



forum

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



Charles E. Trado, MD

President's Message

George C. Barrett, MD: A Man of Rare Talents

George C. Barrett, MD, of Charlotte, one of our North Carolina Medical Board members, soon to complete six years of service on the Board, was elected to the vice presidency of the Federation of State Medical Boards of the United States at the Federation's recent meeting in Orlando, Florida.



Dr Barrett

Obviously, our Board members and staff are pleased that the member boards of the

Federation, which is made up of sixty-eight medical licensing jurisdictions, accorded Dr Barrett this high honor and privilege. In our opinion, a better choice could not have been made. Election to the Federation's vice presidency places him in line for the presidency of the Federation in the year 2000.

Dr Barrett is a man of rare and distinctive talents and he will bring those talents to bear on his work for the Federation, just as he has on his work for the North Carolina Medical Board. **"He is a true visionary"** He is a true visionary, possesses an outstanding intellect, and dedicates himself fully to whatever task is presented. His service as chair of numerous Board committees and as secretary/treasurer, vice president, and president of the Board has been characterized by a keen focus on the welfare of the public and ethical medical practice.

Dr Barrett's vision, clinical awareness, intelligence, and high ideals would be attributes enough for the job at hand. However, it is his commitment to integrity and character that elevates him among his peers.

The North Carolina Medical Board has been fortunate to work with and to be guided by a man of George Barrett's stature. We graciously loan him to the Federation for the benefit of our colleagues in licensing across the nation, knowing he will continue to do work vital to medicine and the welfare of the public as we approach the new millennium. ♦



Andrew W. Watry

From the Executive Director

The Privilege of Service

My first sentiment as the new executive director of the North Carolina Medical Board is gratitude. I am grateful to the Board for the privilege of service to the citizens of North Carolina.

There are several reasons why I describe this job as a privilege. I would like to comment on a few of them here.

Leadership

The North Carolina Medical Board has a proud and rich tradition of leadership. This is one of the oldest continuously functioning medical boards in the country, established April 15, 1859. Harold L. Godwin, MD, a current member of the Board, was appointed shortly thereafter and has served the Board honorably ever since.

I started working as a medical board executive 17 years ago and I was always impressed with the leadership of the North Carolina Medical Board in national affairs. Bryant L. Galusha, MD, of Charlotte, was the father of the uniform medical licensing examination, the USMLE. He was also president of the Federation of State Medical Boards (FSMB) in 1981-82 and executive vice president of that organization from 1984 to 1989. David S. Citron, MD, also of Charlotte, served on the Board of the FSMB and was, among other things, treasurer of the National Board of Medical Examiners. (I should mention that the Board's Joseph J. Combs, MD, and Frank L. Edmondson, MD, also served as presidents of the FSMB, the former in 1956-57 and the latter in 1971-72.)

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Primum Non Nocere



forum

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

Raleigh, NC

Vol. III, No. 2, 1998

The *Forum* of the North Carolina Medical Board is published four times a year. Articles appearing in the *Forum*, including letters and reviews, represent the opinions of the authors and do not necessarily reflect the views of the North Carolina Medical Board, its members or staff, or the institutions or organizations with which the authors are affiliated. Official statements, policies, positions, or reports of the Board are clearly identified.

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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in the country for communicating important medical regulatory information to licensees and the public. And other innovations have been implemented and are being explored that will be discussed in coming numbers of the *Forum*.

Looking Ahead

I would like to conclude with a word about where we are headed: that word is "forward." Though I am far too new in the service of this Board to speak for it in detail on that point at the moment, I can address administrative issues now.

The Board has made dramatic progress in giving consumers better and more timely turnaround time on complaints. We are working on improving use of our computer resources to manage complaints and provide the Board with the information it can use in making appropriate decisions. We are developing our business plan through a special meeting of the Board that will allow the staff to reassess priorities. We are improving the application process, providing new screening mechanisms to identify problem physicians at the application stage. We are looking at other enhancements, like supplying the license application on the Internet and working to lower some of the bureaucratic barriers to interstate mobility.

We are also exploring the options for change in the Medical Practice Act. For example, the Board's disciplinary options are limited in comparison to those available in other states and it is only a misdemeanor to practice medicine without a license in North Carolina.

We are looking at other ways to improve Board support and thus improve public protection. For example, we will make recommendations to the Board on committee structure and find other ways to meet the Board's needs more efficiently.

Conclusion

I am excited about being here. I am grateful for the privilege and I invite your comments. Please feel free to write to me at any time. We would also welcome the opportunity to tell you more about the Board. We are happy to make speakers available to various service and civic groups and to hospital staff and medical society meetings — just call or write our Public Affairs Office with your request — and please give us good advance notice.

We are here to serve the public and the professions we license and we are grateful for the privilege. ♦

Privilege of Service

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My friend and predecessor as executive director of the Board, Bryant D. Paris, Jr, served as a leader of the Administrators in Medicine, the national organization of medical board executives, and as a member of the FSMB's Board of Directors. And now, George C. Barrett, MD, is vice president of the FSMB — to be president of that organization in the year 2000.

The Board's contribution to the FSMB at the national level is particularly valuable, because the FSMB, the national voluntary membership organization of state medical boards, deals with pressing issues, such as the possibility of federal licensure, interstate mobility of physicians, telemedicine, and managed care. It also provides significant services to the boards, including a centralized disciplinary data base, monitoring critical federal and state legislation, administration of the USMLE, and a core credentials verification service.

Public Service and Commitment

In my opinion, of the services provided by

the legislature, those dealing with public protection are the most important. Every citizen of this state depends on the dedication and activity of this Board when he or she seeks the care of a physician, physician assistant, nurse practitioner, or EMT.

The work is important and it has to be done right.

We have an extremely dedicated staff that supports the Board. The Board's staff is its most important asset in achieving its public mandate. I am particularly privileged to be a part of this staff.

Innovation

The Board is poised to resolve problems in innovative ways. It has an extremely effective program for the evaluation and treatment of impaired physicians through the North Carolina Physicians Health Program. It is developing what could be a national model for the assessment and evaluation of physicians with competence, cognitive, and physical problems that may hinder their ability to practice with reasonable skill and safety.

This publication, the *Forum*, is an innovative effort, providing one of the best vehicles

Death Registration: The Physician's Responsibilities

A. Torrey McLean, State Registrar, North Carolina Vital Records, State Center for Health Statistics, Department of Health and Human Services



The process of death registration in North Carolina is complicated by the many unusual circumstances of death and by several other factors. The latter include the availability of those individuals involved in the registration process, the grief of the families concerned and their desire to achieve swift closure to the grieving process, and the need to provide reasonable confidentiality both to the decedents and to their families.

Requirements and Responsibilities

Accurate data about each death are essential for health and safety research and for public health programs to reduce infant mortality and the spread of AIDS and other contagious diseases. In order to facilitate the proper and efficient registration of each death in the state, the North Carolina General Statutes (NCGS) and the North Carolina Administrative Code (NCAC) assign specific legal responsibilities to physicians, funeral directors, hospital staffs, health department personnel, the chief medical examiner, and the state registrar.

NCGS 130A-115 specifically requires the funeral director who first assumes custody of a body to prepare the death certificate, secure the physician's signature, and file the record with the appropriate health department within five (5) days after the death. Additionally, NCAC T15A: 19H.0501 requires hospital staff to provide the funeral director with the name of the deceased, the

date the death occurred, and the name of the attending physician or medical examiner who is legally responsible for certification of the medical facts of death.

"NCGS 130A-115 requires the attending physician or medical examiner to complete cause-of-death information and sign each death certificate within three days after the death occurs."

The physician's responsibilities arise at this point in the process. NCGS 130A-115 specifically requires the attending physician or medical examiner to complete cause-of-death information and sign each death certificate within three (3) days after the death occurs. When the cause or causes of death cannot be ascertained because of a pending autopsy or laboratory test, that should be

stated on the death certificate and the certificate then signed and forwarded to the health department. The supplementary information should be sent directly to the health department as soon as it becomes available in order that accurate cause-of-death information can be added to the certificate.

Medical Examiner's Role

Untimely, violent, unusual, and unattended deaths are automatically considered to be medical examiner cases and each such certificate must be signed by the medical examiner of the jurisdiction. Specifically, medical examiners handle cases of death

- (1) involving or suspected of involving homicide;
- (2) by suicide or suspected suicide;
- (3) by trauma;
- (4) by accident;
- (5) by disaster or violence;
- (6) by unknown, unnatural, or suspicious circumstances;
- (7) while in custody of law enforcement;
- (8) involving poison or suspicion of poison;
- (9) during surgical or anesthetic procedures;
- (10) that is sudden and unexpected;
- (11) that is without medical attendance.

Natural Death

On the other hand, each natural death falls under the authority of NCGS 130A-115 and NCAC T15A:19H.0503, which specify that the physician who last treated the deceased is responsible for completing the cause-of-death information on the death certificate. If that physician is not available, the physician who pronounced death or an associate physician or a physician on call for the attending physician may sign the certificate.

NCGS 130A-97 requires local health directors to administer and help enforce death registration requirements in their

counties or districts. Inherent in this requirement is the responsibility of assisting physicians, hospital personnel, and funeral directors in the resolution of problems. Finally, NCGS 130A-92(a) specifically directs the state registrar ". . . to require the provision of information to make the records complete and satisfactory." This obliges the state registrar to assist in all phases of the registration process when necessary to resolve problems and to report serious or chronic violations of the statutes to the appropriate authorities.

"NCGS 130A-97 requires local health directors to administer and help enforce death registration requirements in their counties or districts."

Recent Problems

During recent years, numerous problems involving death registration have arisen. These problems include obtaining the correct identities of the deceased, determining the appropriate attending physicians in unusual cases, helping to determine which cases are medical examiner cases, protecting the privacy of decedents and their families insofar as legally possible, obtaining physicians' signatures when the attending physicians are not available, and replacing lost certificates.

In every case, effective communication between the physician concerned, the funeral director involved, local health department personnel, and the appropriate state office has enabled the problem to be resolved and the death registered. Many of these situations have caused delays that resulted in failure to meet the specific time requirements of NCGS 130A. However, when communication with and cooperation among the parties involved occurs, the state registrar has considered such delays to have been unavoidable and has not taken legal or administrative action.

Assistance Is Available

Both the state registrar and the chief medical examiner are available to provide direct assistance when necessary to resolve any

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George C. Barrett, MD, Former President of NCMB, Elected Vice President of Federation of State Medical Boards



George C. Barrett, MD

On Saturday, May 2, 1998, in Orlando, Florida, at their Annual Meeting, the members of the Federation of State Medical Boards of the United States elected George C. Barrett, MD, of Charlotte, as the Federation's vice president, placing him in position to become president of that organization in 2000.

Dr Barrett has been a member of the North Carolina Medical Board since 1992, has chaired most of the Board's committees at one time or another, and was president of the Board in 1996-97. He has also been a member of the Federation's Board of Directors since 1996.

A native of Roxboro, North Carolina, he is a graduate of the Bowman Gray School of Medicine and did his postgraduate training at Buffalo General Hospital, Duke University Medical Center, North Carolina Baptist Hospital and Bowman Gray School of Medicine.

He is certified by the American Board of Radiology, with a medallion in nuclear medicine. In 1986 and 1989, he pursued advanced studies in bioethics at the Kennedy Institute of Georgetown University in Washington, DC. He is a fellow of the American College of Radiology and a member of the North Carolina Medical Society, the Mecklenburg County Medical Society, and numerous other professional organizations.

The Federation of State Medical Boards of the United States, founded in 1912, is the national voluntary membership organization of state medical boards. It has 68 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.)

Among other things, the Federation, with the National Board of Medical Examiners, is responsible for the United States Medical Licensing Examination (USMLE). It also 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.

Andrew Watry, executive director of the North Carolina Medical Board, has noted that Dr Barrett is continuing the Board's distinguished record of leadership in the Federation. Over past years, three members of the Board have served as presidents of the national organization: Joseph J. Combs, MD, in 1956-57; Frank L. Edmondson, MD, in 1971-72; and Bryant L. Galusha, MD, in 1981-82. The Board's David S. Citron, MD, served on the Federation's Board of Directors in the 1980s, and Dr Galusha served as the Federation's executive vice president from 1984 to 1989.

