



# forum

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

Fondly, Carolyn: Letters to a Young Physician - page 5



## President's Message

Walter J. Pories, MD

### There Is a Choice: The NCPHP

The attending surgeon, still dressed in his tuxedo, was clearly drunk; the patient, dressed in a revealing party gown, had also had a few drinks. I was the junior resident on surgical call. I never dared to ask how the diagnosis was made but, somehow, during the party, the surgeon learned that she had an inflamed superficial varicosity of her upper thigh. He told her that she needed to have this excised immediately or she could have a pulmonary embolus. I was told to admit her, to bring her to the OR, to inject the raised, thickened lump with local anes-

thetic, and to incise the vein. I followed the orders. To my surprise, I soon withdrew a long clot, about the length of my finger, that

*"I have assisted surgeons when you could smell that sour odor of alcohol seeping around their masks"*

extended into her iliac vein. A few stitches completed the procedure and the two, surgeon and patient, drove off in his car. I never spoke to him about the incident again, but it was clear to me that we had breached some very basic standards. Even today, 48 years later, I am still distressed by my participation.

I have had other troublesome incidents with impaired physicians. In the Air Force, I worked for two years for an alcoholic, bipolar individual who, fortunately, never saw patients and spent two to three days at a time in his office, binge drinking, without going home. Again, as junior officers we tolerated his behavior and never reported him. I have assisted surgeons when you could smell that sour odor of alcohol seeping around their masks; I listened to whispers about nurses sequestering narcotics; and, like my colleagues, I worried, waffled, gos-

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Andrew W. Watry

## From the Executive Director

### Complaints: Handling Them and Learning from Them

I suspect that to many in the medical community the word complaint elicits a visceral, perhaps a Pavlovian response. Complaints appear to be a dominant aspect of practicing medicine and there does not appear to be a light at the end of the tunnel. Complaints about physicians filed by patients with this Board increase dramatically every year. In the past 12 months, our complaint volume has increased by 30 percent. Last year we received 870 complaints from patients.

*"Complaints about physicians filed by patients with this Board increase dramatically every year"*

Does that mean there is more wrong with the house of medicine each year? I don't think so. There are combinations of forces. We don't see trends on the output side of a significantly higher percentage of cases resulting in sanctionable discipline or higher numbers of bad outcomes. People are complaining more about their medical care, perhaps as a result of market influences to drive down costs, access issues, and insurance coverage issues. The issues I described are generally not prosecutable violations of the Medical Practice Act, but we still take each seriously. People are more aware of to whom they can complain about their health care. It could be a major topic by itself to analyze all of these forces, and it would take far more space than we have here. The purpose of this article is

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Primum Non Nocere



# forum

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

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

## North Carolina Medical Board

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## There Is a Choice

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siped, and did nothing.

There weren't many choices: (1) confront the impaired physician in a fight that you are guaranteed to lose; (2) tell others about him or her—another tactic that breeds enemies and accomplishes little; or (3) denial.

My epiphany came when I heard Dr Thomas J. Krizek, a highly respected professor of plastic surgery, in a plenary session of the American College of Surgeons, scold all of us for protecting him during his entire surgical career. He told us that he had been a drunk since he was a teenager, that his "friends protected him" (his quotes) through college, through medical school, through his residency, and all the way to the highest rung of an academic career. He sharply reminded us of our failure to protect his patients; he stung each of us with anecdotes similar to those I had experienced; and he asked us why we did not live up to the ethics of our profession. We gave him a standing ovation and left ashamed.

I was determined, the next time, to do better, but I was not at all certain how I

would resolve the issue. Would I have the courage to do the right thing? The first test was easy: a nurse diverting drugs from patients in a hospital that already had a well-defined process in place. The second test, however, was the classic story: a physician, clearly impaired by alcohol and drugs, caring

***"Since I became a member of the North Carolina Medical Board, I have had a singular . . . opportunity to see the effectiveness of the NCPHP"***

for patients in the presence of embarrassed residents and frustrated nurses. It was time to act. To my delight and relief, the chief of staff told me about a new approach: the North Carolina Physicians Health Program, or the NCPHP, North Carolina's answer to dealing with this awful problem. One anonymous call and within 24 hours our physician was on his way to evaluation, in another two days his problems were being addressed, and within two weeks he was on his way to recovery. It took months, but he eventually returned to work, far more productive than he had ever been. His sense of

humor returned, it was fun to meet him in the hall, he passed all of his random screening examinations, and was restored not only to practice but also to his family. I have been grateful ever since to the NCPHP.

