



# forum

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

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*From the Executive Director*

## Some Questions & Answers



R. David Henderson, JD  
NCMB Executive Director

*"From the Executive Director" reestablishes the regular series of commentaries by the NCMB's executive director that appeared in the Forum for some years. It will appear in numbers two and four of each annual volume, alternating with the "President's Message," which will appear in numbers one and three.*

As Executive Director of the North Carolina Medical Board, I frequently receive telephone calls and letters from physicians, attorneys, and hospital administrators asking various questions. In this first article, I'd like to share three questions I've received lately and my answers to those questions.\*

**QUESTION:** Do physicians who do not have hospital privileges have a responsibility to direct their patients to a hospital with a designated physician or group of physicians who will care for their patients?

**ANSWER:** Some physicians choose not to have hospital privileges. A problem arises, however, when the patient of such a physician requires admission to the hospital. In this case, what is the physician's responsibility?

The Board's Position Statement entitled "Availability of Physicians to Their Patients" states that "once a physician patient relationship is created, it is the duty of the physician to provide care whenever it is needed or to assure that proper physician backup is available to take care of the patient during or outside normal office hours. If the physician is not generally available outside normal office hours and does not have an arrangement whereby another physician is available at such times, this fact must be clearly communicated to the patient, verbally and in writing, along with written instructions for securing care at such times."

Although this language does not explicitly apply to the hos-

pital privileges issue, the same reasoning applies. That is, if the doctor is not able to take care of a patient in the hospital, the doctor should (1) clearly make this known to the patient, and (2) provide written instructions for securing hospital care.

Ideally, the physician will have made arrangements in advance with another physician or practice to admit these patients, and all relevant parties (patients, ER personnel, etc.) will have been notified of this arrangement. Regardless, the physician should make sure that all relevant patients have the physician's contact information so he can provide the patient's medical history and other important information.

**QUESTION:** Can a physician who wishes to terminate her relationship with a patient do so by simply transferring care to a nursing home?

**ANSWER:** No. Although termination might be implicit in this case, the better course of action would be for the physician to notify the patient in writing. The Board's Position Statement entitled "The Physician-Patient Relationship" states that "termination must be accompanied by appropriate written notice given by the physician to the patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other medical care to be secured. . . . It is advisable that the notice of termination also include instructions for transfer of or access to the patient's medical records."

As with many things, good communication is important, especially when terminating a physician-patient relationship.

**QUESTION:** A patient is seen by a physician specialty group and, due to difficulties with the patient, the practice terminates

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*Primum Non Nocere*

# forum

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

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

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its relationship with the patient in accordance with the Board's Position Statement. Several months later, the patient presents to the emergency department with a similar problem. A physician in the same specialty group is on-call at the local hospital for unassigned patients. What are the physician's responsibilities?

**ANSWER:** If the patient consents, good medical practice (and likely the hospital's bylaws) requires that the physician treat the patient, including admitting the patient to the hospital if indicated. The physician should continue to treat the patient until it is appropriate to re-commence the termination process.

I hope these questions and answers are helpful. If you would like to discuss these or any other questions, please do not hesitate to contact me.

\* Except when quoting a Position Statement, the above opinions are mine and not necessarily those of the Medical Board.

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

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

*As director of medical education at Charlotte Memorial Hospital and Medical Center (now Carolinas Medical Center) from 1962 to 1984, I would have made Dr Hart's series of letters to a young physician mandatory reading for all interns and residents on a yearly basis. This requirement would have served to enhance and guide their efforts in becoming complete (or, as Izaak Walton said, Compleat) practicing physicians. Thank you, Dr Hart!*

*And, I have mailed copies of the Fondly, Carolyn series to my eldest grandson, who is currently in an orthopedic surgery residency.*

Bryant L. Galusha, MD  
Former President, FSMB  
Former Executive Vice President, FSMB  
Former Member, National Board of Medical Examiners  
Former President, North Carolina Medical Board

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

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

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

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

## Screening and Brief Intervention for Substance Abuse and Dependence in the Primary Care Setting

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



Dr McEwen



Dr Lohr

### The Problem

Substance abuse/dependence (SA) is a devastating problem that affects millions of Americans every year. SA places a huge burden on society as well as the individual. It is, according to the Robert Wood Johnson Foundation (RWJF), the nation's number one health problem, contributing to myriad serious and costly health problems, family violence and mistreatment of children, a less productive and less safe workplace, and involvement of the criminal justice system. Problem drinkers average four times as many days in the hospital as nondrinkers. Treatment for addiction is as successful as the treatment of other chronic health conditions, such as diabetes and hyper-

tension. Yet, of the 13 to 16 million individuals who need treatment for alcoholism or drug addiction each year, only 3 million receive care. In many cases, physicians fail to identify an SA problem. Consequently, they miss the opportunity to intervene or refer the patient for treatment. This article, the second in the *Forum* series addressing substance use, will focus on substance use disorders in adults. Subsequent articles will address SA in children and adolescents, fetal alcohol syndrome/effects, prescription drug abuse, SA in physicians, and the Physicians' Leadership Council Action Plan.

About a third of all adults engage in some kind of risky drinking behavior, ranging from occasional to daily heavy drinking. Nearly one in four of these risky drinkers already meets criteria for alcohol abuse or dependence and the rest are at increased risk of developing these disorders. Because of the health problems associated with SA, many of these individuals will present for medical care. The proportion of patients with alcohol and other drug (AOD) problems

varies with the clinical setting. It is estimated that approximately 15% of outpatients, 25-40% of hospital patients, 50% of emergency department patients, and up to 80% of burn unit patients suffer from substance use disorders.

### Clinicians Can Have Significant Impact with Minimal Time Commitment.

There is compelling evidence in the literature that screening and brief intervention (SBI) for alcohol problems does work to reduce risky drinking and its harmful medical and social side effects. A recent evidence-based review on SBI revealed 39 published studies, including 30 randomized controlled and 9 cohort studies. A positive effect was demonstrated in 32 of these studies. Major studies have found reductions of up to 30% over 12 months in consumption and binge drinking, as well as significant decreases in blood pressure, GGT levels, psychosocial problems, hospital days, and hospital readmission for alcohol-related trauma. Multiple studies have demonstrated the efficacy of brief intervention in a variety of settings, including general populations, primary care, and emergency departments. A cost benefit analysis in a recent study demonstrated that each dollar invested in brief physician intervention was associated with a fourfold savings in future health care costs.

Every clinical encounter is an opportunity for intervention. The RWJF funded Join Together, an organization that supports community-based efforts to reduce, prevent, and treat SA, recently published *Ten Drug and Alcohol Policies That Will Save Lives*. Making screening for alcohol and drug problems a routine part of every primary care and emergency room visit was one of the 10 recommendations. Through guidelines and policy statements, the AAFP, AAP, ACOG, and AMA have highlighted the importance of screening, early diagnosis, and treatment for patients with alcohol and other drug use. SBI is most effective when put in a clinical context important to the patient. Whenever possible, it is advisable to connect the alcohol and/or other drug use with the reason for the visit. The ED visit is a particularly good opportunity for intervention because patients presenting to the ED are even more likely to have alcohol-related problems than those presenting to a primary care clinic. These visits offer a potential "teachable moment" due to the possible negative con-

*"About a third of all adults engage in some kind of risky drinking behavior, ranging from occasional to daily heavy drinking"*

sequences associated with the event.

### Screening

Screening helps identify individuals who have begun to develop or who are at risk for developing AOD related problems. A variety of screening tools is available. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommends the use of quantity and frequency (Q & F) questions as well as the CAGE test (see shaded NIAAA and CAGE boxes). The Q & F questions can determine whether the patient is drinking over the recommended levels and is at risk for illness and injury, while a positive CAGE screen may suggest problematic use or dependence. Asking the Q & F questions, then adding the CAGE questions if the responses exceed moderate levels, is one way to use the screens. Another approach is to jump to the CAGE questions when dependence is suspected. This eliminates the negative connotations and resistance that can occur when the patient is asked to quantify his or her drinking.

#### When to Screen for Alcohol Problems

- As part of a routine examination
- Before prescribing a medication that interacts with alcohol
- In response to problems that might be alcohol related

#### Different Screening Tools for Women

Physicians have been slow to implement universal screening, and rates of detection and referral to treatment remain low. Studies show that women are less likely than men to be screened or referred. Women's safe drinking limits differ from men's because women generally have proportionally less body water than men do and achieve higher blood alcohol concentrations after drinking the same amount of alcohol.

#### NIAAA Quantity and Frequency Questions

On average, how many days per week do you drink alcohol?

On a typical day when you drink, how many drinks do you have?

What is the maximum number of drinks you had on any given occasion during the last month?

#### Screen is positive if:

Men: > 14 drinks/week or >4 drinks/occasion

Women: > 7 drinks/week or >3 drinks/occasion

Elderly: > 7 drinks/week or >3 drinks/occasion

The American College of Obstetricians and Gynecologists (ACOG) issued a policy statement in May 2004 asserting that obstetricians and gynecologists have an ethical obligation to learn and use a protocol for universal screening questions, brief intervention, and referral to treatment. Because women are more likely to be hidden drinkers and often underreport alcohol use, tests to detect alcohol use in wom-

en must include questions about tolerance. ACOG recommends that in addition to the NIAAA Q & F questions, the TWEAK or T-ACE tests be used for screening nonpregnant women (see shaded Screening for Alcohol Problems in Woman box). Alcohol use during pregnancy is known to cause fetal alcohol syndrome, the leading identifiable cause of mental retardation. Pregnant women should be questioned about any alcohol or drug use and counseled to abstain. Because there is no safe level of alcohol consumption during pregnancy, women contemplating pregnancy should also be informed of the harmful effects of alcohol and advised to abstain.

### Brief Intervention (BI)

Primary care practitioners can significantly reduce both problem drinking and its medical consequences, especially for those who are not alcohol dependent, through brief interventions. Brief interventions, which aim to reduce risk, alcohol-related problems (eg, illness, family, and workplace problems), and alcohol-medication interactions, are short counseling sessions that may last only five minutes. They are designed to fit into the normal flow of a busy practice and are consistent with mainstream, patient-centered care. Brief interventions that address substance use are much like other talk therapies that clinicians often conduct with their patients about chronic health problems or medication.

Brief interventions often incorporate the six elements proposed by Miller and Sanchez, summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy. The "readiness to change" scale is also useful. Patients can be considered to be in one of five stages of change: precontemplation, contemplation, determination, action, and maintenance/termination. Interventions seek to motivate the patient to advance to the next stage by matching the advice to the current stage the patient is in. For "at-risk" or "harmful" drinkers who are not dependent, goal setting within safe limits and a follow-up plan are all that may be needed. For those patients who are dependent or those whose drinking severity is unclear, the BI is a negotiation process to seek further assessment and referral to a specialized clinician or treatment program.

For more information on alcohol screening and brief intervention, go to Join Together's Web site: [http://www.jointogether.org/sa/issues/hot\\_issues/sbi/](http://www.jointogether.org/sa/issues/hot_issues/sbi/).