"I can think of no better person to lead our national organization into the new century and the new millennium," Mr Watry said. "He will bring the same creative vision and dynamism to the Federation that he has shared with the Board." ♦

Ultram® Is Not For Addicts

Robert C. Vanderberry, MD
Medical Director, NCPHP

When Ultram® (tramadol) first came out, it was touted as the next non-addicting oral treatment for moderate to moderately severe pain. Even the *Medical Letter*, on July 7, 1995, stated that "despite some opioid activities, tramadol has not been scheduled as a controlled substance." *The Medical Letter* said that "a controlled trial in former drug addicts" found no subjective effects with 75 or 150 mg of tramadol given parenterally, indicating little potential for abuse.

In 1995 and early 96, seven of our NCPHP participants had positive drug screens for tramadol. All stated that it had been detailed as a non-addictive pain medication and they hoped they had finally found something they could use for pain. One of the seven had definite subjective

effects and let the detail man know in no uncertain terms that for him it was mind altering. We began to tell our participants to avoid this medication.

It didn't take long for the manufacturer, Ortho-McNeil, to find out the true nature of their product. Being an agent that binds to the E-opioid receptors and inhibits the reuptake of norepinephrine and serotonin, it is not surprising that it did prove to be addictive to chemically dependent people.

A medical release from Ortho-McNeil on March 20, 1996, stated that there had been 115 spontaneous reports of adverse events described as drug abuse, dependence, withdrawal, or intentional overdose. It was concluded that patients with a past or present history of addiction or dependence on opioids should not use Ultram®.

There it is, folks — the definitive word. It is now routinely included on the North Carolina Physicians Health Program drug screen. ♦

Death Registration

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death registration problem in the event efforts of the health department staff have failed. Additionally, staff in the Vital Records Branch of the State Center for Health Statistics include field service representatives who are available to assist in the resolution of problems anywhere in the state. With good-faith efforts to comply with registration requirements, effective communication with local health department personnel, and cooperation by all parties involved, we can continue to achieve fast and accurate death registration in North Carolina.

In the event of a problem involving the completion of any death certificate, first call the deputy registrar or the director of the local health department. If the problem cannot be resolved, contact the staff of the Vital Records Branch's Field Services Program at (919) 733-3526, or, if the problem involves a medical examiner case, the Office of the Chief Medical Examiner at (919) 966-2253. No matter how complex the problem, assistance is available.

Finally, let me thank you for your cooperation in performing your important role in this state's death registration process. ♦

"With good-faith efforts, we can continue to achieve fast and accurate death registration in North Carolina."

The Impaired Physician: Twelve-Step Recovery Programs

Daniel M. Avery, MD, President

American Society of Forensic Obstetricians & Gynecologists

Alcoholics Anonymous (AA) was founded in 1935 by Bill Wilson (Bill W.), a New York stockbroker, and Bob Smith (Dr Bob), an alcoholic surgeon. Many alcoholics worldwide have achieved and maintained sobriety through AA since then. An excellent discussion of twelve-step recovery programs is presented in a recently published book entitled *Drug Impaired Professionals*, by Robert H. Coombs, and much that follows is drawn from Coombs material on self-help recovery.

Mutual Help and Encouragement

Many other twelve-step programs have appeared since AA was founded, most based upon the same principles established by Wilson and Smith in 1935. These include Narcotics Anonymous, Cocaine Anonymous, Co-Dependence Anonymous, Al-Anon, Alateen, Adult Children of Alcoholics, Emotions Anonymous, Gamblers Anonymous, and Overeaters Anonymous. These organizations and others like them have become so much an integral part of our culture that they are even occasionally used for comedic effect, as in a recent television reference to "Potato Chips Anonymous."

All twelve-step programs are based on mutual help and encouragement. AA meetings, for example, consist of successfully recovering alcoholics sharing personal experiences, strength, and hope with others recently recovering or non-recovering. The cornerstone of sobriety through AA is "The Big Book," an average-sized book of 575 pages officially entitled *Alcoholics Anonymous*. It has been published by Alcoholics Anonymous World Services, Inc, throughout the world in practically every written language. Over the years, additions have been made to the original true anecdotal stories of recovering alcoholics, but the principles, called "Twelve Steps to Recovery" and "The Twelve Traditions," have remained essentially unchanged. Over 2,000,000 have stopped drinking through AA, making it the most effective means for alcoholics to achieve sobriety.

The Steps and Traditions

The Big Book lists the "Twelve Steps to Recovery."

1. We admitted we were powerless over alcohol — that our lives had become

unmanageable

2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly ask Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our efforts.

The Big Book also lists "The Twelve Traditions."

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority — a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose — to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance or lend the A.A. name to any related facility or outside enterprise, lest

problems of money, property and prestige divert us from our primary purpose.

7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

AA Today

Today, AA meetings are held around the clock in 134 countries and most U.S. cities. Each starts with "The Serenity Prayer": *God grant me the serenity to accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference.* New members normally attend 90 meetings in their first 90 days of recovery, then at least three meetings a week or as many as they need. Each may also request a same-sex sponsor, who should have at least two years of sobriety if possible, be willing to sponsor another member, and be available 24 hours a day if called.

AA is based on recovering members helping others achieve sobriety, and meetings are available at all hours of the day or night. There are also programs for families and spouses. More alcoholics have gained and maintained sobriety through AA than all other means combined, including inpatient hospitalization, halfway houses, counseling, and individual therapy.

Alternatives

Some alcoholics, however, feel that AA is not for them, the most common complaint

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Impaired Physician

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being the emphasis on spirituality and a higher power. Rational Recovery (RR) was formed in 1986 as an alternative to AA, deleting the concept of spirituality. A basic premise of RR is that sobriety can be achieved with complete cure in six to twelve months. AA, on the other hand, teaches that one has the disease forever.

Secular Organizations for Sobriety (SOS) was established in 1987. It is self-described as a secular approach to recovery, separating sobriety from religion or spirituality. Like AA, it regards addiction as a chronic, progressively fatal disease and recognizes total abstinence as the primary treatment goal.

Woman for Sobriety was founded in 1975. It addresses issues specific to women alcoholics and is reported to have 250 to 300 groups in the U.S. with about 500 members. Moderation Management was begun in 1993. It utilizes 30 days abstinence from alcohol followed by drinking in moderation. It is not recommended for chronic alcoholics.

Professional Groups

A number of professional groups have been founded involving physicians, dentists, pharmacists, nurses, lawyers, and other professionals. International Doctors of Alcoholics Anonymous was established in 1949 as a support group for recovering alcoholic physicians and their membership is constantly growing. They address the specific needs of recovering physicians. In the early 1980s, Dr Doug Talbott, co-founder of the Talbott-Marsh Recovery Campus in Atlanta, started the Caduceus program for recovering health care professionals. Today, Caduceus is active in every major U.S. city and many foreign countries.

Birds of a Feather International was created in 1976 by and for recovering pilots, advocating two to three AA meetings each day. The Airline Pilots Association subsequently established its Human Intervention and Motivation Study (HIMS) to rehabilitate commercial pilots impaired by alcohol, safely returning over 90% to the cockpit. Prior to HIMS, a violation of federal or company alcohol regulations permanently canceled a pilot's commercial license and ended his or her career.

The Other Bar was founded in 1971 by and for alcoholic attorneys with most of its chapters in California, Oregon, and Washington, while organizational efforts have been less than successful in the southern U.S. A similar group was formed in

1975 as International Lawyers of Alcoholics Anonymous. Dentists Concerned for Dentists was organized for impaired dentists.

Coombs describes about 750 self-help and mutual support groups in the U.S. with an estimated 15 million members. Self-help groups are probably the most important aspect of all recovery programs, and Coombs provides an excellent description of them.

Whether impaired, recovering, or neither, everyone should read *Drug Impaired Professionals* cover-to-cover. There is a lot to be learned.

References

1. Coombs, RH. *Drug Impaired Professionals*. Cambridge: Harvard University Press, 1997.
2. *Alcoholics Anonymous*. New York: Alcoholics Anonymous World Services, 1976.

Reprinted with permission from the April 1998 number of the American Society of Forensic Obstetricians and Gynecologists publication *The Medicolegal OB/GYN Newsletter*. For information about the ASFOG, write William D. Daniel, MD, PO Box 536, Buckhannon, WV 26201, or telephone (304) 472-8594. ♦

Crossing the Invisible Line: An Impaired Physician's Pilgrimage

An Anonymous North Carolina Physician

It is difficult to pinpoint when and how I became an addict because the line between customary habits and active addictions is invisible and because denial is the paramount problem. The point of crossing the invisible line can only be suggested in retrospect.

Perhaps I was born with an addictive personality. You can't tell when you cross the

"You can't tell when you cross the line, and once you have crossed it, your life steamrolls downward."

line, and once you have crossed it, your life steamrolls downward. Not only are you living in denial, very often you're living in blackouts and, in fact, have no memory of whole stretches of time. When you finally come to, you can't explain your behavior. Eventually, you can't explain how your life comes crashing down. You lose everything you cherish and hold dear.

Losing Everything

In the society in which I lived, social drinking was and still is well established. All social gatherings are still attended by copious consumption of alcohol. Moreover, it was usual to have a drink in my home, to keep some in the office, and to have a drink at the end of the day. But, in time, what started out as the norm for felicitous occasions became a daily drinking pattern.

Moreover, I had found that amphetamines would appear to interrupt the effect of alcohol fairly quickly if I had "one too many." I had experimented with amphetamines in medical school and carried on their use in post-graduate training and medical practice. The combination seemed to satisfy an alcohol and amphetamine "deficiency" that had somehow taken hold of me. They appeared to help me work harder and longer hours and to take on increasing responsibilities. However, my devotion to work would be interrupted by periods of physical and emotional collapse that required psychiatric help and time off. But in short order, the drinking would resume and the use of amphetamines would follow.

Eventually, I got totally lost in work and substance abuse and over time it all fell apart for me. I was caught in a trap while in full flight from reality. I was addicted and my whole life caved in. I lived in and out of blackouts. My behavior was completely unpredictable. I lost my family, I lost my practice, I lost my home, I moved from place to place and lost job after job. The downward spiral of my life could not be interrupted by all the concerned and loving human agencies advanced to sustain or save me at the time. My life was not livable and I tried more than once to end it.

I did not understand I suffered from a spiritual illness, that a complete psychic change would take a spiritual program of recovery, and that it would take a miracle to get me there. I didn't know that miracle awaited me. It came in the form of another physician who had himself suffered from alcoholism and was in recovery and, subsequently, from other physicians in recovery. And it came from other people in Alcoholics Anonymous, a number of whom I had grown up with in my home town. They invited me in and for the first time in years I felt a sense of belonging. I was no longer an outcast. They asked me to join them in a fel-

"My life was not livable and I tried more than once to end it."

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Invisible Line

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lowship, in a different way of life and in a spiritual pilgrimage. The years I have spent in and out of this program of recovery trace my own pilgrimage.

A Chronic, Progressive, Deadly Disease

And so, I am a person who has suffered the ravages of alcoholism/addiction for many years and my story is not unlike the stories of all those other persons who have this affliction. My disease is chronic, progressive, and deadly. Its inevitable consequences are insanity and premature death. But along the way it strips its victims of everything dear and cherished in this life: family, friends, fortune, position, self-respect, personal dignity, and, finally, the will to live. All the while, it assures them they don't have a problem, that everything is the result of circumstances, bad luck, institutions, other people, misunderstandings, harsh judgments. The list is endless, but to the end "it's somebody else's fault." The victim and his family are mired in the insanity of the disease.

The disease affects an estimated 26 million people in this country alone. It is the disease nonpareil of isolation, loneliness, alienation, rejection, and bitter self-destruction. In its web are the traps of delusion, despair, distortion, and abject hopelessness. It is cunning, baffling, and powerful. Without help, the victims are doomed. Long-suffering family and friends and professionals stand helpless and bereft. Society is left wanting. Entire lives are turned upside down, many are blighted.

But alcoholism/addiction can be interrupted through a program of recovery. My own case and the cases of countless others are witness to the power of such a program to change the lives of people once considered to be hopeless.

Struggling to Recover

My problems came to the attention of the North Carolina Medical Board (NCMB) 10 years ago. I had enjoyed a few years of sobriety in the program of AA beginning 10 years prior to relapsing the first time. It is important to understand the thinking that leads to relapses. It can lay a subtle and often disguised trap. Failure to heed warning signs

"Failure to heed warning signs are an ever-present danger to the alcoholic/addict."

is an ever-present danger to the alcoholic/addict. The lessons of relapse often fall hard and are crushing at times, but the disease is very patient. It takes the vigilance of caring others to interrupt a victim's backsliding early on; hence, the necessities of sponsorship and supervision that are pivotal in the equation of recovery — the necessity for an on-going program of support and spirituality.