Since I became a member of the North Carolina Medical Board, I have had a singular and continuing opportunity to see the effectiveness of the NCPHP. I have watched that organization accept professionals destroyed by their addiction, diminished in their self-esteem, and unable to relate to their wives and children. Men whose hands shake so badly that they grip the edges of the table during the interview, women who cannot stop crying as they weep for lost practices and families.

But I have also seen these physicians return for their regular visits with a gradual

***"Yes, the NCPHP is one of our great investments"***

clearing of the eyes, healthy skin, and grooming. I have been relieved to see the real physicians reappear with a devotion to patients and the craft of medicine. I have also had the great pleasure of

telling a number of these doctors that we are proud of their accomplishments, that we are delighted with the quality of their practice, and that they no longer have to come back to the Board.

I am, therefore, especially grateful to the North Carolina General Assembly for raising the Board's annual registration fee from \$100 to 125 per year, the first increase in close to a decade and still lower than most states. This will allow the Board to increase its support for the NCPHP, which is based on the number of individuals licensed by the Board, from about \$400,000 in fiscal 2001, to about \$500,000 in fiscal 2002, and about \$555,000 in fiscal 2003.

Oh, yes, let me share one other number with you: the NCPHP's level of success. At the last tally, 90% of the impaired physicians cared for by the NCPHP returned to practice with full, unrestricted licenses, having successfully dealt with their impairment. Yes, the NCPHP is one of our great investments.

To reach the NCPHP, please call (919) 870-4480 or, toll-free, (800) 783-6792. It's a great way to save lives. ♦

## North Carolina Medical Board



1-800-253-9653

## Complaints

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to discuss the concept of complaints more anecdotally, with an eye to prophylaxis. This is to give you the perspective of an agency that works with complaints day-in and day-out and to pose some lessons learned about how a practitioner may lower his or her exposure to complaints.

We are not permitted to show outside parties our complaint records. There is good reason for this; complaint records are confidential until and unless the Board initiates a public disciplinary process. That protects both the licensee and the patient. This protection is specifically written into the North Carolina General Statutes (NCGS § 90-16, which may be found at our Web Site). I wouldn't have it any other way. If complaints were public, our effectiveness would be significantly compromised. Who would have the courage to complain publicly about sexual exploitation or other sensitive matters? Also, prisoners tend to generate lots of complaints. A mid-western state recently decided to post on its Web site the number of complaints for each physician. It soon found that no one would volunteer to work with the prison population. Who wants to have 15 or 20 complaints from guests of the state next to their name on a Web page? I believe the legislature in that state ultimately retreated from that idea.

Based on our experience, we have developed our own strategies for service to the public and to licensees, service designed to demonstrate the Board's serious evaluation of complaints and to satisfy, to the extent we can responsibly do so, a complainant who expects a disciplinary outcome where the facts don't support a prosecution. In this process, we have also found how important it is that licensees take seriously certain problems that stimulate complaints and that they address those problems in order to avoid what are really unnecessary complaints. Of course, there are higher authorities on this front: many insurers in the field of professional liability offer risk management seminars and materials. However, I think what we might offer, based on our work and taken in concert with such seminars and materials, may be helpful in trying to reduce exposure to one of the major stressors in a medical practice: fear of being sued or being the object of a complaint to a medical board. I offer what follows in that spirit.

***"If complaints were public, our effectiveness would be significantly compromised"***

## Handling Complaints

Prompt attention to a complaint makes a difference. Last year, as I noted above, we received 870 complaints. Each of these was immediately acknowledged within two working days with written correspondence. The vast majority of these cases were investigated and closed within three months. Few, if any, of these complaints involved a person filing a capricious complaint.

Imagine yourself as a complainant. You expect (rightfully so) to be taken seriously. When most complaints do not result in public Board actions, it is a recipe for further disappointment for a complainant, thus the process for handling complaints with sincerity and timeliness takes on added importance. Almost every one of these individuals most certainly felt aggrieved. However, a bad outcome does not translate into a prosecutable Medical Practice Act violation.

