Primum Non Nocere

No. 1, 2007

forum

NC MEDICAL BOARD

Hepatitis C in North Carolina: What Every Physician Should Know

Page 8

President's Message

Before You Turn to the Back Page,

H. Arthur McCulloch, MD

. . .take a moment to read this less interesting, but perhaps more informative, message. Your Medical Board has embarked on a new path with a slight, but meaningful, course correction.

Ask anyone in the general public what they perceive is the Board's responsibility and they will likely answer: "To protect the public from doctors who practice bad medicine." I believe they are correct. The Medical Board's primary responsibility is to assure the public that physicians and mid-level practitioners in North Carolina are competent to practice medicine. We fulfill this responsibility by issuing licenses after a detailed process has been completed, by providing counseling and rehabilitation when necessary, and, finally, through disciplinary action when other measures have failed or are not appropriate for the circumstances.

Of course, the discipline meted out by this Board for unprofessional conduct is usually straightforward. The standards for professional conduct are clear, and proven behavior that fails to meet those standards obviously requires our scrutiny, vigorous investigation, and public notice. The vast majority of Board actions you will find when you turn to the back of this *Forum* result from unprofessional conduct. These include sexual boundary issues, the committing of crimes, drug and alcohol abuse, and, to a great extent, inappropriate or unlawful prescribing practices. Your Board and its professional staff have worked diligently to achieve significant success in this area. National recognition among other states' medical boards as well as a marked reduction in the time from complaint to resolution are distinctive measures of our improved achievement in this portion of our work.

Now it's time to focus on the more difficult and complicated issues of quality of care. Any medical board that is composed of a few members of the profession and the public cannot possibly make independent decisions about medical care that spans more than 130 specialties and subspecialties. However, the complexity of the quality of care issue does not diminish our responsibility to address it. I would like to list the changes we have made to better fulfill this important responsibility.

First, we have gained passage of legislation that gives the Board a broader range of disciplinary options—with or without a formal hearing. As part of this legislation, we have increased financial resources through increased fees. Funds are now available for expert reviews when needed to pass judgment on quality of care issues.

Second, and directly related to this task, we have met with the leaders of the North Carolina Medical Society and they have pledged support for meaningful, specialty-specific, expert review of cases involving quality of care. Without the medical community's support, our ability to address cases where

In This Issue of the FORUM

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NC MEDICAL BOARD

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

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standards or quality of care are in question would be limited to the point of uselessness.

Third, we have restructured our staff and committee functions so that all types of information brought to our attention can be handled with equivalent scrutiny. To that end, pubic complaints, reports of inappropriate behavior, notices of change in hospital staff privileges (reported to the Board by law), and reports of malpractice payments will all be reviewed by the directors of our Medical, Investigative, Complaints, and Legal Departments. This significant change in procedure will provide consistency in our handling of information. (Due in part to this restructuring, the Board has dramatically increased the number of public actions taken in certain types of cases.)

Fourth, we have appointed a Continued Competence Committee to investigate ways to actively address both quality of care and behavioral issues. This committee will be evaluating research that addresses possible indicators that may predict unprofessional conduct before it occurs. Dr Michael Sheppa, the Board's medical director, is busily working with this committee, continuing the work started by his predecessor, Dr Jesse Roberts. He is focusing on the role of CME as it relates to continued competency, and, in cooperation with the Sheps Center at UNC, analyzing what can be learned from the malpractice process that will help the Board prevent care that falls below the standard. Board members and staff have visited the Center for Personalized Education for Physicians in Denver, Colorado. The CPEP employs various resources to assess physician competence and provides plans for rehabilitation and retraining when needed. Assessment of physicians whose competence has come into question may prevent bad outcomes and have the potential benefit of rehabilitating physicians to an appropriate level of practice and service to their patients.

It is far more difficult to determine appropriate Board action in quality of care issues than it is to decide discipline for inappropriate behavior. "Right" and "wrong" can be more difficult to assess. The standard of care may not always be the best care. Qualified experts can disagree. Nevertheless, the Board is unified in its commitment to make continued progress in the assessment of competence. This shift of focus is not just one Board member's goal, but a truly unanimous opinion by all who serve that this direction is appropriate and will serve the public and the profession well.

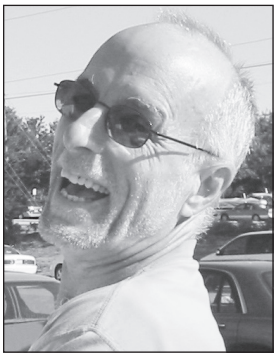
To be sure, there will be critics who will say we have gone too far and we should limit our attention to licensing and to the disciplining of inappropriate behavior. Also, there will be those who continue to claim that we aren't doing enough to protect the public. We should strive to vigorously regulate the medical profession and continually maintain public confidence in our ability and resolve to do so.

One thing is clear. If we fail in this duty, others will step in to do it for us. But we do not intend to fail.

SANTIAGO ATITLAN

The Call of Something Different—Part 5: Thoughts on Leaving Santiago Atitlan

Jack Page, MD



Jack Page, MD

The Good. . .

After two years, Bernie and I have finished up our time at *Hospitalito Atitlan*, Santiago Atitlan, Guatemala. We have shared our good and bad times, our successes and our failures, and now want to share some of our parting thoughts and feelings.

We have experienced an exhausted sense of satisfaction after long hours and much middle-of-the-night care. In fact, short-term volunteers liken the work as similar to residency: long hours, great responsibilities, and much need. Preventing eclampsia in the preeclamptic young mother; saving the baby by C-section in a prima-gravida mother with a breech presentation; curing the respiratory failure/pneumonia in a 55-year-old woman; reducing and casting a fracture for an adequate length of time. These have all been successes.

We have felt the joy of providing a level of service otherwise available only to a select few in Guatemala. Due to much hard work by John Nelson, MD, a Logan, Utah, ob-gyn, laparoscopic surgery has been available at the *hospitalito* for chronic pelvic conditions, chronic cholelithiasis, and others. Literally dozens of women have had quality years added to their lives without the urinary incontinence, prolapse, and bowel problems associated with multiple unattended deliveries complicated by absent prenatal and postnatal care. Literally hundreds have been treated in Santiago, avoiding ambulance trips (a health risk of their own!) for men with bladder outlet obstruction, severe lacerations with brisk bleeding, and closed head injuries.

We have found diseases with important complications/consequences that can be cured or controlled: a lovely two-year-old girl with patent ductus and early pulmonary hypertension was diagnosed and operated on in Guatemala City after the staff found a funding source; a 55-year-old woman (young woman according to me) with congestive heart failure and chronic atrial fib with rapid response who once again can go to the market and walk up the hills; dozens of women found in routine prenatal care to have asymptomatic urinary tract infections that are cured by simple and inexpensive antibiotics; and far too many young boys with machete wounds to their non-dominant hands with occult tendon injuries that would otherwise become life long disabilities and barriers to work.

We have seen our young, poorly trained, indigenous nurses and doctors just soaking up knowledge and skills as mentored by both short- and long-term volunteer nurses and doctors. A pulse ox is now an expected sixth vital sign on all patients at the *hospitalito* (they had already added weight early on). Our first indigenous scrub nurse has learned so much about instruments and surgical procedures that he is now training an equally bright new nurse graduate. Where and how to place urinary catheters and naso-gastric tubes, how to use infusion pumps (critical for oxytocin and magnesium sulfate administration), and how to perform ECGs are all part of routine daily practice after our two years here. But. . .please check the math on all drug doses!

It is really nice to be greeted many times a day by people all over town: "*Buenos dias doctor(a)!*" Many of our mentors had that experience in other times, in smaller towns, but almost never has it happened to us as anonymous emergency physicians in an anonymous hospital in some anonymous urban area.

"At least once a day, we are told 'thank you' by a son, mother, or father for the work we have done"

At least once a day, we are told "thank you" by a son, mother, or father for the work we have done. Often that work is incomplete (supplies, special training, or equipment) or just downright unsuccessful (major stroke in an 80-year-old, massive head injury in a young man, or respiratory failure in a 32-week premature baby). Most seem to recognize the good the *hospitalito* can do and the limits on what is available. Thanks seem to be the same for both the results and for the attempts and desires. Families are constantly giving gifts of a beaded butterfly, a hand-carved fisherman, an embroidered scrub top, or even a bag of live crabs as a way to say thanks. (Too bad the crabs were temporarily forgotten in the doctor's sleep room!)

Bernie Page, MD

While fatalism is at times too much of a presence, we both enjoy being able to comfort and explain when someone is beyond our ability to cure and must prepare for the end of the line with respect and dignity: a

58-year-old woman with an invasive recurrence of her cervical cancer that had previously been treated twice with radiation therapy; a four-day-old septic baby with imperforate anus who was brought in so close to death no viable options were available; progressive renal failure in an elderly woman with chronic hypertension. This society with too little of everything has forced its members to recognize that "doing everything" is at times very much not the right choice. This ability to forgo futile care and at times send patients home to die with their family and loved ones is sometimes one of the best responses medicine has to offer.

Both of us enjoy never, ever, having to do anything for medico-legal reasons. We are able to use our clinical judgment about when to order X-rays and CTs, and to send patients off for specialist care while taking into compassionate consideration the resources of the family, the hospital, and the society along with the costs of such additional treatment. Children here are like children everywhere: they go where they shouldn't, do things they shouldn't, and often land head first. In the U.S., a CT of the head is for many reasons a no brainer; here it is at least a three-hour each way ride, the equivalent of several months income, along with intense social pressure and fear of leaving all that they have known and experienced. Without a safety net, there is no workers' comp to validate; without an adversarial court system (some would say functioning court system), there is no purpose to much civil litigation. Though both of us would say Guatemala is too extreme on the other side, it is a wonderful way to practice medicine from the provider's perspective.

"We have been amazed to learn how easy it is for Americans to make a real difference in the quality of life to those of the third world"

I have found it easier to eat better, exercise more, and watch less television and fewer movies. The nearest Ben and Jerry's is Miami, McDonald's is a two-hour drive (each way). With a five-minute walking commute to work and plenty of time to read while on call, time away from work is available for me to continue my lifelong running. Seriously, my cholesterol had never been known to be below 200 before, and with an HDL of over 70 I will probably live longer than I want to. Books, in English and Spanish, have been the mainstay of after-hours relaxing time and provide the benefit of increasing dramatically the vocabulary in our adopted language. Bernie, on the other hand, a vegetarian and less flexible in accepting new foods, feels she has not kept up her calcium intake. Due to the early robbery experiences, she has not been comfortable walking alone on the many lovely paths in the surrounding countryside and has had less exercise than when she used to bike to work in Durham.

Life is simpler in rural Guatemala and reminds those of us from the U.S. of our growing need to take up less space, use less energy, leave less waste. We have learned the fun of putting on clothes that have been dried on the line in the hot sun and with a brisk breeze. No scented antistatic-cling sheets are needed to appreciate the outdoor smell, the rough freshness of the clothes off the line. However, a washing machine will allow clothes to survive years instead of the months allowed by beating them on a hard rock or a poured concrete washboard. We have found that once you cut the soft spots off an over-ripe tomato it can still make wonderful spaghetti sauce and that those black bananas are the best for really great banana bread.

We have been amazed to learn how easy it is for Americans to make a real difference in the quality of life to those of the third world. Families and parents refuse to go to the specialists in Guatemala City regularly because, in part, they don't have the 50 quetzals (Q) each for round-trip bus fare, 100 Q for a place to sleep, and 25 Q a day for food. For a child with an accompanying parent, staying for two days in the scary capital adds up to 350 Q, which is a little over $45 U.S. So, when we tell parents, often mothers without shoes, dads in cheap sandals, that their child needs to see a specialist in the capital, we frequently pass the hat among the U.S. volunteers and give the parents the wherewithal to make a little less limited decision. Often it works to everyone's benefit!