Fortunately, in 1988, the North Carolina Physicians Health Program (NCPHP) was begun under the auspices of the NCMB and the North Carolina Medical Society with Robert Vanderberry, MD, as its medical director. I signed the second contract offered and over a period of several years fulfilled the contractual agreement. My recovery went well as long as I remained close to my program. Unfortunately, in 1995, I suffered a devastating relapse that nearly ended my life and I came back eventually to Dr Vanderberry, the NCPHP, and the NCMB. I entered my second contractual agreement, becoming the 700th client in the program. Today, I believe that number has reached about 800 and is growing.

In contrast to many other states, North Carolina has an outstanding program of physician rescue and recovery. While carefully protecting the public, the NCMB has chosen to rehabilitate as many of its impaired physicians as possible through the NCPHP, to see them restored to their families, their communities, and their practices. The victims of impairment are not automatically forced to languish in limbo, increasing their anguish and devastation. Despite setbacks in some individual cases, our rate of recovery is unmatched nationally. Thank God we have chosen to take the lead in rehabilitating our professionals.

"North Carolina has an outstanding program of physician rescue and recovery."

The Gift of Recovery

We are dealing with the protean manifestation of a deadly disease, compounded by isolation, alienation, loneliness, self-destructiveness, delusion, distortion, dislocation, and certain death. It is a spiritual sickness and its remedy lies in a program of spiritual searching and renewal. This is the essence of the NCPHP. The witness to the power of a program of support and recovery is clear in the restored lives of all who are continuing to be helped at this moment, countless persons like me.

It is the greatest of blessings for me and others like me to be able to practice medi-

cine in North Carolina and to be a member of the NCPHP. It is the blessing of being able to live and practice our profession.

At a recent meeting I attended with members of the NCMB and the NCPHP, I expressed my eternal gratitude, both for myself and many, many others, for everything that has been done for me and continues to be done for me to help me recover, to be restored to my family, my profession, and my community. They have given me back my personal dignity, integrity, and my will to live! What greater gift can one bestow on another?

I thank my God for these wonderful, loving, concerned, and very caring people — each and every one of them.

The author would be pleased to talk with others interested in the issue of physician impairment. Please write the editor of the Forum, Dale Breaeden, at the NCMB for information on contacting the author. ♦

Patient-Physician Mediation: The Mecklenburg County Experience

*William A. Walker, MD, Chair
Mecklenburg County Medical Society
Mediation Committee*



Dr Walker

Patient dissatisfaction with physicians seems to have become more visible over the past few years. As a service to its members and the citizens of Mecklenburg County, the Mecklenburg County Medical Society (MCMS) has established a Mediation Committee to aid in resolution of conflicts between patients and physicians. The Committee's goal is to mediate and, if possible, resolve complaints brought by patients through an evenhanded and objective review of both patient and physician viewpoints, suggesting, if necessary, possible actions to resolve the disputes.

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Patient-Physician Mediation

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It may also refer cases to the Disciplinary Committee of the MCMS if it feels the actions of a physician represent a violation of the bylaws of the Medical Society. It does not function as a legal group, disciplinary body, regulatory agency, or licensing body, and it takes no part in business disputes, legal disputes, or questions of malpractice.

The Process

The process begins with a telephone call or written request to the MCMS for a complaint form. In Mecklenburg County, the address is published frequently in *The Charlotte Observer's* health section under the heading: "To complain about a doctor." Once the request is received, the patient is sent a letter describing the complaint process and the purpose of the Mediation Committee. The patient is asked to explain in writing the nature and circumstances of the complaint and to provide any documentation available.

When this material is received by the Committee, the physician is contacted and given a copy of the patient's complaint. The physician is required by MCMS bylaws to respond in a timely fashion to both the Committee and the patient. Very often, this is the end of the process. Both the physician and the patient discover a point of misunderstanding that is easily settled once they comprehend the circumstances leading to the complaint. Examples of this type of problem include billing questions, perceptions of rudeness by the physician or staff, or problems getting records or access to the physician. An explanatory letter with an apology or adjustment of the bill as needed usually ends the matter.

More Difficult Problems

Sometimes a patient is not satisfied with the physician's response. When this happens, the Mediation Committee carefully reviews both the patient's complaint and the physician's response. The Committee may contact the physician after this review and suggest a course of action that it believes will lead to a resolution of the problem. Physicians are sometimes too close to the problem or may have become personally invested to the point that objectivity may

have been lost. A simple suggestion from the Committee can often restore a sense of perspective to the situation, allowing a resolution. A \$20 balance on a patient's account is rarely worth fighting over.

At times, due to very honest and legitimate differences of opinion between the patient and physician, the Committee must tell the patient that we were unable to resolve the complaint. The Committee expresses regret at this and thanks the patient for taking the time and effort to go through the process.

If a complaint suggests a serious problem, such as drug use or inappropriate activities with patients, it is forwarded immediately to the North Carolina Medical Board. Such a situation would also result in a review by the Disciplinary Committee of the MCMS. In addition, complaints about non-members of the MCMS are forwarded to the Medical Board.

Results

How has this system worked in Mecklenburg County? In 1997, 65 requests for complaint forms were made. Fourteen forms (22%) were returned to the Mediation Committee. Nine (64%) of the complaints filed were resolved by the physician's initial reply. Five (36%) of the complaints were reviewed by the Committee. Only one of the latter was resolved. The other four were found to be honest differences of opinion with no further action necessary by the Committee.

When these complaints were classified, nine involved quality of care, three related to fees or billing, and two involved professional manner (rudeness, for example). Although these numbers are small, there are undoubtedly many problems that are unreported. Most people simply do not want to bother with the process.

Communication Often the Key

Based on the experience of the Mediation Committee and our discussions, a lack of communication underlies almost every complaint. Even when complaints are not resolved by the Committee, the process itself

"Lack of communication underlies almost every complaint."

is a valuable tool for educating both the patient and physician about the importance of communicating with each other. A few minutes spent explaining the rationale of a course of therapy or diagnosis or of the options available to the patient sometimes avoids hours of effort trying to correct a misunderstanding later.

Likewise, a willingness to inform the patient of the costs involved will also help avoid surprises to the patient when a bill arrives. Rarely will there be a problem if a physician treats a patient as he or she would

like to be treated or would like a member of his or her family to be treated. Interacting with patients with this simple premise in place will almost certainly eliminate the vast majority of complaints about professional manner.

Yes, there are truly difficult patients, but it's our job not to be truly difficult physicians. ♦

"It's our job not to be truly difficult physicians."

New DNR Order Form Availability

In the last number of the *Forum*, Nancy M.P. King, JD, presented an article on the newly developed portable Do Not Resuscitate Order (DNR Order) that replaces the Out-of-Facility Order (the "yellow form") that has been in use since 1991. Quite a few requests have been received by the *Forum* on how physicians can obtain copies of the new DNR Order.

A recent memo from the North Carolina Medical Society (NCMS) indicates that the new DNR Order forms will no longer be supplied by the NCMS. Instead, they will be distributed by local Emergency Medical Service (EMS) units or their designees. A call to the NCMS should elicit the name and number of the EMS unit or designee that can supply you with the form. If you find no distribution agent in your area has been designated as yet, the NCMS can advise you on another approach to obtaining a copy.

Meanwhile, the NCMS has sent information about the new form to every county medical society. It plans to send a sample copy of the form and educational material to each NCMS member with the July *NCMS Bulletin*, which will contain an article on the form.

NOTE: The telephone number of the North Carolina Medical Society is (919) 833-3836 or (800) 722-1350. ♦

Requesting Medical Board Materials and Services: Don't Forget Your Address and Any Fee That May Be Due

Helen Diane Meelheim, JD
NCMB Assistant Executive Director



Ms Meelheim

Few people realize that the North Carolina Medical Board makes a number of informational and educational materials available free to the public and its licensees. It also has some special services for institutions and professionals that require payment of a fee and/or the filing of a form. In both cases, whenever materials or services are requested, it is important that a full mailing address be included in the request. And in those cases when a fee and/or form is required, they should be enclosed with the request. One of our biggest problems in trying to assist both the public and the health care professions in taking advantage of the Board's materials and services is that we often receive no return postal address or an incomplete return address, and, in applicable cases, no payment of the fee required or completed form.

Free Materials

Copies of a booklet containing the North Carolina Medical Practice Act (NCGS Chapter 90), the North Carolina Administrative Code: Title 21, Chapter 32 (the Rules of the Board), and the official Position Statements of the North Carolina Medical Board are available to anyone free on request. A brochure explaining the structure, function, and authority of the Board is also available free on request.

The public may ask for information on licensed health care practitioners by simply calling or writing the Board. And when a licensee has a public file involving some disciplinary action against her or him, up to 50 photocopied pages of the file can be made available without cost. (It is necessary to charge 5¢ per page beyond the first 50 pages — but few public files run to that length.)

The Board's nationally recognized quarterly publication, the *Forum*, is sent free of cost to all licensees, all libraries in the state, the print and electronic media, and others involved in health care throughout the state.

Requests for free materials may be made by telephone (919.828-1212 or 919.326-1100), fax (919.828-1295 or 919.326-1131), e-mail (ncmedbrd@interpath.com) or regular mail (PO Box 20007, Raleigh, NC 27619). In all cases, remember to provide your postal address! And during regular office hours (8:30AM to 5:00PM), you may come by the Board's office (2101 Front Street, Raleigh, NC) to pick up materials.

Internet Site

Some of the Board's materials are also available on the Internet. The Medical Practice Act, the applicable Administrative Code, the Board's Position Statements, selected articles from the *Forum*, the text of the Board's brochure, the Board's most recent disciplinary reports, and a variety of articles about the Board and its work appear on the Board's web page. That page also contains a feature called DocFinder that makes it possible to check on individual licensees and see if they have a public file with the Board. (The DocFinder feature is updated once a month.)

This web page can be reached at www.docboard.org: simply hit the North Carolina logo when you access that site. The Board makes no charge for this access; it is provided as a free service.

Fees Required

When a hospital, health care institution, insurance company, or similar entity wants to verify a license, the fee is \$15 and must accompany the request. Special reports can be generated from the Board's data base (eg, a listing of persons in a certain specialty in certain counties) for a fee of \$100. A full roster of the Board's licensees can be had in electronic format (on disk) for \$25. Mailing labels are available and are printed at the Board's cost, the price varying with the type of label requested.

A number of health care institutions subscribe to the Board's DataLink service so they can verify licenses by direct computer connection with the Board. Those who would like to consider subscribing to this service need only call the Board at (919) 828-1212, extension 211, or (919) 326-

1100, extension 211, for further information. (Those who are not subscribers and do not now plan to subscribe may make an appointment during regular office hours to come to the Board and access the same information without cost. To make an appointment, call the same Board extension: 211.)

The incorporation of a professional entity requires that the proper forms and the fee be submitted together — if not, the result will be a significant delay in completing the process because the Board's staff will have to write the applicant to request the missing items.

Please Help Us Help You

The Board and its staff are eager to provide licensees and the people of North Carolina information and service in an efficient and timely way. You can help us do that by being sure you enclose your postal mailing address when requesting materials and by attaching any fees or completed forms your request may require. ♦

TAKE NOTE

Stadol® Now Controlled Substance

Stadol® (butorphanol tartrate) is now a controlled substance. It was added to the Federal Controlled Substance List on October 1, 1997, as Schedule IV. State laws and rules will soon be changed, but the federal classification takes precedence and the laws and rules relating to controlled substances now apply to Stadol®. ♦

A REVIEW



Dr Roufail

Am I My Brother's Keeper?: The Ethical Frontiers of Biomedicine

Walter M. Roufail, MD

Former Member and President, NCMB

By the time I finished reading the 218 pages of Dr Caplan's book, the April issue of the *Atlantic* magazine had arrived, featuring an article by Edward O. Wilson, the Harvard sociobiologist, entitled: *The Biological Basis of Morality*. Having gone through the demanding reading of his challenging essay, I glanced at the April 1 issue of the *Annals of Internal Medicine* and there I found three articles dealing with the end of life and euthanasia, followed by three editorials on various ethical and moral problems confronting medicine and physicians.