The Board looks for patterns of practice below minimum standards of a nature to indicate that a physician is putting a patient at risk or in jeopardy. A good doctor who has a bad day does not generally see a disciplinary process, though he or she may be called in for an interview to discuss the case. By and large, people who are the subject of discipline are people who abuse patients or in other respects violate the law—performing beyond their competency level, putting patients unnecessarily at risk or in jeopardy, exploiting patients, etc.

So even though the majority of complaints to the Board do not result in disciplinary actions, there is a process involved to give timely response to the aggrieved party and timely resolution of the grievance. The cases that take the longest are the ones where there are apparent violations of the Medical Practice Act and legal processes are put in motion. The point is, timely response to aggrieved patients may result in keeping smaller problems from becoming bigger ones. Many complaints to the Board are avoidable.

What we have found in this process of complaint review, whether disciplinary action results or not, leads me to the following observations that may seem self-evident but do, in fact, reflect two of the most common problems bringing licensees to the Board's attention.

## Communication

Everyone has heard of the three principal rules of real estate—location, location, and location. Well, there are three principal rules on how to avoid complaints to the Board—communication, communication, and, finally, communication. Far and away the most obvious precipitating events that generate

complaints to the Medical Board involve communication problems. It reminds me of discussions I have had with friends who write insurance for professional liability coverage. Various underwriters indicate that bad outcome is not the principal predictor of whether or not a physician is sued; bad communication is the principal indicator. The same is probably true of complaints to the medical board.

So, rule number one is communication. Here is a quote, masked for anonymity, from a recent investigative file: "...she can't prove that the MD botched her surgery, however, assuming that he did not, he certainly acts like a guilty man, ie, a surgeon covering himself to protect against liability." There is no doubt that physicians need to be protective of their assets in this very litigious climate. However, there is a fine line between protecting assets and engaging in activity that actually precipitates complaints. Some physicians seem to be far more skillful than others in explaining and effectively dealing with inevitable bad outcomes in medicine. I like to learn from these physicians.

This leads to another anecdote about some terrible advice being given some medical students. I have been told by many physicians that they were counseled during their medical education that they should never engage patients on a first name basis. This admonition was followed by a suggestion that if they allow this to happen, they will have trouble with their collections. I think this is the exact wrong advice to be giving medical students. In my humble opinion, insisting on this level of professional distance in every instance makes one more of a target when something is perceived to be wrong by the patient.

Professional boundaries need to be maintained. However, many of the complaints we see come from people who are angry because they think their physician doesn't care. Physicians do care in most cases. There is a disconnect. Perhaps the gap between healer and patient needs to be narrowed. It is a classic example in my mind that explains why there is a \$14 billion a year "alternative medicine" marketplace. Alternative practitioners, by and large, do not place a high professional wall between themselves and their patients, and many patients find this appealing. In many cases, these practitioners have the distinct disadvantage of a lack of clinical science to back them up on many of their therapies labeled as alternative, but they have plenty of patients. Food for thought.

I think if you talked to Board members who actually review hundreds of complaints,

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## Complaints

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week-in and week-out, you will find they will tell you that many of these complaints could have been avoided with timely and thoughtful communication.

### Making Things Right

There are occasions when there is an aggrieved patient and when you decide, logically you believe, that you are right and the patient is wrong and that that trumps all other considerations. In retrospect, and upon investigation of facts, this often appears to be a less than pragmatic attitude. For example, a particularly aggrieved patient is complaining about a \$200 bill; he or she demands, upon no rational basis, that it should have been \$100. The Board has no dog in that fight. We don't set fees. However, we occasionally see a licensee spend \$1,000 or \$2,000 worth of his or her otherwise billable time fighting a patient over \$100. Many times, when there is a decision to fish or cut bait, perhaps there should be a pragmatic cutting of bait.

The same is true when the stakes are even higher, say a surgery where there is a known complication. Suppose you fully advise a patient of a generally accepted complication. I will not give a more specific example because it may be traceable with the facts. However, the patient suffers the well-known and predictable complication, comes back to the hospital for corrective surgery, and expects the hospital to pay for the repair. The hospital digs in and maintains that it will not pay for the repair. In many instances, this could be penny wise and pound foolish. You are looking at a few thousand dollars, which in the life cycle of the hospital is not a great amount of money. The hospital and the operating surgeon can easily spend \$15,000 or \$20,000 of valuable staff time defending their decision not to cover the repair procedure.

