, their last contact with the Board may have been many years ago in the context of applying for a license. This is, perhaps, not typically viewed as a pleasurable experience and is, thus, easy to use as a basis for formulating opinions about the Board. If one reads this *Forum*, of course, one gets a broader understanding. To really gain insight into the process, it would be worthwhile to explore some of the organizations with which we relate.

Federation of State Medical Boards

The most important, of course, is the Federation of State Medical Boards of the United States (FSMB). Founded in 1912, this is an organization of all the medical boards in the United States. It has also extended affiliate membership to similar licensing authorities in several other countries. The Canadian provinces and the Federation of Medical Licensing Authorities of Canada hold affiliate membership. The FSMB is based in Euless, Texas, near Fort Worth. Its mission is continual improvement in the quality, safety, and integrity of health care through the development and promotion of high standards for physician licensure and practice. The most valuable

continued on page 3

In This Issue of the FORUM

Item	Page	Item	Page
President's Message:		Is Your Attitude Getting in Your Way?	12
<i>Lessons from a Crow</i>	1	Physician Behavior	14
From the Executive Director:		Social Services for Pregnant and Parenting Adolescents	17
<i>Our Ecosystem</i>	1	The Importance of Verifying the Licensure Status of Nurses Employed in Office-Based Practices	18
Fondly, Carolyn:		As Stewards of the Medicaid Budget, We Can Do Better!	19
<i>Letters to a Young Physician</i>	4	etc etc etc	19
Dr Collman Named Part-Time Medical Coordinator for NCMB	6	Board Actions: 5/2002-7/2002	20
NCMB Elects Officers	7	Board Calendar	24
The Intersection of Public Health and Pharmacy for Older Adults: Making Sure That "Doctors' Orders" Can and Should Be Followed	8	Change of Address Form	24
Dr Dees Honored by Duke University Medical Center	11		
NCMB Revises Two Position Statements	11		

Primum Non Nocere



forum

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

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

North Carolina Medical Board

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George C. Barrett, MD Charlotte <i>Term expires</i> October 31, 2002	Robin N. Hunter-Buskey, PA-C Gastonia <i>Term expires</i> October 31, 2003	Andrew W. Watry Executive Director	Address 1201 Front Street, Suite 100 Raleigh, NC 27609
Elizabeth P. Kanof, MD Raleigh <i>Term expires</i> October 31, 2002	Bryant D. Paris, Jr Executive Director Emeritus	Telephone (919) 326-1100 (800) 253-9653	Fax (919) 326-1130
		Web Site: www.ncmedboard.org	E-Mail: info@ncmedboard.org

Lessons from a Crow

continued from page 1

defined in Rule .0102 of this Section.

The rule misses the mark. Can we assess a baker by the number of hours he spent reading a cookbook? Even so, it is certainly not a demanding requirement. Attending one meeting a year and reading about an hour every two weeks fulfills the rules. Most doctors do far more. They may read for hours trying to find the right treatment for a patient or to learn new health care rules.

The CME requirement arose out of a concern that doctors would not continue to learn once they were out of residency. As if doctors are not eager to learn! The facts show just the opposite. Think of how rapidly laparoscopy spread across the U.S. as surgeons attended courses by the thousands, at significant personal expense, to learn this new technology. Similarly, consider the speed by which other advances crossed the U.S., such as the insertion of cardiac stents, endovascular surgery, new chemotherapeutic agents, and management of arrhythmias. In fact, the prescription of some drugs spreads so quickly that third-party payers have to

conduct sessions to prevent their introduction. There is ample evidence that physicians do not have to be forced to learn.

Bill Gates recently said that more discoveries were made in the last decade than in the rest of recorded time. President Clinton put it a little differently with his statement that science doubles every six years. Either way, it suggests that a 50-year-old physician, who graduated at the age of 26, had to learn 75



Betty at Work

percent of his current fund of knowledge since he finished medical school. Further, before he retires, he will need to expand his knowledge by another 300 percent.

Fortunately, we now have better approaches to learning than textbooks that are often out of date by the time they are published, erratic journal articles, and lectures in far-away-places. The advent of the Internet, the availability of inexpensive computer memory, and the widespread familiarity of physicians with computers allow us to think outside the box. It is now possible to provide full courses over the Internet based on curricula that are stratified to meet the needs of the individual. These courses could be presented in modules so they can be learned or reviewed in manageable segments. Further, it is now feasible to include a test at the end of the course that is graded independently to help the learner evaluate progress.

Many of our medical schools have most of the educational materials required for such a venture. We could review the strengths of each institution and, based on this survey, assign each institution segments of a national Internet curriculum. For example, the Johns Hopkins might be asked to provide a full teaching module covering the diseases of the pancreas, while the Rockefeller Institute might be assigned the course on genetics. With this approach, we could have a living text that is always up to date, with a program that would be available at any time and wherever there is a telephone and computer. Further, successful completion of the test in the module could also provide documentation of learning.

Such an initiative in continuing education would be, I think, an advance over our current approach. It might almost catch us up with the methods used for Betty, the crow.

Photo of Betty the Crow reprinted with permission from *Shaping of Hooks in New Caledonian Crows* by Weir, et al, *Science* 297, 981 (2002) fig 1. Copyright 2002, American Association for the Advancement of Science. ♦

North Carolina Medical Board

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

Our Ecosystem

continued from page 1

aspect of the FSMB to us is its membership. Through this organization, we interact quite regularly with the larger community of medical boards. The primary vehicle for this is an annual meeting held in April. We serve on various FSMB committees, and the year before last the elected president of the FSMB was one of our Board Members, George C. Barrett, MD. This organization is far and away the most influential national organization to coordinate licensure standards among the states. Beyond this, it administers the uniform physician licensing examination (the United States Medical Licensing Examination) and provides other valuable services. A brief sample follows.

Examination Services: In cooperation with the National Board of Medical Examiners, the FSMB created and administered the first uniform licensing examination, known as the Federation Licensing Exam (FLEX), which was adopted by all but one of the states. This was the precursor to the present-day United States Medical Licensing Examination (USMLE), the three steps of which were introduced between 1992 and 1994. This is one of the finest examinations in the examination marketplace, setting the benchmark for psychometric standards. The USMLE very effectively tests graduates of both U.S. and foreign medical schools for knowledge, skills, and abilities necessary to safely practice medicine in the United States. Additionally, there is an osteopathic examination administered by the National Board of Osteopathic Medical Examiners.

Membership: In addition to 68 U.S. boards (some states have separate medical and osteopathic boards, and the boards of the District of Columbia, Puerto Rico, Guam, and the Virgin Islands are included), the FSMB interrelates with many other key players to be described later, including the American Medical Association, the Association of American Medical Colleges, the American Osteopathic Association, the National Board of Medical Examiners, the Educational Commission for Foreign Medical Graduates, the Accreditation Council for Continuing Medical Education, the National Commission on Certification of Physician Assistants, and others.

Post-Licensure Assessment System: The FSMB has developed a post-licensure assessment system to deal with those who have deficits in clinical skills and clinical performance identified by medical boards. There are essentially two components: (1) a special purpose examination known as SPEX, and (2) an assessment center that started out in Colorado but now has evolved to test sites in Texas and Philadelphia. This is a support service for medical boards.

Credentials Verification Service (FCVS): This is a service to greatly facilitate interstate mobility of physicians by providing a central repository of core medical credentials. This is, therefore, a major service to medical boards and the public served by these boards. Having individual applications for licensure in each state that require revalidation of the same core credentials is redundant—a holdover from years ago. The FCVS provides a uniform, core-credential verification system accepted in 47 states, including ours, that provides an alternate pathway for licensees who are highly mobile from an interstate perspective. Six medical boards require FCVS for licensure applicants. It is particularly helpful to foreign medical graduates who may have difficulty obtaining core medical credentials each time they move from state to state.

Other Activities: The FSMB maintains a physician data center, collecting licensure data from all states. It maintains a board action data bank that receives disciplinary data from the state boards in real time and disperses it to other states immediately. This limits a disciplined physician's opportunity to relocate or seek a license in another state without that state knowing about his or her disciplined status. Other FSMB activities include educational offerings at annual meetings and regional meetings, publications, on-line resources, and the FSMB's Web site at www.fsbm.org. The FSMB also represents medical board concerns before the Congress. Here are examples of recent legislation monitored at the Federal level: medical error legislation (HR 4889 & 2590) and the Health Care Safety Net Improvement Act (HR 3450). Each year, there are more and more pieces of proposed legislation at the Congressional level that impact licensing boards. Also, the FSMB monitors legislative trends within the states and feeds this information back to the membership.

Education Commission for Foreign Medical Graduates (ECFMG)

The ECFMG began issuing certificates in 1958. Its principal customers at that time were post-graduate training programs in the United States that were accepting graduates of foreign medical schools. It provided a basis for uniform credentialing of foreign medical graduates through a process with three elements: an English competency examination; a basic medical competency examination; and a credentials check. The ECFMG process has steadily evolved, eliminating redundancies and enhancing public protection. The medical competency portion of its certification process is now a part of the USMLE, thus limiting redundancy. It also requires clinical skills assessment involving standardized patients. This issue addresses the disparity between training at

foreign medical schools and that in LCME and AOA approved facilities, identifies communication problems, and surfaces problems that could not otherwise be detected through multiple choice tests. It also administers a test of English as a foreign language.

National Board of Medical Examiners (NBME)

The NBME has been in existence since 1915. It was founded by the FSMB, the American Medical Association, and other interested medical groups and has vast and experienced psychometric resources for examination development. It developed the National Board of Medical Examiners examination, which was the precursor to the USMLE for graduates of U.S. medical schools. Graduates of foreign medical schools did not have access to this examination and, therefore, principally took the FLEX. The FLEX was developed in cooperation with the NBME. The examinations were, therefore, quite similar and included many examination items from the same item pool. The uniform examination that finally developed, the USMLE, eliminated any of the minor discrepancies existing between the two prior examination pathways. The NBME also provides the expertise for other testing instruments, including the SPEX, mentioned earlier, and instruments in use for clinical skills and post-licensure assessment.

Administrators in Medicine (AIM)

AIM is a national organization of medical board executives formed in 1983. The purpose of this organization is to develop and achieve administrative excellence for medical board executives. It augments but does not compete with the services of the FSMB. Its Web site is at www.docboard.org.

Conclusion

In conclusion, the North Carolina Medical Board needs to work closely with these other organizations in order to provide optimal services to the citizens of this state. In many cases, the Board has established a track record of leadership in these national organizations. The executive leadership of the FSMB and the ECFMG is in the hands of two former North Carolinians—James N. Thompson, MD, and James A. Hallock, MD, respectively. This is the second time the FSMB's executive leadership has been connected to this state. Bryant L. Galusha, MD, a Charlotte pediatrician and former president of the North Carolina Medical Board, was the FSMB's executive vice president from 1984 to 1989. Our support of these organizations reflects continuing commitment to the public mandate of the Board. ♦

Fondly, Carolyn:

Letters to a Young Physician: Part III



Carolyn E. Hart, MD

Dr Carolyn E. Hart, who practices neurology in Charlotte, is president of the Mecklenburg County Medical Society. In place of the usual president's comments in the Society's publication, Mecklenburg Medicine, she has prepared a series of letters to a medical student, "W," whose parents are physicians and friends of hers. Her thoughts, so clearly and simply expressed, unfold as a primer of sorts, laced with insight and wisdom, a gentle and conversational guide and reminder for health care professionals at any point in their careers. We thank Dr Hart and Mecklenburg Medicine for allowing us to present the letters here. We will publish ten letters in all over this year. Five were published in our first two numbers of 2002 and three more appear here to continue the series.

Take Time to Use Your Manners

Dear W:

Your "new" car sounds exciting and—what shall I say—challenging! Are you sure it was a good idea to buy a 15-year-old car that was totaled? Well, I will hush now because I know you know something about cars and I don't. Maybe it wasn't totaled too badly. I know it didn't take much for the insurance company to consider my last car totaled because by that time the poor old thing was barely rolling anyway! Shortly before that, I had a flat tire on that car, and the service station attendant took one look at the car and at me and judged that we were not worth being nice to. In fact, he was rude and sarcastic. Three or four days later, I was on my way home in the evening and got paged to please come back to the hospital to see a five-year-old girl with new-onset seizures. Her parents were deeply scared by what had happened to their daughter. As I spoke with the mother and child, the father faded into the shadows. I finally recognized him as the service station attendant, and he apologized for his previous discourtesy, saying: "I'm so sorry, ma'am, I didn't know you were anybody who mattered." After a moment of internal conflict, grace prevailed and I assured him all was forgiven and that

it would not affect my care for his daughter. The characters' roles in this true story could very well have been reversed. The doctor could have been rude to his/her patient's father, an uneducated man in greasy work clothes, and then could have needed his help with that flat tire. Either way, lack of courtesy could cause a significant problem later. It is therefore very important for physicians to "Take Time to Use Your Manners."

W, I know you are already a kind-hearted and courteous young man, but when physicians get busy and tired, even the gentlest among us may sometimes neglect their manners. We may snap inappropriately at our staff, patients, family, and each other. If this ever happens, admit it! As soon as you realize you overreacted, apologize sincerely, even to your preschool child or your young front-desk clerk. Remember your words have a lot of power. Physicians are usually articulate, strong-willed, and influential over the health, happiness, and/or livelihood of those around us. An encouraging word from you could change someone's life by supporting their college plans or life change. On the other hand, an unnecessarily sharp word from you could reduce someone to tears and he or she might never forget your harshness. Remember, first do no harm.