Am I My Brother's Keeper?: The Ethical Frontiers of Biomedicine

Arthur L. Caplan

Indiana University Press, Bloomington, 1998.

232 pages, \$24.95 cloth
(ISBN: 0-253-33358).

Are we witnessing a form of ethical overload? A passing fad? Ethics committees are the order of the day, national meetings devote whole programs to the subject, and both the medical and lay press are replete with articles and horror stories concerning the moral behavior, or lack thereof, of certain physicians and medical institutions. I would like to think of it as a healthy sign, a rebirth of the dialogues of the School of

Athens, provided we keep the exchanges within civil bounds. I am particularly pleased by the inclusion of non-physicians in the debate because I view the societal ethics of life and death, of rights and responsibilities, in much more need of definition and refinement than professional ethics, which have been around for centuries.

Caplan is not a physician. He is a bioethicist and is presently professor of bioethics and director of the Center of Bioethics at the University of Pennsylvania. Bioethicists are relative newcomers in academia. However, he has been interested in the field for a long time, as evidenced by the number of articles and books he has authored dating back to the early 1980s. I am impressed by his familiarity with the medical fields he addresses, and by his knowledge of history and philosophy.

scriptorium logo

The Cult of the Personal

In the preface, which I suggest should be read last, he links the mores of present American society to the cynicism of that society towards the medical profession. The "cult of the personal" is so pervasive that any rational discussion about who may benefit from the near miracles of present day biotechnology is, to say the least, somewhat difficult. To date, the word *rationing* is almost synonymous with *discrimination*. More appropriate might be to "forego the personal for the benefit of the whole," to become your brother's keeper. Caplan says:

The primary reason bioethics seem so hard and to some simply impossible is that we have lost our faith in our ability to see others as our brothers. Instead we view doctors as our enemies, our insurers as our adversaries, those who make our

drugs and our devices as plotting to rip us off, and each other, when seriously ill, burdens that should be carried rather than as fragile members of community who need our help much as sometimes we will need theirs.

A sad state of affairs.

From Unethical Experiments to Managed Care

Caplan divides his book in five parts, each section containing between three and seven essays. He focuses at times on very specific problems affecting a relatively small segment of society and at other times explores more universal and historical topics. Themes recur in various essays, but this is inevitable considering the range of subjects discussed. The ethical response to these heterogenic situations is limited by the supposition that professional ethics are more of a constant within a narrow range rather than arbitrary and capricious.

Part one explores in vitro fertilization, the use of data from unethical medical experiments, fetal tissue transplantation research, and whether we should glean any lesson from the artificial heart project. I do generally agree with his views, although I do not

believe that more regulations or legislation will help solve those problems.

He espouses a different view in the first essay of the second part: "The Baby Doe Controversy." He asks appropriately: "Whether the federal government has a place at the bedside." Medical futility is the subject of the second essay. Although the author agrees that "evidence based outcome standards" are necessary to informed judgments about the effectiveness of certain therapies, he states categorically that "Without trust [between patient and physician] outcomes based medicine is doomed." He will have no argument from me. The two other essays, on the Holocaust and on euthanasia and Dr Kevorkian, would have been more appropriately placed in section five, where we shall return to them.

Part three deals with "Transplantation

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Review

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whether from cadavers, living donors, or xenografts from primates and genetically manipulated lower mammals." In this series of essays, the author raises the intriguing question: "...whether medicine should simply stop doing transplants or do as many as can be done whatever human cadavers organs and tissues are available." I am afraid we are beyond that sensible argument. Humankind has for millenniums incorporated in its collective psyche the idea that feasting on the raw organs of a successful hunt or cannibalizing defeated enemies added to one's valor, strength, and life span. Now that the myth has become reality, transplantation is here not only to stay but also to expand exponentially. Presently, the debate is how to procure the maximum number of organs and whether we should compensate donors financially before or after death. An Organ Exchange or Futures Market could even be contemplated (an idea that even Adam Smith might find repugnant). The debate, in my view, should focus on post-transplant quality and usefulness of life and on whether the State should reappear at the bedside (it already has) mandating organ donation and demanding equal access to all.

Part four deals with the all too familiar subjects of health and personal responsibility, ethics and managed care, access, and limited resources. Caplan confronts these issues in three comprehensive essays. Unfortunately, bioethicists and physicians have been bypassed in the debate that now continues in the halls of state legislatures and the Congress. Nothing much helpful can come out of that.

Death

To the five essays appearing in part five I shall add the two previously mentioned dealing with the Holocaust and Dr Kevorkian. All seven take us beyond the immediacy and the actuality of the preceding essays and highlight Caplan's philosophical and historical bent. They deal with ideas, social concepts, eugenics, genocide, and mercy killing as well as morality as viewed by modern intellectuals. I will not attempt to comment on each and every one of those topics. The interested reader should study them carefully and patiently. Two themes should be commented on, however, the first being the perception of morality (ethics) as a divine (theological) imperative or a genetically determined (Darwinian) means of survival for the human species. E.O. Wilson labels the two factions as Transcendentalists and Empiricists. The debate started in the Age

of Enlightenment with Newton, Descartes, and Rousseau and will continue, I should guess, for centuries to come. The whole question of death and the longing for immortality is also brought forward and does have significant implications for physicians, particularly in the field of genetic manipulation.

Death by killing and the physician's role in it is the subject of more than one essay. The Holocaust is a prime example of physicians and bioscientists actively participating in a theory of eugenics that resulted in the experimentation on and the slaughter of millions of their own "genetically defective" and elderly, as well as those of Semitic and other "unacceptable" genetic pools. Were those physicians fundamentally evil or convinced that they were embarked on a mission to improve the human genetic pool? Were they guiltier than those who perpetrate the theologically inspired genocide of Northern Ireland, Bosnia, or India? And what of the tribally inspired killing in Rwanda, Somalia, and Sudan, which is closer to E.O. Wilson's genetically determined morality?

Killing, whatever excuse one may want to find for the act, is surely anathema to the most fundamental oath of the physician: "First, do not harm." To me, it is doing the ultimate harm, whether in carrying out a medical experiment, delivering an injection for a death sentence, giving compassionate assistance in a suicide, or, forgive the political incorrectness, causing the death of a

fetus. I believe Caplan shares this view. My only trepidation is that he might leave the door open ever so slightly to any ambiguity in this matter. Medicine should insist on the dogma of healing and doing no harm across cultures. This does not mean that the avoidance of death at all costs should be the primary concern of all physicians. They should be attuned to the cycles of nature, whether cruelly short or painfully long. Healing and soothing should be their primary goal. Mercy killing has no place in this discussion.

Conclusion

The book comprises a total of nineteen essays. Of note is the absence of a twentieth, which should address one of the most divisive moral issues before the American people today: Abortion. I have noticed a reluctance to bring this issue forward at meetings or in published symposia dealing with ethics and the medical profession.

Dr Caplan raises a wide range of ethical issues, not all of which will confront the practicing physician on a daily basis, of course. He also observes the present radical transformation of American society. The delivery of health care will have to accommodate to meet the changes that transformation is bringing. Unless physicians participate in the debate and stand up for basic professional ethics, the autonomy they so cherish will be further constricted by edicts and legislation. ♦

LETTERS TO THE EDITOR

By the Way, You Could Make a Referral

To the Editor: In the No. 1, 1998, NCMB *Forum* article, "By the Way, Are You Married?", the anonymous author describes a female patient in his dermatology practice who wrote him to thank him for his care in excising a benign lesion from her arm. She went on to inquire about his marital status and state that her brief contacts with him were more caring than the whole of her new marriage. "What do you think?" she wrote, and she closed, "By the way, if any of this means you cannot be my doctor, please disregard it."

The author apparently understood this note to be a proposition for nonprofessional contact, and the full note may have conveyed that message more strongly. He described his self doubt and his decision, after discussion with a colleague and his wife, who is a physician, to write her a brief reply stating in part that her flattering note "breached the

principle of objectivity on which the doctor-patient relationship is based." He then terminated their "association" and instructed her on how to find another dermatologist and have her records transferred.

The author clearly attempted to act ethically in this case. He hoped to avoid encouraging the patient or becoming embroiled in obsession. The advice he received was that there should be no compromise with his patient and that the unhealthy situation should be ended immediately. He had felt unprepared by his medical education for this type of interaction. He was thankful that she did not bring up her feelings in person, and he felt unsure how he would react in the future to any such interaction.

As a psychiatrist, I would recognize this interaction as an expression of this patient's transference, an attribution to the doctor of feelings inappropriate to the present situa-

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Letters

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tion and arising from the patient's past. The author appeared to take the patient's note at face value as a proposition directed at him. His trusted colleague pointed out that she seemed needy and was projecting these needs onto the doctor. Transference takes place in varying degrees of perceptibility in virtually every doctor-patient relationship. The so-called negative transferences of frustration or even hatred from the patient in the face of the doctor's sincere effort to be helpful are often more disturbing and easily recognized than the often subtle and flattering "positive" transferences.

As clinicians, we often rely on the patient's idealization of us as a means to give our recommendations force. When the positive transference exceeds warm gratitude or mild idealization, clinicians can react in a number of ways, including taking advantage of patients. The recognition of transference and a capacity to tolerate countertransference, broadly defined as the doctor's emotional response to the patient and the patient's transferences, should be fundamental aspects of the clinical education and personal development of all physicians.

In this case, the doctor discharges the patient summarily. There would have been great danger in encouraging this patient's inappropriate and unrealistic hopes for a relationship with the doctor, but solutions other than discharge are possible. For example, a physician ought to be able to address directly and in person the patient's emotional needs. Clinical medicine occurs in the context of strong human emotions. To say to her something as simple as "It must be hard to feel so unhappy in your marriage" does not necessarily lead the patient on and, hopefully, it allows some clear evaluation of the problem based presumably on unmet emotional needs in the new marriage, but possibly on something deeper. Extensive counseling or therapy by the doctor may not be indicated, but an offer to refer the patient for such treatment or further evaluation would be very appropriate if not more ethical than a rejecting discharge.

As a psychiatrist, I have no trouble referring my patients to a dermatologist. Likewise, there should be no trouble making a referral in the other direction.

Burton R. Hutto, MD, Assistant Professor
Director, Psychotherapy Education Program
Department of Psychiatry
University of North Carolina at Chapel Hill

Brutally Discharging the Patient

To the Editor: In a recent NCMB Forum (No

1, 1998), there was an anonymous essay entitled "By the Way, Are You Married?" in which a fledgling dermatologist discharged a patient from his service because she asked him if he was married! Not exactly *primum non nocere* in my book. As physicians, we are (should be) trained to deal with pathology and disease. This applies to psychological as well as physical ailments. The patient, "Mrs Dalyrimple," was obviously troubled in her own relationships yet bold enough to send a message of help. Her reward — blunt rejection from a physician she obviously respected. "No compromise" is not always sound advice. Though it got the physician out of an uncomfortable situation, it probably injured a very sensitive patient.

Now I know that dermatologists may not be well trained in psychiatric matters, but this pseudo-dilemma could have been handled without brutally discharging the patient. If I, as a family practitioner, discharged everyone who might harbor fond feelings for me, untold damage would be done. We are, after all, supposed to be professionals able to handle unusual circumstances and personalities without "freaking out" as I believe the physician and his seemingly uptight (jealous?) wife did in this case. Perhaps he (and she) should examine their own sexual politics and try to be more tolerant. It would have been far better for the patient to follow her for the dermatological problems with a professional demeanor (with a female nurse in the room if need be), and to work into the conversation some advice for bettering her marriage by offering referral to psychiatry or marriage counseling.

In publishing this essay in the *Forum*, I certainly hope it is not the desire of the Medical Board that all NC physicians act in this callous manner.

PS: I am also sending this letter to the *NC Medical Journal*, as it is doubtful that *Forum* will actually print opposing views (I have yet to see one).

James Stewart Campbell, MD
MEDesign
Pfaftown, NC

The Author Responds

To the Editor: The letters above raise a good question. What is my duty to follow up the now exposed psychological problems of the patient I am discharging?

Although the facts of this case as presented in the article may not make this clear, I felt that the only course was to have no further direct doctor-patient interaction with Mrs Dalyrimple. A personal meeting to discuss this emotionally charged issue would have subjected us both to further embarrass-

ment and would likely have had no therapeutic benefit now that she had been discharged.