I have seen many instances where a hospital and its operating physicians pass up an opportunity to resolve a dispute amicably. The hospital may be right and on the high moral ground by insisting that this is a known complication, the patient signed an informed consent, and they are not going to pay the cost of the repair from the complication. Then they will quite readily spend \$20,000 to defend their position. Two years later, after they have defended against a complaint and rereview by the Board and possibly even a civil suit, they are comfortable in having won the argument. There are two years of headache and rather extensive costs

that could have been avoided by making things right with a patient at a much more modest cost.

Some patients are as stubborn as physicians and hospitals in these matters and will doggedly pursue a complaint at great expense, far exceeding the cost of the alleged transgression. It reminds me of a stubborn dispute over a new car purchase in east Atlanta several years ago. The dealer would not take the car back so the customer rented a lot across the street and mounted the car on a pedestal with the word "lemon" prominently displayed. Two years later the dealer still had not taken the car back but the dealership was for sale. Who won? We see angry complainants who make this dissatisfied customer seem like a choir boy.

I have plenty of medical analogies, but the facts are so bizarre that the cases are traceable. So I'll use one from another state. The most dogged complainant I have ever encountered, bar none, was a man who complained about a "failed cardiac stress test." He wrote several hundred letters to me, the governor, and every public official for whom he could find an address over the span of several years and several terms of office for governors. In his mind, being left on a treadmill a few minutes longer than he should have been was a major infraction, for which the physician should be disciplined. Who knows what benefit a simple holding of breath and the words "I'm sorry" might have had on this Quixotic adventure at the time of the alleged infraction.

The anger of aggrieved patients is understandably worse when their health is involved. Sometimes very simple things can abate the anger and make things right. I encourage you to look for those things, even if you have to hold your breath because you are right.

### Conclusion

In summary, this has been a discussion of approaches to lowering exposure to patient complaints to the Board. Health care professionals these days need to develop strategies to lower exposure in this area just as they need to develop risk management strategies and practice management strategies. Ultimately, everyone benefits from better patient/consumer satisfaction. We take all complaints seriously and we can learn from them all, in one way or another. Complaints will never be eliminated, of course, but the number of unnecessary ones that actually involve no violation of the Medical Practice Act can be reduced dramatically by the use of simple courtesy and common sense. ♦

## Federation Credentials Verification Service: A Note for PAs

*Robin N. Hunter-Buskey, PA-C,  
NCMB Member  
Erin Gough, NCMB PA Coordinator*

At its meeting held on February 21, 2002, the North Carolina Medical Board voted to allow physician assistants applying for licenses in this state to use the Federation Credentials Verification Service (FCVS), which is operated by the Federation of State Medical Boards of the United States, to obtain and report their "core" credentials. In approving this system, the Board agreed to accept such documentation as provided by the FCVS as primary source verification of the "core" credentials. This same process was approved by the Board for physicians in 2000.

It is understood by the Board that FCVS will collect all information and documents in accordance with the most recent version of the FCVS Policies and Procedures. The FCVS acknowledges that the documentation it provides only serves to supplement portions of the Board's overall licensing process and that the Board reserves the right to reject any or all portions of the documentation provided. It is also understood that physician assistant participation in this service is strictly voluntary and that such services are provided at no cost to the Board.

For more information regarding the FCVS, please contact Kevin Caldwell at 817-868-4001, or visit the Federation of State Medical Board's Web site at [www.fsmb.org](http://www.fsmb.org). ♦

## North Carolina Medical Board

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# Fondly, Carolyn:

## Letters to a Young Physician Part I



Carolyn E. Hart, MD

Dr Carolyn E. Hart, who practices neurology in Charlotte, is president of the Mecklenburg County Medical Society. In place of the usual president's comments in the Society's publication, Mecklenburg Medicine, she has prepared a series of letters to a medical student, "W," whose parents are physicians and friends of hers. Her thoughts, so clearly and simply expressed, unfold as a primer of sorts, laced with insight and wisdom, a gentle and conversational guide and reminder for health care professionals at any point in their careers.