### Referral

The most effective referral occurs at the time of the interview. Putting the patient into direct contact with the SA specialist is optimal. If this is not possible, referral information should be provided to the patient. Two-way communication between the clinician and specialty SA treatment providers should

*"Women's safe drinking limits differ from men's because women generally have proportionally less body water than men do and achieve higher blood alcohol concentrations after drinking the same amount of alcohol"*

be established and maintained. It is important that referral information be accurate and up to date. In North Carolina, the Alcohol/Drug Council of NC operates an information and referral service: [www.alcoholdrughelp.org](http://www.alcoholdrughelp.org); (800) 688-4232. Other referral resources include the following.

- Nat'l Drug and Alcohol Treatment Referral Routing Service: (800) 662-HELP
- Alcoholics Anonymous (AA): [www.alcoholics-anonymous.org](http://www.alcoholics-anonymous.org); (212) 870-3400
- Nat'l Council on Alcoholism and Drug Dependence: [www.ncadd.org](http://www.ncadd.org); (800)-NCA CALL
- SAMHSA: [www.findtreatment.samhsa.gov](http://www.findtreatment.samhsa.gov); [info@samhsa.gov](mailto:info@samhsa.gov)
- VA, National Center for Health Promotion and Disease Prevention: [www.nchpdp.med.va.gov](http://www.nchpdp.med.va.gov)

### Alcohol Counseling Saves Hospitals Money

According to a recent *Annals of Surgery* report, offering brief alcohol counseling to injured patients in emergency departments could save U.S. hospitals almost \$2 billion a year. Brief intervention reportedly saved hospitals about \$330 per patient by reducing the risk of repeat injuries. Many trauma centers do not screen injured patients for SA because of a law that allows insurance companies to deny payment for injuries that occur in patients under the influence of alcohol. Six states, including North Carolina, have repealed this law.

### Additional Resources

Locally and nationally, efforts are underway to integrate SA screening and brief intervention into the primary care and ED settings. A number of specialty groups and federal agencies have published materials to facilitate SBI. Among specialties, the American College of Emergency Physicians has taken the lead in addressing substance use disorders in the emergency department and has developed, with NIH and NIAAA funding, a well designed, educational Web site ([www.ed.bmc.org/sbirt/index.htm](http://www.ed.bmc.org/sbirt/index.htm)) with information that all primary care physicians will find useful. Other helpful resources include the following.

- Helping Patients with Alcohol Problems: A Health Practitioner's Guide at [www.niaaa.nih.gov/publications/practitioner/HelpingPatients-Printing.htm](http://www.niaaa.nih.gov/publications/practitioner/HelpingPatients-Printing.htm)
- National Alcohol Screening Day is April 7, 2005. Information at <http://www.nationalalcoholcreeningday.org/events/nasd/index.htm>

### CAGE Alcohol Screening

Have you ever felt that you should Cut down on your drinking?

Have people Annoyed you by criticizing your drinking?

Have you ever felt bad or Guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye opener)

\*Positive screen: 2 Yes answers

### Screening for Alcohol Problems in Woman

#### Pregnant women and women of child-bearing age:

**Do you ever drink?** (Yes is positive screen)

Both pregnant and nonpregnant women need to be informed that there is no safe level of consumption during pregnancy.

Women anticipating becoming pregnant should be counseled to abstain from alcohol to avoid early exposure.

#### Other women (T-ACE and TWEAK):

**T-ACE** (score of 2 or more indicates high risk use)

**T** Tolerance: Does it take more than it used to for you to get high? (yes, 2 pts)

**A** Have you become **A**ngry or **A**nnoyed when others express concern about your use? (yes, 1 pt)

**C** Have you tried to **C**ut down or quit? (yes, 1 pt)

**E** Have you had an **E**ye opener? (yes, 1 pt)

**TWEAK** (score of 2 or more indicates positive screen)

**T** Tolerance: How many drinks does it take before you begin to feel the first effects of alcohol? (if 3 or more, score 2 pts)

**W** Have your friends or relatives **W**orried about your drinking in the past year? (yes, 1 pt)

**E** Do you sometimes take a drink in the morning When you first get up? (yes, 1 pt)

**A** Amnesia: Are there times when you drink and afterwards can't remember what you said or did? (yes, 1 pt)

**K** Do you sometimes feel the need to **C(K)**ut down on your drinking? (yes, 1 pt)

*"According to a recent Annals of Surgery report, offering brief alcohol counseling to injured patients in emergency departments could save U.S. hospitals almost \$2 billion a year"*

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

## Changing Ourselves Is the Key

Paul Edward Hill, MD



Dr Hill

*“I knew all the time I would like to be a primary physician; and my philosophy, then and all the years I practiced, was to treat patients the way I would want to be treated, and I stuck to it”*

After having had an active medical license for 50 years, I will not register this time around. I know how fortunate I am to have the great privilege of becoming a member of the Half Century Club; and it has been an honor for me to practice in North Carolina under the aegis of its fine Medical Board. It has done a superb job over the years and I thank all its members, past and present, very much. Now I would like to take the experienced professional's prerogative of sharing a few thoughts that I hope may be of value to my colleagues and the Board.

When I was accepted to medical school, I was more mature than most of the others, having had to grow up fast as an Army Air Force bomber navigator. I knew all the time I would like to be a primary physician; and my philosophy, then and all the years I practiced, was to treat patients the way I would want to be treated, and I stuck to it. The result was I never had to go through the horrors of a lawsuit, nor threats or rumbles.

For the first many years I practiced, our medical profession was publicly admired and held in high esteem, but over later years our profession has eroded too much to suit me. This is due to issues of doctor-patient interaction and not the quality of the physician; our doctors are good to excellent overall and competent. I am sure there are other reasons we probably cannot control, but nothing bothers me more than the too many physicians who are remiss for their lack of communication with their patients. That is really hurting us as a profession. I know, for I have been out here for many years and that has been patients' number one complaint. Physicians don't call patients back, and, if a call is returned, it is someone in the front office who calls, not the physician. That does not relieve patient anxiety. I know how busy physicians are, but no one was ever busier than I, and I always took care of returning calls, even when it meant staying after hours. Patients also complain of the “door knob doctors.”

I never had any threats of a lawsuit. Of course, no matter how perfect we may be, any one of us could be sued. I always read the Medical Board's *Forum*, and a few years ago it published an excellent article by one of the Board's members on medical liability cases in North Carolina. What was so interesting was that more suits were filed due to lack of communication than to medical errors. Too many doctors are negligent when it comes to communicating, and this includes excellent physicians. That means there are many unhappy campers out there. I believe it because I have

had a personal experience with it.

Last January, my 86-year-old brother-in-law was admitted to an Asheville hospital with an embolic cerebella CVA secondary to a cardiac arrhythmia requiring emergency monitoring and a pacemaker. He was there 11 days and had two neurologists, a cardiologist, and three hospitalists. Throughout the stay, even when admitted to the ICU, none of these doctors called me or the family—not even a nurse, a PA, or an orderly. I gave up early trying to get them. In all my 50 years, I have never before castigated a fellow physician, but I let them have it in a fairly nice but firm manner. The family was furious. This should never have happened. These physicians gave excellent medical management—no complaints. But there was no excuse for this lack of communication. This was neither an isolated case nor one that fell through the cracks, but represents a major problem unfortunately getting worse.

Too many people don't like the medical profession—there is a lot of anger. I truly believe my patients loved me because they knew I loved them. It can be the same with all physician-patient relationships if doctors do not just “care for” their patients but also make them feel “cared about.” This ought to be stressed in residencies. It would save a lot of angry patients and a lot of lawsuits. Many physicians believe that some type of tort reform is needed today, but that will require a legislative decision—made by men and women elected by the people who are our patients. To achieve useful legislative action, public support will be necessary. Right now, however, our profession's popularity with many people is at a low ebb—and that doesn't help the effort. Doctors themselves are the only ones who can change this by changing themselves. When this happens, there will be fewer lawsuits filed and the public should prove more willing to consider reform.

You may think I am overreacting, but that is not so. I am a colleague criticizing doctors and the profession I love. Remember, I have been a primary physician who began in the rural area of the state seeing 75-100 patients a day, delivered hundreds of babies, made hundreds of house calls, did orthopedics, urology, pediatrics, etc, and have seen it all. I have surely developed some medical wisdom and a bit of common sense about all this.

I have had 50 wonderful years serving the public. I never made the money many physicians received, however I was well rewarded with respect and the love of my patients, family, friends, church, colleagues, and community.

---

Dr Hill lives in Flat Rock, NC. He graduated from Duke University School of Medicine in 1954 and did his postgraduate training at Emory and Charlotte Memorial Hospital. He is board certified in internal medicine.

# Sheps Center Releases Two New Publications on Allied Health Professions

*Erin P. Fraher, Director  
NC Health Professions Data System*

The Council for Allied Health in North Carolina, the North Carolina Area Health Education Centers Program, and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill are pleased to announce the release of two new publications: (1) A two-page legislative brief entitled “The State of Allied Health in North Carolina: An Overview of Issues and Opportunities for the Allied Health Workforce,” and (2) “The Allied Health Vacancy Report.”

## **The State of Allied Health in North Carolina: An Overview of Issues and Opportunities for the Allied Health Workforce**

Since 1999, the Council for Allied Health in North Carolina, in partnership with the NC Area Health Education Centers Program and the Cecil G. Sheps Center for Health Services Research, has completed six allied health workforce studies. This brief report summarizes the lessons learned from six years of studying the allied health workforce in North Carolina. The first part of the report focuses on the increasing importance of the allied health workforce to the state’s economy. For example, did you know that:

- in 2003, allied health jobs made up over 35% of health care jobs in North Carolina; and
- between 1999 and 2003, 42% of total job growth in the health care sector was due to the growth of allied health jobs.

The report also highlights the challenges confronting the allied health workforce—shortages, an unequal distribution of providers between rural and urban areas, student and faculty recruitment and retention issues, attrition from educational institutions, and scope of practice issues.

The final section of the report discusses how difficult it is to collect data on the allied health workforce and how important an organizational infrastructure such as the Council for Allied Health is to provide a forum through which practitioners, educators, employers, and policy makers can work to address allied health workforce issues.

In addition to the brief, a PowerPoint presentation is also available with more in-depth information.

## **The Allied Health Vacancy Report**

To help monitor trends in the demand, supply, and distribution of the allied health workforce in

North Carolina, the Council for Allied Health in North Carolina, in partnership with the NC Area Health Education Centers Program and the Cecil G. Sheps Center for Health Services Research initiated a project to track allied health job vacancies. The study and results are presented in the “Allied Health Vacancy Report,” authored by Rebecca Livengood, Erin Fraher, and Susan Dyson. Job classified advertisements for 10 allied health professions were collected from 10 North Carolina Sunday newspapers from February 1 through April 18, 2004, and from September 5 through November 28, 2004. Newspapers from each AHEC region were sampled.

Findings from the report include the following.