The nurses and other staff in your hospital and office deserve your courtesy and respect. They often care and work as hard as you do, and they too help patients through tough times. They also will support your efforts enthusiastically as they witness your politeness and kindness toward your patients. Conversely, your patients watch how you behave toward your staff and may decide on this basis whether or not to trust you with their secrets and their lives. A friend of mine walked out of her physician's office and switched physicians after hearing hers barking at a staff member. While wintering in Florida, another friend needed complex repeat angioplasty and decided to trust the local cardiologist to do it after overhearing the agreeable way in which he spoke with his staff.

Our society now has some amazing tools and toys, like cell phones, PDAs, and portable CD/DVD players. W, you proba-

bly understand how these things work, but I just use them, mindlessly enjoying their magic. (I did buy a book called *How Things Work* but haven't yet found time to read it!)

The reason I mention these technical wonders is that they are new triggers for rudeness in daily life. When you are on your cell phone in a public place, be sure to talk in a normal voice or get a better phone. Don't drive and hold the phone to talk—pull over or get an earpiece so both hands are on the steering wheel. If someone is talking with you, don't bury your head in your PDA, showing him the top of your head and not your eyes. Don't stay on the Internet during family mealtimes or past bedtime. These tools are fascinating, but people are even more so.

Old-fashioned etiquette is important, too. Look people in their eyes and shake their hands when you meet them. Most staff and patients already know you are a doctor, so you usually don't need to say "I'm Dr. G"; just say "I'm WG." You also don't need to put MD on your checks, license plate, or stationery. Let your staff and patients know at least a little about yourself, but not too much; it can be good to keep a distinction between personal and professional parts of your life. Ask about people's lives and interests, make notes and ask again the next time that you see them. Keep a collection of inexpensive congratulations and sympathy cards to send your patients and others in grief or in response to graduation and wedding announcements. Except in crowded corridors, nod or say "Good morning" or "Good afternoon" to everyone you pass. Those golden expressions, "please," "thank you," "I'm sorry," "would you," and "could you please," are still very potent and almost always get a positive result.

Remember what my service station attendant learned and treat everybody as if they were "somebody who mattered." God, through several of the religions of the world, has given us the Golden Rule. He has also set up our cellular aging processes such that by midlife, our facial lines show a lot about our personalities. My grandmother explained it succinctly, saying: "At 40, you get the face you deserve!" So, keep an eye on the mirror over the next couple of decades, W, to see if you are still remembering to "Take Time to Use Your Manners"!

Good luck with that car!

Fondly,
Carolyn

continued on page 5

"When physicians get busy and tired, even the gentlest among us may sometimes neglect their manners"

Fondly, Carolyn

continued from page 4

Take Time to Be Culturally Competent

Dear W:

¿Que pasa? How was your trip to Mexico? I hope you, your brother C, and your folks had a great time. I have a feeling that may be your last trip together as a family since you and C have such busy schedules of your own now. It was too bad B couldn't join you; I'm sure she missed you a lot. Did you get to do any dancing? You know your father, BG, is very good at the Texas Two-Step, and he taught it to me. It somehow reminded me of Cajun dancing and also of clogging and polka. Isn't it intriguing how different cultures sometimes have such similar dance styles and, for that matter, music, customs, and beliefs? You are such a curious and enthusiastic young man, W, I know you will enjoy exploring our world and learning about other cultures. That will help make you a better physician because it is very important for physicians to "Take Time to Be Culturally Competent."

Striving to understand other cultures is not only a compassionate and educational exercise for physicians to undertake but is becoming increasingly necessary to properly care for our patients. Did you know that the U.S. Census Bureau anticipates that in the next five years 48 percent of U.S. residents will be from cultures other than "white/non-Hispanic"? By the year 2050, Hispanics are expected to comprise 24.5 percent of the U.S. population, and African Americans, currently the largest minority, will constitute 15.4 percent of U.S. residents (Salimbene). Other major minority groups include Asians (currently about 3.4 percent), Middle Easterners, American Indians, and emigrés from former Soviet Bloc countries, especially Yugoslavia (Bosnia) and Poland. Within each of these groups, there are subsets based on age, gender, religion, sexuality, etc, and the perspectives of these subsets and of individuals may differ from each other dramatically.

It is very important to learn about other cultures, but not to make assumptions about individual patients based on their nation or culture of origin. This is the difference between generalizing and stereotyping. It is reasonable to use generalizations learned about a culture or country in order to focus on a patient's potential beliefs or perspectives, but not to stereotype the patient. Often, it is helpful to ask the patient about his/her foods, beliefs, family, and health practices. A handbook about cultural differ-

ences can also be useful. The best that I have found are *What Language Does Your Patient Hurt In? A Practical Guide to Culturally Competent Patient Care*, by Suzanne Salimbene, PhD, (2000, ISBN 1883998247, 1-800-865-5549); and *Pocket Guide: Cultural Assessment*, by Elaine Geissler, PhD, (1999, 2nd Ed., ISBN 0815136331, www.us.elsevierhealth.com). Both of these are excellent and describe proper ways of addressing patients, touching patients, collecting and conveying information, reaching decisions, and understanding differing concepts of space, time, and causes/cures of illness. Although these books are enlightening, it may be fun to learn about other cultures by experiencing them through travel (perhaps a medical work trip?).

"Striving to understand other cultures is not only a compassionate and educational exercise for physicians to undertake but is becoming increasingly necessary"

music (Yo Yo Ma's new CD, *Silk Road Journey*, is a wonderful product of many cultural influences), and food. I would also recommend listening to National Public Radio and viewing the Public Broadcasting System, exploring on the Internet (try www.omhrc.gov and magma.national-geographic.com), and reading (try *When I Was Puerto Rican*, by Esmeralda Santiago; *Monkey Bridge*, by Lan Cao; *The Spirit Catches You and You Fall Down*, by Anne Fadiman; and *Aman: Story of a Somali Girl*, by Virginia B. Lee). The best and most enjoyable exploration method of all is to simply chat with your patients, staff, and neighbors from other cultures.

As our society has digested the news of the 9/11/01 attacks and subsequent events, some of our innocent Middle Eastern immigrants, sadly, have felt the backlash of our shock. There have been some shameful examples of stereotyping, though several positive developments have also occurred. I believe we have felt more patriotic gratitude for daily freedoms, deeper respect for our protectors, and a heightened awareness of the rest of the world beyond our borders. We have been jolted into a "frightened eagerness to know about the 'other' world," according to Edward Brynn, director of International Programs at UNC Charlotte, in a recent interview with *The Leader*. Charlotte now has international information and support services (www.charlottemic.org/resource.htm), and many Charlotteans are learning or reviewing Spanish or other lan-

guages, demonstrating a welcoming attitude toward these newcomers. I mentioned a couple of months ago that I have been learning Spanish by listening to tapes and using a CD-ROM program, but my young patients have been my best instructors. At each visit, I ask them to teach me to say something in their language.

W, you are a lucky fellow to be bilingual and to have such familiarity with the Hispanic immigrants and American Indian communities near your Southwest home. Having grown up in an integrated mountain community in South Carolina, I thought I was similarly familiar with African-American culture but have come to realize that there is remarkable diversity among African-Americans' beliefs, backgrounds, and practices. Although most African-Americans help define "mainstream" American culture, others are of very different and unfamiliar backgrounds.

Many ethnic groups have traditional or folk healing methods that may be helpful, neutral, or harmful. I remember that you and your mother, L, have worked with some of the American Indians in New Mexico and Arizona. Did you have any chance to learn of their folk healing methods?

W, I am sorry this letter is a little longer than most, but cultural diversity is one of my favorite topics. You have a cheerful and inquisitive nature, and I know you will consider the project of learning about other cultures, not as a physician's obligation to his or her patients, but as a fun, lifelong exploration of the amazing mosaic of our world. Remember to "Take Time to Be Culturally Competent" and have fun doing so! *Hasta la proxima mes!*

Fondly,
Carolyn

Take Time to Live Healthily

Dear W:

I'm sorry to hear that you got mycoplasma, and I hope you are starting to feel better now. I had mycoplasma once during residency and remember that uncontrollable cough. The doctor at the employee health center paged me and asked me how much I smoked because the chest X-ray showed a large tumor with several lytic bone lesions. This was not an optimal way to hear such scary news, and your mom was very supportive. Since I'm still here to tell the story, you know the ending was happy (for me). I never smoked, and the names on the chest X-rays had just gotten mixed up! On the positive side, that experience helped me focus

continued on page 6

Fondly, Carolyn

continued from page 5

on how to live fully and provided me with a great example of how not to convey bad news to a patient!

As you start feeling better, W, don't forget to finish all your doses! You know doctors are not known for being very good patients! Surely between B and your folks, you will be coerced into taking your meds and also resting properly!

This month is the anniversary of the vicious 9/11/01 attacks, and we are all still bruised. I can't tell you how many kids I have seen this year with increased headaches, sleep problems, and other signs of stress. Many doctors have spent a lot of time since last September trying to comfort our patients, and I thought perhaps it was time to write about how we must take care of ourselves as well. To be a good physician, W, you will need to "Take Time to Live Healthily."

JA, a local obstetrician, says that five things are required for a healthy and happy life: trust in a higher power, a calling, a loving relationship with another adult, an avocation, and exercise. In order to live healthily, a physician must look after his/her mind, body, and spirit. W, you seem to me to be faring well in all three spheres, but it is easy to get "out of shape" in any of them. It is a healthy exercise to take an inventory of each area occasionally, recognizing your strengths and acknowledging your weaknesses. Both were conferred on us by a higher power, and together they make us the special but quirky individuals we are.

Physicians tend to have fairly healthy minds, learning easily and often delighting in mental challenges. Nevertheless, we often have ADHD, learning disabilities, or other imperfections that cause frustrations in our daily lives and inconsistencies in our performance patterns. Contrary to popular belief, these conditions can occur in bright, accomplished adults (see www.chadd.org and www.ldanatl.org). People with an undiagnosed neuropsychiatric condition sometimes resort to self-medicating with alcohol or other substances, often leading to more serious problems. Substance abuse causes huge problems in our world, and physicians and our families are certainly not immune. In fact, we may be more vulnerable than average in this area, perhaps due to our pressured schedules, independence, and reluctance to seek help, especially for problems of the mind or spirit. There is a lot of good help available though, especially through Alcoholics Anonymous (www.aa.org), the

North Carolina Medical Board (www.ncmedboard.org/phlp.htm), and Al-Anon (www.al-anon.alateen.org). W, if you ever experience problems like this, get help! Don't self-medicate!

W, I have never been quite sure how to divide mind and spirit since the fields that study them seem to overlap and since it is all about the brain! OK, OK, I might be a little biased! Somehow spiritual health is more abstract, though, and is the source of happiness, love, serenity, and everything else for which I cannot describe a neural circuit! Just as problems with attention or learning can affect your mental health, difficulties with anxiety, depression, anger, and lack of trust in a higher power can damage your relationships, self-esteem, and overall spiritual health. While preparing to write you this letter, I asked several friends for advice

"In order to live healthily, a physician must look after his/her mind, body, and spirit"

on ideas that could guide one's life. Try asking your friends this; the answers are beautiful. The answers I received included: "The Lord's Prayer"; Frost's "The Road Not Taken"; "Might as well do it right"; "Slow down, Doc, tomorrow ain't promised to none of us" (an employee); "The Serenity Prayer" (www.openmind.org/serenity); and my own favorite, "Desiderata" (Max Ehrmann, 1927; try desiderata as a search word). W, I hope you will always remain humble enough to accept advice from your family and friends and to seek help if you need it!

The importance of physical health seems apparent to physicians, and yet ironically we often neglect our own bodily health. Many of us delay checkups and push ourselves through long workdays, leaving little time for relaxation, conversation, careful nutrition, sleep, and exercise. Although we sleep less (averaging about 6.5 hours) than our predecessors (8.2 hours) a few decades ago, at least we also smoke less, too! In an unpretentious Italian restaurant in Charlotte, there is a framed magazine advertisement picturing a Rockwellian physician and his patient and proclaiming "More Doctors Smoke Camels!" Let's hope not! We have certainly made progress in understanding risk factors and publicizing healthy standards (www.health.discovery.com and www.time.com/time/health), but we still need to remember to eat right, sleep enough, and exercise. Live like your grandmother is watching and "Go outside and get some fresh air!"

Although Epicurus' name has been mistakenly associated with pleasure and privilege (see *Epicurean* magazine, [.com\), he actually espoused a philosophy of life very similar to JA's recommendations for health and happiness. Epicurus recommended basic foods, shelter, and simple clothing, but most importantly, friends and freedom of thought. More recently, Mary Chapin Carpenter's song "Passionate Kisses" provides a similar wish list for achieving health and happiness \(see \[www.geocities.com/islandlyrics\]\(http://www.geocities.com/islandlyrics\)\).](http://www.epicurean</p>
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W, I hope you feel better soon! I have to go now and call for an appointment for my checkup!

Fondly,
Carolyn



Dr Collman Named Part-Time Medical Coordinator for NCMB

Andrew W. Watry, executive director of the North Carolina Medical Board, is pleased to announce the selection of Mitchell S. Collman, MD, FACC, as a part-time medical coordinator for the Board. He joins Gary M. Townsend, MD, JD, who came to the Board as its full-time medical coordinator in the summer of 2000. Dr Collman is board-certified in both internal medicine and cardiology and is actively practicing as a cardiologist in the Raleigh area. He serves as a clinical assistant professor in the Cardiology Division of the University of North Carolina School of Medicine.

A native of New York, Dr Collman received his BS from Rensselaer Polytechnic Institute and his MD degree from Albany Medical College in their combined six-year program. He then did his internal medicine training at the University of Michigan Medical School and his cardiology fellowship at the University of North Carolina.