We have always enjoyed teaching future health care providers. Here we have the opportunity to see the eyes of medical and nursing students as they deliver their first baby, do their first spinal anesthesia, repair their first facial laceration, and reduce their first dislocated shoulder. Since an attending doctor is always present in the hospital and we don't have many years of residents competing for the learning experience, opportunities to do things never done before are present here everyday with careful supervision. The young learners' enthusiasm and pride fill us with needed enthusiasm and a sense of accomplishing more.

For the first year the hospital was open, it didn't have an X-ray machine. It is amazing how good you can get using your hands, ears, and eyes when just ordering a test is not an option. Even now, we have no access to CT scans without a several hour journey each way; sophisticated labs must be taken to the dock by "tuk-tuk" (the little three-wheeled motorcycle with passenger seat), given to the boat operator, taken across the lake, picked up by a "tuk-tuk," taken to our "reference" lab, and, when processed, the results sent to us via e-mail the next business day. Not conducive to heavy reliance on lab tests, so we have learned again to trust our clinical judgment and experience and especially that of our peers. We enjoy being diagnosticians again with less use of X-ray, almost no CT, few labs, and a healthy dose of common sense.

We have recognized the value of meeting with our peers to discuss difficult cases, to focus on what we are able to treat (even if we can't do the fanciest diagnostic test) and on curing the patient. For many of us, this is a variation of the old grand rounds that so many of us did during training. Much is learned and successfully accomplished by the combination of diverse

disciplines and people of diverse experience bringing their wisdom and judgment together to serve a patient's need.

We have learned so much about parts of the world as seen through the eyes of non-Americans. The deportation of hundreds of undocumented Guatemalans working in U.S. meat packing plants, just before Christmas, had quite a different spin placed on it in Guatemala—still illegal, but viewed with a little more sensitivity to the timing and the inevitable economic consequences on hundreds of families in Guatemala. The Free Trade Agreement is felt to be a loser for the working class in the U.S.; it is also felt to be a loser for the working class in Guatemala. Who is winning? Often the Guatemalans hear about the occasional not so good things the U.S. does in Iraq or Afghanistan before people in the U.S. because they hear more readily from Arab and European sources since they do not have a large in-country news media.

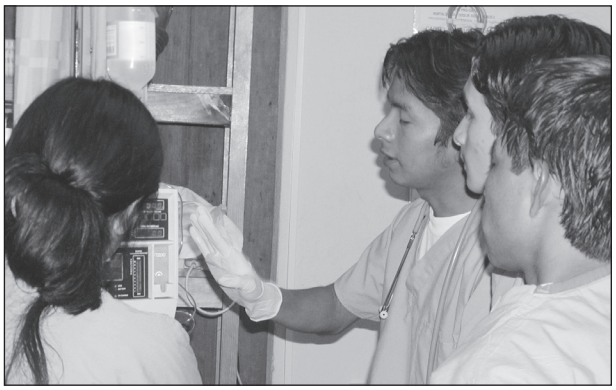
Along with using our medical skills and knowledge, we enjoyed working with others to match the needs of the people in Santiago with the needs of donors throughout the U.S. The satisfaction of bringing the right donor, with the right donation, to meet the otherwise unmet needs of a patient is a wonderful reward bringing good things for all. We and Kathy Roach, a long-term nurse volunteer from Williamsburg, VA, coordinated the care of five children with cleft palates/lips and HELPS volunteer surgeons. One reader was so struck by the old, falling apart shoes of one of my patients that he provided several hundred dollars to meet similar basic necessities of many others. Several volunteers saw the needs of a woman whose husband had been murdered and worked together to fund a job for her that will lead to long-term employment. They also funded an education grant for her three young daughters.

We have always thought trying new things food-wise meant shopping somewhere other than Kroger or Safeway or eating at a restaurant that wasn't a familiar chain. Boy did we get an education! Growing up, I learned green peppers are mild and red ones are hot. Not always so, and I earned some blisters to prove it. Bernie thought butter was butter, but what if the cows eat a little wild onion just before they are milked. You got it: it makes for rather suspect chocolate cookies. Old dogs are tough to teach new tricks, but we have learned to eat and enjoy (at least one of us has) the porous farmers' white cheese of Latin America, corn tortillas, green papaya pie, squash-of-any-kind pie, really HOT salsa, and physically damaged but explosively flavorful fruits and vegetables.

Both of us have noticed that the first-world volunteers are disproportionately female. Sometimes I feel much outnumbered. Is this a function of roles and responsibilities? A function of nurturing and caregiving skills/traits? But whatever the gender, we are proud to see so many first-world residents, who seldom wonder how they will feed their children, come to help others with so much less in the world. The volunteers pay their own way, put up with the hassles of a third-world country, give their time and skills, and then are asked to give money for this or that special need. And they respond over and over. These are true heroes, every one. They do much to lessen the tensions that so divide the world.

Not being in the U.S. is tough on softies like us. No "All Things Considered" and "Morning Edition" (unless you are technologically gifted, which we are NOT). Did you know I didn't see the sixth *Star Wars* movie for months after it came out? How's that for roughing it. No impromptu visits to kids and grandkids. No stopping off at Whole Foods for a little salad after a too long day. No good friends to visit and commiserate with over this or that in the evening. One of the things that stopped me dead in my tracks was hearing the U.S. immigration officer say, "Welcome home." He was right; there is no place on Earth like the U.S.

Seeing and hearing the birds, the flowers, the fruits, the trees, the water, the volcanoes, the colors, the smells, and the noises—we have been recording little snippets of our lives and experiences in Guatemala and sending them to an NPR program based in Chapel Hill. After several hours of recording, the station sent a message: "We don't need more bird sounds!" Bernie loves them and sits for hours, listening to hundreds a day. I use the patio outside the back door of the house for my First Day worship: the trees, the birds, the lake, the volcanoes, the presence of God, and the peace of introspection.



Jacinto, our scrub nurse, teaching other nurses how to use an IV pump.

More than Bernie, I have been learning not to start everything off with, "Well, in the U.S. we. . . ." Wow, talk about how to stop progress. Much of what is done in the U.S. is not possible or culturally acceptable in Guatemala. While it is culturally tolerated to pass out drunk on the side of the road or urinate on the light pole, bare midriffs and letting women go first just doesn't happen much down here. That doesn't mean any of these are right or wrong, just different.

"Along with using our medical skills and knowledge, we enjoyed working with others to match the needs of the people in Santiago with the needs of donors throughout the U.S."

And that is precisely the lesson to be learned and to remember. This is an opportunity to walk in the sandals of or barefoot with people who have no idea of what life is like in the United States. And learn some good things from them—and they from us.

It has been an opportunity for both of us to give thanks to God (for being born in the U.S.), to our families (that valued education and drove us to attain it), and to America (for being a land where many can reach the sky through hard work and determination). It is always hard to realize that much of what each of us "has" or has "accomplished" is often only partly our credit, but also the result of a variety of things that occurred by chance and, at times, in spite of our own efforts. This can appropriately lead to some humility, which is often found in short measure in many of us. We are the product of much more than just ourselves.

The Bad . . .

It didn't take long for both of us to recognize that not all our goals of serving would be realized. Some were just plain unreasonable. I was sure that I had much to offer administratively and just couldn't understand why the local board didn't realize how valuable my advice was. Bernie was frustrated by our desires to provide care to those who couldn't afford it and kept seeing obstacles put in that path (disagreements over fee structures, discounts, sliding scales). We also realized that when we strengthened the weak link in Santiago, it just meant another link became the weakest and patients began to fall through the cracks in Solola (where injured folks tended to die some four to five days after the acute injury) or Guatemala City (where, though needed services might be available, it didn't mean they were provided to needy patients). But without a doubt, Santiago Atitlan is better off with the *hospitalito* than they were before it reopened.

"Attempts to make changes are overwhelmed by a lack of initiative and by a bureaucracy that constantly saps energy"

Never having lived in the tropics before, we were amazed at the variety of bugs of every kind and description that seem to have a penchant for American food. And in Santiago, all screens have holes, all doors have leaks, and all roofs are infested with termites. Sleeping becomes a bit of an all-night slow scratch; standing in the grass talking with neighbors can suddenly change into a quick two-step hither and yon looking for a safe place to stand. Certainly a great place to live, but bring your favorite bug spray and screen patches.

It was and remains very difficult for us to see so many people die and/or suffer because of a lack of clean water, human waste systems, law enforcement, responsible government, or a pittance of money. Surely such problems also occur in the U.S., but not quite so openly and coldly. Chlorination of the water doesn't happen because "the people don't like the taste and it costs money." Lack of good elected leadership seems to be a common problem that skips borders. Human waste goes in rocky, sandy holes dug next to each house. But doesn't all that water just percolate into the lake pretty quickly? The answer, of course, is yes. No leadership here either. Bernie has a great term for what law enforcement is like here: "Barely contained anarchy." We have postulated that the suspicion, stubborn rejection of advice, and absence of controls represent an over-reaction to the years of oppression and control. Finally, it is very hard to see people die for lack of an artificial hip to replace their broken one; or a child waste away for lack of a family's ability to buy peanut butter to make "RUTF," a very tasty and nourishing diet when malnourished; or see passive official avoidance of HIV screening because there is no money to treat those identified.

Attempts to make changes are overwhelmed by a lack of initiative and by a bureaucracy that constantly saps energy. Some locals call it the *custumbre* or culture and tradition, but it is also fear of the unknown and a desire not to call attention to oneself by making waves. The people are afraid of changing, of challenging, of making waves. Rigoberta Menchu (winner of the 1992 Nobel Peace Prize and probable candidate for president of Guatemala in 2007) is definitely not your typical Mayan indigenous. How to foster and channel the anger, disgust, and dissatisfaction into progress is a skill and science well beyond medicine.

Unreliable utilities scheme to warm your vaccines and medicines, cool your cultures, deny you water for laundry and toilets, turn off your suction machines, and let you operate by flashlights (weak batteries of course!). In November, I went to Panajachel to mail some letters; the postman said, "We don't have any stamps but if you leave the letters, and pay the postage, we will mail them when we get some in January." I did; not sure if they did. In December, there was a national shortage of cash; ATM's were out, banks were not allowing withdrawals of cash, payroll checks were not being cashed. Most vendors in Guatemala don't take credit cards or checks (even if the majority of the people had them, which they don't) so most of the consumer economy ran into a brick wall. Just in time for the busiest selling month of the year! "Someone" forgot to order new bills in time. (Maybe this is just more of the stuff from the previous paragraph. Bernie, more skeptical than ever, wonders if this snafu is benefiting some powerful moneyed group.)

Realizing that the more compounded and profound the problem, the more difficult it is to find out where to put the lever to try to get the solutions moving, we think this is a lot like Iraq. We feel the initial American intervention was portrayed as something that couldn't miss. "They will be dancing in the streets welcoming us." Now we have the American victory and it is still such a very complex problem. The same here in Guatemala. They have ineffective and sometimes patently corrupt officials who just get elected time after time. They have an immediate past president in Mexico, fighting extradition for alleged embezzlement

of millions. They have another past president trying to run for president again (ineligible under Guatemalan law) walking the streets campaigning while the European Union has issued an arrest warrant for him for genocide. Literacy is in the single digits outside of urban areas, especially among indigenous. How do they learn their rights? Demand their rights? Expand their horizons?

Parts of the compounded problems are the useless burdens of superstition, fear, ignorance, and some organized religions. Many will not go out at night "because that is when the homeless spirits roam." Most will not file complaints or seek charges for criminal activity because of fear of reprisals and demands by the police for money. Health is compromised and sometimes made flagrantly worse by home remedies with only proven adverse effects. Some religions facilitate these problems by sexual stereotyping the opportunities for the people, condoning self-destructive behavior, and fostering dependence on them instead of self-reliance and growth. Where do you apply the tool to begin the job?