I do agree that additional evaluation is warranted. The issue of offering this is a difficult one. How do you extend a helping hand while avoiding professional and medicolegal risk? I suppose if she were to have made her feelings known during a visit, further inquiry into the basis of her transference could have been safely made and appropriate care planned. (As the article notes, I would not necessarily have had the presence of mind to do this then, but, with my current experience in these matters, would be able to now.)

Could I have put forth the suggestion of follow-up for her emotional problems in the letter I sent her? Yes, I think that would have been the most appropriate action in this instance. ♦

NP-PA Drug Education Requirements

Many questions have arisen regarding the continuing education requirements for nurse practitioners and physician assistants in regard to controlled substances. The rules are similar, but not identical.

The nurse practitioner rule, NCAC 21:32M.0006, requires that "at least three hours of continuing education every two years shall be the study of prescription drugs, controlled substances, and illicit drugs." On the other hand, the physician assistant rule, NCAC 21:32O.0006, requires only that "[t]he physician assistant who wishes to prescribe controlled substances shall complete at least three hours of CME every two years on the medical and social effects of the misuse and abuse of alcohol, nicotine, prescription drugs (including controlled substances) and illicit drugs."

Neither rule specifies how the education must be obtained or what type of CME is required. The choice belongs with the practitioner. Many courses are offered in hospitals, national organizations, AHECs, or commercial ventures. Finding the course that meets the need of the individual, whether on the internet, in a journal, with a post test, in a formal class, or through organized programs, is the challenge of the individual.

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

February-March-April 1998

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

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

Consent Order:

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

Denial:

Final decision denying an application for practice

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

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

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

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

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

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

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

REVOCATIONS

NONE

SUSPENSIONS

See Consent Orders:

JAMES, Paul Marshall, Jr, MD

KILGORE, Larry Charles, MD

SUMMARY SUSPENSIONS

HALL, Jesse McRae, Physician Assistant

Location: Sanford, NC (Lee Co)
Lillington, NC (Harnett Co)

DOB: 6/23/56

License #: 1-01830

Education: Fort Sam Houston (1991)

Cause: Mr Hall may be a habitual user of intoxicants or drugs to such an extent that he is unable to safely perform medical acts.

Action: 3/26/98. Order of Summary Suspension of License issued (effective April 8, 1998).

NABORS, Dennis R., Physician Assistant

Location: Greensboro, NC (Guilford Co)

DOB: 7/26/50

License #: 1-02153

Education: University of Washington (1976)

Cause: Mr Nabors may be a habitual user of intoxicants or drugs to such an extent that he is unable to safely perform medical acts.

Action: 2/14/98. Order of Summary Suspension of License executed. (Effective as of 2/26/98.)

CONSENT ORDERS

BLEMINGS, Ginger Dobbins, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)

DOB: 8/30/63

License #: 1-01410

Education: Bowman Gray (1991)

Cause: Consideration of the license status of Ms Blemings. The Board learned previously that Ms Blemings failed a drug screen given by her employer and on 3/28/97 issued an order of Summary Suspension of License and a Notice of Charges and Allegations against her alleging, in essence, she had a problem with substance abuse; on 4/24/97, she surrendered her license as a physician assistant; she admits that prior to her license surrender, she had been using alcohol, marijuana, and cocaine. She has under-

gone some four months of inpatient treatment for chemical dependency; she has also been under treatment for bipolar disorder, which treatment is going well.

Action: 4/06/98. Consent Order executed: Ms Blemings' license surrender is accepted and the Board dismisses without prejudice the Notice of Charges and Allegations of 3/28/97; she is issued a dated temporary license to expire on the date shown on the license (5/31/98); unless lawfully prescribed by someone else, she shall refrain from use of mind or mood altering substances and from the use of alcohol; she shall undergo drug and alcohol screens as requested by the Board; she shall maintain and abide by a contract with the NCPHP; she shall not practice as a PA without first having obtained written approval from the president of the Board of the proposed supervising physician; she shall have her psychiatrist send reports on her treatment to the Board three times each year; she shall provide all her current and prospective supervising physicians, including backups, with a copy of this Order; must comply with other conditions.

COYNE, Mark Dennis, MD

Location: Stoney Creek, NC (Guilford Co)

DOB: 8/12/49

License #: 00-33493

Specialty: EM/FP (as reported by physician)

Medical Ed: Chicago Medical School (1983)

Cause: Application for reinstatement of license. Dr Coyne admitted and admits having had a problem with alcohol abuse for which he has, from time to time, been treated; he has admitted and admits that he relapsed in his recovery last year; he surrendered his license in a Consent Order dated 11/22/97. He now has a relationship with the NCPHP and has told the Board he has been clean and sober since his relapse; he has expressed a recommitment to recovery.

Action: 2/11/98. Consent Order executed: Dr Coyne is issued a license to practice medicine, limited to emergency medicine and urgent care, to expire on the date shown on the license (3/31/98); unless lawfully prescribed by someone else, he shall refrain from the use of all mind or mood altering substances and all controlled substances and from the use of alcohol; he shall notify the Board within two weeks of his use of such medication or alcohol, identifying the prescriber and the pharmacy filling the prescription; at the Board's request, he shall cooperate with physical screening to determine if he has used any of the substances mentioned; he shall maintain and abide by a contract with the NCPHP and make his employers aware of that contract; he shall attend AA meetings as recommended by the NCPHP; must comply with other conditions.

FELDMAN, Rhonda Glen, Physician Assistant

Location: Boone, NC (Watauga Co)
 DOB: 10/26/63
 License #: 1-01966
 Education: Duke University (1995)
 Cause: To replace the Consent Order of 1/10/96, which modified the Consent Order of 8/16/95.
 Action: 3/02/98. Consent Order executed: Ms Feldman is issued a dated license to expire on the date shown on the license (1/31/99); she shall appear before the Board when requested to do so; she shall maintain and abide by a contract with NCPHP; at the Board's request, she shall cooperate with physical screening to determine if she has used controlled substances; she shall inform her supervising physicians of her history of addiction and arrest and of the terms of this Consent Order; must comply with other conditions. The terms and conditions of this Consent Order supersede those in all previous Consent Orders regarding Ms Feldman.

HOLTKAMP, John Harry, MD

Location: Raleigh, NC (Wake Co)
 DOB: 11/20/54
 License #: 00-28045
 Specialty: CHN/PD (as reported by physician)
 Medical Ed: New York University (1980)
 Cause: To amend Dr Holtkamp's Consent Order. He surrendered his license on 1/17/97 due to a relapse in his alcoholism and the Board issued him a dated license under a Consent Order on 7/23/97; he continues to abide by his contract with the NCPHP and attends AA meetings; he reports that he continues clean and sober; he must limit his working hours to assure his continued recovery.
 Action: 2/05/98. Consent Order executed: Dr Holtkamp's license is extended to expire on the date shown on the license (5/31/98); unless lawfully prescribed by someone else, he shall refrain from use of all mind or mood altering substances and all controlled substances and from the use of alcohol; at the Board's request, he shall cooperate with physical screening to determine if he has used any of the substances mentioned; he shall maintain and abide by a contract with the NCPHP; he shall continue attendance at AA meetings; he shall not practice more than 32 hours a week unless approved by the president of the Board; he shall obtain at least 50 hours of CME relevant to his practice, including 30 hours of Category I CME, each year; must comply with other conditions.

JAMES, Paul Marshall, Jr, MD

Location: Holts Summit, MO
 DOB: 2/17/33
 License #: 00-16695
 Specialty: GS/TRS (as reported by physician)
 Medical Ed: Hahnemann University School of Medicine (1959)
 Cause: Dr James entered an agreement with the Board of Healing Arts of Kansas in which he agreed to certain disciplinary measures restricting his license to practice in Kansas.
 Action: 2/03/98. Consent Order executed: Dr James' North Carolina license is indefinitely suspended.

JORDAN, Richard Liming, MD

Location: Raleigh, NC (Wake Co)
 Jacksonville, NC (Onslow Co)
 DOB: 6/14/46
 License #: 00-19612
 Specialty: FP (as reported by physician)
 Medical Ed: Vanderbilt University (1971)
 Cause: To amend the Consent Order of 10/16/96; Dr Jordan has been diagnosed with bipolar disorder and continues to receive treatment for this condition; he is taking the prescribed medication and is free from symptoms of any mood disorder; he seems to be working effectively about 45 hours per week.

Action: 2/25/98. Consent Order executed: Dr Jordan shall maintain a physician/patient relationship with a psychiatrist approved by the president of the Board; he shall direct his psychiatrist to send quarterly reports on his progress to the Board and to inform the Board immediately if Dr Jordan experiences severe neuropsychiatric problems that could jeopardize patient care; he shall meet with the Board as requested; he is encouraged to attend at least two bipolar group meetings a month and maintain a log of the meetings he attends for submission to the Board; he shall obtain at least 50 hours of CME in his field each year; must comply with other conditions.

KILGORE, Larry Charles, MD

Location: Fayetteville, NC (Cumberland Co)
 DOB: 12/20/50
 License #: 00-26550
 Specialty: FP (as reported by physician)
 Medical Ed: University of Arkansas (1981)
 Cause: On the matter of the Notice of Charges and Allegations dated 10/20/97 against Dr Kilgore. He owned and operated a weight loss clinic in Fayetteville from 5/96 through 9/97; with new weight loss patients, he usually prescribed a three week supply of one or more anorectic drugs (each of which is a Schedule IV controlled substance that may only be prescribed by those registered with the attorney general of the U.S.); he instructed patients to return to the clinic one week after completing their supply of anorectics; when patients returned, he did not meet with or examine them to determine if it was medically appropriate to continue taking the drugs; he abdicated this responsibility to a nutritionist and a laboratory technician that worked at the clinic; they decided whether to reissue the prescriptions; those employees did not have legal authority to prescribe drugs and were not registered to prescribe controlled substances, but they decided, within broad guidelines given by Dr Kilgore, whether to reissue prescriptions; when the employees decided the patient could continue taking the anorectics, they gave the patient a new prescription that Dr Kilgore had presigned for the purpose; Dr Kilgore also authorized the employees to call local pharmacies and prescribe anorectics using his name whenever they ran out of presigned prescriptions; from May through December 1996, the clinic treated some 1,800 new patients, most of whom received prescriptions from the employees during a follow up visit; Dr Kilgore admits that delegating to the employees in this way was unprofessional conduct.

Action: 3/21/98. Consent Order executed: Dr Kilgore's license is suspended for one year; the suspension shall be stayed for three years as long as he complies with the following terms: (a) by 12/31/98, he shall attend the Clinical, Legal, and Ethical Issues in Prescribing Abusable Drugs program of the Florida Medical Association and the University of South Florida, or a similar course approved by the president of the Board, and shall certify to the Board that he attended and successfully completed that course; he shall obey all state and federal laws and regulations; he shall appear before the Board whenever requested; must comply with other conditions.

MARSIGLI, Eduardo Oscar, MD

Location: Rocky Mount, NC (Edgecombe/Nash Cos)
 DOB: 7/01/42
 License #: 00-19514
 Specialty: ORS (as reported by physician)
 Medical Ed: University of Buenos Aires, Argentina (1967)
 Cause: In November 1996, Dr Marsigli performed surgery on a patient's left knee when the procedure should have been done on the right knee; he acknowledges he did not take appropriate steps prior to surgery to prevent this type of error, failing to write pre-operative orders, to review the patient's office chart, and to review the MRI films; Board review of several other patient charts revealed illegible or incomplete notes.

Action: 2/19/98. Consent Order executed: Dr Marsigli is reprimanded; he shall obtain an evaluation of his professional competence from a consultant selected by the Board and cause a copy of the evaluation to be sent to the Board; he shall obtain and document 50 hours of Category I CME relevant to his practice each calendar year; must comply with other conditions.

MEAD, Robert J., Jr, MD

Location: Asheboro, NC (Randolph Co)
 DOB: 12/13/45
 License #: 00-32790
 Specialty: AN/PD (as reported by physician)
 Medical Ed: Jefferson Medical College (1978)
 Cause: Application for a license to practice medicine. Dr Mead was first given a temporary license in August 1988; license surrendered due to substance abuse problems in July 1989; again given a temporary license under a Consent Order in July 1989; license again surrendered due to substance abuse problems in July 1993; issued a temporary license under a Consent Order in August 1994; on 9/19/96, license summarily suspended on information he had written prescriptions for a controlled substance for himself on several occasions by forging other physicians' signatures and had relapsed in his recovery from substance abuse; he surrendered his license on 7/06/97; on 11/05/97, he reapplied for a medical license. Dr Mead has over a year of sobriety and continues to meet with a psychiatrist concerning his recovery efforts and other issues; he regularly attends AA and Caduceus meetings; he has a contract with and is a participant in the NCPHP.