- Occupational therapists, respiratory therapists, and speech-language pathologists had the highest number of job vacancy ads and highest vacancy indices, while professions such as pharmacy technicians, medical lab technicians, and medical technologists had the lowest vacancy indices.
- The number of vacancies varied by AHEC region. For example, after adjusting for the total population in each AHEC, Area L, a smaller and more rural AHEC region, had the highest number of vacancies at 4.56 per 10,000 population, compared to 2.23 per 10,000 population in the Charlotte AHEC, a larger and more urban region.
- The majority of advertisements were for hospital employers (45%); however, vacancy ads for some therapy professions were just as likely to be for a rehabilitation facility as for a hospital.
- Sign-on bonuses were offered in 3% of total job vacancy ads and were most common in the three therapy professions. Bonuses were most commonly offered by large employers such as hospitals, and bonuses offered by out-of-state employers tended to be larger.

These publications are funded through a grant from The Duke Endowment. We hope you find them informative and useful. Electronic copies of the reports and the “State of Allied Health” PowerPoint presentation can be downloaded at the Sheps Center Web site at the following url: <http://www.shepscenter.unc.edu/hp/>.

*“In 2003,  
allied health  
jobs made  
up over 35%  
of health  
care jobs in  
North Caro-  
lina”*

You may contact Erin Fraher at (919) 966-5012 or [erin\\_fraher@unc.edu](mailto:erin_fraher@unc.edu).

## Setting a Good Example

Roselee Papandrea

Jacksonville Daily News

Doctors spend a lot of time examining patients, looking at test results and doling out advice.

But some physicians don't follow their own words of wisdom. It's something Dr Charles Garrett, southeastern regional medical examiner and this year's president of the N.C. Medical Board, wants doctors to change.

"I've seen a number of physicians who have had catastrophic illnesses that could have been handled through preventive or better care," Garrett said. "Over the years, doctors are notorious for ignoring their own health while worrying about their patients' health."

Garrett doesn't really have patients of his own, per se, but over the years he's done hundreds of autopsies at Onslow Memorial Hospital on people who died too young because they didn't take care of themselves.

While his work presented plenty of reasons to change an unhealthy lifestyle, Garrett, who's been a medical examiner for more than 30 years, carried a lot of extra weight for years that put him at risk for many chronic diseases. But it wasn't something he thought about until, at the prompting of his wife, Ann, he had a physical exam in March 2004.

"The doctor didn't see anything wrong with me and said, 'Come back and see me in a year,'" Garrett said.

But then Garrett's laboratory work was returned and his blood-sugar levels were high.

"I see complications from diabetes in many of the autopsies that I do," he said. "I decided the long-term solution was to lose a lot of weight, eat better and exercise. But I had to see the numbers in black and white on paper. They were numbers that couldn't be ignored."

After a year of what the 64-year-old Garrett refers to as "no white food" - bread, pasta, rice and grits - he is 80 pounds lighter, his blood-sugar levels are normal and he's trekked hundreds of miles on a treadmill.

"I haven't had a piece of bread, except for a communion wafer, in a year," Garrett said. "I love bread. I haven't had potatoes, rice and grits. Let's face it. I'm from South Carolina. Those are staple foods, but I quit all that stuff."

Garrett also decided it was time to get serious about urging other physicians to be mindful of their health. After he was named president of the N.C. Medical

Board for the second time in November, he thought it appropriate to write about the importance of a physician's health in *Forum*, the N.C. Medical Board's quarterly publication.

As a member of the medical board, Garrett interviews a lot of physicians with medical licenses and many seeking licenses in North Carolina. Most of the doctors he interviews say they are in good health but few have a personal physician and can't recall when they had their last physical, Garrett said.

"We are supposed to be role models for our patients," Garrett wrote. "But it amazes me, once again, how many of us are overweight, don't know our cholesterol profile numbers, get a colleague to sign off on our physical exams for renewal of our hospital privileges, or just put our heads in the sand when it comes to our own health. We do the same things we would give our patients hell about doing."

Garrett is a believer in the annual physical exam that includes blood work to check for cholesterol and blood-sugar levels. He also insists that doctors need to find a personal physician they

trust.

As a former size 52 portly, Garrett, who now wears a size 43 regular jacket and a size 38 in pants, still cringes at body mass index requirements. He wants to lose another 10 pounds, and he's recently purchased an abdo-men crunch machine to firm up his middle.

He said he still has work to do, but he hopes his efforts will encourage his colleagues to pay better attention to themselves.

"Physicians need to get good health care just like everybody else," he said.

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*The best medicine: Dr Charles Garrett says physicians need to have annual physicals from doctors they trust.*

*"I've seen a number of physicians who have had catastrophic illnesses that could have been handled through preventive or better care"*

### North Carolina Medical Board

#### Web Site:

[www.ncmedboard.org](http://www.ncmedboard.org)

#### E-mail:

[info@ncmedboard.org](mailto:info@ncmedboard.org)

## The Most Powerful Teaching Tool

*Kelly Carter Nelson, MD*



*Dr. Nelson*

Medical students are at a unique crossroads where we feel connected to both patient and physician. As we observe interactions, we can sense the patient's frustration with abbreviations like PO and DVT while we can predict our attending's differential diagnosis by the questions posed to the patient. As I learn to become a physician, I understand more fully the daily intersection between medicine and ethics. My interest in ethics and self-regulation began at Davidson College where our final examinations were self-scheduled and unproctored, and I sat on the student-run honor council. As a student at the University of North Carolina School of Medicine, I was privileged to serve as the attorney general of the Honor Court, responsible for deciding whether potential violations of the honor code merited a charge statement and then representing the school's interest in the subsequent hearings.

When I was given the opportunity for a non-clinical project in one of my fourth-year electives, I decided to

pursue the different ways physicians are regulated and spent an afternoon observing cases with the North Carolina Medical Board. It was an interesting experience because all three cases I saw were distinct, yet addressed fairly universal issues within medical ethics: the importance of truthfulness, physician autonomy, and responsibility for patient care. And in two of the three cases, physicians were directly questioned about their medical school experience.

Medical schools exist to provide the fundamentals not only of biochemistry and pharmacology but also of professional interactions. Ideals of honesty and responsibility are as crucial to building the foundation of medical practice as the traditional curricula taught by PowerPoint presentation. And what better place to learn? While guidance from bodies such as honor courts and medical boards is important, there is no more powerful teaching tool than watching those that you admire. Whether the role model is an attending surgeon or a fellow physician, establishing a mentor and aspiring to greater standards in both clinical and ethical behaviors are principles integral to the practice of medicine.

Dr. Nelson is now in her first year of residency in internal medicine/dermatology at the University of North Carolina School of Medicine, Chapel Hill. This article was written prior to the end of her fourth year of medical school.

*"Ideals of honesty and responsibility are as crucial to building the foundation of medical practice as the traditional curricula taught by PowerPoint presentation"*

## Weathering the Storm

*James A. Wilson, JD*



*Mr. Wilson*

I have been in the company of hundreds of physicians as they undergo investigations, reviews, and prosecutions of their licenses, privileges, credentials, and registrations. The process is always extremely stressful, and the outcome depends a great deal on what the physician has done and what the physician is willing to do about it.

There are two simple things, though, that come up time and time again that physicians can do, well in advance of any trouble, to help make these problems easier to weather.

### Have a Doctor Other Than Yourself

"Physician, heal thyself," if ever intended to be taken literally, certainly should not be today. Somewhat like the tale of the cobbler's children having no shoes, I see many physicians who themselves have no doctor. Some

might think they do not need one or do not have the time. Some do not want one of their colleagues, particularly someone from the same community, to know of their health issues. These are valid concerns.

However, I have known several physicians whose legal problems stem entirely and directly from their own medical problems being poorly managed. Sometimes this includes untreated or under-treated pain that becomes disabling. Self-prescribing is a predictable result. Self-prescribing is never a good idea and always, when detected, arouses the suspicions of regulators.

Once these physicians delegate their care to a colleague, their legal problems become relatively simple to resolve. Sadly, though, many physicians have gone through months of unnecessary suffering, and had legal problems leave indelible marks on their lives and careers, all from not having a doctor.

### Buy Good Insurance

The second thing I have noticed is that, generally speaking, physicians with good insurance have an easier time and do better through these troubles than physi-

cians without any. I urge you to spend some money on insurance. Most of us hate buying insurance; it costs money but brings no revenue. There is a great deal to know about insurance before you buy it, and I do not mean for this article to be a comprehensive statement on the subject; however, I want to share some thoughts.

### *Health Insurance*

Corresponding to the need for physicians to have their own doctor comes the need to have the means to pay for it. Pay attention to the mental health and substance abuse benefits. Physicians, I have read, need such services at about the same rate as the population as a whole, and these services, if needed, can be quite expensive. Being able to get good help for whatever ails you can make all the difference in saving your career.

Similarly, get health insurance for your family and employees, too, and make them use it. Do not treat them yourself. The erosion of boundaries in treating your staff can be a problem. Can you be objective? How will you and those close to you feel in the event of an adverse outcome? How will it look to regulators? Will they become suspicious that the prescription you are writing is really to obtain drugs for your own use? Are you keeping proper records of your treatment of friends and family?

### *Malpractice Insurance*

Some malpractice insurance covers the costs of defense of licensing, privileging, and credentialing problems. Some companies expressly cover disciplinary proceedings, tax audits, billing disputes by payors, and other regulatory proceedings. Some companies cover such matters if they are related to a traditional malpractice claim. Even companies that do not explicitly cover such matters will sometimes pay a lawyer to represent you in

these if the company believes success in the matter lessens their liability exposure. A few companies will pay a lawyer for such matters, even if not otherwise covered, just to maintain good relations with their insured.

Usually there are limits for this coverage, often approximately \$25,000. Sometimes deductibles and co-payments apply. Occasionally an insurer will pay beyond these limits if the company believes it is in its interest.

### *Disability Insurance*

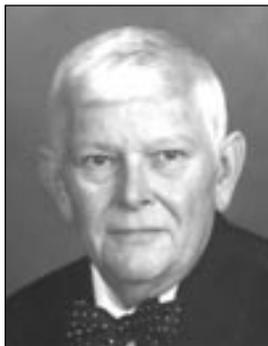
A significant fraction of problems physicians have with their licenses, privileges, and credentials arise when the physician has a medical problem that interferes with practice. Better disability insurance policies pay benefits under such circumstances. Look for "own occupation" coverage, meaning basically that you will receive benefits if you are disabled from practicing in your specialty, even if you are capable of other work. Some policies also have a rehabilitation benefit that will pay for care to get you back into practice, sometimes beyond what health insurance would pay for. Also available, separately, is disability insurance that will pay office expenses. This is particularly important for solo and small practices and can make the difference between having a practice to return to and having to start over.

### **Conclusion**

Facing a disciplinary proceeding is never pleasant or easy. Having a doctor and having good insurance has helped many physicians avoid legal trouble altogether or, where trouble came anyway, helped many physicians recover from these problems.

Mr Wilson is a lawyer in private practice in Durham, NC. He has represented physicians in a variety of regulatory matters. This article is provided as general information and should not be taken as legal advice.