We were struck by the long-time failure to develop a joint mission, vision, and values statement, and by the lack of communication between health care professionals and the lay board of trustees at the *hospitalito.* None of the folks involved are "bad" people, but all come with their own agendas and goals. Most are mutually achievable, but without open discussion and prioritization each individual pulls in his or her own direction and lets things slide otherwise. Without a joint vision, the power of group consensus cannot be obtained and brought to bear on the challenges faced. Human weaknesses and frailties often win.

Conclusions

It is right and just for those of us who have much to help those who have less, sometimes unbelievably less. Each of us should give of what we can, when we can, to help make the quality of life better for all. To do otherwise adds to the instability in the world and the eventual price all of us will have to pay. We feel we have made a down payment.

"Each of us should give of what we can, when we can, to help make the quality of life better for all"

This concludes the Page's series of *Forum* articles about how they lived and worked during their two-year stay in Santiago Atitlan, Guatemala. If you would like to contact them, they can be reached at *brpage@yahoo.com* or *jackpage45@yahoo.com* In January, Bernie and Jack returned to the U.S., Bernie to resume working at Duke and Jack for a three-week visit. Jack then went to a new work site in San Benito, Peten, Guatemala, where there is another hospital to open. Bernie will join him several months a year as a volunteer.

Governor Appoints Andrea Bazán-Manson, of Durham, and Peggy R. Robinson, PA-C, of Durham, to the NCMB

R. David Henderson, executive director of the North Carolina Medical Board, has announced that Governor Easley recently appointed Andrea Bazán-Manson, of Durham, as a public member of the Board and Peggy R. Robinson, PA-C, of Durham, as the physician assistant member of the Board. Ms Bazán-Manson and Ms Robinson replace Aloysius P. Walsh and Robin Hunter-Buskey, PA-C, both of whom served two terms on the Board. Mr Henderson said: "The members and staff of the Board deeply appreciate the distinguished service of Mr Walsh and Ms Hunter-Buskey and are pleased by the appointment of such outstanding and public-spirited individuals as their successors. Ms Bazán-Manson and Ms Robinson are fully committed to the work of the Board and to the health and safety of the people of North Carolina. We look forward to working with them."

He noted that the Board is made up of 12 members appointed by the Governor for three-year terms. Its membership includes physicians, public members, and an allied health professional.

Ms Bazán-Manson

Andrea Bazán-Manson is president of Triangle Community Foundation, a charitable foundation that manages funds established by individuals, businesses, and families and makes grants, averaging $12 million annually, to nonprofits, schools, and community efforts. As president, Ms Bazán-Manson is responsible for leading the 23-year-old foundation and overseeing the stewardship of its more than $110 million in assets.

Ms Bazán-Manson

Before joining the foundation, Ms Bazán-Manson served as executive director for El Pueblo, a statewide advocacy and public policy organization based in Raleigh, North Carolina. For several years, she served as the first Latina lobbyist at the North Carolina General Assembly and she also lobbied at the national level.

She has held positions in state government at the North Carolina Office of Minority Health, Department of Health and Human Services, where she conducted research and helped develop programs for minority communities. She has also worked in various research and interdisciplinary projects focusing on women's

health, reproductive health, and Latin America at the University of North Carolina at Chapel Hill's School of Public Health, Department of Maternal and Child Health.

An active member of her community, she is a frequent speaker at the local, state, and national levels and has served as a mentor to many young students. In 2006, El Pueblo recognized her contributions by establishing the "Andrea Bazán-Manson Youth Leadership Award," given annually.

Ms Bazán-Manson serves on various boards and committees, including the North Carolina Medical Care Commission and the North Carolina Institute of Medicine, appointments made by Governor Easley. At the national level, she serves as vice-chair for the Board of Directors of the National Council of La Raza, based in Washington DC, and is a board member of the National Immigration Law Center, based in Los Angeles, California, and the National Immigration Forum. She also sits on state and local boards, including the North Carolina Zoological Society, the John Rex Endowment, and Wachovia Bank in Raleigh, North Carolina.

Ms Bazán-Manson is the recipient of numerous awards and recognitions, including being named Alumni of the Year for the UNC School of Public Health and for the UNC School of Social Work. She was also named Tar Heel of the Week by the *News & Observer*, was inducted into the Public Health Honorary Society, and received the 2006 "Women of Achievement Award" by the Federation of Women's Clubs.

She holds a master's degree in social work and a master's degree in public health from the University of North Carolina at Chapel Hill, and was a 1997-1999 William C. Friday Fellow for Human Relations.

Ms Robinson

Ms Robinson

Peggy R. Robinson, PA-C, earned a BS degree in biology from Springfield College, in Springfield, MA. She then attended the Medical College of Virginia, where she received a master of science in microbiology. In 1992, she earned a master of health science and certificate of completion from Duke University School of Medicine's Physician Assistant Program, in Durham, NC. Upon graduation, she received the Richard J. Scheele Memorial Award, and was recognized by Duke's PA Program for outstanding academic performance.

Ms Robinson has served in a number of capacities as a graduate teaching assistant, instructor, and laboratory specialist. In 1992, she joined Duke University Medical Center as a physician assistant in the Department of Gastroenterology. In 1993, she became a part-time instructor and practiced as a physician assistant at Duke's Infectious Disease Clinic. Ms Robinson currently serves in the Physician Assistant Program at Duke as an assistant professor in the Department of Community and Family Medicine. She is a pre-major advisor at Duke's Trinity College of Arts and Sciences, and also practices as a physician assistant in family medicine and urgent care at The Family Doctor – Rams Plaza, in Chapel Hill, NC.

Ms Robinson is an active member of the American Academy of Physician Assistants, the North Carolina Academy of Physician Assistants, and Pi Alpha (the National Physician Assistant Honor Society).

May Is Hepatitis Awareness Month

Hepatitis C in North Carolina: What Every Physician Should Know

Susan Thompson, RN, MPH
Former North Carolina Hepatitis C Coordinator, Hepatitis C Program

Hepatitis C virus (HCV) infection is the most common blood-borne viral infection in the United States. Studies done through the Centers for Disease Control and Prevention (CDC) show that 1.6% of Americans (about 4 million) are infected with HCV, most of whom are chronically infected (2.7 million).[1] Many of these individuals are not aware of their infection and have no overt symptoms of the disease. Because hepatitis C progresses slowly, the consequences of the disease may not become apparent until 10-20 years after infection. Studies show that 60-80% of HCV-infected persons develop chronic infection.[2] Chronic HCV infection and subsequent liver disease result in significant morbidity and mortality and contribute to high health care costs associated with specialized medical care, medications, and hospitalization. Major morbidities associated with HCV infection include progressive liver fibrosis, cirrhosis, end-stage liver disease, and hepatocellular carcinoma. CDC predicts that the HCV-related mortality might double or triple over the next 10 to 20 years.[3] Research has projected that the national cost of direct medical care for hepatitis C from 2010 through 2019

will reach over $10 billion.[4] Hepatitis C has been described as "a silent epidemic" due to these millions of undiagnosed cases.

Risk factors for HCV infection include injection drug use, even if only once many years ago, transfusion of blood and blood products before 1992, use of blood clotting components before 1987, tattoos/piercings with a contaminated needle, occupational exposures to blood, birth of an infant to an infected mother, and, to a lesser extent, sexual contact with an infected partner.[5]

The incidence of acute cases of HCV is actually decreasing nationwide as blood tests and screening have become more sophisticated and those at greatest risk are becoming more educated about ways to reduce their risks. More alarming are the growing numbers of people who were unknowingly infected with HCV years ago and are only now experiencing the devastating effects of the disease. For these people, primarily in the 40-65 age group, learning they have chronic hepatitis C is a frightening and bewildering prospect.

Ms Thompson

CDC recommends that health care professionals routinely assess patients and their history of injection drug use and that they counsel, test, and evaluate persons with such histories for HCV infection.[6] Surveys of primary care physicians show that many appropriately evaluate persons with HCV infection, but few elicit risk histories that could identify such persons.[7] In some areas of the country, it is difficult to find a physician who cannot only diagnosis hepatitis C, but also treat and properly manage the disease. Management of hepatitis C can be a complicated process, and many physicians have neither the time nor the resources to treat these patients.

What does all this mean for North Carolina? Using national statistics, it is estimated that over 150,000 North Carolinians have been infected with HCV. Approximately 110,000 of these people are chronically infected and capable of spreading the disease to others. However, due to the insidious nature of the disease, it is likely that most of these North Carolinians are unaware of their HCV infection.

In 2003, the North Carolina Division of Public Health, through grant funding from CDC, established a Hepatitis C Program. The Hepatitis C Program is integrated with the HIV/STD Prevention and Care Branch because both HCV and HIV infections involve blood-borne pathogens requiring similar disease response and prevention. The programs serve similar at-risk populations. A primary focus of the Hepatitis C Program has been to provide education not only to health care providers and professionals across the state, but also to consumers. Efforts have concentrated largely on providing hepatitis education to staff at local health departments across the state, but have also included educational collaborations with other state agencies, community-based organizations, Ryan White Title II and III projects and clinics, support groups across the state, jails, mental health services, substance abuse facilities, and the Veterans Administration, among others. Education, in the form of presentations, written materials and videotapes, is available from the state Hepatitis C Program. Two good sources of information available from the Hepatitis C Program are the *Hepatitis C: Get the Facts* information packets designed for newly diagnosed clients and the *Hepatitis C Resource Directory for North Carolinians*. Both provide a wealth of information about hepatitis C, including testing, counseling, and medical management, along with support group services available throughout the state.

Another key effort of the NC Hepatitis C Program is the state Viral Hepatitis Task Force, which is composed of representatives from the aforementioned agencies and groups and was created in 2005. The task force has developed a state strategic plan for viral hepatitis. Currently, the members are exploring creative ways to fund an intensive education and awareness campaign, as well as free HCV testing programs—both desperately needed in the state. The task force meets in Raleigh on a quarterly basis.

"Using national statistics, it is estimated that over 150,000 North Carolinians have been infected with HCV"

A third element of the state's fight against hepatitis is the provision of hepatitis A and B vaccine in local health departments. CDC recommends that all persons with hepatitis C infection be vaccinated against hepatitis A if liver damage is present and hepatitis B if they are at risk for the infection.[8] To this end, the Hepatitis C Program has collaborated with the state Immunization Branch to provide a combined hepatitis A and B vaccine through all local health departments to adults at high risk and those already diagnosed with hepatitis C and HIV.

According to current predictions, our state will experience the increasing burden of treating persons with HCV-related liver disease over the next several years. Currently, few resources are available to support prevention, detection, and management of HCV infection. The vision of the NC Hepatitis C Program and the Viral Hepatitis Task Force is for all North Carolinians to have access to viral hepatitis testing, treatment, and prevention services, regardless of ability to pay, and that education and awareness of viral hepatitis will become a statewide priority.

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Peter Moore, North Carolina Hepatitis C Coordinator, Hepatitis C Program, HIV/STD Prevention and Care Branch, welcomes your questions and comments regarding hepatitis C. Please contact him for materials and information at 919-733-2030, ext 56 or by email at *pete.moore@ncmail.net*.

REVIEW

Not Your Usual Practice Management Manual

Mark A. Crissman, MD

Dr Crissman

Medical practice management books can be frustrating. When I read them, I frequently finish them with a long list of unanswered questions. I presume my colleagues have the same reaction. If you are starting a practice, then you are already overwhelmed with questions. If you are already in practice, you are living with unanswered questions.

I have yearned for a book with specific answers, and finally we have one! *Medical Practice Management in the 21st Century: The Handbook* does more than just answer questions. Each chapter begins with a list of important questions that are then answered. Not only do the authors guide the reader through the questions and answers, but they provide very detailed worksheets to help the reader work through his/her own solutions.

"An example of the book's clarity that I particularly like is the comparison between a business plan and the scientific method"

This book provides excellent insight into the necessary components of a medical practice: practice organization, financial management, human resources, quality improvement, and compliance. For each of these components, the authors explain the importance and provide specific examples and solutions to common problems. They present the information in a clear manner that makes sense to medical professionals not trained for the business world (and that would be most of us).