Dr Collman also has experience as an emergency medicine physician and acts as a consultant for the Social Security Administration and Medical Review of North Carolina. He is a fellow of the American College of Cardiology and a member of the Wake County and North Carolina Medical Societies.

Dr Collman will serve as an advisor to the Board staff in areas requiring medical expertise and facilitate the Board's evaluation of the increased volume of complaints, malpractice reports, and other matters involving issues of medical care in North Carolina. ◆

NCMB Elects Officers: John T. Dees, MD, President; Charles L. Garrett, Jr, MD, President Elect; Mr Hari Gupta, Treasurer; Stephen M. Herring, MD, Secretary

Andrew W. Watry, executive director of the North Carolina Medical Board, has announced the Board's election of its officers for the coming year: John T. Dees, MD, of Bald Head Island, president; Charles L. Garrett, Jr, MD, of Jacksonville, president elect; Mr Hari Gupta, of Morrisville, treasurer; and Stephen M. Herring, MD, of Fayetteville, secretary. They take office on November 1, 2002 and will serve until October 31, 2003. (Note that the position of vice president of the Board is eliminated as of November 1, 2002. It is replaced by the newly created office of president elect.)

John T. Dees, MD, President

John T. Dees, MD, of Bald Head Island (formerly of Cary), becomes the Board's president on November 1, 2002, replacing



Dr Dees

Dr Walter Pories, of Greenville, in that position. A family physician, he practiced for many years in his native Burgaw, a rural area of the state. He received his undergraduate education at the University of North Carolina, Chapel Hill, and his

MD from Duke University School of Medicine. He did his internship at Durham's Watts Hospital and his residency at Duke Hospital. He is a charter diplomate of the American Board of Family Physicians.

Besides his private practice, Dr Dees has served, among other things, as Pender County Health Director, chief of staff of Pender Memorial Hospital, and medical director of the Huntington Health Care Center. He has rendered distinguished service to a wide variety of professional organizations, including the North Carolina Academy of Family Physicians, the North Carolina Medical Society, the American Academy of Family Physicians, the Southern Medical Association, the Wake and New Hanover-Pender County Medical Societies, and the American Medical Association. He served as president of the North Carolina Medical Society in 1991-92 and is a member of the Society's Executive Council and an alternate delegate to the American Medical Association's House of Delegates. He has

also been an active participant in civic affairs in Burgaw and Pender County and at the state level.

Dr Dees was first named to the Board by Governor James B. Hunt, Jr, in 1997. While on the Board, Dr Dees has served, among other committees, on the Complaints Committee, the Physicians Health Program Committee, the Investigative Committee, the Clinical Pharmacist Practitioner Joint Subcommittee, and the Executive Committee. He currently chairs the Licensing and PHP Committees. In 2000, he was elected secretary-treasurer of the Board. He served as the Board's vice president from November 2001 through October 2002.

Dr Dees says his philosophy is that "service to humanity is the best work of life."

Charles L. Garrett, Jr, MD, President Elect

Charles L. Garrett, Jr, MD, of Jacksonville, served as the Board's secretary/treasurer through October 2002 and will become president elect on November 1. Dr Garrett is director of laboratories at Onslow Memorial Hospital; managing senior partner of Coastal Pathology Associates, PA; medical director and adjunct faculty member at the School of Medical Laboratory Technicians at Coastal Carolina Community College; medical examiner of Onslow and Jones Counties; southeastern regional pathologist for the Office of the Chief Medical Examiner of North Carolina; and executive director of the Onslow County Medical Society. A native of South Carolina, he received his undergraduate education at Wofford College in Spartanburg, SC, and took his MD, magna cum laude, at the Medical College of South Carolina in Charleston.



Dr Garrett

Dr Garrett did his postgraduate training at the Medical University Teaching Hospitals in Charleston, South Carolina, and a fellowship at the Medical College of Virginia and in the Office of the Chief

Medical Examiner of Virginia. He is certified by the American Board of Pathology. He also served in the U.S. Navy, from which he was honorably discharged as a lieutenant commander.

A fellow of the College of American Pathologists, the American Society of Clinical Pathology, and the American Academy of Forensic Sciences, Dr Garrett is active in a large number of professional organizations and served as president of the North Carolina Medical Society in 1998. He continues his work with the Medical Society today in several capacities and is a Society delegate to the American Medical Association. He is also on the Board of Directors of the AMA's Political Action Committee.

Among his many other professional activities, Dr Garrett has presented a number of papers on forensic medicine to legal groups in North Carolina and other states. In 1998, Governor Hunt presented him the Order of the Long Leaf Pine. He is very active in church and civic affairs in Jacksonville.

Appointed to the North Carolina Medical Board in January 2001, he has been a member of the Board's Investigative and Executive Committees, and chairs the Policy and Legal Committees.

Mr Hari Gupta, Treasurer



Mr Gupta

Mr Hari Gupta, of Morrisville, was born in London, England, and grew up in Vancouver, British Columbia, Canada. He earned two bachelor of science degrees, one in computer science and the other in civil engineering, from Washing-

ton State University.

Mr Gupta began his professional career as a programmer and systems analyst in Toronto, Canada, and soon moved on to a consultant's post with the Computer Task Group in Columbus, Ohio. In 1990, he joined SAS Institute in Cary, North Carolina, beginning as a software developer and then moving to applications development. In 1996, he became consulting direc-

continued on page 8

NCMB Elects Officers

continued from page 7

tor for SAS Asia Pacific/Latin America, and doubled AP/LA consulting revenues for two consecutive years. In 2000, he assumed the role of general manager for SAS Global Services, building and managing a 70-member team of software consultants based in India and the United States.

In 2001, Mr Gupta became director of SAS Consulting Partners, responsible for building and managing alliances with key SAS partners and for developing and monitoring guidelines for the SAS Consulting Partner program.

He left SAS in late 2001 to develop other business interests. He is currently pursuing a career in residential and commercial real estate and is working on establishing a furniture import business.

Mr Gupta was appointed to the Board in February 2002. He has served on the Board's Legal and Complaints Committees and will take his position as treasurer on November 1, 2002.

Stephen M. Herring, MD, Secretary

Stephen M. Herring, MD, of Fayetteville, a native of Chapel Hill, North Carolina, took his BA degree at the University of North Carolina, Chapel Hill. He earned a DDS from the University of North Carolina



Dr Herring

School of Dentistry, followed by an MD from the Wake Forest University/Bowman Gray School of Medicine. He did his internship in general surgery and a residency in general surgery and plastic surgery at Bowman Gray. He is certified by the American Board of Plastic Surgery and holds licenses in both medicine and dentistry.

Currently in the private practice of plastic surgery in Fayetteville, Dr Herring is affiliated with Cape Fear Valley Medical Center and Highsmith-Rainey Memorial Hospital. He is a member of the American Society of Plastic and Reconstructive Surgeons and is active in state and local professional organizations. He is also a past president of the Cumberland County Medical Society and author and co-author of several journal articles.

Dr Herring was first named to the Board in 1998. He has served on several Board committees and currently serves on the Policy Committee and chairs the Investigative Committee. He will assume the position of Board secretary on November 1, 2002. ♦

The Intersection of Public Health and Pharmacy for Older Adults: Making Sure That "Doctors' Orders" Can and Should Be Followed

*Gina Upchurch, RPh, MPH
Executive Director, Senior PHARMAssist*



Ms Upchurch

In the age of diminishing reimbursement for patient care and increasing emphasis on "productivity," more health care providers are opting not to accept new Medicare patients. Older adults often have multiple chronic conditions and are taking multiple medications, requiring more than the allotted time for appointments. While many providers feel rushed and dissatisfied with current reimbursement models, the Medicare payment structure isn't likely to reverse direction anytime soon given the current economic forecast and the lack of prevention foresight.

Providers' lack of face-to-face time with seniors is also a growing concern for community pharmacists who are being relegated to deciphering insurance or "discount" cards and filling more and more prescriptions as reimbursement rates per prescription shrink. It is projected that annual outpatient prescriptions will grow to 3.13 billion in 2002, and sales for these medications will exceed \$188 billion.¹ This comes at a time of a national pharmacist shortage, which may be leading to more medication dispensing errors as the sheer volume of prescriptions and the plethora of "discount" cards overwhelm community pharmacists.

If this shortage of time with seniors is not a large enough public health concern, it gets worse. In a recent survey of seniors conducted by the Kaiser Family Foundation, the Commonwealth Fund, and Tufts-New England Medical Center in eight states, 22 percent of all seniors surveyed said they did not fill a prescription because it was too expensive or that they skipped doses of their medications to make them last longer. For the seniors who lacked prescription coverage, 35 percent skipped doses or did not have prescriptions filled. Therefore, a medication could have been properly prescribed and dispensed, and yet the expected outcome is out of reach. Even prescription "coverage" is not an assurance of medication adherence. Close to one in four seniors in the survey (including many with prescription coverage) reported spending \$100 per

month on their medications in 2001, which is a significant financial challenge for many seniors with fixed, limited incomes.²

In addition to reimbursement barriers for health care providers working with seniors, and the inability of many seniors to afford the medications prescribed for them, many older adults are receiving medications they do not need and, in fact, may be causing harm. It is projected that for every \$1 spent

paying for medications in the ambulatory setting in the U.S., we spend \$1.36 dealing with medication-related problems in this same population.³ Fortunately, many of these problems can be avoided when the patient, provider, and pharmacist work together to ensure that everyone is on the same "medication page."

While there are definite limitations within the health care system that currently do not support the comprehensive treatment of older adults with multiple concerns, there are, nonetheless, many providers who effectively handle the issues of limited time and of medication payment and appropriateness to ensure high quality care for their older patients. In this age of advanced technology, I would like to highlight some of the issues involved with prescribing for older adults, along with a few inexpensive, low-tech methods that health care providers can incorporate into their practices to ensure that the medications prescribed are taken appropriately and bring more good than harm.

Polypharmacy and Medication Inappropriateness

In 1998, people over the age of 65 comprised 13 percent of the U.S. population, yet they consumed 34 percent of prescription medicines ordered, which represented 42 percent of prescription expenditures.⁴ While polypharmacy (the use of multiple medications) may be necessary and beneficial, sometimes it is a result of a senior having

"Many older adults are receiving medications they do not need and, in fact, may be causing harm"

continued on page 9

Pharmacy

continued from page 8

multiple providers and pharmacists, with no one provider having a complete picture of all the medications a senior may be taking, including prescription, over-the-counter, and herbal products. In a nationwide survey conducted in 2000, community-dwelling seniors reported filling 28.5 different prescriptions on average over the course of a year.⁵ Polypharmacy seems particularly troublesome upon hospital discharge when the discharge summary and prescriptions are not written by the provider who follows the senior in the community. Even if the regular community provider discharges the patient, seniors are often confused about how to “merge” discharge medications with their regular medications, possibly leading to inappropriate drug regimens.

There is an increased risk of adverse effects and drug interactions as the number of medications increases. While many drug-drug interactions are not clinically significant, many are. In addition, there are drug-disease interactions (ie, arthritis medicines that can worsen GERD) and drug-nutrient interactions (ie, less levothyroxine absorption if taken within a few hours of calcium) that can negatively affect the lives of older adults.

Polypharmacy is not a prerequisite for medication-related problems in the elderly; one medication can decrease the quality of life for a senior. Findings from the 1996 Medical Expenditure Panel Survey indicated that 21.3 percent of noninstitutionalized elderly in the U.S. received 1 of 33 potentially inappropriate medications. In fact, the study likely underestimated the “inappropriateness” of medication use in the elderly, as it only used explicit criteria developed by Beers and colleagues (a list of 33 medications) and did not include dosage, dosing intervals, indication criteria, or duplicate therapy.⁶

While more clinical trials are beginning to include older adults, the complexity of the study design necessitates that seniors with several co-morbidities taking multiple medications (confounders) be excluded from many of the studies. Unfortunately, in real life, there are older adults with multiple problems and pharmaceutical remedies swirling around when new agents are added to the mix. Post-marketing surveillance is critical for understanding the effects of medications in the elderly.

Attach to the hectic health care provider scenario the fact that very few health care providers have any formal training in geriatrics and geriatric pharmacology, and we have a dangerous intersection where pharmacy meets public health.

Pharmacology and Adherence with Older Adults

Older adults differ from younger cohorts in two major ways with regard to pharmacokinetics. While there is individual variation among the senior population, two generalizations remain: 1) renal function declines with age, and 2) hepatic function (especially Phase I metabolism) is decreased in the elderly. Some medications that are eliminated primarily by the kidney, which may need to be adjusted in an older individual, even with a normal creatinine, include metformin, digoxin, allopurinol, lithium, and amantidine. Medications that depend on Phase I metabolism (eg, hydroxylation, oxidation, etc) include several of the benzodiazepines (eg, flurazepam, triazolam, diazepam), making them less appropriate for use in the elderly.

In addition, clinical experience demonstrates that many older adults are simply more sensitive to the effects of medications than the younger cohorts, who are often included in the clinical trials. The senior’s “reserve” for avoiding adverse effects is more limited. For example, medications with anticholinergic side effects may be a small nuisance to a young person (ie, dry mouth); however, anticholinergics may significantly impair an older person (ie, mental confusion, urinary retention, constipation, orthostatic hypertension, etc).