## **Charles L. Garrett, Jr, MD, President of NCMB, Honored by MUSC Medical Alumni Group**



*Dr Garrett*

The Medical Alumni Association of the Medical University of South Carolina, at its annual meeting in April 2005, presented a Distinguished Alumnus Award to Charles L. Garrett, Jr, MD, of Jacksonville, North Carolina.

Dr Garrett, who has served on the North Carolina Medical Board since 2001 and is currently president of the Board, was a 1966 *magna cum laude* graduate of the Medical University of South Carolina College of Medicine. He is director of laboratories, emeritus, for

Onslow Memorial Hospital in Jacksonville, where he is also managing senior partner of Coastal Pathology Associates, PA, and an adjunct faculty member of the School of Medical Laboratory Technicians for Coastal Carolina Community College. He also serves as medical examiner for Onslow and Jones Counties, North Carolina; as southeastern regional pathologist for the Office of the Chief Medical Examiner of North Carolina; and as executive director of the Onslow County Medical Society. He has held many other positions of leadership with professional organizations, including the American Medical Association, where he served on the Board of Directors of the AMA's Political Action Committee, and the North Carolina Medical Society, of which he is a past president. In 1996, he received the Order of the Long Leaf Pine from Governor James

*"Having a doctor and having good insurance has helped many physicians avoid legal trouble altogether"*

B. Hunt of North Carolina.

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

Examiner of Virginia. He is certified by the American Board of Pathology in anatomic and forensic pathology; and is a fellow of the College of American Pathologists, the American Society of Clinical Pathology, and the American Academy of Forensic Sciences.

## Robin N. Hunter-Buskey, PA-C, NCMB Member, Elected to Board of Federation of State Medical Boards



Ms Hunter-Buskey

On Saturday, May 14, 2005, in Dallas, Texas, at the Annual Meeting of the Federation of State Medical Boards of the United States, Robin N. Hunter-Buskey, PA-C, of Raleigh, a member of the North Carolina Medical Board, was elected to the Federation's Board of Directors. Ms Hunter-Buskey is the first physician assistant ever elected to the Feder-

ation's Board. She is the sixth member of the North Carolina Medical Board to be elected to a position on the Federation Board in the past 48 years, and continues the Board's distinguished tradition of leadership on the national scene. (Four of the previous five members of the Board who served with the Federation also served as presidents of the organization and one served as the organization's executive vice president.)

The Federation is the national voluntary organization of state medical boards. It has 69 member boards representing every medical licensing jurisdiction in the United States, including Puerto Rico, Guam, and the Virgin Islands. (In some states, medical doctors—MDs—and doctors of osteopathy—DOs—are licensed by separate boards. All belong to the Federation, however.) The Federation was founded in 1912.

Among many other things, the Federation, with the National Board of Medical Examiners, is responsible for the United States Medical Licensing Examination (USMLE). It also publishes the *Journal of Medical Licensure and Discipline* and operates the Board Action Data Bank, which is a permanent record of disciplinary actions taken by all medical boards and which keeps each member board informed of disciplinary actions taken by other member boards.

The Federation is a major force in the field of medical licensure and regulation in the United States and is a founding member of the International Association of Medical Regulatory Authorities.

Born in New York, Ms Hunter-Buskey, a member of the North Carolina Medical Board since November 2000, took two BS degrees, one as a physical therapist and the other as a physician assistant, from the State University of New York at Stony Brook. She was certified in both fields. From 1981 to 1997, she worked in one or both of

these capacities in several New York institutions, including the VA Medical Center, the Bronx, and Montefiore Hospital and Medical Center, the Bronx. From 1989 to 1997, she was a member of the New York Board of Professional Medical Conduct. From 1997 to August 2003, she worked as a physician assistant at CaroMont Internal Medicine in Gastonia, North Carolina. While there, she was involved in a number of clinical studies and trials. In 2002, she earned a master's degree (MPAS) from the University of Nebraska Medical Center. She is presently on active duty as a United States Public Health Service Officer—Rank 04. She is serving with the Department of Justice, Bureau of Prisons, at the Federal Medical Center, Butner, North Carolina.

In 1994, she received the Outstanding Leadership Award from the New York Society of Physician Assistants, and in 1996, the Distinguished Alumnus Award from SUNY at Stony Brook School of Health Technology and Management. In the latter year, she was also given the Innovations in Health Care: Clinical Excellence Award from the American Academy of Physician Assistants and Pfizer Pharmaceuticals. In 1998, she received the "Women Who Dare to Be Different" Community Service Award from Congressman Edolphus Towns.

Ms Hunter-Buskey is a member of the American Academy of Physician Assistants, the North Carolina Academy of Physician Assistants, and the New York State Society of Physician Assistants. She has been deeply involved in the organizational and educational activities of each of these professional groups and was president of the Physician Assistant Foundation from 1999 to 2001. She has also been a lecturer and clinical instructor in geriatrics at the Harlem Physician Assistant Program of the City University of New York, the SUNY Downstate-Brooklyn, the SUNY at Stony Brook, and other institutions. She is currently a member of and consultant to the National Advisory Boards for primary care issues (diabetes, depression).

As a member of the North Carolina Medical Board, Ms Hunter-Buskey has served as chair of the Board's PA Advisory Council and its Allied Health Committee. She has also been a member of the Board's Licensing, Compliance, Investigative, and Midwifery Committees and its Joint Subcommittee on Nurse Practitioners. She has given numerous presentations to PAs and PA students throughout North Carolina about the Board and its work. She has served on the Federation of State Medical Board's Rules and Bylaws Committees.

# Santiago Atitlan: The Call of Something Different

*Drs Bernadette and Jack Page*



*Dr Bernadette (Bernie) Page*



*Dr John (Jack) Page*

*“Now was the time to entertain their perceived need to address some unjust material inequalities in other societies”*

In September 1966, Bernadette Ryan Page and Jack Page met on the sidewalk outside the Loyola-Stritch School of Medicine while waiting alphabetically in line to pay their tuition. One thing led to another and, in December 1967, they were married in Bernadette's childhood community of Plano, Illinois. As their senior year approached, they learned of a fellowship offered by what was then Smith, Kline and French to American medical school students who wanted to experience medicine in a third-world country. They spent three and a half months over the New Year of 1969-70 in Rhodesia, now Zimbabwe, helping two volunteer physicians at a mission hospital in rural native lands. Little did they know what impact that experience would have

on their lives.

Jack wanted to become a doctor so he could make his father proud of him, earn respect, make a decent living, and make a contribution to society. All are signs of Jack's right-brained life. Bernadette wanted primarily to help people and, at the same time, support herself economically; indeed, more in line with her left-brained life style. They both came to the discipline of emergency medicine by different routes. Bernadette did a “rotating 0” internship and then started a second year in pediatrics. After six months of pediatric outpatient clinics, she felt she wanted something more challenging. She thought that emergency medicine would offer more variety, always be interesting, and allow flexibility for more time with her family. Ultimately, the latter turned out to be a very mistaken expectation. Jack was given the opportunity to serve in the navy after his first year of family practice and found, like many of his peers, a lot of free time for other activities. He began to moonlight in

emergency rooms with a group in Long Beach, California, and when discharged after two years of navy service, he joined that group full time. He chose emergency medicine because it offered no economic screens to patients, was exciting, and had a quick patient impact that was and is attractive to him. After some initial moonlighting with other emergency groups in southern California, Bernie joined Jack with the same group that staffed three hospitals in California.

## Central America It Was

Thirty-plus years and four adult children later, they both felt a need and desire to do something different. By always paying their retirement plans first, they had accumulated enough resources for their eventual retirement. They knew that after the graduation of their youngest child from college there would be a period of time when they would be relatively young and in good health and could undertake service in a rather remote area and do considerable clinical good. Although they each have an elderly parent, they knew time would make neither their parents nor themselves younger. Now was the time to entertain their perceived need to address some unjust material inequalities in other societies, a growing feeling of cynicism about some of the patients they were seeing in emergency departments in the U.S., and the call of something different, exotic, in a unique and intriguing culture.

So after talking about it for several years, in the spring of 2004, they shared with their family ideas about a five to six week trip that summer to visit some eight different locations in three different countries (Nicaragua, Honduras, and Guatemala) to look at sites where they might volunteer beginning in 2005. Though several of the family were surprised that they really meant what they



*The hospitalito*

had talked about and others questioned the where and the when of going, the family understood Bernie and Jack's need and were universally supportive. They had focused on Central America because, generally speaking, it was only one day's travel to return to the states, there was great need in all the countries for health care assistance for the poor, and the generally lower cost of living

would allow them to go now rather than wait to earn more income to support their expenses while serving. Jack, of course, has never done well in English, much less a foreign language, and after struggling for several years to at least speak some Spanish, he wasn't about to try

to learn some other language too! So Central America it was, and off they went for their summer tour with a couple of extra weeks for Spanish school thrown in.

### Nicaragua

Nicaragua was the first stop and was hot, dusty, and poor. The town they visited was northwest of Leon, an ancient capital, and was growing faster than services could be provided. The people were all Spanish-speaking and the economy mixed agricultural and light industry. A local, multi-national sponsored hospital was thinking of being open year-round rather than just the 12 to 14 weeks a year when visiting medical teams were in town. When labor is cheap, and in Central America it is, mechanization is absent. Construction is all done by hand, with cement made bag by bag, carried five-gallon bucket by bucket, and dumped. Fields are tilled not by tractor but by individuals with hand tools and the occasional horse or donkey. Sugar cane is big on the Pacific lowlands and harvesting is a hot and exhausting process. The men work outside the home and the women work in it, the latter also often tending a local *tienda*, laundry, or restaurant in the front room. The need in Nicaragua was great, but the local hospital staff was ambivalent about being open year-round and the mixed goals communicated a sense of uncertainty to Bernie and Jack.



Jack Page (left) and visiting Harvard medical student in redone emergency room

times. The word would spread that “the doctors are here” and patients would appear from every little path in the neighborhood. Mostly they were women with their young children, since frequently the men and the older

children were at work or school respectively. On the bus, no records were kept, no vitals were routinely taken, no labs were available, and very limited meds were dispensed. Malaria and dengue are rampant in this and many communities in Central America, but the resources to check for either are limited to the health departments in larger communities, so patients with those possible diseases were routinely referred for

the hours-long bus rides and hours-long waits of going to a public clinic. The need was great but the resources were scarce. Though Bernie and Jack felt they could help, they thought they could offer more in a setting with more seriously ill patients and a few more resources.

Still in Honduras, they visited a new medical school and several public hospitals, and they met with various health care workers to talk about dreams of pediatric hospitals serving the poor and mobile clinics going to the barrios where the poor live (and die) in the growing urban sprawl of San Pedro Sula. It would be flattering to teach in the medical school, but the Pages were concerned that their ignorance of the culture and local needs would probably impact the quality and appropriateness

of what they might teach. And the other programs lacked organization, funds, equipment, or all of the above. A final location to visit was Trujillo, visited by Columbus in 1502, where a tiny orphanage, school, and clinic served some 80 children on campus and provided health services to several thousand in the tiny villages around it. This visit was a real test of their resolve to get involved.