An example of the book's clarity that I particularly like is the comparison between a business plan and the scientific method with which physicians are familiar. Quoting from the book, "A business plan should not be a foreign concept to physicians since it closely resembles components of the scientific method. A business plan forces management to create a hypothesis for a business strategy, to evaluate the underlying assumptions, and determine the fiscal market and non-market steps that are needed to make the strategy successful." The book then outlines an easy-to-use format that allows the reader to fill in the blanks. The reader is thus led from an explanation of the need for a plan to an understanding of the plan itself, with examples and a format for executing the plan. The authors offer detailed solutions for developing, using, and carrying out a business plan. In summary, they tell us to use a business plan:

1. as a guide to help make decisions;
2. as a checklist to measure progress (as a roadmap of sorts);
3. as a recruitment tool;
4. to obtain financial support;
5. to match job descriptions that are consistent with the practice's stated goals.

Here's another example of the way in which the book helped me. When I look at practice management books, I am usually tempted to skip over the chapters on marketing. Because I have a very busy practice, I have never thought it was necessary to "market" my practice. As I read this material, however, I discovered that marketing involves much more than my perception of it as an ad in the newspaper. Satinsky and Curnow point out that, "You may like to think your patients judge you solely on the quality of care that you provide, but in truth, they scrutinize your processes for delivering care and your workflow as carefully as they assess the clinical services they receive. They also notice the information technology to support your practice—ie, your practice management system, your Web site, electronic health records, e-prescribing, and the integration among all these applications." I realized that, unknowingly, I have "marketed" my practice everyday without the use

of conventional advertising, but with every interaction that I have with my patients.

In the chapter on human resources, the authors provide a specific list of questions for the interview process, but they don't stop there. They explain what questions not to ask and why, helping the reader to understand important legal requirements. The book goes well beyond recruitment and provides information on employee orientation, managing retention, and handling departures from the practice. Most books stop with the recruitment process and never address the other important issues.

One of the best features of this book is the appendices. I know how frustrated I have been when I have spent time reinventing the wheel. This book contains important tools such as patient satisfaction surveys, performance evaluations, job checklists, and forms for assessing vendors of electronic health records. You can use the forms in the appendices and on the companion Web site by inserting your own practice name and copying or modifying the text.

What truly sets this book apart from other practice management books for physicians is that it does not stop with having developed a plan. It offers powerful practical and useful strategies for implementing a plan, even in established practices such as mine. Having successfully taken over and guided my father's solo family practice after his retirement, with the number of employees rising from two to 13 and with two nurse practitioners now supporting my practice, I honestly felt that another practice management book would be of little benefit to me. Marjorie Satinsky and Dr Randall Curnow have written a book that offers more than the average practice management manual.

Whether you are considering starting a new practice or are a part of a large, well-established practice, the *Medical Practice Management in the 21st Century: The Handbook* is an essential tool that will help you practice the medicine for which we have been trained.

Medical Practice Management in the 21st Century: The Handbook
Marjorie A. Satinsky, MBA; Randall T. Curnow, Jr, MD, MBA, CPE
Radcliffe Publishing, Oxford & New York, 2007; 192 pages
$59.95 ISBN-10 1 84619 023 1 and ISBN-13 978 1 84619 023 0
[Introduction, appendix, list of Web appendices, index]

"What truly sets this book apart from other practice management books for physicians is that it does not stop with having developed a plan"

Dr Crissman practices at Crissman Family Practice in Graham, NC.

NCMB Policy Committee Continues Study of Position Statements

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

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

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

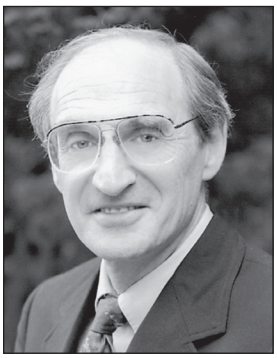
Physician Supervision of Other Licensed Health Care Practitioners

The physician who provides medical supervision of other licensed health care practitioners is expected to provide adequate oversight. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise the appropriate amount of supervision over a licensed health care practitioner which will ensure the maintenance of quality medical care and patient safety in accord with existing state and federal law and the rules and regulations of the North Carolina Medical Board. What constitutes an "appropriate amount of supervision" will depend on a variety of factors. Those factors include, but are not limited to, the following.

- The number of supervisees under a physician's supervision
- The geographical distance between the supervising physician and the supervisee
- The supervisee's practice setting
- The medical specialty of the supervising physician and the supervisee
- The level of training of the supervisee
- The experience of the supervisee
- The frequency, quality, and type of ongoing education of the supervisee
- The amount of time the supervising physician and the supervisee have worked together
- The quality of the written collaborative practice agreement, supervisory arrangement, protocol, or other written guidelines intended for the guidance of the supervisee
- The supervisee's scope of practice consistent with the supervisee's education, national certification, and/or collaborative practice agreement

The Center for Professional Well-Being: A Brief History

John-Henry Pfifferling, PhD, Director
Center for Professional Well-Being



Dr Pfifferling

What is now an internationally-known center for dealing with occupational stress and for crisis counseling and prevention began with a compassionate coincidence.

Out of the Desert: Studying the Medical Tribe

In 1968, I returned from the desert of northwestern Argentina where as a medical anthropologist I had studied the epidemiology of high altitude (folk) medicine, only to discover that funds were unavailable for me to return and complete my dissertation research. I subsequently enrolled at Pennsylvania State University in a course taught by a neurologist, William Jeffries, MD.

"Why did these problems stay hidden and why did no one openly assist physicians who were silently screaming and obviously suffering"

The course's objective was to familiarize engineers with the diagnostic process, using headache and epilepsy as examples. As the only non-engineer in the course, I asked very different kinds of questions than the other graduate students. This kindled a close friendship with Dr Jeffries. As his friend, I discovered this kind, compassionate, knowledgeable physician was having serious difficulty in convincing his colleagues to use the problem-oriented medical record system (POMR). He was subjected to slander and ostracism by those who opposed the idea. They even attempted to undermine his status as the preeminent neurologist at the institution, though he was the chief of neurology and had practiced there for 25 years. Dr Jeffries was politically shunned in spite of doing "everything right." I saw the "natives" ostracizing one of their own while resisting a system designed to promote scientific honesty and feedback. Dr Jeffries suffered culture shock (and a blow to his idealism), and I experienced reality shock. Wow! Why not study doctors as a tribe?

Thus began a 35-year expedition into the private realms of physician culture, particularly inter-physician abuse and rampant dehumanization, along with the resulting economic, social, and emotional costs to doctors, the profession of medicine, and patients.

I began my pilot anthropological research at the Geisinger Medical Center, Danville, Pennsylvania, in 1972. That led me to approach 60 sites, in each of which a local physician expressed an interest in supporting the study of physician resistance to change. After a year and a half of searching, however, only one community, in Maine, opened its doors. It had three groups of "natives": government physicians, community physicians, and residents in a fledgling family medicine residency. The resulting two-year anthropological study became my doctoral dissertation: "Culture and Revitalization." What started as an analysis of medical subcultures reacting to change disclosed severe stressors: depression, isolation, dysfunctional communication, perverted competitiveness, alcoholism (and other -isms), family disharmony, and witnessing attempts at suicide and homicide. Why did these problems stay hidden and why did no one openly assist physicians who were silently screaming and obviously suffering?

The dissertation led to two more two-year field studies: one in Mississippi studying family physicians and residents in 1975, and the other at Duke Medical Center trying to study residency stress and coping in internal medicine residents in 1977-79. The field study at Duke changed me permanently because of deep friendships with several wise physicians concerned about the effectiveness of physician training and its abusive initiation rituals. These physicians included now deceased Drs William DeMaria, George Baylin, and William Stead, Jr. With the advice of about a dozen other North Carolina physicians, especially the former chief resident in radiology at Duke, Dr Jeffrey Blum, of Concord, North Carolina, the idea for a center was conceived. This core group visualized a national center concerned with preventing distress and promoting health among physicians and others in the healing professions. Each of them pushed me to leave research and commit to action. Little did I know I would become a full-time physician advocate—protecting patients from harm and bolstering the fallen nobility of medicine.

Creating a Center: A Challenging Dream

The conceptual thesis for founding what became the Center for Professional Well-Being was simple. Physicians remain energized for a lifetime of providing care and hope to their patients, their family, and their profession if they are committed to their own well-being. Society and the profession lose if they are deficient in self-care.

In 1979, modest start-up funds came from the CCB; Dr Blum; the Commonwealth Foundation (via Dr Stead's support); Dr DeMaria, medical director of Blue Cross Blue Shield; and volunteers. I became the acting director with hopes of a salary. Initially, requests for help came from medical students and residents wanting to cope better with unrealistic demands,

emotionally depleting incidents, perfectionistic training, and similar challenges. Presentations led to requests for advice and counseling, but selling the idea of presentations on preventing distress for health professionals was an almost insurmountable task. Dissent came from every front. Medical organizations felt the topic was inappropriate or unpleasant or "did not exist in their house." Pharmaceutical companies did not want their names associated with negative topics. Insurance carriers wanted data to prove preventive tools were effective. Medical boards were not committed to preventive education programs for their licensees. Denial, devaluation, and rejection were and still are pervasive.

Even when presentations occurred, for every 50 or so presentations there was only one request for help from a practice—rarely, however, was the request for preventive help, and it would come just as the practice was close to divorce through internal litigation or dissolution. As I and other associates wrote more articles and received television exposure (various news and talk shows), a movement toward recognition of the problem began. Recovering physicians were particularly important in removing some of the stigma and establishing assistance programs for colleagues in need of help from drug abuse or alcoholism.

Concerns for other health professionals, like pharmacists, dentists, veterinarians, and mental health providers (particularly psychiatrists) also grew, but interest and support were almost nonexistent. At one time, the Center had a volunteer nurse trying to establish a nurse well-being division. She was never able to become a full-time advocate for nurse well-being in the U.S., and after five years of effort she gave up. Even 25 years later, advocacy for distress prevention and assistance for other helping professions is still in its infancy.

A highlight of this period was the publication of my *Freedom from Stress for Pharmacists,* distributed by the American Pharmaceutical Association, as well as pieces on nursing distress, residency coping, and coping in medical school (*Beyond Survival*, 1980, published by the American Medical Association).

Publications from the Center on physician stress stimulated more understanding by outside media and physicians began to be seen as human rather than arrogant or alcoholic. The Center's educational objective was, and is, *physicians (and other professionals) are persons first, with medicine as their special interest.* Two videotapes on physician stress were done for a pharmaceutical company but never released because the marketing directors changed their minds after the productions were completed. Center associates came and went, but support was ephemeral or unpredictable. Invitations to offer grand rounds at medical centers were increasing, but follow-up to actually develop interventions were rare.

Denial appeared to increase dramatically as one approached academic centers. Every offered opportunity to conduct a retreat for academic deans or a presentation on faculty burnout was cancelled with comments like: "limited resources" or "(we) can deal with it." Counseling individual physicians for career burnout and stress (with the doctor as "problem" patient) remained our primary service. Unfortunately, the contribution of the practice, the surrounding system, or the chaos of the delivery model to the problem was minimized or ignored. Funds to defray costs were rarely available from the practice and it was assumed to be the doctor's problem. Small inroads have been made into this mindset and there has been a gradual increase in requests for retreats. In hindsight, it is noteworthy how many retreats were late-stage band-aids prior to practice dissolution. Aggregating some of our observations from those retreats, I wrote an article in 2005: "The Danger of a Dysfunctional Medical Practice" (*Family Practice Management*, May 2005).

Moving Ahead: Striving for Change

In the early 1980s, the Center developed a novel method of intervention incorporating assessment and practice-changing methods. We likened the approach to surgery: brief, intense, and concrete. Physicians came to the Center for one, two, or three days, usually with their spouse/partner, and met with me and one other associate. The associates were often other physicians or an experienced family therapist, or sometimes both. We decided on a behavioral and not a medical approach to reduce stigma and vulnerability. If our assessment, plan, and interventions were realistic, then positive change ensued. What mattered was not a diagnosis but successful change. Sometimes it became clear that medical assessments were necessary and these were discussed or "mandated" as part of the treatment plan. Hundreds of physicians have now been seen at the Center with successful outcomes.