After a medication is appropriately prescribed and dispensed, medication administration and adherence are usually left up to the senior and his or her caregiver. Medication adherence is a means to an end, not an end unto itself. Twenty years ago, Cooper and colleagues found that seniors were no more or less adherent than younger adults when matched for complexity of drug regimen. And interestingly, when older adults were non-adherent, 90 percent of the time they underused the medication and 73 percent of the underuse was intentional. Many of the seniors noted that they did not perceive a need for the medication at all or in the dosages prescribed.⁷ They also cited side effects and the growing concern that “I simply cannot afford it.” In fact, sometimes nonadherence is justifiable and appropriate. The key is that these circumstances need to be exposed and, if possible, alternative therapies begun that satisfy the side effect and pocketbook profile. This can happen with honesty, rapport, and time.

Clash Between Rising Expenditures and Our Ability to Pay

Medication expenditures have risen at double-digit rates during the last few years. In 2000, 42 percent of the year’s 18.8 per-

cent rise was attributed to an increase in the number of prescriptions written, 36 percent was attributed to a shift to the use of more expensive medications, and 22 percent was due to actual price increases from the previous years.⁸ Approximately 10 percent of our health care dollars are spent on medications, but these expenditures are rising much faster than other segments in health care. While much has been said about the massive increase in direct-to-consumer advertising, roughly 50 percent of advertising dollars are spent on medication samples of the newest medications.⁹ Many providers try to help their seniors who struggle financially by using their sample cabinets as pharmacies. In addition, many providers are willing to help access medications for seniors and others who cannot “foot their pharmacy bill” by applying for medications via the drug manufacturers’ patient assistance programs. These ever-changing programs, which are manufacturer specific and sometimes drug specific, combined with the newer “discount” cards, create a new level of “service” in the providers office. With decreasing reimbursement and, thus, less time with patients, many providers are reluctant to embrace the challenge of completing additional paperwork to ensure access to medications.

What Is a Provider To Do? Practical Tips for Working with Older Adults

In many instances, older adults are prescribed appropriate and necessary medications, and pharmacists dispense the medications correctly and provide counseling at the pharmacy counter. However, there is another critical partner in this scenario: the patient. In fact, in the prescribing-dispensing-administering triangle, there are at least three people—the provider, pharmacist, and patient—and many times, nurses, social workers, caregivers, and others involved. There are several ways to strengthen the prescribing-dispensing-administering triangle.

1. Bear in mind that “any symptom in an elderly patient should be considered a drug side effect until proved otherwise.”¹⁰ Discontinue medications that are no longer needed and be vigilant about monitoring for side effects. Before prescribing a medication, make sure that what is being treated is not an adverse effect from another medication.

2. Consider whether adding a new medication to a senior’s regimen is necessary, even if she or he comes with a particular drug name in mind and even if your writing a prescription may speed up the interview. Consider whether other alternative forms of treatment (eg, smoking cessation

continued on page 10

Pharmacy

continued from page 9

counseling, nutrition counseling, Kegel exercises, etc) or simply explaining the benefits of not adding a drug to the current regimen is truly “the best medicine.”

3. Educate yourself about the cost of drug therapies and ask your patients if they are able to afford their medications. If they need help, consider whether there are cheaper alternatives or other resources that you can use to ensure that the prescribing-dispensing-administering triangle doesn't break down because of practical decisions that your patients have to make. A close relationship with a community pharmacist may prove invaluable in this regard.

4. Adopt the geriatric mantra: “Start low and go slow.” When prescribing a medication for an older adult, a general rule is to add one medication at a time and begin with low doses and slowly increase the dose as necessary. The same could be said for withdrawing a medication with CNS effects: slowly decrease the dose before discontinuation.

5. Ensure that accurate labels are on prescription bottles. If you change the dose or directions for administration, write a new prescription. This will help the senior or caregiver who may struggle to remember the myriad of directions. In addition, it will allow the pharmacist to correctly counsel the patient, thus reinforcing the intended use of the medication rather than serving to confuse.

6. Place the indication for the medication on the prescription if at all possible. This will help the patient and pharmacist understand the use of the medication. The pharmacist cannot type the indication for a medication on a label (even if it is obvious) unless the indication is on the prescription. Seniors on multiple medications may have a difficult time remembering the indications for their medicines without help from the labels.

7. Write both the generic and brand name of a medication on the prescription (and label) to help prevent duplicate therapy, especially when multiple providers and pharmacies are involved.

8. Ask all of your patients to carry a list of all their medications, including prescription, over-the-counter, and herbal products, with them at all times. In addition, ask your patients to show this to any and all providers before anything gets added to the list. Adding past medication allergies, adverse effects, and the names of current providers and pharmacies can be very beneficial.

9. Ask open-ended questions about medication administration and have “show and tell” with medicines to ensure proper medication schedules and administration techniques. “You take this twice a day—right?” may elicit a very different response than, “Tell me how you actually take your blood pressure medication.”

10. Try to determine if older adults are included in the drug clinical trials you review and, if so, consider whether the study population is similar to the people you treat.

11. Simplify drug regimens as much as possible. Can “take the medication every six hours” be changed to “take after each meal (after you have checked that they do indeed eat three times a day) and before bedtime”?

At times, the barriers to providing good medical care to older adults, including time, costs, and other resources, can seem overwhelming to the busy health care provider. While most of the ideas on this list sound so simple, incorporating them into practice can make a major difference. Given that many senior “encounters” are short on time, but vast in need, your willingness to be attentive to medication problems and costs can drastically improve the lives of your “chronologically gifted” patients.

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SENIOR PHARM Assist

Senior PHARM Assist is a community-based, nonprofit organization in Durham County that complements the work of busy providers and community pharmacists and addresses many of the issues raised in the previous article. The program was designed to help seniors with incomes just above Medicaid eligibility remain as active and independent as possible for as long as possible. Since June 1994, Senior PHARM Assist has helped over 900 seniors in Durham directly with medication management, preventive health measures, and financial assistance with their medications. An evaluation published in the *North Carolina Medical Journal* demonstrated that 30 percent more participants knew the indications for their medications, 29 percent fewer participants stayed overnight in hospitals, and 31 percent fewer participants visited emergency rooms after being enrolled in Senior PHARM Assist for one year.* These seniors had incomes at or below 150 percent of the federal poverty level (currently \$1,108/single or \$1,493/couple), lived in Durham, and had no other prescription insurance. Senior PHARM Assist has helped an additional 2,400 individuals with either medication management or improved access to medicines via tailored referral to the drug manufacturers' patient assistance programs, Medicaid, TriCare for Life, and other pharmacy and health care programs.

Senior PHARM Assist:

- educates Durham County senior adults about preventive health measures;
- consults with seniors and health care providers about safe and effective medication use;
- provides financial assistance for necessary medications to seniors with limited incomes; and
- develops partnerships with others that share its mission.

For further information about Senior PHARM Assist see: Upchurch GA, Menon MP, Levin KS, Catellier DJ, and Conlisk EA. Prescription Assistance for Older Adults with Limited Incomes: Client and Program Characteristics. *J Pharm Technol*, January/February 2002; 17:6-11. Also, access the Senior PHARM Assist Web site at www.seniorpharmassist.org.

continued on page 11

Senior PharmAssist

continued from page 10

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Dr Dees Honored by Duke University Medical Center



John T. Dees, MD

John T. Dees, MD, a member of the North Carolina Medical Board since 1997, was honored on October 18 by Duke University Medical Center and the Duke Medical Alumni Association at a special Awards Luncheon held at the Washington Duke Inn in Durham. Dr Dees was one of three honorees receiving the 2002 Distinguished Alumnus Award. Present for the award were Sheila Moriber Katz, MD, MBA, President of the Duke Medical Alumni Association; Ralph Snyderman, MD, Chancellor for Health Affairs; and R.C. Waters, Vice Chancellor for Special Projects.

In their letter to Dr Dees, Dr Katz, Dr Snyderman, and Dr R. Sanders Williams, Dean of the School of Medicine and Vice Chancellor for Academic Affairs, wrote: "The leadership of the Medical Center and the Medical Alumni Association are very proud of your accomplishments. You have brought honor to Duke University Medical Center as an alumnus, and it will be a pleasure for us to recognize your achievements. . . ."

Dr Dees, who served as president of the North Carolina Medical Society in 1991-92, will assume the presidency of the North Carolina Medical Board in November 2002. ♦

NCMB Revises Two Position Statements

At its meetings in July and August 2002, the North Carolina Medical Board completed work on and approved revisions of two of its position statements. These revisions are further refinements of changes made in the same statements earlier in the year. They are presented below in marked versions to clearly indicate the changes made. Added language has been underlined. Deleted language has been lined through.

WRITING OF PRESCRIPTIONS

- It is the position of the North Carolina Medical Board that prescriptions ~~for controlled substances or mind-altering chemicals~~ should be written in ink or indelible pencil or typewritten or electronically printed and should be ~~manually~~ signed by the practitioner at the time of issuance. Quantities should be indicated in both numbers AND words, eg, 30 (thirty). Such prescriptions must not be written on presigned prescription blanks.

- Each prescription for a DEA controlled substance (2, 2N, 3, 3N, 4, and 5) should be written on a separate prescription blank. Multiple medications may appear on a single prescription blank **only** when none are DEA-controlled.

- No prescriptions, ~~including those for controlled substances or mind-altering chemicals~~, should be issued for a patient in the absence of a documented physician-patient relationship.

- No prescription ~~for controlled substances or mind-altering chemicals~~ should be issued by a practitioner for his or her personal use. (See Position Statement entitled "Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist.")

- The practice of pre-signing prescriptions is unacceptable to the Board.

- It is the responsibility of those who prescribe controlled substances to fully comply with applicable federal and state laws and regulations. Links to these laws and regulations may be found on the Board's Web site (www.ncmedboard.org).

- ~~A physician who prescribes controlled substances should pay particular attention to the part of the Code of Federal Regulations dealing with prescriptions, which may be found at 21 CFR 1306, entitled "Prescriptions."~~

(Adopted May 1991, September 1992)
(Amended May 1996; March 2002; July 2002)

LASER SURGERY

It is the position of the North Carolina Medical Board that the revision, destruction, incision, or other structural alteration of human tissue using laser technology is surgery.* Laser surgery should be performed only by a physician or by a licensed health care practitioner working within his or her professional scope of practice and with appropriate medical training functioning under the supervision, preferably on-site, of a physician or by those categories of practitioners currently licensed by this state to perform surgical services.

Licensees should use only devices approved by the U.S. Food and Drug Administration unless functioning under protocols approved by institutional review boards. As with all new procedures, it is the licensee's responsibility to obtain adequate training and to make documentation of this training available to the North Carolina Medical Board on request.

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 a ~~licensed health care practitioner working within his or her professional scope of practice and with appropriate medical training functioning under the supervision, preferably on-site, of a physician who bears responsibility for those procedures.~~ an individual designated as having adequate training and experience by a physician who bears full responsibility for the procedure. The responsible supervising physician should be on site or readily available to the person actually performing the procedure.

*Definition of surgery as adopted by the NCMB, November 1998:

Surgery, which involves the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skills, post-operative management, and follow up.

(Adopted July 1999)
(Amended January 2000; March 2002; August 2002) ♦

Is Your Attitude Getting in Your Way?

Aloysius P. Walsh, Chair
NCMB Complaint Committee



Mr Walsh

Increasingly, that is precisely what is happening to the relationship between doctors and patients.

Whatever the underlying cause may be, patients are complaining more frequently that their physi-

cians are insensitive, arrogant, don't listen, are short-tempered, and simply don't care about the patients or their problems. Of course, this does not happen in the majority of the cases. The patient/doctor relationship is as solid as ever most of the time. However, an increasing number of complaints to the Board by patients or those responsible for them indicate that alarming changes are occurring, both in reality and in perception, that suggest that practitioners are not putting enough effort into establishing and maintaining their relationship with their patients. The best technical training in the world occurs here in the good old U.S.A., but it goes for naught if communication with patients suffers.

Effective Communication

It has been estimated that approximately 90 percent of our communication is non-verbal, and that highly effective people spend a significant amount of time and energy listening (Covey, 1989). Many psychologists also feel that the ability to listen and understand is one of the highest forms of intellectual behavior.

It has been estimated that during her or his average career, a physician/practitioner will have over 100,000 visits with patients. Obviously, what takes place most of the time in those encounters is conversation. However, the automatic assumption that conversation is communication must be tempered with the realization that, although we say we are listening, we are likely rehearsing in our heads what we are going to say when the other party is finished talking.

The effective listener must acquire the skill of focusing on the patient and concentrating on the verbal and nonverbal aspects of what the patient is trying to communicate. Unfortunately, although more medical schools are offering courses in communication skills, this is still a difficult task. The

physician is frequently challenged to diagnose difficult cases with very limited information, particularly if there is a language barrier added to the equation. Under the circumstances, in such situations, it's remarkable that we do as well as we do, given the likely complications in communications that occur on a day to day basis.

The Other Person's Footsteps

There have been several articles offered in the *Forum* over the years aimed at helping to reduce the incidence of complaints, but in the complicated dynamics of today's practice it is increasingly difficult to meet the pressures of the tight schedules, cultural differences, etc, and still keep patients contented and feeling welcome and well-informed.

A short time ago, I happened on a film on television titled "The Doctor." It told the story of a successful physician who was so busy in his practice, and so wrapped up in his own pursuits, that he lost sight of the need for relating to his patients and colleagues. He became insensitive, abrasive, and even arrogant in his outlook, and his relationships suffered accordingly. Sound familiar?

Then the doctor was stricken with cancer. As he suffered through his illness, he started out as a terrible patient, but he gradually learned through his personal experience what illness was like from the patient's perspective. Fortunately, he survived and eventually recovered completely. He also went through a profound transformation in his own outlook and attitude. He found that his subsequent encounters and relationships with his patients, colleagues, and students were similarly transformed. The insensitivity, abrasiveness, and arrogance were gone, replaced by humility, caring, and compassion. I believe this film should be required viewing for everyone, as it communicates so eloquently the benefits of "walking a mile in the other person's footsteps."