Action: 2/05/98. Consent Order executed: Dr Mead is issued a dated license to expire on the date shown on the license (3/31/98); he shall not practice without prior approval of the president of the Board as to type and location of practice, number of hours worked, and length of proposed employment; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions

NABORS, Dennis Ray, Physician Assistant

Location: Greensboro, NC (Guilford Co)
 DOB: 7/26/50
 License #: 1-02153
 Education: University of Washington (1976)
 Cause: Regarding the Board's Notice of Charges and Allegations against Mr Nabors dated 2/14/98. On or about 6/05/97, Mr Nabors entered into a Stipulation Settlement and Disciplinary Order with the PA Examining Committee of the Medical Board of California in which he admits: that on 9/19,20,23/94 he represented he was acting with authorization and on a physician's order when he transmitted prescriptions purportedly for his wife to various pharmacies several controlled substances; that he did this without good faith examination or medical indication and without a patient-specific order or authorization from the physician; that he used or self-administered these controlled substances; that on 6/12/91, he was convicted in California, on his guilty plea, of driving while having a blood alcohol level of .08 or more on 5/11/91 and was placed on probation for three years. On 6/19/96, Mr Nabors signed an application for a PA license in North Carolina, answering "no" to the question: "Have you ever been charged with any violation of any federal, state, or local law?" He also answered "no" to the questions: "To your knowledge, have you ever been the subject of any investigation conducted by a medical board, the United States Drug Enforcement Administration, or any other governmental regulatory agency?" and "Have you ever personally used or consumed any drugs or controlled substances other than those prescribed for you by a physician or dentist?" He admits that by giving those answers, he fraudulently or deceptively obtained a PA license. On 1/15/98, he presented a prescription for a controlled substance, dated 3/24/97, signed by him as a PA and written to his wife, to a pharmacy in Greensboro, NC; the prescription was written on a Primacare preprinted form, although he last worked for Primacare six months previously and no longer had authority to

use its forms; he engaged in similar activity on 1/19/98, 1/23/98, 1/29/98, and 1/30/98; he admits that by this conduct he fraudulently or deceptively used his PA license; throughout this period he was not registered to dispense controlled substances and was in violation of the Federal Controlled Substances Act, which he admits; he admits that he is a habitual user of intoxicants or drugs to such an extent he is unable to practice safely.

Action: 4/20/98. Consent Order executed: Mr Nabors surrenders his North Carolina PA license; the Board accepts his license surrender and dismisses its case without prejudice.

POWELL, Thomas Edward, MD

Location: Durham, NC (Durham Co)
 DOB: 7/11/64
 License #: 98-00439
 Specialty: AN (as reported by physician)
 Medical Ed: University of Texas, San Antonio (1995)
 Cause: Application for a license to practice medicine in NC. Dr Powell was issued a resident's training license on 7/03/96. While employed as an anesthesia resident, he diverted hydromorphone hydrochloride, a Schedule II drug, for his personal use. Dr Powell admitted to a substance abuse problem and desired help; he signed a contract with the NCPHP on 8/21/97 and is in compliance with its terms; from 8/21/97 through 11/21/97, he underwent treatment at the Farley Center in Williamsburg, VA, which he successfully completed; he is involved in an active recovery program with AA and Caduceus; on 1/22/98 he voluntarily forfeited anonymity to the Board by applying for a full license.

Action: 4/09/98. Consent Order executed: Dr Powell is issued a dated temporary license to expire on the date shown on the license (9/30/98); he shall practice only in a structured setting approved by the president of the board; he shall provide a copy of this Order to all current and future employers prior to beginning work; he shall not register with the DEA to prescribe controlled substances and shall not purchase, administer, prescribe, dispense, or order controlled substances defined as such under the federal Controlled Substances Act; unless lawfully prescribed by someone else, he shall refrain from use of mind or mood altering substances and from the use of alcohol; he shall report to the Board within two weeks any use of such medication or alcohol, including the identification of the prescriber and the pharmacy filling the prescription; he shall undergo drug and alcohol screens as requested by the Board; he shall maintain and abide by a contract with the NCPHP; he shall not prescribe any drug for his own use; he shall obtain 50 hours of Category I CME relevant to his practice each year; must comply with other conditions.

PULEO, Joel Gregg, MD

Location: Pinehurst, NC (Moore Co)
 DOB: 9/15/53
 License #: 00-27965
 Specialty: OBG (as reported by physician)
 Medical Ed: Duke University School of Medicine (1979)
 Cause: To make modifications in the Consent Order of 11/97. Dr Puleo has sought the Board's permission to practice in another setting in service to his community.

Action: 3/03/98. Consent Order executed: Dr Puleo is issued a temporary/dated license to expire on the date shown on the license (5/31/98) and limited to the Columbus, Cumberland, Harnett, Hoke, Robeson, and Scotland County Health Departments, and to the obstetric clinics operated by both Robeson Health Care Corporation and Southeastern Regional Medical Center; he shall limit his practice with the Columbus and Scotland County Health Departments to AIDS prevention and treatment; he shall obtain 50 hours of Category I CME each year; he shall not see any patient without a chaperon being present; he shall not supervise PAs, NPs, or nurse midwives; must comply with other conditions. The numbered paragraphs of this Consent Order supersede paragraphs 1-11 of the Consent Order of 11/97.

REESE, Perry, III, MD

Location: Cary, NC (Wake Co)

DOB: 8/17/58

License #: 94-00988

Specialty: FP (as reported by physician)

Medical Ed: Wayne State University (1990)

Cause: Regarding the Board's Notices of Charges and Allegations against Dr Reese of 5/29/97 and 6/25/97. Under a Consent Order dated 6/07/96, Dr Reese, among other things, was to have a chaperon present during all examinations of female patients; prior to executing that Consent Order, he was evaluated and treated at the Behavioral Medicine Institute with no remarkable findings; on 11/22/96, he was issued a temporary/dated license, which expired 5/31/97 and was not reissued; on 1/19/97, while he was employed as an ER physician at a North Carolina hospital, he examined a female patient without a chaperon being present; the close nature of the examination and the way in which Dr Reese palpated the patient's abdomen made her uncomfortable; Dr Reese left the examination room and the patient advised the charge nurse that she was uncomfortable, which was communicated to Dr Reese; he then reentered the examination room without a chaperon; Dr Reese admits examination of the patient without a chaperon present violated his Consent Order.

Action: 3/19/98. Consent Order executed: effective 6/01/98, Dr Reese shall be issued a temporary/dated license to expire on the date shown on the license; once licensed, he shall limit his practice only to male patients; he shall provide a copy of this Consent Order to all current employers and to future employers before beginning work; he shall obtain and document 50 hours of Category I CME relevant to his practice each calendar year; in the event he presents competent evidence to the satisfaction of the Board with respect to his ability to practice safe medicine and surgery, the Board may lift any limitations imposed by this Consent Order; must comply with other conditions.

SUVILLAGA, Victor Ivan, MD

Location: Wilmington, NC (New Hanover Co)

DOB: 10/19/48

License #: 00-26877

Specialty: FP/EM (as reported by physician)

Medical Ed: University of El Salvador (1979)

Cause: To modify the Consent Order of 6/12/97. Dr Suvillaga has been practicing pursuant to his Consent Order and is apparently doing well.

Action: 4/27/98. Consent Order executed: Dr Suvillaga is issued a temporary/dated license to expire on the date shown on the license (7/31/98); he shall practice only in a structured setting approved by the president of the Board in writing; he shall not practice in a solo, unsupervised practice under any circumstances; he shall practice no more than 45 hours a week; he may not supervise NPs or PAs; he shall not administer, prescribe, dispense, or order any controlled substances classed as Schedule II or II-N; he shall not apply to the DEA for registration to administer, prescribe, dispense, or order controlled substances in Schedule II or II-N; he shall continue his therapy and treatment and shall have the therapist send annual reports to the Board; he shall notify his employers of this Consent Order; he shall obtain and document 50 hours of CME relevant to his practice each year, including at least 30 hours of Category I; must comply with other conditions. The terms and conditions of this Consent Order supersede those of the Consent Order of 6/12/97.

TARASZKA, Steven Robert, MD

Location: Atlanta, GA

DOB: 4/22/65

License #: 96-00070

Specialty: AN (as reported by physician)

Medical Ed: St Louis University (1991)

Cause: Consideration of the Summary Suspension and case against Dr Taraszka. On 2/02/96, the Vermont Board issued charges against Dr Taraszka based on a Petition for Emergency Suspension dated 1/31/96; that petition alleges a relatively large quantity of "drug paraphernalia had been found in the motel room vacated by [Dr. Taraszka]" and that he has an "apparent addiction to narcotics"; by a Stipulation and Consent Order of 2/08/96 between him and the Vermont Board, he voluntarily surrendered his license in Vermont in lieu of a hearing and agreed never to seek relicensure in Vermont; in that Stipulation and Consent Order, he agreed to seek an evaluation from a chemical addiction program; the North Carolina Board learned that on or about 2/23/96 Dr Taraszka left that program against medical advice; on 2/24/96, the Board summarily suspended his license to practice in North Carolina and issued charges against him; he has admitted he suffers from the disease of chemical addiction, particularly to midazolam Versed; he admits he has been unable to practice with reasonable skill and safety by reason of drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material within the meaning of the NC General Statutes; he admits his surrender of license in Vermont is an action against his license within the meaning of the NC General Statutes. On 2/26/96, he was admitted to an impaired professional's program in Georgia; on 2/27/96, his attorney wrote the Board in an attempt by Dr Taraszka to self-report this matter; he successfully completed the Georgia program and is being monitored by that program.

Action: 3/18/98. Consent Order executed: the Board lifts the Summary Suspension of Dr Taraszka's license and dismisses without prejudice the Notice of Charges of 2/24/96; he shall not practice anesthesia; he may practice only in a structured setting approved by the president of the Board; unless lawfully prescribed by someone else, he shall refrain from use of mind or mood altering substances and from the use of alcohol; he shall report to the Board within two weeks any use of such medication or alcohol, including the identification of the prescriber and the pharmacy filling the prescription; he shall undergo drug and alcohol screens as requested by the Board; if he begins residing in North Carolina, he shall maintain and abide by a contract with the NCPHP; he shall not prescribe any drug for his own use; must comply with other conditions.

WEST, Harold Kenneth, Jr, MD

Location: Apopka, FL

DOB: 4/21/54

License #: 98-00437

Specialty: FP (as reported by physician)

Medical Ed: Loma Linda University (1979)

Cause: Application for medical license. While practicing in Florida, Dr West had an administrative complaint brought against him by the Florida Board for having a sexual relationship with a patient; he neither admitted nor denied the allegations; on or about 5/09/96, he entered into a Consent Agreement with the Florida Board whereby it suspended his license for six months (the last three being stayed), fined and reprimanded him. Dr West has admitted this in connection with his application for a license in NC; his probation in Florida requires him to participate in and comply with the Physicians' Recovery Network, which has included a forensic psychiatric examination that revealed no psychiatric diagnosis; he has apparently been compliant with his Florida probation; he is undergoing counseling regarding his alleged sexual relationship with a patient, which counseling is apparently going well.

Action: 3/18/98. Consent Order executed: Dr West is issued a temporary/dated license to expire on the date shown on the license (5/31/98); he shall continue his counseling and shall cause reports to be sent to the Board every six months; he shall ensure a chaperon is present during every encounter with a female patient; he shall obtain 50 hours of CME relevant to his practice each year, 30 of which must be Category I; must comply with other conditions.

MISCELLANEOUS BOARD ORDERS**BONOMO, Michele Lee, Physician Assistant**

Location: Raleigh, NC (Wake Co)

DOB: 7/09/71

License #: 1-02129

Education: Kings College (1995)

Cause: Hearing on application for extension of temporary PA license. Ms Bonomo failed the NCCPA examination once before applying for a temporary NC license in 1996. She failed again in 1997. Her temporary license has never been extended. The physicians with whom she works, including her supervising physician, indicate she is knowledgeable, professional, and competent. The Board may extend a temporary PA license for up to one year in the event an applicant fails to pass the examination.