We thank Dr Hart and Mecklenburg Medicine for allowing us to present these letters here. In all, ten letters will be published over this year. The following three first appeared in January, February, and March 2002.

### Take Time to Comfort

Dear W:

I am so glad to hear that you want to become a physician. I really am surprised at how happy I am about that. I recently have been guilty of saying that I would not do it again if I had it to do all over, but of course that isn't true. I love what I do, despite the drudgery and frustration of dealing with managed care and other obstacles regarding patient care.

You asked my opinion and advice, and I am pleased to be asked. I have to respond with some hesitation and humility, though, because I am not really a senior voice yet (middle-aged, maybe, but not senior!). I have been a physician for most of your life, but truth be told, that isn't really very long! You were a child during my residency, and your mother was my best friend and colleague. Your father faithfully brought you to the hospital for visits every time he was on call. You grew up with the sound of beepers and the smell of alcohol wipes, playing or sleeping through codes and sometimes chaos. You actually seemed to like Pediasure milkshakes for snacks!

W, I am sorry that you and other youths are coming into a world with such hatred as was shown on September 11. I guess you

now know the worst about mankind, but you must try to remember there are more "good guys" than bad ones. Just look at how people have pulled together, shown patriotism, and helped each other during these unnerving times. You know, it is at a time like this that people turn for guidance to their traditional leaders and comforters: clergy, teachers, firemen, police, military, doctors, and nurses. Even more than others, these professions are called on now to play old-fashioned roles of community leadership by volunteering, comforting others, and setting good examples. A perceptive Charlotte policeman, Officer Edwin Carlton, wrote recently in *Dilworth Quarterly*, a neighborhood newsletter, that some people are more sensitive to stress than others and their neighbors may notice signs of depression or anxiety. Everyone needs a little support right now, and physicians are often privileged to know their patients' innermost concerns. We are in an excellent position to help recognize the more troubled folks Officer Carlton described.

You should have heard some of the heartbreaking comments from some of my pediatric patients after the September 11 attacks. On September 12, one young boy leaning against my window and looking toward

***"I want to show you there must be time in your day as a physician to offer comfort to people"***

uptown Charlotte said, "Excuse me, ma'am, is that New York?" The little girl after him said, "Are we too high here? Is someone going to see us?" Now, W, you may think I am rambling and I don't have a point, but it is this. I want to show you there must be time in your day as a physician to offer comfort to people. I didn't accomplish much by refilling those children's prescriptions, maybe a little, but not much. I think I did more by just talking with them about their fears and reassuring them with our shared beliefs and unity. After "Do No Harm," I think the next principle of being a good physician is "Take Time to Comfort."

During your busy clinic, try to remember to sincerely ask patients how and what they are doing. Take brief notes on what your patient says, and next time ask about his aging parents about whom he was concerned. Ask if she is still taking music lessons and how her job application turned out. This recommendation is found

nowhere on the managed care documentation guidelines for "level of service," which really is just an insurance measure of billing rates. But this is the only "level of service" worth providing. You could be technically the best physician around, but if you don't take time to comfort your patients, your competence may help little.

When you go out, look around you for your patients' faces. Unless you are a psychiatrist and need to be careful not to betray confidences, nod and smile to your patients. Don't worry, they usually won't ask you medical questions (and if they do, handle it gently with a suggestion to call your office so you or your assistant can consult the chart properly). Also you won't have to remember their names; they will just be touched that you recognized and acknowledged them.

In modern times, we might underestimate it, but a physician is still very much a guidepost for his or her patients. Try to always behave in a balanced way that would allow your patients, whether you saw them in a restaurant or not, to say affectionately, "That is my doctor."

W, I know you will be a great physician. You were a compassionate and smart child and will be such a man. I am honored to share in advising you and will write again soon with more ideas.