"Counseling individual physicians for career burnout and stress (with the doctor as 'problem' patient) remained our primary service"

The Center's structure as a non-profit educational and coaching group, using a core staff and ad hoc associates for counseling, promotes openness to change. Volunteers have also been very useful in raising awareness, fund-raising, soliciting presentations, peer counseling, computer assistance, and editing. Infrequent donations to the non-profit Center have been used mostly for continuing operating expenses, scholarships to students/clients, and for presentations where funds are unavailable. Calls received are usually requests for resources, treatment referrals (particularly addiction centers), and crisis interventions—for example: spouses in abusive relationships (physician and non-physician), unbearable practice situations, intense self-loathing, and the impact of isolation in rural practice settings.

I have never forgotten pleading requests to give a grand rounds "healing" presentation after successful deaths by suicide—six or more physicians at three elite training institutions. After the presentations, further

requests to design preventive systems were not received. Even as simple a change as incorporating psychological autopsies into a feedback system to learn from the suicides has not yet occurred. Cynically, I feel the physician is simply viewed as a commodity, not as a vital human resource. So far, attempts to train "attendings" as peer counselors to prevent suicidal trajectories have been rebuffed by many institutions.

Recent publicity given the Center's work in better management of grief syndromes (burnout), disruptive behavior, and litigation stress has given new impetus to our efforts in spite of organizational/institutional and collegial avoidance. And we understand the public and the media do not realize the dilemmas facing professionals. If they did understand, would that help increase philanthropic and other financial support for proven efforts to address and change the predictable human costs of medical practice?

We do take pleasure in praising the cooperative work of assistance programs for physicians and other professionals to advocate for those in need of help. When we began the Center, there were only a handful of physician health programs and they were exclusively concerned with alcoholism and addiction. Currently, some of these programs also deal with occupational and litigation stress, aging, and disabilities. Much work is still needed to deal with factors promoting disruptive behavior, litigation stress, dysfunctional work environments, and disabling conditions.

"We understand the public and the media do not realize the dilemmas facing professionals"

Recently, we had a case of a department chairman asking for help with his "depression and rage." Seeking that help, he was told he would be out on extended leave and if anything went wrong when he returned he would be removed. This inexcusable response was given even though he had led in developing an assistance program for his practice. The Center assisted him and suggested a medical work-up, resulting in discovery of a terminal tumor. He was offered no financial or social support by his own practice.

We were pleased when another practice contracted with us for a preventive program, including limited sessions for each partner to confidentially deal with professional stress. But the program was rescinded by a new managing partner who, it was alleged, was himself severely disruptive. The new partner stopped the assistance program, according to his partners, because they would be supported in confronting his behavior. Given professional reluctance to seek help through employee assistance programs or with local mental health professionals, the need for confidential, behaviorally-oriented counseling is significant.

Looking Forward: It's Only the Start

New issues continue to arise: the shock of reality as professionals become employees; the impact of "sham" peer review; the inability to keep up with cascading information; the bureaucratic mandating of policies without resource allocation; and an epidemic of "writing up" Code White Coat (disruptive) doctors. We also expect productivity pressures, with mandated electronic medical records, to stress providers.

As a Center, we hope to teach professionals that unified standards of professionalism will help their patients as well as their own self-care. As we add associates specializing in organizational development, partner counseling, and assertive communication and negotiation skills, we hope to continue our efforts in offering a life-skills curriculum for physicians. Even as seemingly simple an intervention as teaching physicians to manage disagreement dramatically reduces anxiety and fear. Learning to manage anger or frustration without casting blame also reduces stress.

Great success has been achieved by support programs set up by physician organizations for those suffering from alcoholism and addictions, but the continuing struggles of physicians coping with stress, burnout, isolation, and unrealistic expectations are inadequately addressed. Career crises at the individual and at the practice level need help both at the early and late stages of stress. Dilemmas of personal and professional balance cause inordinate pain yet receive minimal assistance. The toll of perfectionism with resultant losses—of family, self-esteem, and even practice freedom—silently cry for management skills. The physician now in the role of an employee faces an enormous potential for abuse—who is going to let our physicians know about the shock of that reality? The Center is taking an activist role—helping those who reach out for help and pushing against the grain to transcend denial. I guess what some have said may well be true, the Center is: "America's most unusual non-profit."

Caring for physicians and other helping professionals is good for our society—we know it, the professions know it, and society knows it. The issue is turning that knowledge into action.

The CPWB is located in Durham, NC. Telephone (919) 489-9167; e-mail *cpwb@mindspring.com*.

NC Guideline for Management of CA-MRSA Revised

The "North Carolina Consensus Guideline for Management of Suspected Community-Acquired Staphylococcus aureus (CA-MRSA) Skin and Soft Tissue Infections (SSTIs)," published in *Forum* #1, 2006, and updated in *Forum* #2, 2006, was revised in March 2007. The revised version appears at *http://www.unc.edu/depts/spice/CA-MRSA.html*. Changes are related to clinical presentation, risk factors, and patient education. Questions may be directed to Karen Hoffmann, Associate Director, Statewide Program for Infection Control and Epidemiology (SPICE) at: *khoffman@med.unc.edu*.

Emphasis on Clinical Skills Continues to Grow

Since its implementation into Step 2 of the United States Medical Licensing Examination in 2004, the clinical skills examination (Step 2 CS) has been one of several forces working to strengthen the teaching and assessment of physician-patient relationship skills. The new licensing requirement, coupled with initiatives such as the Accreditation Council for Graduate Medical Education's inclusion of interpersonal and communication skills in its list of core competencies and the National Board of Osteopathic Medical Examiners' COMLEX-USA Level 2 Performance Evaluation, have put a spotlight on how important clinical and communication skills are to quality patient care.

"As a result, more medical schools have clinical skills centers and provide formal programs in communication skills and doctor-patient relationships," said Ann Jobe, executive director of Clinical Skills Evaluation Collaboration (CSEC), a joint collaboration between the Educational Commission for Foreign Medical Graduates and the National Board of Medical Examiners.

Putting Greater Focus on Clinical Skills

Several studies have verified the impact the new licensing requirement is having on medical education.

- A survey of medical school curriculum deans published in the October 2005 supplement of *Academic Medicine* found that 84 percent of respondents conducted a comprehensive clinical skills assessment during the third or fourth year of medical school. Of these schools, 32 percent had launched their programs within the last three years. In addition, two-thirds of respondents reported that the new standardized patient licensing requirement elevated the importance of in-house clinical skills examinations.
- According to a survey published in the January 2005 issue of the *Journal of the American Medical Association (JAMA)*, 55 medical schools made curriculum modifications to specifically address clinical skills training as a result of the new Step 2 CS. Twenty-six schools made changes to their physical facilities to accommodate clinical skills training.

"Our results demonstrate that the majority of medical schools nationally have implemented comprehensive clinical skills assessments using standardized patients during the third and fourth years of medical school, and that curriculum deans view the USMLE Step 2 CS requirement as a motivator to enhance in-house clinical skills assessments," stated the *Academic Medicine* survey.

The impact becomes even clearer when the results of earlier studies are added to the picture. For example, in an earlier survey cited by the Federation of State Medical Boards in a 2000 position paper titled "In Support of Adding a Clinical Skills Examination Using Standardized Patients to the USMLE," only 56 percent of the 125 MD-producing medical schools employed standardized patients for clinical skills training. A clinical skills field trial survey, conducted before the new licensing requirement was implemented, indicated 20 percent of fourth-year students had been observed interacting with a patient by a faculty member two or fewer times. One in 25 indicated never having been observed by a faculty member.

Ensuring Competence

The Step 2 Committee of the USMLE oversees Step 2 CS. It is the committee's responsibility to make sure that the examination assesses the minimum level of competence in clinical and communication skills required for physicians to enter graduate medical education.

The examination focuses on clinical presentations that are common to patient care under supervision. During an eight-hour period, candidates spend 15 minutes with each of 11 to 12 "standardized patients" — gathering patient histories and performing a focused physical exam. Candidates must summarize the pertinent history, physical findings and diagnostic impressions and outline plans for further evaluation if necessary.

In the June 2004 to 2005 period — the first period in which the Step 2 CS was administered — the passing rate for U.S. and Canadian medical graduates was 96 percent. The passing rate for foreign medical graduates was 83 percent. The scores for both groups are in line with the scores on other sections of the licensing exam.

"Curriculum deans view the USMLE Step 2 CS requirement as a motivator to enhance in-house clinical skills assessments"

Improving the Quality of Health Care

While medical schools and physicians are paying greater attention to how to communicate with and treat patients, it's difficult to directly measure the impact this increased focus is having on the quality of health care. Intuitively, assessing the clinical and communications skills of medical school students and graduates as part of the medical education and licensing process should result in improved skills being carried over into the practice of medicine. Research substantiating this presumption can be expected. For example, Canada implemented a clinical skills component to its licensing process in 1992. Studies published in *JAMA* during 1998 and 2002 detailed a positive correlation between performance on a licensing exam and subsequent patterns of behavior/treatment in physicians' practice.

"The clinical skills that are taught and tested will be incorporated into the routines of most graduates as they move on in their education," says Jobe. "As those skills become routine, I believe it will result in better communication in the practice of medicine."

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NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

November—December 2006—January 2007

DEFINITIONS:

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

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

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

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

Dismissal:
Board action dismissing a contested case.

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

NA:
Information not available or not applicable.

NCPHP:
North Carolina Physicians Health Program.

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

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

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

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

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

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

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

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

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

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

ANNULMENTS
NONE

REVOCATIONS

STROUD, Joan Marie, Physician Assistant
Location: Gastonia, NC (Gaston Co) | DOB: 4/24/1956
License #: 0001-01476
PA Education: Pennsylvania State University (1980)
Cause: Ms Stroud violated her Consent Order of November 2003 and has a history of substance abuse.
Action: 9/18/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 4/12/2006: Ms Stroud's North Carolina PA license is revoked.

REEVES, Donna Faye, Physician Assistant
Location: Sparta, NC (Alleghany Co) | DOB: 11/28/1955
License #: 0001-01196
PA Education: Bowman Gray (1989)
Cause: Ms Reeves, who voluntarily surrendered her license in January 2005, has been convicted of a felony related to possession and distribution of controlled substances.
Action: 12/15/2006. Entry of Revocation issued: Ms Reeves' North Carolina PA license is revoked by operation of law as of 12/12/2006.

SUSPENSIONS

WILLIAMS, Cleveland, MD
Location: Washington, DC | DOB: 6/20/1949
License #: 0095-00287 | Specialty: PH/LM (as reported by physician)
Medical Ed: University of Florida (1977)
Cause: Dr Williams was denied a license by Florida in April 2005 based on his failing to disclose material facts on his application form and on multiple disciplinary proceedings against his medical licenses in other states.
Action: 10/26/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/18/2006: Dr Williams' North Carolina medical license is suspended indefinitely.

See Consent Orders:
HANEY, Douglas Jeffrey, Physician Assistant
LOZANO, Joseph John, MD
McMANUS, Shea Eamonn, MD
MERCIER, Randall Robert, MD
RUSSELL, Anthony Otis, MD
WEED, Barry Christopher, MD

SUMMARY SUSPENSIONS

ADKINS, Paula Clark, MD
Location: South Charleston, WV | DOB: 11/26/1965
License #: 0099-00745 | Specialty: EM (as reported by physician)
Medical Ed: Marshall University School of Medicine (1996)
Cause: The Board is informed Dr Adkins recently tested positive for opiates. She has a criminal history that includes the commission of crimes involving deception and fraud related to her substance abuse. She is unsafe to practice medicine with reasonable skill and safety. Specifics are contained in the Charges and Allegations dated 12/21/2006.
Action: 12/21/2006. Order of Summary Suspension of License executed: Dr Adkins' North Carolina medical license is suspended.