This is, of course, another example of the Golden Rule, but in light of the number of complaints from patients, and occasionally from other professionals, regarding "communications" problems, it prompts the question: is your attitude getting in your way?

Communication and Complaints

As a member of the Board's Complaint Committee, I'm privileged to see firsthand the complaints we receive about our

licensees, complaints that regrettably are on the increase. There are a number of reasons for this increase, of course, including patients' growing desire to participate in treatment decisions and their willingness to question and to challenge. And there is an increasing awareness of the complaint mechanism open to them, easily available by calling the Board or visiting the Board's Web site at www.ncmedboard.org. However, a very substantial portion of the increase is due to communications issues, including insensitivity, rude staff members, unwillingness to listen, abrasiveness, and even arrogance on the part of the practitioner or physician. These are the types of complaints that can be virtually eliminated. An ego suppressant, an infusion of compassion, and a large dose of humility is a great place to start.

Although many practitioners are gifted with the characteristics that constitute what we call a good "bedside manner," for those lacking the requisite gifts, there is a shortfall in the amount of training to acquire the skills aimed at filling the gaps. Training in communications, sensitivity, etc, is readily available, of course, but it is not always included in full measure in our medical education programs, nor is it sought out by those who may be in the greatest need of developing those skills, particularly those in denial! Denial is frequently due to an attitude, and attitude is a choice.

There are any number of articles in medical and legal journals that speak to communications problems as a leading cause for complaints and malpractice suits, and the development of a good bedside manner tends to have an insulating and even a remedial effect, though it is not a sure cure. The acquisition of a skill must be accompanied by the right attitude to be effective in the long term.

Staff Involvement

Involving one's staff in the process of developing and maintaining good patient relationships also calls for considerable leadership. Employees should be made fully aware of the importance of good communi-

"The ability to listen and understand is one of the highest forms of intellectual behavior"

continued on page 13

Your Attitude

continued from page 12

cations with patients. Self-improvement and advancement opportunities should reflect that commitment. Clear lines of communication, including a path for feedback without fear of reprisal, should be in place to assure communications in the office are effective in supporting communications with patients. Staff should be kept well informed about practice matters and what is expected of them; and regular performance evaluation of staff should include a significant communications element. Remember, from the patient's perspective, staff attitude reflects practice attitude.

The practice that is focused on the well-being and satisfaction of the patient stands a much better chance of success. Patient surveys, conversations with patients that include empathic listening, and seeking patients' input (not just telling them what you want them to do) are much more likely to result in a contented patient. Remember, communications is a two-way process involving both sending and receiving. Simply listening is probably the best single thing you can do, particularly with an angry patient who mostly needs to let off some steam. If he or she feels you're really interested, a potentially explosive situation can often be defused. Responding with hostility or defensiveness practically guarantees a similar reaction from the patient. Whatever the situation, your own negative reaction really reflects your own weakness, and suggests a lack of humility on your part.

"Bad listeners are lazy, closed minded, opinionated, insincere, bored, and inattentive"

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Less Talking, More Listening

Various authors have offered helpful hints over the years for more effective listening. Davis (1967) suggested that, first, you stop talking, show that you want to listen, empathize, be patient, stop talking, hold your temper, go easy on argument and criticism, ask questions, and, last, stop talking. DeMare (1968), among other things, further suggests that you put the speaker at ease, hear the patient through, be prepared on the subject, make allowances for circumstances, avoid getting sidetracked, summarize basic ideas, and restate the substance of what you have heard. Golen(1990) also opined that bad listeners are lazy, closed

minded, opinionated, insincere, bored, and inattentive!

Since good listening skills are more important than ever, we offer a brief quiz at the end of this article to help you rate your listening level, which is key to having a caring and compassionate bedside manner.

Conclusion

In closing, I would offer a couple of brief

additional suggestions. First, keep in mind that your purpose, first and foremost, is taking care of patients, and you would do well to park your ego in the garage or parking lot, and make humility and compassion a large part of your diet. Second, remember that your patients may not recall clearly what you say or do to them, **BUT THEY WILL NEVER FORGET HOW YOU MADE THEM FEEL.** ♦

Rate Your Listening Level

How would you rate yourself as a listener? Answer the following questions by checking the term that most accurately describes your usual behavior.

	4 Always	3 Often	2 Sometimes	1 Never
Do you look at the person with whom you are speaking?				
Do you withhold judgment until the speaker is finished?				
Do you like to listen to other people talk?				
Do you listen even if you do not like the person?				
Do you ask what the words mean if you don't know?				
Do you ask questions in order to fully understand?				
Do you listen regardless of choice of words and manner?				
Do you actively think about what is being said?				
Do you put aside thought of what you have been doing?				
Do you listen equally to men, women, young and old patients?				
Do you stay aware of gestures, inflections, and other clues?				
Do you ignore distractions while listening?				
Do you let the speaker finish?				
If the speaker hesitates, do you encourage him/her to go on?				
Do you re-state what has been said to make certain you understand?				
Do you listen even when you anticipate what will be said?				
Do you give your full attention to the speaker?				
Do you take notes while listening?				

Total possible score: 72. 72-65: Artful listener. 64-59: Good listener. 58 or below: Listening skills need work; negotiating with patients (or anyone else) is probably difficult.

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Physician Behavior

Nicholas E. Stratas, MD, LEAPA
Former Member, Former President, NCMB



Dr Stratas

Over the past 35 years, the public and medical licensing boards have paid increasing attention to behavior of physicians. Problems with alcohol were the initial focus and the term “impaired physician” was coined and added to our vocabulary.¹ While substance-related disorders continue to be the major focus, there is greater recognition of mood disorders, relational disorders, particularly marital, and behaviors that are “boundary violations,” sometimes simply verbal and not necessarily physical.²

Recently, another group of physicians has been labeled “the disruptive physician.” There is decreasing tolerance for behaviors that now thrust the physician into reviewing and disciplinary processes that frequently require a psychiatric evaluation.

These behaviors are varied and include, among others, rudeness; loud, abusive or demeaning language; abuse of staff, patients or relatives; sexually offensive language or behavior; aggressive behavior; presenting to clinical settings with alcohol on the breath. Patients, families, office and hospital staff, administrators, and fellow physicians, even within the same practice, complain to various institutional bodies including hospital medical staff, administration, and state medical licensing boards. These behaviors are not new, but focus on them is. In the past, they would have been excused either on the basis of the physician being a highly valued healer, a special member of society, or with rationalizations such as “he must have been up all night” or “that’s the way he is, you know.” The public has discovered we have clay feet, most of us sleep well at night, and there is no longer a willingness to anoint our narcissism with oil.

What follows is based on my personal experience as a psychiatrist in private practice seeing, on average, over 20 physicians a year, some self-referred, others referred for evaluation, some from medical organizations, some from the North Carolina Medical Board (NCMB). In addition, during my NCMB tenure, I had the privilege of conducting hundreds of interviews with physicians.^{3,4,5} I was also fortunate to be part

of the origination, start-up, development, and initial board of the North Carolina Physicians Health Program (NCPHP). I also served on the NCPHP’s Clinical Committee, which reviews all cases, many anonymously. I also cite data from Alabama.^{6,7}

I will focus on the “disruptive physician.” This term is reminiscent of the time we had pejoratives such as the “drunk doctor” for those now identified as having “substance-related disorders,” many of whom have disruptive behavior but are not so labeled. When I see these doctors, I do not find them incompetent or bent on creating havoc. Rather, they are generally suffering narcissistic injury, are hurt, defensive, frightened, angry, and even arrogant, but hardworking and well-meaning. They feel misunderstood and have not had a meaningful supportive relationship. Other than substance-related disorders or other psychiatric conditions, the best way to identify and understand the features of the physicians who present with disruptive behavior is through personality makeup. My preferred nomenclature is Disruptive Behavior Disorder of Adulthood (DBD).

The North Carolina Medical Board

A review of the reasons physicians were summoned to interviews with the NCMB and of the number of actions taken by the NCMB reveals inappropriate prescribing was the most frequent cause, followed in order by substance abuse, issues of medical competence, malpractice events, psychiatric condition, inadequate supervision of physician extenders, patient complaints, sexual misconduct, changes in hospital privileges, self-prescribing, insufficient medical education, felony conviction, and unlicensed practice. Those reasons potentially affecting behavior—substance abuse, psychiatric condition, sexual misconduct, self-prescribing, patient complaints, and felony conviction—comprise a total of 46 percent of interviews and 30 percent of actions.

In North Carolina, family and general practice and psychiatry are the specialties with the highest probability for interview and discipline. Emergency medicine is a specialty with increasing numbers.

The odds ratio for likelihood of interview and for disciplinary action identifies psychiatry as the fourth likely to be interviewed and the third likely to be disciplined. If we com-

bine general practice and family practice, then psychiatry is number two. General and family practice are overrepresented in areas of inappropriate prescribing, inadequate supervision of physician extenders, changes in hospital privileges, and insufficient medical education. Psychiatry is prominent because of boundary violations and substance abuse. These are three-year figures and do not include NCPHP data.

Alabama has kept figures regarding the primary clinical diagnosis of evaluations done. Substance abuse problems lead at 61 percent. Affective disorders are next at 29 percent and personality disorders are third at 10 percent.

Private Practice

I first came to Raleigh as one of the earliest, if not the earliest, with a training background in cognitive behavioral as well as psychodynamic work. Physicians who became aware of this sought me out either for themselves or their families, and I have

“In North Carolina, family and general practice and psychiatry are the specialties with the highest probability for interview and discipline”

seen them in consultation for individual, couples, and couples group therapy.¹⁰ Over the years, physician referrals have increased by word of mouth. Prior to my appointment to the NCMB, I was seeing more than a dozen physicians a year. During my tenure on the NCMB, physician referrals declined. Following my tenure, I have averaged over 20 physicians per year. Two-thirds are self-referrals. The other third were referred for evaluation and report by hospital medical staffs, practice associates, attorneys for physicians who were being investigated either by the NCMB or their own hospital staff, and by the NCMB. I have also been consulting with physician practices regarding organizational and practice issues. These contacts have given me an additional window into the life and issues of physicians and their families. Substance abuse cases are being diverted now to twelve-step programs and to addictionologists.

The problems triggering referral to me are: neuropsychiatric—(37%); marital dys-

continued on page 15

Physician Behavior

continued from page 14

function—(30%); disruptive behavior—(21%); quality of care issues—(10%); chemical abuse—(2%).

In self-referred physicians, marital dysfunction and affective disorders are the most common problems. In marital dysfunction, the primary driving dynamics arise out of the underlying personality makeup, with traits of narcissism, compulsivity, avoidance, and histrionicity predominating, in that order. This is supported by the Alabama data. Of the physicians referred to me for evaluation, the largest group is that of personality traits or disorders, followed by affective disorders.

Disruptive Behavior

Of 14 physicians referred in the past two years because of disruptive behavior, 10 had a primary diagnosis of personality problems, with patterns in order of prevalence: obsessive-compulsive, narcissistic, avoidant, and histrionic. In addition, three had an affective disorder, one abused alcohol and was dependent. Single, separated, or divorced physicians were overrepresented.

In physicians being evaluated generally, affective disorders, personality disorders, and chemical dependence are the most common diagnoses, with marital dysfunction frequently the presenting problem. In the group with “disruptive behavior,” personality problems are the most prevalent.

When evaluating physicians with disruptive behavior, differential diagnoses to be considered include: substance related; personality disorders; adjustment disorders; sleep deprivation; bipolar disorder; other medical problems; and organic brain disorders. Of course, more than one may be present at the same time. Moreover, biology is increasingly identified as a factor in personality disorders.¹²

Early warning signals for the physician with DBD include: being unmarried; in solo practice; lack of involvement in medical organizations; overwork; marital infidelity; increased alcohol intake; legal events; practice changes; complaints/malpractice/disciplinary events; clinical practice changes; clinical disruptions; and lack of an organizing belief system.

Physicians’ problems show up in their primary, personal relationships long before they impact the practice and even before the

physician may be aware of the problem.⁸ The career is the last place where problems appear. Physicians in solo practice are more vulnerable than their colleagues who are in group or institutional practices. The latter are more likely to be self-referrals, appear earlier in their difficulties, and avoid disciplinary processes.

Physician stressors, which occur with some frequency, include: finances/decreasing incomes; buyouts; mergers and closures of practices and hospitals; managed care; overwork, unhealthy competition for jobs; and unhealthy competition for patients. Also stressful are declining collegiality; physician-to-physician marriage; difficulty with intimacy; self-medicating; the stigma of psychiatric problems; and decreased satisfaction.

Vignettes

The following case vignettes are illustrative. Changes have been made, of course, to protect identities.

Doctor A was a 45-year-old male surgeon from the eastern part of the state, twice divorced and the father of two children. He was referred to me by the hospital medical staff executive committee for aggressive behavior, abuse of hospital staff nurses, and unorthodox techniques. Complaints had come to the administrator from a surgeon colleague and surgical nurses. The administrator turned the case over to the president of the medical staff.

My evaluation revealed a hard-working physician who had continued to keep up with CME, who was working long hours, in solo practice. Two physicians had come to his practice and then left. He was practicing in a town with few surgeons and had become isolated from his colleagues. His two teenagers, living with him, were doing well. Substance dependence was suspected but ruled out, and the impression was of someone with mixed personality traits of narcissism and compulsivity with significant relational problems.