Fondly,  
Carolyn

### Take Time to Volunteer

Dear W:

As I write you this month, Charlotte is blanketed with seven or eight inches of lovely snow. It brightens and softens everything, and even the sky is a muted pastel. The roads are tricky though, and my little truck could not pull the hill on my long country driveway. Pantyhose just don't make it in this kind of weather, so after changing, I have been trudging back and forth unloading the groceries I just had to pick up on my way home! I know you don't get any snow where you live, and by the time you receive this letter, it will be February and our snow, too, will be long gone. February has always seemed sad to me somehow, and I am glad every year when it is over. The best ways I know to get through it are to get away for a few days to someplace warm and colorful and to do something to help others.

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## Fondly, Carolyn

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The latter is what I wanted to talk with you about this month, W, as you look toward a career in medicine. Volunteering has been a long tradition in medicine but is sometimes forgotten or omitted as our lives and practices get busier. Although physicians have been financially and emotionally injured by managed care, litigation, and legislation, most of us are still much more fortunate than average. Christian, Jewish, and Islamic teachings all require that one donate time and resources to help others in our communities. It is just the right thing to do. Volunteering is also good for “public relations” for you and your practice as you meet, labor with, and enjoy the company of people in other fields. Lastly, volunteering is good for you as a person; it brightens and softens your outlook, much as the snow has done for our city this week.

Last weekend, I traveled with friends to a bed-and-breakfast in North Carolina’s beautiful mountains. We ate breakfast with a neuropsychology doctoral student who was seeking a historical figure to psychoanalyze for her dissertation. She had started with Mother Theresa but later concluded that “you cannot analyze Mother Theresa; she was a saint.” That may be true, but I think there is a little of Mother Theresa, or what drove her, in each of us. In other words, we have both a moral obligation and a personal need to volunteer.

**“We have both a moral obligation and a personal need to volunteer”**

There are many opportunities for volunteers in every community. The most obvious one for medical volunteers in Charlotte is our Shelter Medical Clinic, which, sadly, has had to cut its hours by 50 percent recently due to lack of physician involvement. Our Mecklenburg County Medical Society is going to offer pins as a token of appreciation and recognition of physicians and their spouses who volunteer, although the real reward, of course, is not a little pin but internal.

I mentioned last month that physicians must “take time to comfort,” and to that I would now add that we must also “take time to volunteer.” Have a great month, W, and say hello to your family for me.

Fondly,  
Carolyn

## Take Time to Keep Learning

Dear W,

You would have really enjoyed a speaker I heard last night at our county medical society’s annual meeting. It was Erik Weihenmayer, the blind man who climbed Mount Everest last May. As a climber yourself, you understand better than I what a feat that was. Although there were naysayers, Erik attributed his success largely to the many people who encouraged him. He pointed out that “encourage” is a meaningful word—to instill or imbue with courage. I wish I had thought of that word when I wrote you a couple of months ago about taking time to comfort. Maybe it would have been better to describe that concept as taking time to encourage rather than necessarily to comfort.

Ah, hindsight!

This time I wanted to urge you to always “take time to continue learning.” It occurred to me that this should be our next concept when I found myself, at midnight after that dinner meeting, looking up “congenital retinoschisis,” the disorder Erik explained had blinded him by age 13. When I could not find it in my trusty textbooks, I engaged in that twenty-first century vice and got on line in the middle of the night! Now, that is not a very good example and I will disavow it in the “take time to live healthy” letter yet to come! I have learned a lot from my partner, Bob, about how to use the Internet for many purposes, but primarily for learning. Google.com, the search engine he suggested, told me all about “congenital retinoschisis” in milliseconds! Check it out!

W, you might respond that, of course, you will continue learning since you still have a few years before certification, but I mean after that. Once you are fully trained and certified, it is still crucial to “keep up.” The pace of progress in medicine has been dizzying. Of the 30 or so medications that I routinely prescribe, only about 10 were available when I finished training 10 years ago! Also, patients are much better informed now, mainly because of the Internet, and many are interested in alternative treatment methods about which allopathic physicians receive little if any education. Reading, listening, and learning constantly are the only ways I know to be able to continue to answer their questions competently and without having to resort to those weapons of insecurity—defensiveness and condescension. The North Carolina Medical Board now requires North Carolina physicians to earn 150 hours of continuing medical edu-

cation credit over three years to maintain their licenses. Happily, most doctors don’t need such a requirement to keep them learning because most of us are compulsive students, driven by a desire to know, a deep curiosity. This is nobly portrayed in Rembrandt van Rijn’s (1606-1669) painting, *Philosopher Reading*, which hangs in the Nationalmuseum/Stockholm, though you could settle for seeing it on line at [www.abcgallery.com/R/rembrandt/rembrandt8.html](http://www.abcgallery.com/R/rembrandt/rembrandt8.html). Many physicians are endlessly stimulated by a child-like wonder at the biological sciences we study and a sense of personal satisfaction, perhaps even joy, at gaining new knowledge or skills. Continuing to learn is also good for your brain; try “nuns and longevity” on your search engine!