Trujillo is reached by something over a five-hour bus ride to literally the end of the paved road, and, of course, the bus broke down on the way there. They took the bus of a different company on the way back, but darned if it didn't break down too. The temperature was 95° plus and so was the humidity; they showered in the morning and before lunch they were soaking wet again. Finally, the orphanage was about five miles out of town, on a dirt road that literally forded

*“The dust, poverty, and cheap labor they had seen in Nicaragua were even more evident [in Honduras]”*

### Honduras

Next was a trip to Honduras, which the Pages had visited before while taking some earlier Spanish lessons. They visited two rural clinics northeast of the capital, Tegucigalpa, run by a nurse practitioner from a religious order in New England. The dust, poverty, and cheap labor they had seen in Nicaragua were even more evident here. The absence of light industry contributed to an even lower standard of living, with agriculture the only “reliable” income stream. Medical services were offered most days a week in the clinic buildings in two little towns about an hour and a half apart, with records being kept, vital signs being taken, some labs available, and meds being dispensed. At least one day a week was spent on a rejuvenated antique U.S. school bus that would pull up to a church in a little town or crossroads and honk its horn several



Hospital guard and family

some three or four streams to reach the campus. All this was a little bit too much for Bernie and Jack, so on to Guatemala they went.

### Guatemala

They had planned to visit one location in Guatemala after taking two weeks of Spanish classes, but while looking on the Internet for where to take the Spanish, they found a town, Santiago Atitlan, on the south shore of Lake Atitlan with a link to a page about reopening a little hospital. In the 1960s, a local church, supported from the United States, built the 20 bed *hospitalito* and then turned it over to Concern America in about 1986. In 1990, 14 residents

*“In 1990, 14 residents of Santiago Atitlan were machine-gunned to death during a peaceful protest outside the gates of the local army camp”*

of Santiago Atitlan were machine-gunned to death during a peaceful protest outside the gates of the local army camp. The hospital had been struggling financially and, after the massacre, Concern America closed the hospital and left. The people of Santiago Atitlan petitioned the national government and succeeded in having the army removed from the city within a month of the massacre. However, the hospital has remained closed for 14 years. In that time, the building and grounds were abandoned, stripped of all plumbing fixtures, copper pipe and wire, and filled with dirt, human waste, and debris. An emergency doctor from Missouri, Gil Mobley, started coming to Santiago Atitlan about 1996 to volunteer in town, then to bring his friends, then to talk about reopening the hospital. With local donations of time and labor and U.S. donations of money, it came to be. Now the hospital is scheduled to open on March 15, 2005, for its first patients in over a decade. This is considered a major sign of healing by the town, which is estimated to have 1,500 or more people who “disappeared” in the era when the hospital closed.

The big needs should not be a surprise to anyone who thinks about needs in rural, third-world countries. The women often die during childbirth, the babies do, too; and far too many, men and women, die from preventable diseases and from trauma, most often automobile related. So the local committee reopening the hospital was looking for doctors who could help with complicated OB, sick kids, and emergencies. The hospital had already recruited a young doctor who had finished her family practice program

and taken a year of child and maternal health, so OB and newborns were pretty well addressed. The Pages felt they could do well on the trauma side, including training the *bomberos* (firemen) who respond to emergencies, and, by adding two more docs to the list, make an every third day on-call schedule viable for all.



*Traditional weaving*

So they were fired up about returning to Guatemala before they even got home from their summer visit. The clincher was the news they received just after they got back to North Carolina: one of the Mayan men they had spent some time with while visiting had his two-year old daughter die from “a throat infection” the weekend after the Pages left. Whether epiglottitis or diphtheria, both real

possibilities, either probably could have been treated successfully.

So the Pages are now sitting in a rental house a cornfield up from a lake that reminds them of Lake Tahoe without the snow: a mile high, encircled by mountains, breathtaking, primitive, gorgeous. The town’s population is about forty thousand, 95 percent Mayan in extraction. The men, 50 percent of whom speak Spanish, usually go to the third or fourth grade. The women, less than 10 percent of whom speak Spanish, are usually out of school by second grade. The employment is scanty and primarily centered on small agricultural plots of one to two acres of corn, tomatoes, and peppers. There are some orchards with lots of citrus, mostly oranges but some grapefruit, tangerines, lemons, etc. There are about 50 private cars in town, 40 owned by gringos like the Pages. The public transportation system for long distances is commercial



*Marketplace on Sunday, the main market day*

buses, painted in rainbow colors, that go over 40 mph in 25 mph zones, horns blaring, weaving across the double yellow lines (where there are any!). Short distances are covered by *fletes*, pickups with metal bars welded in the bed to give the standing passengers a chance to hold onto something. In the 500-year-old, narrow, spaghetti streets, it is not a problem when the maximum speed might be 15 mph. On the edges of

town, however, the young drivers like to go a bit faster, so hang on literally for your life. The women carry everything on their heads, 40 to 50 pounds worth. Almost all wear hand woven, beautiful, colorful *trajes* (blouse and long skirt) in the colors appointed by the Spanish to this

village 500 years ago—blue and purple. Most men, especially younger ones, wear Levis and t-shirts with the ubiquitous baseball cap; but older men wear mid-calf white pants, with colorful embroidery about the cuffs, white western shirts, and cowboy hats when dressed up. They carry everything on their backs and 100 pound loads are the usual. Needless to say, they have a lot of neck and back pain in this town.

So what do the Pages hope to accomplish in this great big world when over two billion people live on less than \$2 a day? They want to see the *hospitalito* reopened and successful at improving the lives and health of the people it serves. They want to see the *hospitalito* develop access to funding sources so it can reasonably continue to exist, meeting the needs of the poorest in the area indefinitely. They want to help establish strong ties with



*Dirt road behind hospitalito*

first-world medicine to continue to enhance the quality of care in Santiago by periodic visits of short-term volun-

teers giving of their time and resources. They want to see Mayans replace the foreign, long-term volunteers, thereby providing quality job opportunities for the indigenous people and role models for others in the area. They want to see fewer human beings living without hope and with unnecessary pain and death. They want to fill their personal need to give. They want to learn some of the richness of the Tz'tujil culture and people.

*“They want to see fewer human beings living without hope”*

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

## Medical License Registration: An Annual Event

*Dena M. Konkol, Assistant Editor, NCMB Forum  
and David B. Shere, NCMB Operations Department*

It's that time of year again. Your birthday is approaching, and aside from the anticipation of growing another year older, if you are a physician licensed in the state of North Carolina, you are aware that your birthday also means it is time to renew your medical license registration.

Approximately 60 to 90 days before your birthday, you will receive a letter from the North Carolina Medical Board reminding you to renew your license registration and providing you with instructions on how to do so. The NCMB offers you the choice of registering on-line at its Web site ([www.ncmedboard.org](http://www.ncmedboard.org)) or of requesting a registration form by contacting [registration@ncmedboard.org](mailto:registration@ncmedboard.org). You have up to 30 days after your birthday to complete the registration process. After that, the NCMB will assess you a \$20 late fee. Continued failure to register can lead to the NCMB placing your license on inactive status; you will not be able to practice medicine in North Carolina unless your license is reactivated or reinstated.

Please note that the NCMB has recently changed the structure of its Web site. To reach the portion of the site related to annual registration, you will need to click on “For Physicians” in the main navigation bar. Besides providing information on license registration, this section contains information regarding position statements, rules, license applications, disciplinary actions, and other topics. Physician assistants, nurse practitioners, and clinical pharmacist practitioners will find their registration information by

clicking on the “For Physician Extenders” section of the main navigation bar.

In the past, the Board required each practitioner to register by entering his or her registration identification number. On the new Web site, electronic registration now requires the practitioner to log in by entering his or her file identification number and date of birth. Your file identification number is the same as your registration certificate number and does not change from year to year. If you do not click on the correct log-in for your license type, you will get a message saying that you do not have any pending registration.

On-line license registration is the preferred method, used by 90 percent of the NCMB's licensees. On-line license registration is faster, more secure, and more accurate than the alternative method of registering through the mail.

We welcome and appreciate any comments and suggestions regarding the annual registration process.

Although the NCMB prefers that each physician register his or her own individual medical license, we are aware that a number of practitioners assign this task to other individuals—office staff or spouses. Should this be the case with you, it is important you know that registering your medical license is still your responsibility. You are accountable for the answers in response to the questions on the registration form, for the accuracy of the report of your

CME hours, and for all other information requested.

Reporting correct information on your registration form is essential for the NCMB to update your file. Falsifying information on your registration form could lead

to disciplinary action by the NCMB. Should you choose another person to complete your license registration, you would be wise to review the information before submitting it to the NCMB.

*From the Board of Pharmacy*

## Tiendas and Contraband Pharmaceuticals

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



Mr Work

*“This is an interstate and international matter that needs to be addressed by the Food and Drug Administration”*

A recent article in the *Charlotte Observer* pointed out the problems with North Carolina’s Latino population obtaining prescription drugs in Mexican grocery stores known as *tiendas*. A segment followed this on WUNC-FM radio describing the dangers of this practice.

Many physicians are surprised to learn that we have two systems for consumer access to prescription drugs in this country: one for the Hispanic community and a different one for all other consumers. This is completely contrary to the principle of equal treatment for all citizens inherent in our society.

The normal procedure for access to prescription drugs includes a visit to a physician followed by a prescription order filled by a pharmacist. Hispanics in their native lands often have no physicians available, so they self-diagnose their conditions and obtain pharmaceuticals at food stores known as *tiendas*. Along with tacos and piñatas, they brought this self-treatment custom with them from their homeland.

Physicians in this state complain that Spanish-speaking patients arrive at emergency rooms with unprescribed antibiotics, steroids, and even controlled substances. Every hospital is obliged to treat patients who arrive under emergency conditions. Charges not covered by health plans are absorbed and contribute to the increasing costs in health care. The Latino population is a new and growing burden on hospitals, their health problems often complicated by their unorthodox and unsupervised use of pharmaceuticals.

One fundamental fact of drug use is that there is an immense difference between oral and injectable products. A patient who is in distress from an adverse reaction to an oral product can have their intestinal tract evacuated on both ends if necessary. This is uncomfortable but effective in removing the offending product from the body. Drugs administered by injection, however, are virtually impossible to remove once inside the skin. Treatment is much more difficult and sometimes it is not possible to save the patient from an adverse reaction from an injected drug.

Part of the transplanted Hispanic culture is self-diagnosis followed by the use of injectable drugs. This results in very powerful antibiotics such as Lincocin and Gentamicin being used indiscriminately without a competent diagnosis. Serious allergic reactions or runaway infections and deaths have resulted from using the wrong antibiotic to treat an infection. Even the injectable steroid Phenylbutazone, only used in horses in this country, is available for human use at some *tiendas*. This drug has not been available for human use in the United States for over 30 years.