Recommendations were for psychotherapy, involvement with organized medicine, monitoring of a fixed number of cases, and review in six months. He was initially angry and defensive. However, as I interpreted the evaluation, bringing out the dynamic issues and focusing on his increased efforts to “work harder and longer” as pressures increased, thus increasing his isolation and unawareness of his impact on relationships, he became tearful and in touch with his sad-

ness. He opened up and expressed his need for help. He is following through with the recommendations and has done well.

Doctor B was a 58-year-old, recently widowed primary care physician from a rural area of the state with two grown, married children. She was referred because of complaints by the hospital nursing staff to the administrator about her irritability and two episodes of coming in to the hospital with alcohol on her breath. She had rebuffed the administrator’s referral to NCPHP. Her anonymity was broken and her name was given to the NCMB. They invited her to an informal interview and then referred her to me for evaluation. She had an excellent history, personally and professionally, but over time had gradually decreased professional contacts and stopped doing hospital work. One year earlier, her husband of 33 years had died after several months of illness. She was drinking more than usual, but she was neither dependent nor an abuser. In fact, she had most of the criteria for major depression. Her underlying personality makeup consisted of narcissistic and avoidant traits.

She was guarded at first, but wanting to cooperate in the treatment plan that was recommended, including goal-oriented, cognitive behavioral therapy; grief work; discontinuation of alcohol and caffeine; and use of antidepressants. She did very well and is no longer depressed. She says she has “a new lease on life,” is golfing with her friends and children, traveling, and reinvolved with professional colleagues. With my evaluation report and follow-up in hand, the NCMB saw her again in an informal interview and took no further action.

As an aside, I have mentioned that I did not think Doctor B was an alcohol abuser, although she was accused of coming to the hospital with alcohol on her breath. Apropos of this, I should note that one of my most recent referrals, from his attorney and from NCPHP, was diagnosed at Rush Presbyterian in Chicago as an abuser of alcohol. They based that diagnosis simply on the record of his coming into the hospital with alcohol on his breath on two occasions. He said he had used alcohol several hours before going to the hospital on both occasions to help get to sleep. He did this on the recommendation of a medical colleague subsequent to several night shifts. He has a history of minimal and appropriate alcohol use.

Doctor C, a 40-year-old, single emergency room physician, was referred to me by his group practice associates because of complaints received from patients and nursing staff about his brusque and short behavior and comments. He had been the subject of

continued on page 16

“Physicians’ problems show up in their primary, personal relationships long before they impact the practice and even before the physician may be aware of the problem”

Physician Behavior

continued from page 15

a lawsuit that had gone against him. Initial interview revealed a very compulsive detailed individual who was obsessing about the lawsuit that had been closed two years earlier, about a failed relationship, and, now, about being asked to have a psychiatric consultation. He was in a very busy practice and evidently had not had any problems related to quality of care. Even the case settled against him was peer reviewed and his performance was found to be appropriate.

Although he did qualify for a diagnosis of anxiety disorder, his primary problem was his underlying compulsive personality. He had been in psychotherapy years earlier and, although it was brief, he recalled it as a positive experience. He was very defensive and protective of information about himself. He rejected out of hand any medications, and therapy has been brief and episodic. He is still in practice, having had no further complaints, and is still single. However, he has joined several social organizations and has dated a woman he met there.

Discussion

My impression is that those who are organized and structured in such a way as to succeed, and who draw attention to their success, have been more likely to be the successful medical school candidates. A clearer and more objective understanding of behavior, personality traits, personality disorders, and primary mental illness in those who select medicine as their career as compared to the general population is needed. Moreover, medical students need workshops regarding predominant personality patterns that make for success and at the same time create vulnerabilities.¹¹ Increased sophistication regarding psychological patterns that promote medicine as a career, increased attention to the human element in medical school, awareness of the importance of personal and family support systems, a sensitivity to early signals of increased neediness—all will allow promotion of health and balance in the physician and early detection. It seems that medicine is attractive to those who have overcompensated with attitudes of uniqueness and entitlement and who seek admiration.

Patients' needs, played out in their positive and negative transference, interact with the physician's needs. Traits such as narcissism and compulsivity may interfere with the sensitivity the physician must have to the transference phenomena that are representative of the patient's needs.^{14,15} A physician's over-sensitivity to demands and situational

pressures and threats to status can lead to behavior and allegations that produce hurt, anger, and projection. The compulsive physician works hard and, when faced with increased pressures or questions, can become defensive, self-focused. As a result, he or she can end up "working harder and longer."

It behooves us, particularly in psychiatry, to be comfortable and competent with the physician as patient in stepping up to advocacy issues as they develop with those in authority relationships with the physician.

We must appreciate the anger in the referred physician, which is inevitably present, and encourage awareness of the sadness and even fear that is frequently repressed and likely related to early developmental history. Sadness is the key to narcissism and the root of tenderness. Use of letting-go techniques and other cognitive behavioral skills are important for obsessional and compulsive individuals.

At times, confrontation is very important and needs to be timely and not delayed. It may even be necessary in the first interview. On many occasions, my confrontation of the physician with the statement that a given behavior "is unacceptable" has been the beginning of the necessary alliance for productive work.

Physicians as a group do better than the general population, even when they have presented unwillingly as the result of pressure or referral from someone else. I believe this is because they have had a lifetime of complying with structure and expectations, because of the peer pressure inherent in the process of evaluation and treatment of a physician by a physician, and because the medical career is, in most instances, an integral part of most physician's self-image.

Finally, times have changed and physicians are retiring in great numbers. Identification and assessment of those who have retired with a successful medical career without patient complaints, disciplinary actions, litigation, or evidence of decompensation probably provide an avenue for understanding factors that have helped them and that need to be applied in preventive and therapeutic undertakings with physicians.

Summary

This article is based on my retrospective and personal experience with the NCMB and my private practice. Concern about the "impaired physician" has been around for a good while, focused on chemical abuse and dependence, now with increased acknowledgement of other psychiatric syndromes, especially the affective disorders. Complaints have emerged regarding behaviors including rudeness; disrupted patient

care; loud or abusive language; using instruments as weapons; abusing staff, patients or family; and sexually offensive behavior or language. These behaviors are predominantly related to personality patterns, including compulsivity, narcissism, and avoidance, at times associated with primary psychiatric problems. These personality patterns are likely active in the selection of and success with a medical career. Frequently, marital relational status and counter dependence are factors. As with all patient transactions, the patient-doctor alliance is the key to a successful resolution. In the main, physicians, a group with a lifelong pattern of success, have a significantly higher success rate than the general population.

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Social Services for Pregnant and Parenting Adolescents

Anne Dellinger, JD

Professor, Public Law and Government, Institute of Government
The University of North Carolina at Chapel Hill

This commentary continues Professor Dellinger's presentation of titles in the new series on pregnant and parenting adolescents being published by the Institute of Government, the University of North Carolina at Chapel Hill.

Professor Dellinger has been a faculty member at the Institute since 1974. She was formerly of counsel with Hogan & Hartson, Washington, DC, and is author of numerous publications on health and hospital law, including an article, *How We Die in North Carolina*, in *Forum* #2, 1999. Her article on the first volume in the Legal Guide Series appeared in *Forum* #3, 2001.



Professor Dellinger

Summer before last, in early August, a health department nurse asked what could be done for one of her patients, a 17-year-old in late pregnancy. The nurse's concerns were not medical; the young woman

had been keeping her appointments and was healthy. Still, her problems were serious. Months earlier, on discovering the pregnancy, her mother had told the girl to leave, and the patient made her way to a stepfather in North Carolina. Here, she became semi-homeless. That is, some nights the stepfather let her stay with him, but otherwise she had difficulty finding a bed. The girl's greatest concern was school. She had been a very good student, wanted to do her senior year here, and hoped for a college scholarship. However, the local high school's registrar would only enroll her if the stepfather came to school between 8 AM and noon on a weekday. He was a construction worker and unwilling or unable to lose a day's pay to do it.

The nurse was advised to call the local department of social services (DSS) and also to talk with a school attorney at the Institute

"Thousands of girls 17 or younger become pregnant every year in North Carolina (7,227 in 2000) and the great majority of them become parents (5,415 in that year)"

of Government. Before she could take those steps, however, the patient left town.

This true story suggests how important a caring physician or other health provider can be to a young woman experiencing an underage pregnancy and to her family—and suggests the value of a physician knowing something about what a DSS can offer. Thousands of girls 17 or younger become pregnant every year in North Carolina (7,227 in 2000) and the great majority of them become parents (5,415 in that year). Since few of these very young mothers marry or stay in touch with their partner, they look to trusted adults both inside and outside the family for assistance. Health providers are one such group of adults; DSS staff is another.

A DSS can help girls and families negotiate the legal complexities of difficult circumstances. Legal issues the agency may become involved in include the following.

- Can parents put a pregnant minor child out of their home?
- What are a pregnant or parenting adolescent's rights to attend school or community college or, for that matter, to work?
- Are teens responsible for their child's support? If not, who is?
- Does a foster child who becomes a mother have a right to have her child with her in foster care? If so, can she take the child when she leaves at age 18?
- Can a DSS with custody of a minor who is a mother and of her child fairly represent both?

A book on the legal aspects of adolescent health care during pregnancy (*Health Care for Pregnant Adolescents: A Legal Guide*) was discussed here recently (*Forum*, #3, 2001) and sent to approximately 8,000 health providers, thanks to grants from the Z. Smith Reynolds Foundation and the School of Government, UNC, Chapel Hill. (The health providers' book can be printed from www.adolescentpregnancy.unc.edu or purchased from the Institute of Government, 919.966-4119.)

Now, a second volume, *Social Services for*

Pregnant and Parenting Adolescents: A Legal Guide, has been published. Some physicians may want this guide as well to help them advise patients and their parents. Although the book is primarily for DSS employees and other social workers, a limited number of copies is available without charge for physicians. (To request a copy, e-mail Anne Dellinger, dellinger@iogmail.iog.unc.edu, and include a mailing address.)

The second guide may also be printed from the Web site above.

The story that opens this article is typical in that even a pregnant or parenting girl who is mature, bright, and competent for her age probably lacks some of the resources needed now or for the future: sufficient income and education, housing, transportation, health insurance, employment, child care, and child support among others. In addition, as a minor she lacks the ability under law to control most—though not all—of her decisions. For these clients, as well as for their parents and children, a DSS is a crucial resource.

Under state law, a DSS may be called on to protect a minor from abuse, neglect, or dependency; to pass along to law enforcement information about statutory rape, domestic violence, or other crimes that may have physically harmed a minor; perhaps to act as a minor's custodian, consenting to her medical care in some instances or other important matters; to seek termination of her parents' rights or of her own rights as a parent; to find a home for her and perhaps a child; or to help her place a child for adoption. For minors who need less support, DSS may still be the gateway to essential services such as cash assistance, child support, day care, Medicaid, or the food supplements of the WIC program. Another possibility is that a DSS will encounter a minor solely as a parent when it undertakes for her child some of the obligations mentioned above. Federal law, too, requires that a DSS work with unmarried pregnant teens and preteens

continued on page 18



Social Services

continued from page 17

in numerous specific ways.

Like *Health Care for Pregnant Adolescents*, the DSS book reviews the legal and medical requirement to explain pregnancy options to a patient so she can decide to continue or end the pregnancy. It also describes the law of emancipation, marriage for minors, the process the General Assembly recently established for surrendering a newborn, and basic information for parents who are considering placing a child for adoption. The guide emphasizes DSS's general legal responsibilities to minor clients: protection, information, advocacy, impartiality, and confidentiality. It contains sections on domestic violence in adolescent relationships, on DSS directors' and employees' personal liability, and much broader coverage of parenting issues than the health providers' book. Possible living arrangements for minors are discussed, along with parents' rights and duties, termination of parental rights, and how—and why—a single mother should establish her child's paternity, seek to have the child legitimated, and obtain a child support order. As a companion to the book, a resource list for social services is posted on the Web site, www.adolescentpregnancy.unc.edu. ♦

From The Board Of Nursing

The Importance of Verifying the Licensure Status of Nurses Employed in Office-Based Practices

Each employer has a responsibility to ensure that those licensed persons in their employ are appropriately credentialed. One should never accept just a presentation of the wallet-sized card as validation of the person's licensure status. To validate that a nurse holds a current license to practice in North Carolina, call (919)-881-2272 or access our Web site at www.ncbon.com and click on "Verify License." You will need the individual's Social Security number or North Carolina nursing certificate number to access this system. If you are unable to verify the license through one of these applications (telephone verification or Web-based verification), immediately call the Board of Nursing for clarification at (919) 782-3211.

In addition, under North Carolina General Statute 90-640, any health care practitioner who is licensed, certified, or registered to engage in the practice of medicine, nursing, or other health profession must wear a badge or otherwise display in a readily visible manner that person's name and licensure, certification, or registration title

when providing care to patients.

This year, the North Carolina Board of Nursing has received an alarming increase in the number of complaints related to persons who represent themselves to the public as licensed nurses when they do not hold, nor have they ever held, a license to practice nursing in North Carolina. These individuals have ranged from individuals working in office-based practices who call themselves "office nurse" to imposters who create and present fraudulent documents indicating they are licensed nurses.