Having studied languages that are really not useful to me now, I am trying to learn Spanish, a skill that is increasingly important for communicating with many of my patients. My Hispanic patients have been my main teachers, of course, but I am using tapes in the car and a Spanish immersion course on CD-ROM. You, clever thing, have been speaking Spanish since infancy, so you would not have been as baffled as I when my moderately retarded patient said “Dame cinco!” First she asked it playfully, then a bit louder, then with distress, and finally rocking and whimpering tearfully while her parents shook their heads to my question and tried to hush and distract her so she would not bother me. When the meaning (“Give me five!”) finally dawned in my old brain and I did it, her relief and smile were beautiful, as was the accompanying quiet! Often, Hispanic patients do speak English or an interpreter is available for your medical visits, but knowing at least a little about the Hispanic cultures and speaking a little Spanish will certainly build your relationships with your patients and add fun to your day.

The more you learn through reading, listening, and experience, the more confident, capable, and intuitive a physician you will become. Erik Weihenmayer, whom I think should be called Erik the Encourager, related that he learned from the Sherpas that your mind is like water: if you do not disturb it, it will become clear. That seems especially true if that mind is deeper than a shallow puddle and is already full of knowledge and, even more importantly, curiosity!

Give hugs to your family for me, and keep studying!

Fondly,  
Carolyn



*Part 3 of a Series*

## Experiences in Moldova: On Assignment with the North Carolina National Guard

*Major Brenda E. Moy, RN, and Lieutenant Colonel Morton Meltzer, MD*

The medical mission of the North Carolina National Guard in Moldova is part of the North Atlantic Treaty Organization's Partnership for Peace Program (PFP), which was launched by the January 1994 NATO summit meeting. The PFP is designed to establish strong links between NATO and its new democratic partners in the former Soviet bloc, links intended to provide a foundation for joint multilateral activities, such as humanitarian assistance, peacekeeping, and crisis management. Twenty-seven nations, including Moldova, have joined the PFP. North Carolina is a partner of Moldova in the program and the North Carolina National Guard is the agency designated to implement that partnership. The National Guard's medical efforts in Moldova reflect the value of the humanitarian aspects of the PFP. Better known, of course, is the NATO peacekeeping operation in Bosnia in which 13 PFP members worked side-by-side with the NATO allies.

Going to Moldova has become second nature for many of us involved in the continuing North Carolina National Guard (NCNG) mission to Moldova. However, our trip in March 2001 was augmented by the joint efforts of the NCNG and the NC-Moldova Partnership Committee, integrated with the East Virginia Medical School's (EVMS) contribution, which was focused on retraining Moldovan physicians as primary care doctors.

From the NCNG, there were LTCs Meltzer and Rick Broadhurst and Majs Jeffrey Weiss and Moy (the latter wearing two hats, one as part of the NCNG and the other as part of the NC-Moldova Partnership Committee headed by Drs Garland Hershey, Stephen Mackler, and Richard Mumford). The EVMS component was led by Francine Lutz, assisted by Dr Eric Fee, who was the first civilian Minuteman Fellow sponsored by the NCNG to go to Moldova last year.

The first group to hit the ground was the NCNG team of Broadhurst, Meltzer, and Weiss. Dr Mackler had arrived earlier and Drs Hershey and Mumford didn't arrive until the subsequent Sunday, when Dr Fee and Ms Lutz arrived. Maj Moy flew in on the flight to Moldova with the NCNG contingent, but initially teamed with Dr Mackler.

### First Days

The NCNG team initially gave three days of lectures. The first day was at the Military Hospital and dealt with the operational organization of the NCNG and its response to disasters. Two other areas were also covered: TB evaluation and blood-borne pathogen protection. The second day was a rerun of the first, but instead of giving it to hospital doctors we delivered it to the Military Poly Clinic. The physicians at the first day were from the Central Military Hospital and the second from the Poly Clinic.