The Food and Drug Protection Division of the North Carolina Department of Agriculture has state jurisdiction over this conduct and has investigated complaints on this activity. When their investigators were stalked by an obvious criminal element, they wisely retreated to re-evaluate their procedures. These dedicated civil servants are not trained to deal with or expected to confront this kind of intimidating behavior.

Complaints filed for selling this contraband have come from Raleigh, Winston-Salem, Gastonia, Hickory, Morganton, and Conover. The Burke County sheriff raided a store twice and seized over 75 products, including controlled substances. There are now nearly 400,000 Hispanics in the state, a population about the size of Greensboro and Winston-Salem combined.

This practice of distributing contraband drugs at Latino food stores must stop before serious damage is done. Recently in California, a young boy died from *ad hoc* treatment with illicit drugs. The coroner found that the child would be alive today had standard health care been applied. At least two other children had the same fate. I urge physicians, nurses, and pharmacists who encounter patients who have used these illegal products to contact their congressional representatives on this issue.

This is an interstate and international matter that needs to be addressed by the Food and Drug Administration. Meanwhile, the North Carolina Board of Pharmacy, the North Carolina Department of Agriculture, the Office of the Attorney General, and other interested parties have formed a Task Force to build an educational effort directed at immigrants as well as *tienda* owners. Physicians can help in this effort by reporting adverse events from contraband products to the North Carolina Board of Pharmacy, attention Kristin Moore, PO Box 4560, Chapel Hill, NC 27515-4560, (919) 942-4454, ext 209, or e-mail: [kmoore@ncbop.org](mailto:kmoore@ncbop.org).

# NORTH CAROLINA MEDICAL BOARD

## Board Orders/Consent Orders/Other Board Actions

### February-March-April 2005

### DEFINITIONS

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

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

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

**Denial:**  
Final decision denying an application for practice authorization or a motion/request for reconsid-

eration/modification of a previous Board action.

**NA:**  
Information not available.

**NCPHP:**  
North Carolina Physicians Health Program.

**RTL:**  
Resident Training License.

**Revocation:**  
Cancellation of the authorization to practice.

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

**Suspension:**  
Temporary withdrawal of the authorization to practice.

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

**Voluntary Dismissal:**  
Board action dismissing a contested case.

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

**ANNULMENTS**

NONE

**REVOCATIONS**

**BIRDSONG, Michael Sidney, MD**

Location: Cordova, TN  
 DOB: 3/28/1953  
 License #: 0000-34820  
 Specialty: N/GP (as reported by physician)  
 Medical Ed: University of Tennessee (1979)  
 Cause: In February 2004, the Tennessee Board of Medical Examiners indefinitely suspended Dr Birdsong's Tennessee medical license by an Agreed Order. The Tennessee Board found Dr Birdsong was twice convicted of DUI and that on two other occasions he demonstrated behavior of an intoxicated person. In May 2004, Tennessee revoked his license by default order after finding he failed to attend an evaluation he had agreed to undergo in the February order.  
 Action: 3/11/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 2/16/2005: Dr Birdsong's North Carolina medical license is revoked.

**DUBEY, Subu, MD**

Location: River Forest, IL  
 DOB: 2/21/1961  
 License #: 0094-01175  
 Specialty: IM (as reported by physician)  
 Medical Ed: Northwestern University (1987)  
 Cause: Dr Dubey was convicted of a felony, Obstruction of Criminal Investigations relating to Federal Health Care Offenses, in the U.S. District Court, Eastern District of North Carolina (case number 7:02CR00109-001). Because of his imprisonment, the hearing on this matter was not scheduled until February 2005.  
 Action: 3/11/2005. Findings of Fact, Conclusions of Law,

and Order of Discipline issued following a hearing on 2/16/2005: Dr Dubey's North Carolina medical license is revoked effective 8/26/2004.

**IRVING, Declan Patrick, MD**

Location: Chesapeake, VA  
 DOB: 6/24/1947  
 License #: 0000-39827  
 Specialty: GS/VS (as reported by physician)  
 Medical Ed: University College of Dublin (1970)  
 Cause: In May 2002, the Virginia Board of Medicine entered into a Consent Order with Dr Irving, reprimanding him on his care of a patient and his lack of record keeping about that care. In April, 2004, the Virginia Board revoked Dr Irving's license on the finding his surgical treatment of a patient demonstrated gross ignorance and carelessness.  
 Action: 3/09/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 2/16/2005: Dr Irving's North Carolina medical license is revoked.

**SUSPENSIONS**

**GURKIN, Worth Wicker, MD**

Location: Greenville, NC (Pitt Co)  
 DOB: 3/06/1956  
 License #: 0000-29117  
 Specialty: PD (as reported by physician)  
 Medical Ed: East Carolina University School of Medicine (1982)  
 Cause: Dr Gurkin has had a history of alcohol and substance abuse that, in 1994, resulted in the surrender of his North Carolina medical license. Prior to his surrender, he entered into a Consent Order with the Board and was granted a series of temporary licenses allowing him to practice under certain terms and conditions, including monitoring by the NCPHP. In 1997, the Board granted him a full and unrestricted license

due to the progress he had made in combating his problem with alcohol and substance abuse. In March 2004, Dr Gurkin again surrendered his license due to his relapse in abusing alcohol and hydrocodone. He has undergone inpatient treatment in Louisiana for his problem.

Action: 3/11/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 2/16/2005: Dr Gurkin's North Carolina medical license is indefinitely suspended.

#### **MURTUZA, Sarwar, MD**

Location: North Wilkesboro, NC (Wilkes Co)  
 DOB: 1/07/1951  
 License #: 0000-33721  
 Specialty: IM/FP (as reported by physician)  
 Medical Ed: Osmania Medical College, India (1976)  
 Cause: On May 21, 2003, Dr Murtuza was arrested and charged with DWI in Roan Mountain, Tennessee. Investigation revealed a passenger in the vehicle was an employee and patient of Dr Murtuza's and was also impaired. Blood tests at the time of Dr Murtuza's arrest were positive for diazepam, nortriptyline, amitriptyline, and valporic acid. He was convicted of DWI and put on probation. He was evaluated by the NCPHP but never complied with their treatment recommendations.

Action: 3/02/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 2/17/2005: Dr Murtuza's North Carolina medical license is indefinitely suspended.

#### **NASH, James Frank, MD**

Location: Longview, TX  
 DOB: 10/08/1943  
 License #: 0000-27621  
 Specialty: FP/EM (as reported by physician)  
 Medical Ed: University of Tennessee (1974)  
 Cause: Action was taken against Dr Nash's licenses in Georgia, Virginia, and California. He surrendered his Georgia license in March 2004 in lieu of proceedings against him due to allegations he committed boundary violations with patients.

Action: 3/02/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 2/17/2005: Dr Nash's North Carolina medical license is indefinitely suspended.

#### *See Consent Orders:*

**AUSTERMEHLE, Paul Edward, Physician Assistant**  
**BRAY, Anthony David, MD**  
**HARRIS, Dennis Bret, Physician Assistant**  
**JAWA, Gurpreet Singh, MD**  
**ROGERS, Bruce William, MD**  
**THRIFT-COTTRELL, Alesia Dawn, MD**  
**WHITE, Anne Litton, MD**

#### SUMMARY SUSPENSIONS

NONE

#### CONSENT ORDERS

#### **AUSTERMEHLE, Paul Edward, Physician Assistant**

Location: Doylestown, PA  
 DOB: 8/04/1966  
 License #: 0001-02541  
 PA Education: Philadelphia College Textile (1997)  
 Cause: Mr Austermehle was the subject of a criminal investigation in Asheville, NC, due to suspicion he had writ-

ten prescriptions for controlled substances in his wife's name that he diverted for his own use. He admitted this to law enforcement officials and said he had become dependent on pain medications due to injuries to both shoulders and recent surgery on his left shoulder. He surrendered his North Carolina PA license in July 2004 and, in the same month, was charged with five counts of Obtaining a Controlled Substance by Fraud.

Action: 4/01/2005. Consent Order executed: Mr Austermehle's North Carolina PA license is suspended indefinitely.

#### **BERMAN, Larry E, MD**

Location: Charlotte, NC (Mecklenburg Co)  
 DOB: 9/09/1959  
 License #: 0000-39238  
 Specialty: IM (as reported by physician)  
 Medical Ed: Sackler School of Medicine, Israel (1987)  
 Cause: In March 2001, Dr Berman entered into a Settlement Agreement and Consent Order with the U.S. government, agreeing to pay a settlement amount of \$1,470,000 to the government. The U.S. attorney contended that from September 1994 to July 1998 Dr Berman up-coded services he provided to patients in violation of the False Claims Act. Dr Berman did not admit he submitted false claims and the Agreement does not find he did so, but Dr Berman acknowledged he had an independent responsibility to ensure correct billing and he failed to fulfill that responsibility. He agrees that should he fail to do so in the future, that would be unprofessional conduct.

Action: 4/29/2005. Consent Order executed: Dr Berman is reprimanded.

#### **BRAY, Anthony David, MD**

Location: Burlington, NC (Alamance Co)  
 DOB: 11/15/1961  
 License #: 0094-00023  
 Specialty: FP (as reported by physician)  
 Medical Ed: University of North Carolina School Medicine (1992)

Cause: Dr Bray treated Patient A, an employee of his practice, from about January 2001 through June 2003. In January 2002, he began an intimate and sexual relationship with Patient A, lasting until July 2003. In July 2003, he assaulted Patient A in his office and a warrant for his arrest was issued based on that conduct. He was charged with assault on a female and received a prayer for judgment on the charge. Dr Bray treated Patient A's husband, Patient B, from April 2002 through March 2003. In July 2003, Patient B discovered the sexual relationship between his wife and Dr Bray. In August 2003, Dr Bray unlawfully damaged the personal property of Patient B by shooting the tire on Patient B's truck with a rifle. He was arrested for unlawfully discharging a firearm and damaging personal property. He received a prayer for judgment continued on the charge of injury to personal property and the charge of discharging a firearm in city limits was dismissed. In January 2004, the Board ordered Dr Bray to submit to an evaluation by the NCPHP and order that he cooperate fully with all evaluations and submit to further evaluations as deemed necessary by NCPHP. NCPHP previously evaluated Dr Bray and sent him a contract in January 2003 that required he obtain a comprehensive assessment at the Professional Renewal Center or other center approved by the NCPHP. Dr Bray signed that contract and obtained

an assessment at the Professional Renewal Center in September 2004. The assessment resulted in a determination that Dr Bray suffers from depression but is not unfit to practice. Dr Bray established a relationship with a physician and is receiving psychiatric care for treatment of major depressive disorder and adult attention deficit disorder.

Action: 11/01/2004. Consent Order executed: Dr Bray's license is suspended for 18 months; suspension is stayed subject to conditions; he shall maintain and abide by a contract with the NCPHP; he shall maintain a relationship with an NCPHP approved therapist; he shall return to the Professional Renewal Center for reevaluation in March 2005; he shall complete a CME course titled "Maintaining Proper Boundaries" at Vanderbilt and provide the Board documentation of his successful completion of the course no later than November 2005; must comply with other conditions.