CONSENT ORDERS

AHMAD, Nasiha, MD
Location: Carrollton, TX | DOB: 3/15/1947
License #: 0000-28916 | Specialty: OB/GYN (as reported by physician)
Medical Ed: Dacca, Bangladesh (1970)
Cause: In April 2006, Texas took action against Dr Ahmad via a Consent Order requiring her to take a course on ethics and to pay a fine of $1,000 for failing to disclose her complete hospital practice history in her medical practice questionnaire. She has now obtained the required CME.
Action: 11/07/2006. Non-Disciplinary Consent Order executed: Dr Ahmad shall send the Board proof of having done her required CME.

BODINE, Victoria Lee, Physician Assistant
Location: Wilmington, NC (New Hanover Co) | DOB: 2/12/1982
License #: NA
PA Education: Marywood University (2003)
Cause: Having approved Ms Bodine's request in early 2006 for a Reentry Agreement for a PA license, the Board sent her an Agreement to sign. She never responded and the Board, in turn, denied her application. She appealed later, saying she had been pregnant and decided to wait until after her child was born to begin work. Therefore, she did not believe she had to sign the Agreement so soon. She admits she should have responded to the Board in any case.
Action: 12/21/2006. Non-Disciplinary Consent Order executed: The previous denial of Ms Bodine's application is vacated and she shall be granted a PA license via a Reentry Agreement.

CLARKE, Theresa Sharon, Physician Assistant
Location: Raleigh, NC (Wake Co) | DOB: 1/15/1959
License #: 0001-03209
PA Education: Cornell Medical School (1994)
Cause: In March 2006, the Board learned Ms Clarke had been discharged from her position and failed to complete certain patient charts following her dismissal. In June 2006, the Board reviewed her medical records for five patient and found she failed to maintain adequate records.
Action: 1/23/2007. Consent Order executed: Ms Clarke is reprimanded; she shall strictly comply with the Board's Position Statement on Medical Record Documentation; within six months, she shall attend an acceptable records training course and provide proof of satisfactory completion of the course; must comply with other requirements.

CLAY, Denise Elaine, MD
Location: Pembroke Pines, FL | DOB: 2/03/1957
License #: 2003-00576 | Specialty: IM/EM (as reported by physician)
Medical Ed: Marshall University (1983)
Cause: In February 2006, Florida fined Dr Clay $10,000, set a community service and CME requirement for her, and issued her a letter of concern for failing to practice medicine with the necessary level of skill and care in treating a patient who later died of decubitus ulcer sepsis. She did not admit or deny the allegations.
Action: 11/01/2006. Consent Order executed: Dr Clay is reprimanded; she shall comply with all the terms and conditions of the Florida order of February 2006; must comply with other conditions.

FINK, Burton Merrill, MD
Location: Hot Springs, NC (Madison Co) | DOB: 5/06/1942
License #: 2006-01790 | Specialty: US (as reported by physician)
Medical Ed: New York Medical College (1971)
Cause: On application for license. In May 1994, Michigan took action against Dr Fink via a Consent Order reprimanding and fining him on allegations regarding his management of a prostate cancer patient in 1988. He did not admit the truth of the allegations, but accepted the Consent Order.
Action: 11/07/2006. Non-Disciplinary Consent Order executed: Dr Fink is issued a North Carolina medical license.

FOULKS, Carl Alvin, MD
Location: Fayetteville, NC (Cumberland Co) | DOB: 6/10/1947
License #: 0000-23526 | Specialty: IM/ADDM (as reported by physician)
Medical Ed: Howard University (1976)
Cause: The Board was informed that Dr Foulks failed to provide adequate advance notice of his retirement and closing of his practice to provide continuity of care to his patients and that he failed to inform patients how to obtain their medical records. He contends he posted a notice in his office about his intentions to close during his last year of practice, but two patients complained they received no notice. He attempted to inform patients how to obtain records by way of a voice message on his phone and a notice in the local newspaper. He also referred former patients to another physician by way of a message on his phone. He did not mail letters to current patients. He has now allowed his license to become inactive.
Action: 11/20/2006. Non-Disciplinary Consent Order executed: Dr Foulks shall put in place contact information for patients to call to obtain records and shall promptly respond to all such requests; a notice with such information will be placed at his former office for six months or placed in the local newspaper; he shall keep the Board informed of any changes in his address or phone number; should he apply for reactivation of his license, all the issues noted herein will be considered.

GALYON, Ronald Curtis, MD
Location: Virginia Beach, VA | DOB: 8/12/1953
License #: 2003-01531 | Specialty: OS (as reported by physician)
Medical Ed: Eastern Virginia Medical School (1986)
Cause: Request for amended Consent Order.
Action: 1/23/2007. Amended Consent Order executed: The numbered paragraphs of Dr Galyon's Consent Order of 12/18/2003 are no longer in effect; prior to resuming practice in North Carolina, however, he must obtain site approval from the president of the Board, meet with the Board, and complete a program of reentry.

GHEN, Mitchell Joseph, DO
Location: Landrum, SC | DOB: 2/19/1950
License #: 0098-00252 | Specialty: FP/N (as reported by physician)
Medical Ed: Philadelphia College of Osteopathy (1980)
Cause: In April 2004, Dr Ghen's North Carolina license became inactive at his request. In 2004 and 2005, ultra-

sounds performed by technicians of a Florida diagnostics company for a North Carolina practicing physician were sent to Dr Ghen for interpretation at a time he did not have an active North Carolina license. He contends he did not intend to violate the rule or law by this alleged conduct. The Board holds that interpreting ultrasounds on behalf of North Carolina residents is the practice of medicine and Dr Ghen's action was unprofessional conduct. There was no allegation of patient harm and no patient complaint was generated. Dr Ghen neither admits nor denies the allegations.

Action: 11/15/2006. Consent Order executed: Dr Ghen is reprimanded.

HANEY, Douglas Jeffrey, Physician Assistant

Location: Wilson, NC (Wilson Co) | DOB: 6/19/1961
License #: 0001-01569
PA Education: Alderson-Broaddus (1984)
Cause: Mr Haney gave a patient an antibiotic to which the patient was allergic. The result was the death of the patient. The Board recognizes factors beyond Mr Haney's control, including system errors, contributed to the patient being inappropriately treated. (Mr Haney contended the allergy was not noted on the nurse's assessment of the patient and that records from an ER visit two days before could not be located.)
Action: 11/17/2006. Consent Order executed: Mr Haney's license is suspended for 60 days, suspension being stayed subject to probationary terms and conditions; he must attend 10 hours of CME on risk management and must provide the Board a description of changes in his practice designed to avoid such problems in future; he shall be prepared to discuss with the Board the changes he has made and their effectiveness.

JUSTICE, Brenda Jean, Physician Assistant

Location: Fayetteville, NC (Cumberland Co) | DOB: 10/02/1970
License #: 0001-01923
PA Education: Alderson-Broaddus (1992)
Cause: Ms Justice has had several health-related issues beginning in 2005; in April 2006, her license became inactive after she failed to submit her annual registration. She has applied for reinstatement.
Action: 12/13/2006. Consent Order executed: Ms Justice is issued a PA license under terms and conditions; unless lawfully prescribed by someone else, she shall refrain from the use of mind-or mood-altering substances and shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, she shall supply bodily fluids or tissues to allow screening for use of such substances; she shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

LASSITER, Alan Kent, MD

Location: Raleigh, NC (Wake Co) | DOB: 7/09/1956
License #: 2007-00151 | Specialty: Admin Med/ PD (as reported by physician)
Medical Ed: University of Texas, Galveston (1981)
Cause: On application for licensure. Dr Lassiter has been president and CEO of several medical business consulting firms since 2001. He has not been involved in clinical practice. He has no plans to practice clinical medicine at present.
Action: 1/22/2007. Consent Order executed: Dr Lassiter is granted an administrative license limited to administrative medicine and not to include clinical practice; should he plan to resume clinical practice, he must obtain approval of a plan to update his skills and approval of the practice site by the president of the Board.

LOZANO, Joseph John, MD

Location: Pisgah Forest, NC (Transylvania Co) | DOB: 2/03/1957
License #: 2001-01239 | Specialty: IM/PD (as reported by physician)
Medical Ed: Saba University (1977)
Cause: In 2004, Dr Lozano issued prescriptions for controlled substances for Patient A and her husband, Patient B, without keeping an adequate record of the same. He also engaged in unprofessional conduct with Patient A, violating patient-physician boundaries.
Action: 12/07/2006. Consent Order executed: Dr Lozano's license is suspended for 12 months; suspension is stayed after 14 days on probationary terms and conditions; he shall attend the Vanderbilt course on proper boundaries; he shall comply with the Board's position statements on "Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist" and on "Medical Record Documentation"; he shall be assessed by the NCPHP and abide by its recommendations; must comply with other requirements.

McMANUS, Shea Eamonn, MD

Location: Wilmington, NC (New Hanover Co) | DOB: 11/04/1965
License #: 0097-01056 | Specialty: IM (as reported by physician)
Medical Ed: Tulane University (1994)
Cause: Dr McManus has a recent history of alcohol and substance abuse. New Hanover Regional Medical Center changed his staff privileges in October 2006 and the Board learned from Dr McManus that he underwent 14 weeks of inpatient treatment for alcohol and drug addiction beginning in August 2006. He has remained alcohol and drug-free since then.
Action: 1/21/2007. Consent Order executed: Dr McManus' North Carolina medical license is indefinitely suspended.

MERCIER, Randall Robert, MD

Location: Pinehurst, NC (Moore Co) | DOB: 12/06/1953
License #: 0000-26898 | Specialty: IM/SM (as reported by the physician)
Medical Ed: Tulane (1980)
Cause: In 2004, Dr Mercier and a patient of his formed a strong emotional attachment and began a relationship going beyond the appropriate boundaries. He also continued to treat and prescribe a controlled substance for her. In 2005, he left his practice, suffering from bipolar disorder. In October 2005, the Board summarily suspended his license. He has entered a contract with the NCPHP and is complying with it.
Action: 11/17/2006. Consent Order executed: Dr Mercier's North Carolina medical license is suspended indefinitely effective 10/25/2005.

OH, John Namki, MD

Location: Raleigh, NC (Wake Co) | DOB: 2/11/1968
License #: 2001-00753 | Specialty: PM (as reported by physician)
Medical Ed: Temple University (1994)
Cause: On license application. Dr Oh's previous North Carolina medical license became inactive in 2005. He has at-

tended Duke University to pursue a masters in business administration and intends to follow a career with a pharmaceutical company. He does not intend to return to clinical practice at this time.

Action: Consent Order executed: Dr Oh is issued a limited administrative license that does not allow him to engage in clinical practice; should he ever plan to resume clinical practice, he must update his skills and seek practice site approval from the president of the Board, which the president is not obliged to give.

POLLEY, Dennis Charles, DO

Location: Wilson, NC (Wilson Co) | DOB: 4/14/1951
License #: 0000-27881 | Specialty: D (as reported by physician)
Medical Ed: Iowa College of Osteopathic Medicine (1979)
Cause: In September 2005, Dr Polley performed an examination of a female patient and made an inappropriate sexual comment to her. He contends the comment was intended to convey clinical information and put the patient at ease, but understands it could have been misinterpreted.
Action: 10/18/2006. Consent Order executed: Dr Polley is reprimanded for engaging in a boundary violation; he shall ensure the presence of a female chaperone during examinations of female patients who are unclothed or whose breasts or genitals are to be examined; he shall complete CME on boundary violations and must comply with other related requirements.