Action: 4/08/98. Findings of Fact, Conclusions of Law, and Order issued: Ms Bonomo's temporary PA license is extended until the end of the day on 8/17/98, or such sooner time as may be provided by law.

JARBATH, M. Denise, Physician Assistant

Location: Durham, NC (Durham Co)

DOB: 3/31/58

License #: 1-02384

Education: Bayley Seton Hospital (1996)

Cause: Hearing on application for extension of temporary PA license. Ms Jarbath failed the NCCPA examination twice before applying for a temporary NC license; due to lack of study time, she failed it a third time in October 1997 while working more than 40 hours a week at Duke Medical Center. She has excellent clinical skills and has served in an exemplary manner; she is considered by her supervising physician to be one of the best PAs with whom he has worked; she has a letter of support from her division chief at Duke, who says she has done an outstanding job; her temporary license has never previously been extended; the Board may extend a temporary license for a period not to exceed one year in the event an applicant fails to pass the examination.

Action: 3/26/98. Findings of Fact, Conclusions of Law, and Order issued: Ms Jarbath's temporary PA license is extended until the end of the day on 6/30/98, or such time sooner as may be provided by law, subject to her working no more than 40 hours per week prior to taking the NCCPA exam, performing her tasks in the operating room only in the presence of a supervising physician, and having a supervising physician available within 60 seconds for out of OR patient encounters.

DENIALS OF LICENSE/APPROVAL

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

SURRENDERS**BYRUM, Christopher Edwards, MD**

Location: Hillsborough, NC (Orange Co)

Lake Wylie, SC

DOB: 10/19/53

License #: 00-35599

Specialty: P (as reported by physician)

Medical Ed: University of Virginia (1988)

Action: 3/27/98. Voluntary surrender of license.

GORSKI, Karen, Physician Assistant

Location: Charlotte, NC (Mecklenburg Co)

DOB: 1/08/57

License #: 1-02145

Education: State University of New York, Stonybrook (1982)

Action: 4/17/98. Voluntary Surrender of License.

See Consent Orders:

BLEMINGS, Ginger Dobbins, Physician Assistant**NABORS, Dennis Ray, Physician Assistant**CONSENT ORDERS LIFTED**MORGAN, Roger Eliot, MD**

Location: Raleigh, NC (Wake Co)

DOB: 6/06/57

License #: 00-36781

Specialty: GS/TRS (as reported by physician)

Medical Ed: University of Illinois College of Medicine (1983)

Action: 2/19/98. Order lifting Consent Order of 7/31/97.

SELTZER, Stephen Charles, MD

Location: Albemarle, NC (Stanley Co)

DOB: 7/30/49

License #: 00-22828

Specialty: FP (as reported by physician)

Medical Ed: University of Iowa (1974)

Action: 2/19/98. Order issued lifting Consent Order of 3/30/96.

TEMPORARY/DATED LICENSES:EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES**COYNE, Mark Dennis, MD**

Location: Stoney Creek, NC (Guilford Co)

DOB: 8/12/49

License #: 00-33493

Specialty: EM/FP (as reported by physician)

Medical Ed: Chicago Medical School (1983)

Action: 3/20/98. Temporary/dated license extended to expire 5/98.

FULGHUM, Thomas Grady, MD

Location: Sanford, NC (Lee Co)

DOB: 6/29/57

License #: 00-31987

Specialty: EM/IM (as reported by physician)

Medical Ed: Duke University School of Medicine (1983)

Action: 3/20/98. Temporary/dated license extended to expire 9/30/98.

GLENN, Robert Alan, Physician Assistant

Location: Asheville, NC (Buncombe Co)

DOB: 3/13/59

License #: 1-01972

Education: George Washington University (1989)

Action: 2/18/98. Temporary/dated license extended to expire 9/30/98.

HARRIS, Donald Philip, MD

Location: Greensboro, NC (Guilford Co)

DOB: 4/09/34

License #: 00-13127

Specialty: IM (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1961)

Action: 3/20/98. Temporary/dated license extended to expire 7/31/98.

MEAD, Robert J., MD

Location: Asheboro, NC (Randolph Co)

DOB: 12/13/45

License #: 00-32790

Specialty: AN/PD (as reported by physician)

Medical Ed: Jefferson Medical College (1978)

Action: 3/20/98. Temporary/dated license extended to expire 5/98.

MEYER, Graham Scott, MD

Location: Fayetteville, NC (Cumberland Co)

DOB: 11/11/58

License #: 95-00405

Specialty: EM/PD (as reported by physician)

Medical Ed: University of Ontario (1986)

Action: 3/19/98. Full and unrestricted license reinstated.

MORRIS, Robert Harry, Physician Assistant

Location: Fayetteville, NC (Cumberland Co)
 DOB: 11/18/50
 License #: 1-00110
 Education: Howard University (1975)
 Action: 2/18/98. Temporary/dated license extended to expire 9/30/98.

O'DONNELL, Robert William, MD

Location: Shallotte, NC (Brunswick Co)
 DOB: 1/30/42
 License #: 00-29636
 Specialty: P/ADP (as reported by physician)
 Medical Ed: University of Maryland (1974)
 Action: 2/18/98. Temporary/dated license extended to expire 9/30/98.

PAINE, Karen Nicholson, MD

Location: Raleigh, NC (Wake Co)
 DOB: 7/07/46
 License #: 00-20834
 Specialty: FP/EM (as reported by physician)
 Medical Ed: New York University (1971)
 Action: 2/18/98. Temporary/dated license extended to expire 9/30/98.

SHIVE, Robert Macgregor, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 11/02/33
 License #: 00-13226
 Specialty: P (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1961)
 Action: 3/20/98. Temporary/dated license extended to expire 3/31/99.

THOMPSON, Robert B., MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 2/29/56
 License #: 00-40006
 Specialty: N/EM (as reported by physician)
 Medical Ed: University of Miami (1987)
 Action: 3/20/98. Temporary/dated license extended to expire 9/30/98.

WHEELER, James Hastings, III, MD

Location: Marion, NC (McDowell Co)
 DOB: 10/20/50
 License #: 00-33912
 Specialty: ORS (as reported by physician)
 Medical Ed: Medical College of Wisconsin (1977)
 Action: 2/18/98. Temporary/dated license extended to expire 11/30/98.

WOLEBEN, Martyn Dean, MD

Location: High Point, NC (Guilford Co)
 DOB: 11/13/56
 License #: 97-00428
 Specialty: OBG (as reported by physician)
 Medical Ed: University of Mississippi (1988)
 Action: 2/18/98. Temporary/dated license extended to expire 3/31/99.

See Consent Orders Lifted:

MORGAN, Roger E, MD
SELTZER, Stephen C., MD

DISMISSALS

See Consent Orders:

BLEMINGS, Ginger Dobbins, Physician Assistant
TARASZKA, Steven Robert, MD

North Carolina Medical Board

Meeting Calendar, Application Deadlines, Examinations

June 1998 -- May 1999

Board Meetings are open to the public, though some portions are closed under state law.

North Carolina Medical Board July 15-18, 1998

July Meeting Deadlines:
 Nurse Practitioner Approval Applications June 1, 1998
 Physician Assistant Applications June 2, 1998
 Physician Licensure Applications June 30, 1998

North Carolina Medical Board September 16-19, 1998

September Meeting Deadlines:
 Nurse Practitioner Approval Applications August 3, 1998
 Physician Assistant Applications August 4, 1998
 Physician Licensure Applications September 1, 1998

North Carolina Medical Board November 18-21, 1998

November Meeting Deadlines:
 Nurse Practitioner Approval Applications October 5, 1998
 Physician Assistant Applications October 6, 1998
 Physician Licensure Applications November 3, 1998

North Carolina Medical Board January 20-23, 1999

January Meeting Deadlines:
 Nurse Practitioner Approval Applications December 7, 1998
 Physician Assistant Applications December 2, 1998
 Physician Licensure Applications January 5, 1999

North Carolina Medical Board March 17-20, 1999

March Meeting Deadlines:
 Nurse Practitioner Approval Applications February 1, 1999
 Physician Assistant Applications February 3, 1999
 Physician Licensure Applications March 2, 1999

North Carolina Medical Board May 19-22, 1999

March Meeting Deadlines:
 Nurse Practitioner Approval Applications TBA
 Physician Assistant Applications April 1, 1999
 Physician Licensure Applications May 4, 1999

👉 **Residents Please Note USMLE Schedule**

Examinations Schedule

United States Medical Licensing Examination (USMLE) Step 3

December 1-2, 1998 Sitting
 Deadline for receipt of application: September 2, 1998
 May 11-12, 1999 Sitting
 Deadline for receipt of application: February 10, 1999

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 400 Fuller Wiser Road, Suite 300, Euless, TX 76039 or telephone (817) 868-4000.

LICENSES RECENTLY MADE INACTIVE

(Results from Licensee's Request or from Failure to Register)