**EATON, Hubert Arthur, Jr, MD**

Location: Wilmington, NC (New Hanover Co)  
 DOB: 5/25/1943  
 License #: 0000-17858  
 Specialty: IM (as reported by physician)  
 Medical Ed: Meharry Medical College (1969)  
 Cause: On Dr Eaton's application for reinstatement of his medical license. His license was summarily suspended in May 2003 and was indefinitely suspended by Consent Order in February 2004 due to allegations of substance abuse and improper prescribing. In January 2004, he completed a 12-week residential program for substance abuse. In February 2004, he signed a five-year contract with the NCPHP and is in compliance with that contract.

Action: 3/15/2005. Consent Order executed: Dr Eaton is issued a license to expire on the date shown on the license [7/31/2005]; he shall inform the Board in writing when he opens his practice and he shall work no more the 20 hours a week; 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 or any other abusable substance; he shall maintain and abide by a contract with the NCPHP; he shall provide medical records to the Board on request and shall cooperate with representatives of the Board who may appear for unannounced visits to his practice; must comply with other conditions.

**GILLILAND, Corey William, DO**

Location: Ft Bragg, NC (Cumberland Co)  
 DOB: 5/02/1967  
 License #: 2000-01486  
 Specialty: GP/AM (as reported by physician)  
 Medical Ed: University of Health Sciences College of Osteopathic Medicine (1999)

Cause: Dr Gilliland was arrested in Fayetteville and charged with 20 felony counts of Second Degree Exploitation of a Minor and 20 felony counts of Third Degree Exploitation of a minor relating to photographs found on his home computer. He pled no contest to 10 misdemeanor counts of Contributing to the Delinquency of a Minor in Cumberland County Superior Court. He was given a suspended sentence and placed on probation.

Action: 3/04/2005. Consent order executed: Dr Gilliland is

reprimanded.

**GOTTSCHALK, Bernard Joseph, MD**

Location: Wilmington, NC (New Hanover Co)  
 DOB: 5/10/1955  
 License #: 0000-30162  
 Specialty: IM (as reported by physician)  
 Medical Ed: University of Pittsburgh School of Medicine (1981)  
 Cause: To amend the Consent Order of 4/17/2003 to allow him to supervise physician extenders. He has complied with all the conditions of his 2003 Consent Order.

Action: 4/28/2005. Consent Order executed: Dr Gottschalk is issued a license to expire on the date shown on the license [3/31/2006]; 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 14 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; he shall attend AA and NA meetings as recommended by the NCPHP; he may supervise PAs, NPs, or nurse midwives; must comply with other conditions.

**HARRIS, Dennis Bret, Physician Assistant**

Location: Goldsboro, NC (Wayne Co)  
 DOB: 8/03/1967  
 License #: 0001-02356  
 PA Education: Kettering College (1997)  
 Cause: In May 2003, Mr Harris self-reported to the NCPHP seeking assistance with a possible substance abuse problem. He voluntarily entered a treatment center and successfully completed an intensive inpatient treatment program for substance abuse. He entered into a contract with the NCPHP and the NCPHP reports he has been compliant with that contract.

Action: 3/15/2005. Consent Order executed: Mr Harris' PA license is suspended for 30 days; suspension is stayed on terms and conditions; unless lawfully prescribed by someone else, he shall refrain from the use of mind- or mood-altering substances; he shall maintain and abide by a contract with the NCPHP; he shall obey all laws; must comply with other conditions.

**JAWA, Gurpreet Singh, MD**

Location: Raleigh, NC (Wake Co)  
 DOB: 5/03/1966  
 License #: 0097-00298  
 Specialty: P (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1992)

Cause: In August 2004, the Board received information Patient A had a personal, romantic, sexual relationship with Dr Jawa during and after the time she was his patient. During investigation, Dr Jawa proved cooperative with the Board and admitted the relationship with Patient A, which extended from November 2000 to August 2001. In August 2001, he advised Patient A to see another psychiatrist, which she did. They continued their relationship, however. In March 2004, Patient A ended her relationship with Dr Jawa. When the Board became aware of the relationship, it requested Dr Jawa surrender his license, which he did in October 2004. He has entered a health care facility that specializes in assessing and treating physicians who have committed boundary violations.

Action: 2/17/2005. Consent Order executed: Dr Jawa's license is indefinitely suspended

**KOMJATHY, Steven Ferenc, MD**

Location: Pope AFB (Cumberland Co)  
 DOB: 5/19/1969  
 License #: 0097-01440  
 Specialty: IM/GPM (as reported by physician)  
 Medical Ed: University of Maryland School of Medicine (1996)

Cause: Application for restoration of license. Dr Komjathy has a history of alcohol abuse. He surrendered his license in March 2004. He and the Board entered into a Consent Order on 7/02/2004 indefinitely suspending his license. He met with the Board in January 2005 to discuss his license application. He has been a participant with the NCPHP and has undergone inpatient treatment for alcohol abuse. The NCPHP reports he is in compliance with its contract. In January 2005 he entered a Consent Order with the Georgia Board that indefinitely suspended his license, based on the previous action of the North Carolina Board.

Action: 2/10/2005. Consent Order executed: Dr Komjathy is issued a license to expire on the date shown on the license [9/30/2005]; he must notify the Board should he intend to resume practice in the state; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; he must continue to attend AA and NA meetings; must comply with other conditions.

**LUGO, Raul Nelson, MD**

Location: Spartanburg, SC  
 DOB: 5/10/1954  
 License #: 2005-00498  
 Specialty: GS (as reported by physician)  
 Medical Ed: New York Medical College (1979)  
 Cause: On application for a license. Dr Lugo's New York medical license was suspended for six months in 2001 when he was accused of a boundary violation by one of his patients. He denies having committed any boundary violations and he is still actively licensed in New York. There are no other reports of misconduct by Dr Lugo. He has met with members of the Board to discuss his application.

Action: 4/20/2005. Consent Order executed: Dr Lugo is granted a North Carolina medical license; he shall meet with the Board whenever requested; he shall obey all laws and all rules and regulations related to the practice of medicine.

**MELGAR, Tammy Strickland, Physician Assistant**

Location: Wilmington, NC (New Hanover Co)  
 DOB: 12/02/1958  
 License #: 0001-03239  
 PA Education: NA  
 Cause: Ms Melgar practiced from June 2003 through July 2004 in Wilmington and treated family members. She did not keep appropriate patient charts relating to such treatment.

Action: 3/03/2005. Consent Order executed: Ms Melgar is

reprimanded.

**MUNCHING, Aaron Albert, Physician Assistant**

Location: Wilmington, NC (New Hanover Co)  
 DOB: 1/10/1961  
 License #: 0001-00016  
 PA Education: Alderson-Broadus (1990)  
 Cause: On application for reinstatement of license. In July 2001, Mr Munching signed prescriptions under the name of Dawn Quarfordt, MD, for hydrocodone, ostensibly for use by his father. At that time Dr Quarfordt was no longer licensed in North Carolina, did not have a DEA registration, and did not authorize use of her name. Mr Munching admits to writing prescriptions for patients under physicians' names and has done so for years; and he admits diverting part of the hydrocodone he prescribed for his father for his own use. Mr Munching has a substance abuse problem which required inpatient treatment. He has now completed that treatment and maintains a contract with the NCPHP. He surrendered his PA license in August 2001. In April 2003, he entered a Consent Order with the Board wherein his license was suspended indefinitely and agreed not to petition for reinstatement for at least one year. The NCPHP reports Mr Munching has complied with his NCPHP contract.

Action: 3/10/2005. Consent Order executed: Mr Munching is issued a license to expire on the date shown on the license [7/31/2005]; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other requirements.

**PRADHAN, Ashutosh Ashok, MD**

Location: Durham, NC (Durham Co)  
 DOB: 6/19/1974  
 License #: RTL  
 Specialty: NS (as reported by physician)  
 Medical Ed: Duke University School of Medicine  
 Cause: Dr Pradhan failed to disclose a 2002 criminal conviction on his annual registrations for 2002 and 2003. On his registration for 2004, he falsely reported the conviction had occurred in 2003.

Action: 4/14/2005. Consent Order executed: Dr Pradhan is reprimanded; must comply with other conditions.

**ROGERS, Bruce William, MD**

Location: Clayton, NC (Johnston Co)  
 DOB: 8/11/1947  
 License #: 0000-32563  
 Specialty: FP/EM (as reported by physician)  
 Medical Ed: Medical College of Pennsylvania (1982)  
 Cause: Between January and September 2003, Dr Rogers obtained Lortab® by fraud on at least six occasions, writing prescriptions using a patient's name but intending to use the medication himself. He voluntarily stopped practicing medicine in September 2003 and has not resumed practice. He successfully completed a four-month inpatient program in February 2004. He entered into an NCPHP contract and the NCPHP reports he has been compliant with the contract.

Action: 4/27/2005. Consent Order executed: Dr Rogers' North Carolina medical license is suspended indefinitely.

**THRIFT-COTTRELL, Alesia Dawn, MD**

Location: Elizabethtown, NC (Bladen Co)  
 DOB: 6/06/1964  
 License #: 2002-01318  
 Specialty: FP (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1997)

Cause: The Board learned from the Bladen County Hospital that Dr Thrift-Cottrell had written prescriptions on hospital forms for controlled substances for two patients not treated at the hospital during her employment there or when the prescriptions were written. She admitted writing the prescriptions and said they were written as part of her "Mobile Medical" practice, which lasted from late November to mid-December 2004. She did not have her own prescription blanks at that time. Her Mobile Medical practice consisted of her seeing patients in their homes or in her home. She prescribed controlled substances in an unacceptable manner and had inadequate medical records. She is now employed full time in an emergency department and her work there is proving acceptable to the department's manager.

Action: 4/26/2005. Consent Order executed: Dr Thrift-Cottrell's license is suspended indefinitely; such suspension is stayed on certain conditions; she shall remain employed at her present work location; she shall petition the Board's president for approval prior to changing her job site; she shall enter a contract with the NCPHP if judged necessary by NCPHP; she will be subject to prescription surveys; must comply with other conditions.

**WESLEY, Robert Benjamin, MD**

Location: Raleigh, NC (Wake Co)  
 DOB: 2/16/1966  
 License #: 0097-00420  
 Specialty: CD/IM (as reported by physician)  
 Medical Ed: Emory University (1992)  
 Cause: On more than one occasion, Dr Wesley prescribed Ritalin® and Fiorinal® to Patient A, who was a registered nurse and an employee of his practice. No prior physician-patient relationship existed between them and Dr Wesley authorized these prescriptions without performing a physical examination of Patient A. Dr Wesley also knew Patient A was being treated by another physician but he made no effort to contact that physician prior to authorizing the prescriptions.

Action: 2/19/2005. Consent Order executed: Dr Wesley is reprimanded.