ROGERS, Melissa Quader, Physician Assistant

Location: Clayton, NC (Johnston Co) | DOB: 11/21/1969
License #: 0010-00739
PA Education: Gannon University (1991)
Cause: On license application. Ms Rogers and the Florida Board entered a Consent Agreement in 2001 to resolve allegations she ordered a patient receive an NSAID without first reviewing the patient's record, which showed he was allergic to the drug. She quickly discovered the error and took measures to prevent permanent harm to the patient. She received a Letter of Concern from the Board, paid a fine of $2,000 and costs of $869.46. She also agreed to attend five hours of CME in risk management. She met with the North Carolina Board and has taken steps to prevent the recurrence of such an incident.
Action: 11/21/2006. Non-Disciplinary Consent Order executed: Ms Rogers is issued a North Carolina PA license.

ROSS, Robert Edward, Jr, MD

Location: Hendersonville, NC (Henderson Co) | DOB: 9/22/1963
License #: 2001-01488 | Specialty: FP/OB/GYN (as reported by physician)
Medical Ed: University of Mississippi (2000)
Cause: Dr Ross had some issues with the Tennessee Board relating to substance abuse and to competency during residency. He was required to enter a five-year agreement with the Tennessee Medical Foundation in February 2006 when the Tennessee Board issued him a license. He self-referred to the NCPHP in 2004 and the NCPHP reports he has been compliant.
Action: 1/22/2007. Non-Disciplinary Consent Order executed: Dr Ross shall maintain and abide by an NCPHP contract; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; must comply with other requirements.

RUSSELL, Anthony Otis, MD

Location: High Point, NC (Guilford Co) | DOB: 5/07/1961
License #: 0000-35491 | Specialty: AN/APN (as reported by physician)
Medical Ed: New York University (1987)
Cause: Dr Russell was arrested in July 2006 in High Point and charged with three felonies: possession of Schedule II anabolic steroids, possession of precursor chemicals for methamphetamine, and possession of precursor chemicals with intent to manufacture methamphetamine. He voluntarily surrendered his medical license on July 5, 200. He is a participant in the NCPHP and is reported to be compliant. He has entered a deferred prosecution agreement with the Guilford County District Attorney's office for one year and is to be compliant with his NCPHP contract and this Consent Order. The District Attorney has agreed to give him credit for the counseling and therapy he has completed since his license surrender.
Action: 1/18/2007. Consent Order executed: Dr Russell's medical license is indefinitely suspended and he shall not reapply for at least one year from the date of his license surrender.

SEBHAT, Berhan, MD

Location: Durham, NC (Durham Co) | DOB: 10/22/1966
License #: 2001-01395 | Specialty: IM (as reported by physician)
Medical Ed: Medical College of Ohio (1998)
Cause: Dr Sebhat has been diagnosed as alcohol dependent.
Action: 10/18/2006. Non-Disciplinary Consent Order executed: Dr Sebhat shall refrain from the use or possession of alcohol; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of alcohol; he shall maintain and abide by a contract with the NCPHP.

SOFFA, David Jack, MD

Location: Deerfield, IL | DOB: 1/14/1944
License #: 2006-01981 | Specialty: R (as reported by physician)
Medical Ed: University of Michigan Medical School (1968)
Cause: On application for a license. Dr Soffa wishes to function in a specific administrative capacity only and does not intend to practice clinical medicine.
Action: 12/19/2006. Consent Order executed: Dr Soffa is granted a limited administrative license; prior to engaging in clinical practice, he must obtain approval by the president of the Board, which the president is not obliged to grant.

UMESI, Joseph Jack, MD

Location: Angier, NC (Wake Co) | DOB: 10/01/1958
License #: 2004-00427 | Specialty: FP (as reported by physician)
Medical Ed: East Carolina University School of Medicine (2000)
Cause: The Board has identified concerns regarding Dr Umesi's ability to practice obstetrics. It has also identified other concerns regard his practice that need attention. He reports he no longer practices obstetrics.
Action: 1/30/2007. Non-Disciplinary Consent Order executed: Before resuming practice of obstetrics, he must get Board approval; his practice shall be observed by a physician colleague for six months and that physician

shall report to the Board after three months and after six months concerning Dr Umesi's clinical skills; he shall meet with members of the Board as requested.

WASHINGTON, Clarence Joseph, III, MD
Location: Fayetteville, NC (Cumberland Co) | DOB: 1/11/1947
License #: 0000-32295 | Specialty: GYN (as reported by physician)
Medical Ed: University of Michigan (1974)
Cause: Reinstatement of license, which he failed to register in a timely way and which was declared inactive as of 4/14/2006.
Action: 11/28/2006. Non-Disciplinary Consent Order: No disciplinary action is imposed; Dr Washington's license is reinstated effective 11/28/2006.

WEED, Barry Christopher, MD
Location: Raleigh, NC (Wake Co) | DOB: 7/06/1969
License #: 2002-00625 | Specialty: P (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1998)
Cause: Dr Weed has a history of alcoholism and abusing other substances. He entered the NCPHP after graduation from medical school and was reported to be compliant with that program. However, beginning in 2002, he began to believe he could drink in moderation. In 2005, he had a single-vehicle accident and was charged with DWI. He disclosed this incident on his 2006 registration, but a criminal record check found he had not disclosed certain misdemeanor convictions on his license application. He said he did not believe he had to report those events because they happened when he was a teenager. He entered inpatient treatment for his abuse problem in June 2006 and reports he successfully completed treatment. He surrendered his license in November 2006.
Action: 1/18/2007. Consent Order executed: Dr Weed's medical license is suspended indefinitely effective November 27, 2006.

WESSEL, Richard Frederick, MD
Location: Coinjock, NC (Currituck Co) | DOB: 1/24/1959
License #: 0096-00772 | Specialty: C/IM (as reported by physician)
Medical Ed: Eastern Virginia Medical School (1990)
Cause: On application for a license. Dr Wessel surrendered his North Carolina license in April 2004. Under a Consent Order of October 2005, his North Carolina license was suspended based on inappropriate prescribing and for testing positive for cocaine and hydrocodone. He reports he has maintained sobriety since June 2005. He has not practiced since April 2004.
Action: 11/01/2006. Consent Order executed: Dr Wessel is issued a license to expire on the date shown on the license; he shall have a physician colleague observe his practice for six months and report in detail to the Board on his performance within the first 60 days of Dr Wessel's practice and each month following; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other requirements.

WHITE, Steven William, Physician Assistant
Location: Fayetteville, NC (Cumberland Co) | DOB: 12/19/1962
License #: 0001-02116
PA Education: Midwestern University (1996)
Cause: Request for amended Consent Order.
Action: 1/31/2007. Amended Consent Order executed: Mr White is issued a temporary/dated license to expire on the date shown on the license [7/31/21007]; his supervising or back-up supervising physician must be on-site not less than 10 full work days a month; must comply with other conditions.

WINGFIELD, Thomas Whetsell, MD
Location: Gastonia, NC (Gaston Co) | DOB: 1/10/1939
License #: 0000-17744 | Specialty: AN (as reported by physician)
Medical Ed: University of Maryland (1965)
Cause: In 2006, Dr Wingfield prescribed drugs to a close friend who was not his patient, did not document the precriptions, and did not discuss the person's treatment with the treating physician. Also in 2006, he prescribed drugs to a close relative without documentation.
Action: 1/16/2007. Consent Order executed: Dr Wingfield is reprimanded; must comply with the Board's position statement on Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist.

MISCELLANEOUS ACTIONS

DONALDSON, Brian Robert, MD
Location: Healdsburg, CA | DOB: 12/22/1947
License #: 0000-23692 | Specialty: EM/FP (as reported by physician)
Medical Ed: Stanford University (1974)
Cause: In an agreement with the Alaska Board, Dr Donaldson accepted certain terms and conditions based on the allegation, which he denied, that he had made inappropriate remarks to a female patient and that, over time, he exhibited irregular and delusional thought patterns. He was required to undergo mental evaluation, after which medication was prescribed and he entered therapeutic treatment. Appropriate conditions were placed on his practice.
Action: 11/08/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/18/2006: Dr Donaldson is reprimanded.

MOORE, James Tracey, MD
Location: Daytona Beach, FL | DOB: 2/25/1945
License #: 0000-19265 | Specialty: P (as reported by physician)
Medical Ed: University of Missouri, Columbia (1971)
Cause: In February 2006, the Florida Board, among other things, assessed Dr Moore a fine of $5,000, required his taking of a record-keeping course, and issued him a letter of concern about his failure to practice with reasonable skill and care in the case of a patient for whom he ordered a drug to which the patient had said she was allergic. Dr Moore did not admit or deny the allegations.
Action: 12/18/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/18/2006: Dr Donaldson is reprimanded.

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

DENIALS OF LICENSE/APPROVAL

BAHADORI, Reza, MD
Location: Raleigh, NC (Wake Co) | DOB: 5/22/1934
License #: 0000-32463 | Specialty: GYN/FP (as reported by physician)
Medical Ed: University of Tabriz, Iran (1961)
Cause: In a Consent Order of January 2006, Dr Bahadori admitted he asked explicit questions of some female patients that made them feel uncomfortable and were not medically necessary. Expert review of six patient charts also found deficiencies in patient management and record-keeping.
Action: 12/20/2006. Letter issued denying Dr Bahadori's application for reinstatement of his North Carolina medical license. [A hearing on this denial may be requested.]

SURRENDERS

CARBONE, Dominick John, MD
Location: Winston-Salem, NC (Forsyth Co) | DOB: 8/09/1965
License #: 0097-00498 | Specialty: US (as reported by physician)
Medical Ed: University of Michigan (1990)
Action: 1/17/2007. Voluntary surrender of North Carolina medical license.

KELLER, Philip Arthur, Physician Assistant
Location: Currituck, NC (Currituck Co) | DOB: 7/10/1961
License #: 0001-02305
PA Education: Hahnemann University (1985)
Action: 11/29/2006. Voluntary surrender of NC PA license.

GUARINO, Clinton Toms Andrews, MD
Location: Hickory, NC (Catawba Co) | DOB: 2/04/1966
License #: 0099-00062 | Specialty: IM (as reported by physician)
Medical Ed: Wake Forest University School of Medicine (1996)
Action: 12/07/2006. Voluntary surrender of NC medical license.

LOYD, Doyne Whittington, MD
Location: Pickens, SC | DOB: 4/16/1945
License #: 0000-32396 | Specialty: P (as reported by physician)
Medical Ed: University of Arkansas (1976)
Action: 10/20/2006. Voluntary surrender of NC medical license.

STEINER, Drew John, MD
Location: Elkin, NC (Surry Co) | DOB: 12/03/1962
License #: 0099-01479 | Specialty: FP/EM (as reported by physician)
Medical Ed: Georgetown University (1989)
Action: 1/11/2007: Voluntary surrender of North Carolina medical license.

WEED, Barry Christopher, MD
Location: Raleigh, NC (Wake Co) | DOB: 7/06/1969
License #: 2002-00625 | Specialty: P (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1998)
Action: 11/27/2006. Voluntary surrender of NC medical license.

See Consent Orders:

PUBLIC LETTERS OF CONCERN

KONA, John Andrew, MD
Location: Elizabeth City, NC (Pasquotank Co) | DOB: 3/01/1949
License #: 0000-28246 | Specialty: ORS (as reported by physician)
Medical Ed: Eastern Virginia (1981)
Cause: Two DUI charges against Dr Kona, one in 2003 and another in 2005, were dismissed in exchange for his plea of guilty to reckless driving. The Board remained concerned about the underlying conduct. He successfully completed a court approved alcohol treatment program and he signed and is compliant with an NCPHP contract. There is no evidence patient care was ever compromised by his consumption of alcohol in his private life.
Action: 11/17/2006. Public Letter of Concern issued: Dr Kona is admonished and he is encouraged to be more careful and circumspect in future. Any further complaints of this kind may lead to disciplinary proceedings.