North Carolina General Statute 90-171.43 states: "No person shall practice or offer to practice as a registered nurse or licensed practical nurse, or use the word 'nurse' as a title for herself or himself, or use an abbreviation to indicate that the person is a registered nurse or licensed practical nurse, unless the person is currently licensed as a registered nurse or licensed practical nurse as provided by this Article." To practice nursing without holding a license is a violation of the Nursing Practice Act; a misdemeanor in

Nota Bene

About the Legal Guide Series

Health Care for Pregnant Adolescents: A Legal Guide was published by the Institute of Government, the University of North Carolina at Chapel Hill, in fall 2001. The second title in the series, *Social Services for Pregnant and Parenting Adolescents: A Legal Guide* (discussed in the previous article), is now available. A third guide will follow for public school employees; a fourth for parents of pregnant and parenting teens and preteens; and a fifth for adolescents themselves. Each will be announced in the *Forum* when it is available.

Comments on *Social Services for Pregnant and Parenting Adolescents: A Legal Guide*

"This handbook. . . is an impressive piece of work and I think will be very useful to county staff in offering support to this population. Dellinger has done her research well."

—David Atkinson, Division of Social Services, NC Department of Health and Human Services

"I really like the tone. It's clear and readable without telling busy caseworkers more than they need to know."

—Gretchen Aylsworth, District Administrator, Guardian Ad Litem Program

"This document is wonderfully 'pithy'—full of terrific info. I can only imagine the time and focus it took!"

—Beth Brandes, Associate Director, Catawba County Department of Social Services

"This is a great resource—easy to follow, informative, and non-judgmental."

—Sharon Holmes, University of North Carolina at Chapel Hill School of Social Work, former Director, Orange County Adolescent Parenting Program

"You have done an outstanding job with this and it will be an invaluable resource."

—Tyrone Wade, Associate County Attorney/Mecklenburg

"No one had any comments except positive ones. We all found the guide to be very readable, clear, concise, with information well organized. We can see where this manual will be a valuable tool for us, as a supplement to policy and procedures already in place."

—Sandra Wilkes, Director of Social Services, Rowan County ♦

North Carolina.

Just recently it came to the Board of Nursing's attention that an individual had been employed in an office-based practice for nine years as the "Chemotherapy Nurse" even though this person had never been licensed to practice as a nurse. Other individuals working in office-based practices who represented themselves as nurses, but did not hold, nor had they ever held, a license to practice nursing have been reported to the Board by consumers who are concerned about the safety of care they receive.

The Board of Nursing requests your support in helping protect the public by ensuring that only appropriately licensed individuals use the term "nurse" and that all name badges include the proper licensure credentials. Please confirm current licensure by utilizing our automated verification system as noted above. The public needs to be assured that their health care providers are properly licensed and wear name badges that accurately present them to the public they serve. ♦

From NCDHHS Division of Medical Assistance

As Stewards of the Medicaid Budget, We Can Do Better!

*David H. Gremillion, MD, EACP
N.C. Medicaid DUR Board Member
President, Wake County Medical Society*



Dr Gremillion

As our third year of state budget crisis drags on, we all are taking a careful look at our personal and professional lives for frugal remedies. A significant component of recent growth in state expenditures has been the Medicaid program. This program provides needed services to the most vulnerable in our community and is absolutely essential to preserving health and preventing catastrophic illness and wasteful crisis health care expenditure.

A significant component of the increased expenditure has been pharmaceutical supplies, with over one billion dollars committed to this essential function during the past year. The growth in this component of the state budget has been far greater than any projections, partly due to the introduction of new drugs and exciting new therapies.

These new therapies, however, often come with a high price tag. The 2001 cost is staggering: Celebrex® \$21 million, Prilosec® \$39 million, Oxycontin® \$15 million, and Vioxx® \$15 million, to name a few. On the horizon are exciting but costly new drugs, among them recombinant growth hormone (Serostim®) for AIDS wasting syndrome for a mere \$6 thousand per month per script. Did we really consider older and established agents before prescribing all that Celebrex®? Use of generic drugs can produce enormous savings. A 30-pill bottle of generic atenolol costs \$6.99 compared to brand name Tenormin® at \$36.57. Are 30 pills of Zocor® at \$66.94 really that much better than generic lovastatin at \$36?

These examples of high cost items are harbingers for some of the challenges we will face as new drugs become available over the near future. No one wishes to balance our state budget on the backs of the most vulnerable in our society but there is room for

improvement in our fiscal management of this precious pharmaceutical resource. Any physician with practice experience recognizes that although the new agents with fancy attributes and the glossy promotional brochures are exciting, they are also costly and relatively unknown in the post marketing or practice environment. How well we remember such examples as Omnifloxin®, which was released to great fanfare only to be removed from the market precipitously eight weeks later with unanticipated hemolysis. Our experience tells us that some of the tried and true agents are not only equal to the newly released products but superior in many ways since the toxic profiles, side effects, and prescribing nuances are well known. These agents often provide equal or even superior therapeutic benefit at dramatically reduced cost. As physicians, we are in the unique position to have an immediate impact on the state Medicaid budget by conscientiously and thoughtfully prescribing medications that are needed, but with a careful awareness of the cost issues. ♦

2001 Medicaid Pharmacy Costs

Approximately one-sixth of the expenditures for the entire Medicaid program in North Carolina were for pharmaceutical drugs. Eleven classes of drugs accounted for over 50% of that cost. The top six drug classes and expenditures are cited below.

1. Gastric Acid Secretion Reducers: \$97,817,941 for 9.7% of total expenditures
2. Anti-Psychotics (atypical, dopamine, and serotonin): \$83,599,968 for 8.3% of total expenditures
3. Anticonvulsants: \$50,019,568 for 4.97% of total expenditures
4. Selective Serotonin Reuptake Inhibitors: \$47,972,910 for 4.77% of total expenditures
5. Analgesics/Narcotics: \$45,344,908 for 4.5% of total expenditures
6. NSAIDS/COX Inhibitors: \$44,877,835 for 3.5% of total expenditures

Etc Etc Etc



Risk Management - 2002

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

May - July 2002

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

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

Consent Order:

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

Denial:

Final decision denying an application for practice

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

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program.

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

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

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

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

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

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

ANNULMENTS

NONE

REVOCATIONS

NONE

SUSPENSIONS

TALLEY, Joseph Harold, MD

Location: Grover, NC (Cleveland Co)

DOB: 4/20/1937

License #: 0000-15270

Specialty: FP (as reported by physician)

Medical Ed: University of Virginia (1963)

Cause: Following a hearing on March 21-23, 2002, the Board found Dr Talley failed to perform adequate physical or objective examinations in order to evaluate or diagnose patients' complaints, that he failed to perform follow-up physical examinations to rule out or confirm the causes of pain prior to instituting or continuing opioid therapy, that he failed to inquire if his patient has received medications from other physicians or sources when he knew or had reason to believe the patient had a history of abusing drugs, that he failed to monitor patient compliance with the prescribed therapeutic regimen when he knew or had reason to believe the patient had a history of abusing drugs, and that he diverted and stockpiled fenfluramine for his own use by asking patients to return their supplies of the drug to him. A penalty hearing was held 4/18/2002. At that hearing, the Board determined Dr Talley's license would be suspended indefinitely as of 4/18/2002 and that he could not seek reinstatement before 4/18/2003.

Action: 6/20/2002. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Talley's North Carolina medical license is suspended indefinitely, effective 4/18/2002. He may not seek reinstatement before 4/18/2003. Should he petition for reinstatement, the Board shall decide the question based on all the facts and circumstances available at the time the petition is submitted.

See Consent Orders:

FORD, Angela B., Physician Assistant

NGUYEN, Dianne Hathanh, MD

PAGE, Catherine Marie, MD

SUMMARY SUSPENSIONS

MARBACH, James Christian, MD

Location: Temple, TX

DOB: 2/10/1957

License #: 2002-00050

Specialty: R (as reported by physician)

Medical Ed: Baylor College of Medicine (1983)

Cause:

The Board has information that Dr Marbach may be unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of a physical or mental abnormality. It also has information that Dr Marbach's Wyoming medical license has been suspended.

Action:

4/04/2002. Order of Summary Suspension of License issued: Dr Marbach's North Carolina medical license is summarily suspended.

CONSENT ORDERS

BERRY, David Don, MD

Location: Winston-Salem, NC (Forsyth Co)

DOB: 4/20/1952

License #: 0000-30288

Specialty: NPM/PD (as reported by physician)

Medical Ed: University of Texas, Galveston (1978)

Cause: On application for reinstatement of his license, which was surrendered in July 2001. In April 2000, Dr Berry entered a five-year monitoring contract with the NCPHP following a diagnosis of alcohol dependence. In May 2001, he was arrested for driving while impaired and in June 2001 consumed alcohol in violation of his NCPHP contract. He was removed from clinical duties as a pediatrician with Wake Forest University School of Medicine in June 2001 and has not treated patients since. In July 2001, he surrendered his license. Dr Berry admits that his use of and dependence on alcohol render him unable to practice with reasonable skill and safety. He reports he successfully completed a two-month inpatient alcohol treatment program in the latter part of 2001 and NCPHP reports he is in compliance with his contract with NCPHP.

Action:

6/19/2002. Consent Order executed: Dr Berry is issued a license to expire on the date shown thereon (10/19/2002); he shall maintain and abide by a contract with the NCPHP; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind-or- mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall attend AA and/or Caduceus meetings as recommended by NCPHP; he shall provide a copy of this Consent Order to all current and prospective employers; must comply with other conditions.

BREWER, Thomas Edmund, Jr, MD

Location: Denton, NC (Davidson Co)

DOB: 11/04/1956

License #: 0000-28141

Specialty: GP/OM (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1983)
 Cause: To amend Dr Brewer's Consent Order of 10/29/1999, which was issued following his surrender of his license on 9/18/1998 following a positive urine drug screen for cocaine. He has had a history of substance abuse. In 2001, he asked the Board to terminate the provision of the Consent Order limiting his license to a temporary period of time.

Action: 7/31/2001. Consent Order was executed: Dr Brewer was issued a license with no expiration date shown. Unless lawfully prescribed for him by someone other than himself, he was to refrain from the use of all mind- or mood-altering substances and all controlled substances, and to refrain from the use of alcohol; he was to notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he was to supply bodily fluids or tissues for screening to determine if he had used any of the substances noted above; he was to maintain and abide by a contract with the NCPHP and attend AA, NA, and/or Caduceus meeting as recommended by the NCPHP; he was to continue his relapse therapy and have his therapist provide quarterly reports of his progress to the Board; he was to provide the Consent Order to all prospective employers; he was not to supervise PAs or NPs; he was to obtain and report to the Board 50 hours of relevant Category I CME each year; was to comply with other conditions.

NOTE: On 6/17/2002, Dr Brewer voluntarily surrendered his North Carolina medical license.]

FORD, Angela B., Physician Assistant

Location: Eden, NC (Rockingham Co)
 DOB: 9/08/1969
 License #: 0001-02891
 PA Education: Not recorded

Cause: On information that Ms Ford tried to obtain a controlled substance that was not authorized and engaged in unlawful practice as a physician assistant. Ms Ford admits and the Board finds she had migraine headaches for which she sought treatment; her physician treated her with Oxycontin[®], but in a dosage insufficient to give her relief; she took twice the prescribed dosage and found relief; she reported this to her physician, but he refused to prescribe increased amounts; in December 2001, she filled out a prescription for herself and presented it to a pharmacy to be filled; the pharmacist questioned the prescription and called Ms Ford's supervising physician, who confirmed he had not authorized the prescription; at Ms Ford's request, the pharmacist returned the prescription to her without dispensing the medication. Ms Ford has entered into a contract with the NCPHP and the NCPHP reports she has been compliant. She is being treated for her headaches with modalities that do not include Oxycontin[®] and she is undergoing counseling for the issues that led to the incident. In March 2002, Ms Ford found another job as a PA. Her Notification of Intent to Practice form was faxed to the Board, but the Board does not accept such faxed filings. In April, she began to practice in her new job even though she had not received acknowledgement from the Board that her Notification of Intent to Practice had been received by the Board as required by law. In May 2002, it was brought to her attention that she had been practicing unlawfully and she promptly corrected the situation.

Action: 7/31/2002. Consent Order executed: Ms Ford's PA license is suspended. Suspension is immediately stayed on the following conditions. Unless lawfully prescribed for her by someone other than herself, she shall refrain from the use of all mind- or mood-altering substances and she shall refrain from the use of alcohol; she shall notify the Board within 10 days of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, she shall supply bodily fluids or tissues for screening to determine if she has used any of the substances noted above; she shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

HAYES, Edward Elem, MD

Location: Conway, SC
 DOB: 1/30/1952
 License #: 0000-33528
 Specialty: U (as reported by physician)
 Medical Ed: Medical University of South Carolina (1978)

Cause: On application for reactivation of Dr Hayes' license, which was made inactive on 12/21/2001 at his request. On 2/21/2002 in U.S. District Court in South Carolina, Dr Hayes pled guilty to and was convicted of five counts of mail fraud based on his use of the U.S. mails to submit false claims for reimbursement. He also has a medical license in South Carolina, which state reprimanded and fined him based on his mail fraud convictions.

Action: 6/14/2002. Consent Order executed: Dr Hayes is reprimanded; his North Carolina license is reactivated as of the date of this order; he may not supervise PAs, NPs, or certified nurse midwives; must comply with other conditions.