JANUARY 1998

Name (alphabetical)	License #	Name (alphabetical)	License #	Name (alphabetical)	License #	Name (alphabetical)	License #
Abbott, Gian Thomas	94-01108	Graham, Michael Lucien	00-38622	Moffet, Hugh Lamson	00-13173	Strang, Paul Joseph	00-17666
Agha, Bilal Mohammed	96-00436	Groopman, David Samson	95-00360	Mondoa, Emil Isume	97-00109	Strickland, Donald Winfred	00-39488
Anabtawi, Isam Nazmi	00-31105	Haas, Joseph Edward	00-34340	Monzon, Gary Robert	00-35440	Stuart, Andre St. Clair	00-39698
Atwell, Darryl Munroe	95-01479	Hadley, Lanny Carroll	00-27799	Moore, Andrew Maurice, II,	00-24980	Studenski, Stephanie Anne	00-27743
Barker, Theodore Albert	00-14117	Henline, Donald William	95-01549	Moorman, Claude Thurman, III,	00-39201	Summerlin, Jack Donald	00-08828
Bell, Karen Sue	97-01694	Hetelekidis, Stella	93-00488	Mulvihill, Denise Mary	00-38146	Thomas, Joseph Raker	00-38224
Bennie, Kelly Shaffer	96-00454	Hickman, Gregory Victor	00-34039	Musche, Frank Wilbur, Jr.,	97-00342	Tomely, Joseph Patrick	93-00831
Blackburn, Katherine Slaughter	94-01379	Hodulik, Charles James	00-22740	Neal, Charles Bodine, III,	00-10188	Tribble, Kevin Anthony	00-38858
Blackmon, Donald Lee, Jr.,	00-24223	Hong, Yong-Woo	00-21799	Nguyen, Cam Ha Thi	95-01359	Trifiro, Richard Gary	00-33161
Boente, Matthew Patrick	00-39397	Howard, Martin Leonard, Jr.,	00-34355	Nicklin, Sarah	93-00552	Trippett, Tanya Maria	00-31753
Boggio, Elizabeth Bennetts	00-36654	Hughes, James Richard	00-39826	Olivares, Patricia Mae	00-39861	Upchurch, Charles Marion	00-13937
Bogvi, Antonia Maria	00-32992	Hunter, William Legrand, Jr.,	00-19245	Onaitis, Mark William		Valentin, Manuel	93-00352
Bokhari, Sabahat	96-01236	Hutcheson, Grace Autumn	97-00077	Pandya, Varsha Jadunath	00-32552	Velvis, Harmannus	00-39344
Boles, Samuel Frank	96-00198	Jennings, Clark William, Jr.,	00-13003	Pantelakos, George Constantine	00-39456	Vitorisz, Esteban Cesar	95-00751
Brabant, Gordon Val	93-00659	Joe, Thomas	00-38784	Paul, Randal Howard	00-39459	Villavicencio, Jose Raul S.	94-00385
Burke, Leah W.	00-36073	Johnson, Sigrid Rae		Piva, Enrico Ernesto	97-01847	VonHaam, Karen Elisabeth	97-01890
Campbell, Patricia Fuyuki	95-00030	Jones, Stephen Donald	00-35002	Poore, Raymond Earl, Jr.,	00-36012	Wahi, Ranjit Singh	00-33909
Caple, Karen Sheree	00-25853	Joy, Robert Arthur	95-00107	Pope, Thaddeus Harris, Jr.,	00-10899	Walker, Bradley Steven	94-00386
Chen, Lan Shu	00-29194	Joyce, William Terence, III,	94-01231	Prager, Robert Edward	00-18286	Wall, Richard Wayne	00-20858
Conrad, Larry Lee	00-29731	Karlin, Fred Robert	93-00176	Ranes, Raymond David	00-10562	Walls, Jay David	00-35782
Cox, Jonathan Michael	00-39574	Kawam, Mohamed Nour-Eldean	00-34370	Rathmell, James Phillip	00-38174	Wan, Caroline De-Ming	00-39736
Creighton, Clara Smith	00-30622	Keldie, Carl James	00-23577	Rayburn, Barry Kennedy	93-00291	Warren, Stafford Gay	00-17914
Culclasure, John Weeks	00-35112	Kelley, Michael James	95-00114	Reichert, Daniel Robert	00-38680	Webb, Pamela Joyce	00-22986
Dallam, Deborah Lynn	00-31471	Kennedy, Allan Laurence	96-00434	Rielly, James S.P.	00-36413	Weingates, Joseph Aloysius, III,	00-19000
Das, Anurag Kumar	00-38502	Kim, Christopher Kisok	94-01432	Riordan, Linda Lee	00-39212	Weinstein, Jeffrey William	00-36071
De Haven, Ruth Schirmer	00-35316	Kraemer, Diana Lynn	00-34656	Rogoff, Edward Eugene	00-19538	Weiser, Joel James	00-13586
De Leo, Nicholas Carl	00-36341	Kramer, Carl L.	00-38368	Rosen, Stephanie L.	96-00713	Wilemon, William Kelly, Jr.,	00-13252
De Lossantos, Teodoro Asis	00-17334	Kutcher, Theodore John, Jr.,	94-00885	Russum, Jeffrey Harold	00-35190	Williams, Anderson James, Jr.,	00-13295
DeMasi, Richard James	00-33027	Lasker, James Combs	00-30827	Schaeffer, Cameron Sherwood	94-01018	Winslow, Robert Brown	00-17294
Dix, James Earl	95-01223	Lingo, Stephen Todd	96-00388	Seelig, Charles Boris	00-32855	Witkin, Robin Gugenheim	00-36132
Dorman, Kenneth Randall	00-39412	Locklear, J. C.	00-31863	Shipman, Charles Edward	00-33141	Wolffington, Michael Dean	97-00427
Eddy, Janet Mary	00-38934	Mackey, Steven Lynn	00-33395	Shiro, Cindy Aline	93-00809	Wombolt, Duane George	00-25760
Elkins, Irving Barefoot	00-16353	Mathias, Brad Trafton	00-39024	Sigman, Kenneth Martin	00-30095	Wright, Susan Jane	97-00001
Faulkner, Robert Lee, Jr.,	00-14098	Matson, Paul Arthur	94-01447	Singh, Daljit	94-01042	Youn, Young Joo	00-20585
Fitzgerald, Allison Ann	00-39421	McMasters, Robert Earl	00-15367	Smucker, Douglas Ronald	00-35516	Yousseff, Amoun Kamel	00-30264
Flack, John Mark	94-01404	Mendelsohn, Mark Jeffrey	00-39303	Spivak, Scot Jay	95-01426	Zbyski, David Todd	00-35556
Foosaner, David Elliott	00-34006	Mihelic, Fabian Matthew	00-29344	Starke, Helen	00-07089	Zinna, Rosario Federico	00-13591
Galphin, Claude Mabry	00-29110	Millard, Peter Simon	00-39650	Stephens, Leonora	00-26156	Zuercher, Paul Stephen	95-00285
Gilkeson, Robert Chapman	93-00474	Mirmow, Dwight Paul	97-01067	Stewart, Leland Todd	93-00822	Zung, William Wen-Kwai	00-13713
Goldman, James Oswald, Jr.,	00-21782	Mody, Elinor Anne	00-34938	Stowe, Arthur Chester, Jr.,	00-36484		

FEBRUARY 1998

Adams, Leon Ashby	00-07357	Frank, Beverly Ann	95-00581	McCullough, James Arthur	00-38136	Sheikh, Tariq Mohammed	00-35752
Ahmad, Zia Moizuddin	00-39384	Gibson, Valda O'Ray	00-32705	McDonald, Velvet Lavern	00-36116	Shenasa, Hossein	00-39087
Alexander, Carla Suzanne	00-24570	Glickman, Andrew Scott	00-34012	McKoy, James	00-23214	Sherman, Frederick Stuart	93-00808
Arroyo, Julio Cesar	00-33341	Gruver, Carol Lynn	95-00087	McNeal, Jerry Reed	95-00147	Siekanowicz, Andrew John	95-01096
Aughey, Michael John	94-01122	Haase, Harold Francis	00-24072	Mills, Georgia Vestal	00-09702	Smyth, Edward Meiling	00-34740
Averette, Hery Evans, Jr.,	00-11107	Harper, Kristine Denise	00-39608	Moore, Thomas Joseph	00-29633	Sofianek, Joseph James, III,	94-00148
Banez, Winston Wagner Paul	93-00019	Harrah, Michael Floyd	00-18653	Moreland, Clyde Hamilton	96-01678	Spencer, William Caldwell	00-39481
Barber, Brent Allen	93-00021	Hartle, James Edward, II,	94-00263	Morrow, Valerie Clayborn		Steckl, Peter Daniel	00-36438
Barnhart, Vincent John	97-00183	Hartsell, Stephen Carl	00-28981	Moufarrej, Ramzi Kamel	97-01506	Steinem, Cynthia Ann	95-00732
Beatty, Mary Ellen	00-26189	Herndon, Claude Nash	00-05368	Moussalli, Clarice	00-25066	Stokes, Curtis Dean	00-34913
Beltran, Normandy B.	00-23157	Hittalmani, Shankar N.	00-21346	Mrose, Helen Elizabeth	96-01410	Stokes, David Kershaw, Jr.,	94-00650
Bennett-Guerrero, Elliott	95-00828	Holovacs, Thomas Francis	97-00593	Mughelli, Olumide Michael	00-38543	Stone, Charles Keith	00-34171
Bennie, Jonathan Edward	94-00203	Hom, Elaine Gam	94-00841	Nadaraja, Sriyalatha Irangani	00-19026	Sturner, Raymond Arthur	00-20514
Bettermann, Kerstin		Howard, Kaylar Viola Greer	96-01633	Nase, Harold Wallace	00-23628	Swift, Michael Ronald	00-17906
Bhatti, Zulfiqar Ahmed	96-01230	Hsieh, Wen-son	97-00287	Natvig, Paul Wayne	00-34885	Swhart, John Jacob	00-22444
Billings, Thomas Allen	96-00865	Hunter, Billy Ray	00-26445	O'Leary, Michael Dennis	00-28887	Talley-Willis, Sandra K.	00-32326
Brayer, Paul Joseph	94-00024	Jain, Avaniindra	00-30370	Orris, Gary Steven	00-39661	Talluri, Murali Dhar	00-38699
Brown, Kevin Timothy	00-31942	Johnson, Donald Edward	00-13837	Osman, Magdy A.	00-24478	Thomas, Harold Andrew, Jr.,	00-22066
Buffone, David Allen	00-29828	Jones, Dean Cicero, Jr.,	00-10507	Oswley, James Harold	00-11333	Thomas, Ioan Talfryn	00-33754
Burrus, David Richard	93-00053	Jones, Jason Daniel		Pate, William Henry	00-08194	Thompson, Robert Bruce	00-40006
Caddell, Tillie Horkey	00-09311	Kalyanam, Pattabiraman	96-01358	Patrick, Ronald Dennis	00-37918	Tricarico, Joseph James	00-17448
Chan, Krammie Mei-Kwan	00-35802	Kelemen, Mark David	93-00499	Patton, Robert William, Jr.,	94-00122	Tural, Ahmet Cemal	95-01445
Channa, Gulle Halli	00-17325	Kim, Kyoung-Soon	93-00877	Paul, Leena	00-38405	Turk, Robert Spencer	00-14144
Choo, Byeng-Sun	00-20711	Knox, Julie Johnson	00-30561	Pfundstein, Joann	00-35465	Victory, Colleen	00-34535
Colle, Gregg Joseph	94-00225	Leinbach, Laurence B.	00-09106	Powell, Thurston Gates	00-05389	Walker, Everett Darryl	00-34493
Cripe, Larry Dean	00-31466	Levine, Charlotte Clark	00-32259	Powers, Stephen Kent	00-27279	Walker, James Callan	00-28709
Dawson, Robert Edward, Sr.,	00-07326	Loftus, John Richard	00-30669	Price, Scott Keith	96-01444	Wallace, Stanley William	00-22287
Dishbrow, Kristina Lynn	95-01221	Lomasney, Laurie McAdams	00-34382	Raab, Stephen Spencer	00-34438	Wallman, James Kaunitz	00-20357
Donald, Felicia Lyn	00-29557	Love, Beverly Ray	00-22140	Randolph, Michael Anthony	00-38413	Wang, Natalie Yeu	00-35222
Driver, Paul John	00-35882	Low, Nancy Neidlinger	00-39969	Ray, Verna Gail	00-29377	Watson, David Gregory	95-00267
Dukes, Andrew Scott	00-32691	Lustgarten, Gary James	00-25725	Roesch, Thomas Markus	00-32845	Weltz, Christina Ray	96-01520
Dunlap, Carol Lee	00-31805	Manzarbeitia, Cosme Y.	00-29818	Rollins, James Letcher	00-13709	Whitaker, Gregory Knox	00-27338
Dyke, Peter Cummins	00-13792	Marriott, John Daughtry	00-13494	Ross, Arthur J., III,	00-22174	Wilson, Dennis Norman Farmer	00-38575
Edwards, Charles Herbert	00-21030	Marshall, Delphia Ellen	97-00657	Sabatier, Richard Edward	00-22819	Wood, Herman Clifford	00-35234
Elliott, John Ervin	00-31275	Mason, Thomas Glenn, II,	00-39023	Schacherer, Timothy Gordon	00-39991	Yarborough, Lynn Vivica	00-26785
Farmer, Woodard Eason	00-07570	May, Daniel Scott	93-00225	Schulman, Jeffrey Irving	95-00217	Yates, Carl Douglas	00-26786
Feichter, Ralph Norbert	00-14087	McBride, Anne Kathryn	96-01669	Schwartz, David Neal	00-35746	Young, Paul Ralph	00-34778
Flume, Patrick Allen	00-38939	McConnell, Robert William	00-14842	Seward, Daniel Peter	00-38845	Yusen, Roger David	00-35795
Fooks, Henry, Jr.,	95-00903	McCoy, James Joseph	00-21204	Sewell, Daniel William	94-01027	Zaheer, Qudsia Hyder	95-01283

CHANGE OF ADDRESS FORM

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

Please print or type. Date: _____

Full Legal Name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

Business: _____

Phone: (_____) _____ Fax: (_____) _____

Home: _____

Phone: (_____) _____ Fax: (_____) _____

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

Bulk Rate
US Postage
PAID
Permit No. 1486
Raleigh, NC



Official Statement of the North Carolina Medical Board on the New Medical License Registration System

(What follows is an official statement of the North Carolina Medical Board. It should be clipped and saved for use whenever information concerning the new medical license registration system is required by health care institutions, credentialing bodies, accreditation agencies, etc. Please feel free to make copies as needed.)

There have been recent and significant changes in the North Carolina Medical Practice Act (NCGS 90, Article 1). An important change that will affect all physicians licensed in North Carolina relates to the date on which they must register their medical licenses with the North Carolina Medical Board each year.

Beginning on January 1, 1998, all physicians must register their medical licenses annually within 30 days of their birthdays. The Board will send a registration form by first class mail to registered physicians approximately one month before their birthdays. Should any physicians not receive such a mailing, they must contact the Board within a day or two of their birthdays and request a registration form.

Despite the wording on its face, the certificate of registration held by all currently registered physicians WILL NOT EXPIRE on January 31, 1998. That certificate will continue to be valid for 30 days after each physician's 1998 birthday. Within that time, physicians who complete the registration form and send it and the required \$100 fee to the Board will receive their new annual registration certificate.

Another change that should be noted is that any physicians who are 30 days delinquent in registering their licenses will be sent notices of failure to register. If there is no response from those physicians within 30 days, their licenses will automatically become inactive. No other notices will be sent to them. **Physicians may not practice medicine in North Carolina while their licenses are inactive.**

North Carolina Medical Board
P.O. Box 20007
Raleigh, NC 27619
Address correction requested