McNEAL, JoAnn Erlene, Physician Assistant
Location: Raleigh, NC (Wake Co) | DOB: 10/24/1956
License #: 0010-00807
PA Education: Charles R. Drew University of Med and Science (1983)
Cause: Action was taken in 1987 against Ms McNeal through a Stipulation Settlement with the California Board based on her alteration of the expiration date on her California Interim Approval card in 1985 and her practicing with an expired card for two months. She was placed on probation for three years. She disclosed this information on her application to the North Carolina Medical Board and has had no other actions against her since that time.
Action: 1/02/2007. Public Letter of Concern issued: Ms McNeal is cautioned that a repetition of behavior similar to that that led to the California action may lead to disciplinary proceedings.

STALLINGS, Martin Wade, MD
Location: Kings Mountain, NC (Cleveland Co) | DOB: 6/30/1943
License #: 0000-19089 | Specialty: PD (as reported by physician)
Medical Ed: University of Alabama (1969)
Cause: Writing prescriptions for family members.
Action: 1/30/2007. Public Letter of Concern issued: Dr Stallings is admonished and he is cautioned that repetition of the practice may lead to disciplinary proceedings.

COURT APPEALS/STAYS
NONE

CONSENT ORDERS LIFTED

HOOPER, Jeffrey Curtis, MD
Location: Greensboro, NC (Guilford Co) | DOB: 9/21/1964
License #: 0097-00286 | Specialty: FP (as reported by physician)
Medical Ed: Vanderbilt University School of Medicine (1995)
Action: 12/20/2006. Order issued lifting Consent Order of 10/18/2004

KOMJATHY, Steven Ferenc, MD
Location: Lenexa, KS | DOB: 5/19/1969

License #: 0097-01440 | Specialty: IM/GPM (as reported by physician)
Medical Ed: University of Maryland (1996)
Action: 12/18/2006. Order issued lifting Consent Order of 2/09/2005.

LONGAS, Philip Lee, MD
Location: Lenoir, NC (Caldwell Co) | DOB: 10/19/1964
License #: 2006-00127 | Specialty: IM (as reported by physician)
Medical Ed: East Tennessee State University (1995)
Action: 12/19/2006. Order issued lifting Consent Order of 2/02/2006.

STEPHENS, Kathryn Johnson, MD
Location: Charlotte, NC (Mecklenburg Co) | DOB: 11/11/1952
License #: 0000-23993 | Specialty: OB/GYN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1978)
Action: 12/20/2006. Order issued lifting Consent Order of 10/25/2004.

WHITE, Anne Litton, MD
Location: Winston-Salem, NC (Forsyth) | DOB: 11/23/1954
License #: 0000-29552 | Specialty: FP/Derm (as reported by physician)
Medical Ed: Indiana University (1980)
Action: 12/13/2006. Order issued lifting Consent Orders of 2/16/2005 and 7/22/2005.

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

BARBER, Robert Anthony, DO
Location: Morehead City, NC (Carteret Co) | DOB: 9/30/1954
License #: 2003-00222 | Specialty: FP (as reported by physician)
Medical Ed: Univ of Health Sciences Coll of Osteo Med, Kansas City (1989)
Action: 11/16/2006. Temporary/dated license extended to expire 5/31/2007.

GARDNER, James Eric, MD
Location: Collierville, TN | DOB: 9/18/1970
License #: 2002-00116 | Specialty: VS/GS (as reported by physician)
Medical Ed: University of Tennessee (1996)
Action: 12/19/2006. Temporary/dated license extended to expire 6/19/2007.

HARRIS, John Joel, Jr, MD
Location: Wilmington, NC (New Hanover Co) | DOB: 6/30/1958
License #: 0000-32114 | Specialty: AN (as reported by physician)
Medical Ed: University of Tennessee, Memphis (1984)
Action: 11/16/2006. Temporary/dated license extended to expire 11/30/2007.

KINNALLY, Steven Joseph, Physician Assistant
Location: Wilmington, NC (New Hanover Co) | DOB: 11/11/1952
License #: 0010-00347
PA Education: University of Washington (2001)
Action: 11/16/2006. Temporary/dated license extended to expire 5/31/2007.

LONGAS, Philip Lee, MD
Location: Lenoir, NC (Caldwell Co) | DOB: 10/19/1964
License #: 2006-00127 | Specialty: IM (as reported by physician)
Medical Ed: East Tennessee State University (1995)
Action: 11/16/2006. Full and unrestricted medical license issued.

MORTER, Gregory Alan, MD
Location: Wilmington, NC (New Hanover Co) | DOB: 12/03/1959
License #: 0000-36401 | Specialty: Ped (as reported by physician)
Medical Ed: University of Pittsburgh (1986)
Action: 11/16/2006. Temporary/dated license extended to expire 11/30/2007.

ROGERS, Bruce William, MD
Location: Zebulon, NC (Wake Co) | DOB: 8/11/1947
License #: 0000-32563 | Specialty: FP/EM (as reported by physician)
Medical Ed: Medical College of Pennsylvania (1982)
Action: 11/16/2006: Temporary/dated license extended to expire 1/31/2007.

See Consent Orders:
WESSEL, Richard Frederick, MD
WHITE, Steven William, Physician Assistant

DISMISSALS

ELBAOR, James Edward, MD
Location: Arlington, TX | DOB: 5/08/1944
License #: 0000-21170 | Specialty: ORS/RHU (as reported by physician)
Medical Ed: Loyola University, Stritch School of Medicine (1969)
Action: 8/21/2006. Notice of Dismissal issued: Case arising from Charges of 5/15/2006 is dismissed with prejudice.

KHAN, Ahmed Iqbal, MD
Location: Plano, TX | DOB: 6/13/1946
License #: 0000-38790 | Specialty: VS/GS (as reported by physician)
Medical Ed: Dacca, Bangladash (1972)
Cause: Good cause to dismiss was determined following hearing.
Action: 1/30/2007. Order Dismissing Charges Without Prejudice issued. Charges of 7/13/2006 are dismissed without prejudice.

MASON, Rudolph Amadeus George, MD
Location: Norcross, GA | DOB: 12/10/1965
License #: 2002-00954 | Specialty: FP/SM (as reported by physician)
Medical Ed: Howard University (1994)
Cause: Good cause to dismiss was determined following hearing.
Action: 1/31/2007. Order Dismissing Charges Without Prejudice issued. Charges of 5/30/2006 are dismissed without prejudice.

POLLEY, Dennis Charles, DO
Location: Wilson, NC (Wilson Co) | DOB: 4/14/1951
License #: 0000-27881 | Specialty: D (as reported by physician)
Medical Ed: Iowa College of Osteopathic Medicine (1979)
Action: 11/07/2006. Notice of Dismissal issued: Administrative action against Dr Polley is dismissed

WYBLE, Linda Gilbert, MD
Location: Tampa, FL | DOB: 1/01/1957
License #: 0000-38871 | Specialty: AN (as reported by physician)
Medical Ed: University of Maryland (1982)
Action: 8/21/2006. Notice of Dismissal issued: Case arising from Charges of 5/15/2006 is dismissed with prejudice.

REENTRY AGREEMENTS

BODINE, Victoria Lee, Physician Assistant
Location: Wilmington, NC (New Hanover Co) | DOB: 2/12/1982
License #: NA
PA Education: Marywood University (2003)
Cause: Ms Bodine has never practiced as a PA, though she received her degree in 2003. Her CME is also not up to date.
Action: 12/21/2006. Reentry Agreement executed: Ms Bodine is issued a PA license and shall have her supervising physician observe her practice for 12 months; twice during the observation period, the physician shall report to the Board in detail on Ms Bodine's performance; Ms Bodine shall obtain at least 50 CME hours in her first year; must comply with other requirements.

BYRD, Lelan Clinton, MD
Location: Zirconia, NC (Henderson Co) | DOB: 10/30/1955
License #: 0000-34262 | Specialty: US (as reported by physician)
Medical Ed: Medical College of Georgia (1986)
Cause: Dr Byrd has not been in practice since September 2001.
Action: 1/23/2007. Reentry Agreement executed: Dr Byrd is issued a North Carolina medical license; his practice shall be observed by a physician colleague for 12 months and that physician shall report to the Board after six months and after 12 months concerning Dr Byrd's clinical skills; he shall meet with members of the Board as requested.

KUHL, Lauren Elizabeth, Physician Assistant
Location: Cary, NC (Wake Co) | DOB: 9/25/1967
License #: 0010-00805
PA Education: Yale University School of Medicine (2003)
Cause: Ms Kuhl has not practiced since November 2004.
Action: 1/18/2007. Reentry Agreement executed: Ms Kuhl is issued a North Carolina PA license; her practice shall be observed by her supervising physician for 12 months and that physician shall report to the Board after six months and after 12 months concerning Ms Kuhl's clinical skills; she shall meet with members of the Board as requested.

LEVY, Antoinette Donna-Marie, Physician Assistant
Location: Matthews, NC (Mecklenburg Co) | DOB: 12/18/1965
License #: 0010-00764
PA Education: Antioch College (1989)
Cause: Ms Levy has not practice as a PA since August 2004. She is updating her CME.
Action: 112/14/2006. Reentry Agreement executed: Ms Levy is issued a full PA license; she shall have her supervising physician report to the Board in detail on her performance after a six-month period of observation; she shall meet with the Board as requested to discuss her reentry.

MOGUL, Robin Jean, MD
Location: Charlotte, NC (Mecklenburg Co) | DOB: 8/01/1961
License #: 2006-01982 | Specialty: ChP (as reported by physician)
Medical Ed: State University of New York, Upstate (1990)
Cause: Dr Mogul has not practiced since 2000. She is licensed in several other states.
Action: 12/28/2006. Reentry Agreement executed: Dr Mogul is issued a NC medical license; she shall arrange with a physician colleague to observe her for the first year of practice and report in detail to the Board at the end of six and 12 months on Dr Mogul's performance; Dr Mogul shall obtain at least 50 hours of Category I CME in her first year; must comply with other requirements.

WILLIAMS, Dwight Morrison, MD
Location: Roanoke Rapids, NC (Halifax Co) | DOB: 2/15/1952
License #: 0000-33577 | Specialty: OB/GYN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1982)
Cause: Dr Williams has not practiced medicine actively since February 2003. He has a history of substance abuse, which led him to surrender his license at that time. He also entered into a Consent Order with the Board that indefinitely suspended his license.
Action: 11/02/2006. Reentry Agreement executed: Dr Williams is issued a temporary license for a period of six months; he shall arrange to have a physician colleague observe his practice for six months and report at the end of that period to the Board on his performance; Dr Williams shall refrain from use of mind- or mood-altering substances and alcohol; he must comply with other conditions related to his history of substance abuse and shall maintain and abide by a contract with the NCPHP.

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

The Board requests all licensees maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 60 days of a move.

NCMB Panel of Expert Reviewers Being Updated

The North Carolina Medical Board evaluates a large number of quality of care issues each year. To accomplish this, the Board draws on the knowledge and experience of expert reviewers from all fields of medicine. These reviewers analyze medical records and report their opinions and conclusions to the Board for its consideration. On occasion, a reviewer may be asked to offer testimony at a formal hearing of the Board. Generally, these evaluations are confidential and are handled by mail. Because the issues involved must be dealt with in a timely manner, evaluation reports are required to be completed in four weeks. Although the time required to complete an evaluation report varies, a typical review may take two or three hours. Compensation is provided at the rate of $150 per hour.

The Board began developing its panel of expert reviewers six years ago and recognizes the importance of updating its list of experts from time to time. We would like to invite North Carolina licensed physicians and physician assistants and approved nurse practitioners who might be interested in assisting the Board as a part of its panel of experts to contact the Board's medical director by regular mail, and include a detailed CV. Direct correspondence to:

C. Michael Sheppa, MD, Medical Director | North Carolina Medical Board |
P.O. Box 20007 Raleigh, NC 27619

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: May 16-18, 2007; June 20-21, 2007; July 18-20, 2007; August 15-16, 2007; September 19-21, 2007

Residents Please Note USMLE Information

United States Medical Licensing Examination

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

Special Purpose Examination (SPEX)

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

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