LOCK, George Joseph, Physician Assistant

Location: Princeton, NC (Johnston Co)
 DOB: 8/26/1958
 License #: 0001-01050
 PA Education: Bowman Gray School (1987)

Cause: Regarding Mr Lock's application for a PA license. Mr Lock admits and the Board finds that he was first licensed in January 1988, that he practiced in High Point, and that he was terminated by the clinic in August 2000 for asking an employee if she would take a prescription for hydrocodone bitartrate written by him in the employee's name to a local pharmacy, have it filled, and give the drug to him. He had made a similar request of the same employee two years earlier. In November 2000, Mr Lock signed a contract with the NCPHP and agreed to abstain from mood-changing chemicals unless lawfully prescribed and approved by the NCPHP. Thereafter, he took tramadol hydrochloride for shoulder pain but did not obtain the approval of or disclose the fact to the NCPHP until asked for a urine sample. He knew this drug was potentially addictive and considered by many to be a "gateway" drug to narcotics. The NCPHP cautioned him that he must abstain from such drugs. Some two weeks later, he took hydrocodone bitartrate for pain related to kidney stones but did not obtain the approval of or disclose the fact to the NCPHP until asked for a urine sample. When confronted, he admitted he intentionally withheld the information from the NCPHP. Mr Lock surrendered his PA license on 2/08/2001. In December 2001, he signed a new five-year contract with the NCPHP and the NCPHP reports he has fully complied with its terms. In February 2002, Mr Lock successfully completed a ten-week drug treatment program and currently participates in an after-care program and regularly attends Caduceus meetings.

Action: 7/15/2002. Consent Order executed: Mr Lock is issued a PA license to expire on the date shown on the license [10/31/2002]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind- or mood-altering substances and he shall refrain from the use of alcohol; he shall notify the Board within ten days of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall not work more than 40 hours per week and may only work at one location; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

NGUYEN, Dianne Hathanh, MD

Location: Wailuku, HI
 DOB: 3/15/1967
 License #: 0097-01834
 Specialty: IM (as reported by physician)
 Medical Ed: State University of New York (1994)

Cause: Dr Nguyen admits and the Board finds that Dr Nguyen, as an independent contractor, provided medical services through Virtual Medical Group (VMG), located in Morrisville, NC, that renders medical services via the Internet. On various dates between July 2000 and October 2001, Dr Nguyen prescribed medications, including Cipro[®] without physical examination of patients and without any prior physician-patient relationship that might have permitted, depending on good medical practice, issuing a new prescription without a physical examination. She now recognizes that was a potentially dangerous practice. During the same time period, VMG, through Dr Nguyen, rendered medical care to patients in North Carolina, thus engaging in the unauthorized practice of medicine. Again, during the same period, Dr Nguyen permitted VMG to bill patients for medical services rendered by her, a portion of the fees collected being paid to her as compensation, the remainder going

to VMG. These acts constituted unprofessional conduct by Dr Nguyen. There is no evidence Dr Nguyen's prescribing irregularities caused any harm to any patient and she asserts a representative of VMG informed her that the Board was aware of its activities and the physicians associated with it and acquiesced in such activities. She ceased her participation immediately on learning those activities violated the standards of care and professional ethics enforced by the Board. She has given notice to VMG of her termination of her contractual relationship with VMG. She has cooperated fully with the Board and has volunteered to cooperate with the Board and other authorities in any investigation of VMG.

Action: 6/10/2002. Consent Order executed: Dr Nguyen's license in North Carolina is suspended for 60 days. Suspension is stayed on the following conditions: Dr Nguyen shall not prescribe for any person in North Carolina without first physically examining that person unless the prescription is part of an admission order for a newly hospitalized patient, for a patient of another physician for whom she is taking call, continuing medication on a short-term basis for a new patient prior to a first appointment, or for an established patient where a new history and physical may not be required, depending on good medical practice; she shall not assist VMG or any other entity in the unauthorized practice of medicine; she shall not share fees with a business corporation except as permitted by law; must comply with other conditions.

PAGE, Catherine Marie, MD

Location: Talbott, TN
 DOB: 6/09/1955
 License #: 0000-31348
 Specialty: P (as reported by physician)
 Medical Ed: East Tennessee State University (1982)
 Cause: Dr Page's Florida medical license was revoked effective 4/17/2001 [for misrepresentation and failure to inform the Florida Board of action taken against her by North Carolina and Virginia]. Her Virginia license was summarily suspended on 5/24/2001 and surrendered for suspension on 5/20/2002 [for, among other things, unprofessional conduct, misrepresentation, and failure to comply with her Recovery Monitoring Contract with the Virginia Health Practitioner's Intervention Program]. [Details of the Virginia and Florida actions are available in documents related to Dr Page on the NCMB's Web site.]
 Action: 6/20/2002. Consent Order executed: Dr Page's North Carolina medical license is suspended indefinitely.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

COOPER, Neil Ross, Physician Assistant

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 9/09/1951
 Cause: Mr Cooper failed to satisfy the Board of his qualifications for a PA license. He responded "No" to questions on the PA application asking if he had been investigated or disciplined by a licensing board or governmental agency, but, in fact, the NC Acupuncture Board had investigated him and censured him in 2001. He continued to deny the actions by the Acupuncture Board in a meeting with members of the Medical Board.
 Action: 5/02/2002. Mr Cooper's application for a PA license is denied. A public hearing on this action may be requested within 10 days of the applicant's receipt of the denial letter.
 5/08/2002. Mr Cooper requests a hearing on the Board's denial of a PA license.

COOPER, Neil Ross, Physician Assistant

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 9/09/1951
 Cause: Mr Cooper failed to satisfy the Board of his qualifications for a PA license. He responded "No" to questions on the PA application asking if he had been investigated or disciplined by a

licensing board or governmental agency, but, in fact, the NC Acupuncture Board had investigated him and censured him in 2001. He continued to deny the actions by the Acupuncture Board in a meeting with members of the Medical Board. His PA license application was denied on 5/02/2002. He requested a hearing on 5/08/2002. That hearing was held on 6/20/2002.

Action: 7/03/2002. Findings of Fact, Conclusions of Law, and Order issued: following a formal hearing, the Board concludes Mr Cooper gave false answers on his application for a PA license. As a result, Mr Cooper's application for a PA license is denied.

NUSHOLTZ, Marc Sheldon, DO

Location: Fort Wayne, Indiana
 DOB: 6/01/1948
 Specialty: Not reported
 Medical Ed: Des Moines College of Osteopathic Medicine (1976)
 Cause: Dr Nusholtz obtained an evaluation at the Board's request and declined to share its result with the Board. He concealed from the Board material information in connection with his application.
 Action: 2/05/2002. Dr Nusholtz' application for a medical license is denied. A public hearing on this action may be requested within 10 days of the applicant's receipt of the denial letter.
 2/19/2002. Dr Nusholtz requests a hearing on the Board's denial of a medical license.

SURRENDERS

BREWER, Thomas Edmund, Jr, MD

Location: Denton, NC (Davidson Co)
 DOB: 11/04/1956
 License #: 0000-28141
 Specialty: GP/OM (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1983)
 Action: 6/17/2002. Voluntary surrender of medical license.

CARBALLO, Frank Edward, MD

Location: Lumberton, NC (Robeson Co)
 DOB: 4/30/1963
 License #: 0000-35291
 Specialty: IM (as reported by physician)
 Medical Ed: University of South Florida (1989)
 Action: 6/27/2002. Voluntary surrender of medical license.

KEEVER, Richard Alan, MD

Location: High Point, NC (Guilford Co)
 DOB: 6/11/1941
 License #: 0000-16400
 Specialty: OTO (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1969)
 Action: 11/05/2001. Voluntary surrender of medical license.

LEMAIRE, Pierre-Arnaud P., MD

Location: Wilson, NC (Wilson Co)
 DOB: 3/24/1960
 License #: 0000-39440
 Specialty: GS/Vs (as reported by physician)
 Medical Ed: University of Medicine and Dentistry of New Jersey (1985)
 Action: 7/12/2002. Voluntary surrender of medical license.

MATTHEWS, Charles Joseph, MD

Location: Raleigh, NC (Wake Co)
 DOB: 2/03/1955
 License #: 0000-27245
 Specialty: N (as reported by physician)
 Medical Ed: University of Virginia (1978)
 Action: 5/15/2002. Voluntary surrender of medical license.

McCOOK, Thomas Allan, MD

Location: Shreveport, LA
 DOB: 10/12/1952
 License #: 0000-23736
 Specialty: R (as reported by physician)
 Medical Ed: University of Florida (1978)
 Action: 5/31/2002. Voluntary surrender of medical license.

MOORE, Benjamin Rutledge, DO

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 11/23/1957
 License #: 0000-34688
 Specialty: FP/N (as reported by physician)
 Medical Ed: Texas College of Osteopathic Medicine (1989)
 Action: 6/13/2002. Voluntary surrender of medical license.

NABORS, Dennis Ray, Physician Assistant

Location: Greensboro, NC (Guilford Co)
 DOB: 7/26/1950
 License #: 0001-02153
 PA Education: University of Washington (1976)
 Action: 5/09/2002. Voluntary surrender of PA license.

WHITT, John Alan, MD

Location: Wilson, NC (Wilson Co)
 DOB: 10/21/1958
 License #: 0000-31692
 Specialty: P (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1985)
 Action: 5/01/2002. Voluntary surrender of medical license.

COURT APPEALS

NONE

CONSENT ORDERS LIFTED**BRIDGES, Michael Howard, MD**

Location: Greensboro, NC (Guilford Co)
 DOB: 6/12/1966
 License #: 0096-00463
 Specialty: IM/PD (as reported by physician)
 Medical Ed: Wright State University (1992)
 Action: 6/10/2002. Order issued lifting Consent Order of 1/23/2002.

CLAYTON, Thomas Vann, MD

Location: Andrews, NC (Cherokee Co)
 DOB: 9/20/1956
 License #: 0000-30895
 Specialty: FP (as reported by physician)
 Medical Ed: St George's, Grenada (1983)
 Action: 5/13/2002. Order issued lifting Consent Order of 6/01/2001.

ESSEX, Charles Phillip, MD

Location: North Wilkesboro, NC (Wilkes Co)
 DOB: 2/03/1953
 License #: 0097-00236
 Specialty: FP (as reported by physician)
 Medical Ed: Medical College of Wisconsin (1979)
 Action: 6/10/2002. Order issued lifting Consent Order of 8/25/2001.

WASHINGTON, Clarence Joseph, III, MD

Location: Chapel Hill, NC (Orange Co)
 DOB: 1/11/1947
 License #: 0000-32295
 Specialty: GYN (as reported by physician)
 Medical Ed: University of Michigan (1974)
 Action: 5/14/2002. Order issued lifting Consent Orders of 1/25/1997, 8/27/1999, and 7/31/2001.

WORLAX, Frank, MD

Location: Pembroke, NC (Robeson Co)
 DOB: 1/06/1939
 License #: 0000-21384
 Specialty: FP (as reported by physician)
 Medical Ed: Duke University School of Medicine (1976)
 Action: 5/14/2002. Order issued lifting Consent Orders of 8/18/1998, 10/28/1999, and 4/16/2001.

TEMPORARY/DATED LICENSES:ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES**BRIDGES, Michael Howard, MD**

Location: Greensboro, NC (Guilford Co)
 DOB: 6/12/1966
 License #: 0096-00463
 Specialty: IM/PD (as reported by physician)
 Medical Ed: Wright State University (1992)
 Action: 5/16/2002. Full and unrestricted license reinstated.

DECLERCK, Paul A., MD

Location: Kinston, NC (Lenoir Co)
 DOB: 10/07/1947
 License #: 0000-24240
 Specialty: FP (as reported by physician)
 Medical Ed: University of Brussels, Belgium (1975)
 Action: 7/18/2002. Full and unrestricted license reinstated.

GUALTEROS, Oscar Mauricio, MD

Location: Pinehurst, NC (Moore Co)
 DOB: 5/11/1964
 License #: 0099-00236
 Specialty: IM (as reported by physician)
 Medical Ed: University of Navarra, Spain (1991)
 Action: 7/18/2002. Temporary/dated license extended to expire 1/31/2003.

HEINER, Daniel Edward, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 7/06/1964
 License #: Resident Training License
 Specialty: ORS (as reported by physician)
 Medical Ed: University of Kansas, Kansas City (1997)
 Action: 7/18/2002. Temporary/dated RTL extended to expire 7/31/2003.

PRESSLY, Margaret Rose, MD

Location: Sylva, NC (Jackson 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: 5/16/2002. Temporary/dated license extended to expire 8/31/2002.

RIDDLE, William Mark, MD

Location: Faison, NC (Duplin Co)
 DOB: 3/20/1956
 License #: 0000-39871
 Specialty: FP/ADDM (as reported by physician)
 Medical Ed: East Carolina School of Medicine (1985)
 Action: 6/19/2002. Full and unrestricted license issued.

STROUD, Joan Marie, Physician Assistant

Location: Gastonia, NC (Gaston Co)
 DOB: 4/24/1956
 License #: 0001-01476
 PA Education: Pennsylvania State University (1980)
 Action: 5/14/2002. Temporary/dated license extended to expire 5/31/2002.
 5/16/2002. Temporary/dated license extended to expire 11/30/2002.

See Consent Orders:

BERRY, David Don, MD**LOCK, George Joseph, Physician Assistant**DISMISSALS

NONE

CHANGE OF ADDRESS FORM

Mail Completed form to: North Carolina Medical Board
1201 Front Street, Suite 100, Raleigh, NC 27609

Please print or type. Date: _____

Full Legal Name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

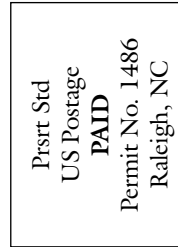
Business: _____

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.



North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: November 20-22, 2002; December 18-19, 2002; January 22-24, 2003;
February 19-20, 2003; March 19-21, 2003

Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the North Carolina Medical Board's Web site at <http://www.ncmedboard.org/exam.htm>. If you have additional questions, please e-mail Tammy O'Hare, GME/Examination Coordinator, at tammy.ohare@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
1201 Front Street, Suite 100
Raleigh, NC 27609