**WHITE, Anne Litton, MD**

Location: Winston-Salem, NC (Forsyth Co)  
 DOB: 11/23/1954  
 License #: 0000-29552  
 Specialty: FP  
 Medical Ed: Indiana University (1980)  
 Cause: In several instances, Dr White's practice appeared to "upcode" office visits by billing for services that were not performed and by billing for services at a higher level than was medically justified. Further, Patient L specifically asked Dr White to give her injections of Perlane® and Restylane® for cosmetic reasons. Though neither Perlane® nor Restylane® was approved by the FDA for any purpose, Dr White complied with Patient L's request. Thereafter, the patient became dissatisfied and complained to the Board. During investigation, Dr White denied to the Board's investigator that she ever administered Perlane® and

Restylane®. Dr White admits there is evidence from which the Board can find she did, in fact, administer Perlane® and Restylane® and that her denials were false. Further, Dr White has advertised in local media and on her Web site that she practices dermatology. That advertising also states she is "Board Certified." However, she is not board certified in dermatology; she is certified in family medicine. Her use of the term "Board Certified" in her advertising creates the false impression that she is certified in dermatology. The Board has also received complaints including, but not limited to, inappropriate billing, improper use of untrained individuals performing cosmetic, medical procedures without proper supervision, and, on at least one occasion, having an unlicensed physician in her office assisting her during an office-based surgical procedure.

Action: 2/16/2005. Consent Order executed: Dr White's license is suspended for two years beginning 4/18/2005; said suspension is stayed for all but 60 days on terms and conditions; she shall submit to random audits of her billing records; she shall not advertise that she is "board certified" unless the ad notes clearly she is certified in family medicine; she shall not advertise her services in conjunction with any other physician who is board certified in a specialty other than family medicine unless it is clear she is only certified in family medicine; she shall not advertise her practice in the dermatology section of any directory of any kind; she shall certify within 30 days of this Consent Order and through an independent physician chosen by the Board that her office meets minimum standards for performing office-based surgeries, and any deficiencies shall be discussed with her and/or her staff, and if she fails to meet the certification requirement or fails to obtain an extension from the Board she shall cease to perform such procedures; all medical procedures must be performed by her or a licensed health care professional supervised by her while she is on site; she shall undergo an assessment by the NCPHP; must comply with other conditions.

**ZIMMERMAN, James Robert, MD**

Location: Atlanta, GA  
 DOB: 12/26/1960  
 License #: 2002-01209  
 Specialty: R (as reported by physician)  
 Medical Ed: University of Mississippi (1990)  
 Cause: In June 2004, the Mississippi Board entered into a Consent Order with Dr Zimmerman by which his Mississippi license was suspended, with a stay contingent on certain conditions. Mississippi had found that on his application for renewal in 2003 Dr Zimmerman had failed to disclose he was the subject of an investigation and disciplinary action by the Florida Board.

Action: 2/10/2005. Consent Order executed: Dr Zimmerman is reprimanded.

**MISCELLANEOUS ACTIONS****ROSNER, Michael John, MD**

Location: Hendersonville, NC (Henderson Co)  
 DOB: 12/04/1946  
 License #: 0000-26865  
 Specialty: NS (as reported by physician)  
 Medical Ed: Virginia Commonwealth University School of Medicine (1972)

Cause: Motion for modification of the Board's Order of

7/23/2004. In its earlier Order, the Board placed two conditions on Dr Rosner's continued practice. The second was that he could perform surgery for hypoplastic posterior fossa only when included in a formal research project under the oversight on Institutional Review Board (IRB). The IRB has expressed concern that this requirement may call on the IRB to do more than it is constituted to do and may imply patients are not free to choose whether to participate in research. To clarify this situation, the Board agreed to modify the prior Order.

Action: 3/10/2005. Board Order issued following a hearing on 2/17/2000 and modifying the previous Order as noted: Whenever Dr Rosner proposes to perform surgery for hypoplastic posterior fossa, he shall ensure the patient has first gotten a second opinion from another North Carolina-licensed neurosurgeon approved by the Board, though that opinion need not agree with Dr Rosner's in order for him to perform the surgery; Dr Rosner will conduct research on the effect of surgery for hypoplastic posterior fossa under the auspices of an IRB; he may perform the surgery when medically indicated and any given candidate may choose whether or not to participate in the research project, though if the candidate declines to participate Dr Rosner may perform the procedure as the non-research practice of medicine; Dr Rosner shall report to the Board quarterly, providing the name of each patient undergoing the procedure, the date of surgery, degree of tonsillar herniation (if any), and other specific information on each procedure.

#### DENIALS OF RECONSIDERATION/MODIFICATION

NONE

#### DENIALS OF LICENSE/APPROVAL

NONE

#### SURRENDERS

##### **OLCHOWSKI, Steven Edward, MD**

Location: Ionia, MI  
 DOB: 11/24/1947  
 License #: 0095-00169  
 Specialty: GS/CRS (as reported by physician)  
 Medical Ed: St Louis University (1973)  
 Action: 3/09/2005. Voluntary surrender of North Carolina medical license.

##### **KPEGLO, Maurice Kobla, MD**

Location: Greensboro, NC (Guilford Co)  
 DOB: 1/04/1949  
 License #: 0000-29314  
 Specialty: GP/PD (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1983)  
 Action: 4/25/2005. Voluntary surrender of North Carolina medical license.

##### **TRACY, Stephen Evarts, MD**

Location: Delmar, NY  
 DOB: 12/04/1950  
 License #: 0000-27986  
 Specialty: IM (as reported by physician)  
 Medical Ed: Albany Medical College (1981)  
 Action: 4/22/2005. Voluntary surrender of North Carolina medical license.

##### **WARD, Amy Elizabeth, MD**

Location: Winston-Salem, NC (Forsyth Co)  
 DOB: 9/19/1969

License #: 0096-00833  
 Specialty: A&IG/PD (as reported by physician)  
 Medical Ed: Bowman Gray School of Medicine (1995)  
 Action: 4/18/2005. Voluntary surrender of North Carolina medical license.

#### COURT APPEALS/STAYS

##### **LUSTGARTEN, Gary James, MD**

Location: North Miami Beach, FL  
 DOB: 2/26/1941  
 License #: 0000-25725  
 Specialty: NS (as reported by physician)  
 Medical Ed: University of Iowa (1965)  
 Cause: Appeal to Wake County Superior Court of the Board's Order of Discipline of 3/30/2004 (following a second hearing as directed by the Superior Court on 4/17/2003) suspending Dr Lustgarten's license for one year for unprofessional conduct in repeatedly testifying without a good faith or evidentiary basis that another physician's medical records were false.  
 Action: 4/15/2005. Wake County Superior Court Order issued affirming the Board's Order of Discipline suspending Dr Lustgarten's North Carolina medical license for one year.

#### CONSENT ORDERS LIFTED

##### **ARTIS, Karlus Cornelius, MD**

Location: Goldsboro, NC (Wayne Co)  
 DOB: 4/09/1964  
 License #: 0000-34782  
 Specialty: FP/OM (as reported by physician)  
 Medical Ed: East Carolina University School of Medicine (1990)  
 Action: 4/15/2005. Order issued lifting Consent Order of 8/06/2004.

##### **DONDIEGO, Richard Michael, MD**

Location: Reidsville, NC (Rockingham Co)  
 DOB: 1/15/1955  
 License #: 0095-01225  
 Specialty: IM/C (as reported by physician)  
 Medical Ed: Universidad Central Del Caribe School of Medicine (1981)  
 Action: 4/20/2005. Order issued lifting Consent Order of 11/03/2003.

##### **LEMAIRE, Pierre-Arnaud Paul, MD**

Location: Wilson, NC (Wilson Co)  
 DOB: 3/24/1960  
 License #: 0000-39440  
 Specialty: GS/VS (as reported by physician)  
 Medical Ed: University of Medicine and Dentistry of New Jersey (1985)  
 Action: 4/22/2005. Order issued lifting Consent Orders of 3/31/2003 and 11/05/2003.

#### TEMPORARY/DATED LICENSES:

#### ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

##### **CARLSON, James Lennart, MD**

Location: Cerro Gordo, NC (Columbus Co)  
 DOB: 11/20/1959  
 License #: 2002-00010  
 Specialty: FP (as reported by physician)  
 Medical Ed: Medical College of Wisconsin (1991)  
 Action: 3/18/2005. Temporary/dated medical license extended to expire 9/30/2005.

**DONDIEGO, Richard Michael, MD**

Location: Reidsville, NC (Rockingham Co)  
 DOB: 1/15/1955  
 License #: 0095-01225  
 Specialty: IM/C (as reported by physician)  
 Medical Ed: Universidad Central Del Caribe School of Medicine (1981)  
 Action: 3/18/2005. Full and unrestricted medical license issued.

**MOIR, Ronald Jeffrey, MD**

Location: Charlotte, NC (Mecklenburg Co)  
 DOB: 12/30/1956  
 License #: 0000-31176  
 Specialty: A/AM (as reported by physician)  
 Medical Ed: East Carolina University School of Medicine (1984)  
 Action: 3/18/2005. Temporary/dated medical license extended to expire 9/30/2005.

**SMITH, David Lewis, Physician Assistant**

Location: Wilmington, NC (New Hanover Co)  
 DOB: 9/19/1951  
 License #: 0001-01503  
 PA Education: Alderson Broaddus College (1992)  
 Action: 3/18/2005. Temporary/dated PA license extended to expire 7/31/2005.

*See Consent Orders:*

**EATON, Hubert Arthur, Jr, MD**  
**MUNCHING, Aaron Albert, Physician Assistant**

**REENTRY AGREEMENTS****VARANASI, Sangeeta Chughra, MD**

Location: Pinehurst, NC (Moore Co)  
 DOB: 4/01/1972  
 License #: 2005-00479  
 Specialty: IM (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1998)  
 Cause: On the application for a license following almost three years out of practice while on extended maternity leave. There is a need for her to complete a program of reentry into practice in order for the Board to issue her a license. She has completed over 150 hours of CME in the past two years and agrees to have her practice observed by a colleague for six months. That colleague will report on her clinical skills to the Board.  
 Action: 3/30/2005. Reentry Agreement and Order executed: the Board shall issue Dr Varanasi a full and unrestricted license; Dr Varanasi shall arrange to have a physician colleague observe her practice for six months and report on her work in a letter to the Board.

**DISMISSALS**

NONE

## CHANGE OF ADDRESS FORM

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

Please print or type: \_\_\_\_\_ Date: \_\_\_\_\_

Full Legal name of Licensee: \_\_\_\_\_

Social Security #: \_\_\_\_\_ License/Approval #: \_\_\_\_\_

(Check preferred mailing address)

Business: \_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Home: \_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

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

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Raleigh, NC



## North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: August 17-18, 2005; September 21-23, 2005;  
October 19-20, 2005; November 16-18, 2005

### 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](http://www.fsmb.org). If you have additional questions, please e-mail Amy Ingram, the Board's GME Coordinator, at [amy.ingram@ncmedboard.org](mailto:amy.ingram@ncmedboard.org) or visit the Board's Web site at <http://www.ncmedboard.org>.

#### Special Purpose Examination (SPEX)

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

North Carolina Medical Board  
1203 Front Street  
Raleigh, NC 27609