On the third day, we delivered much of the same material to the medical personnel



*L to R: Irena Poppov, MD, her assistant, a patient, Dr Meltzer at the Christian Medical Center*

(MD's) from all the field units of the Moldovan military. On this day, Maj Moy joined our presenting team, delivering material about and narrating a film on the floods which ravaged North Carolina in September 1999. We also added material from "SORT" (Special Operations Response Team of Winston-Salem, which is headed by Dr Lou Stringer and managed on a day-to-day basis by Walt Kaplan). The purpose here was to demonstrate how all facets of American society work integrally in handling disasters to obtain economy of scale. We again covered the organizational structure of the NCNG, blood-borne pathogen management, and TB education. Involved in all of this were Cols Pisla, Passat, Targon, Gutu, and the retired Col Suruceanu, and, at the Poly Clinic, Col Ribacico, who the year before handled our GI's with the acute gastro-enteritis outbreak. On the second day, there was Col Hustiu and Col Capcelea from the Ministry of Defense.

Names, ranks, and units of key personnel we met included O-6 and above personnel, along with civilians, ministers, etc: Col Pisla, Chief of the Medical Department, Ministry

of Defense; Col Targon, Chief of the Central Military Hospital; Col Ribacico, Chief of the Central Military Poly Clinic; Col Adam, Chief Dentist, Central Military Hospital; Col Passat, Command Surgeon of the General Staff; Col Gutu, deputy to Col Targon, Central Military Hospital; Dr Marianna Ciabanu, private neurologist, interpreter. Additional information about the structure of the Medical Department, Ministry of Defense: Col Pisla, Chief, Medical Department, Ministry of Defense; Col Hustiu, Deputy Chief, Medical Department, Ministry of Defense; Col Capcelea, Chief, Medical Section, Medical Department, Ministry of Defense; Col Bernaz, Chief, Pharmacy Section, Medical Department, Ministry of Defense.

### Humanitarian Aid

The next assignment for our team and the group from EVMS, and Drs Mackler, Hershey, and Mumford, and Maj Moy, was the delivering of humanitarian aid to two small communities in northwestern Moldova in cooperation with local and Moldovan military doctors and dentists, along with medical and dental students from



*L to R: Dr Meltzer, Major Moy, Major Weiss, Interpreter, Driver*

the Medical and Dental Universities in Chisinau, the capital city.

We ended up with two separate areas to cover and sent teams of doctors to both the Poly Clinic in the town of Ungheni and the clinic in the village of Sculeni. Our total team consisted of 30 people on Saturday, 24 March, and of 20 on Sunday, 25 March. The primary U.S. team was two doctors and one dentist (LTC Meltzer, LTC Broadhurst, and Maj Weiss) from the NCNG. They were supplemented by one NCNG nurse (Maj Moy) in a dual capacity of being on military orders to augment the NCNG team and to

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## Experiences in Moldova

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support the NC-Moldovan Partnership contingent of Drs Mackler, Hershey, and Mumford. Dr Mackler was the civilian dentist from North Carolina that traveled at his own expense. There was one civilian physician, Dr Eric Fee, from Virginia, who had previously been a Minuteman Fellow. He had spent nine weeks in Moldova the summer before and works with EVMS under its USAID grant to work with the Medical University of Moldova. We also had the assistance of Laura Fredricks, the wife of an embassy employee who is a current and qualified U.S. physician and is a member of the U.S. Army Reserve. Our team of American doctors, dentists, and one exceptional nurse was further supplemented by one doctor and two dentists from the National Army of Moldova and three doctors (residents) and three nurses from the Medical University of Moldova. In addition, there were a Moldovan doctor who



*Patients waiting to be seen at the medical facility in Ungheni*

works for the Ministry of Health in a management capacity, another Moldovan doctor, Liliana Shantsevaia, who is the part-time local physician for the U.S. Embassy, and, finally, Dr Marianna Ciabanu from Chisinau, who works closely with several different aspects of the State Partnership Program and who had spent three months in the U.S. at Wake Forest University on a Minutemen Fellowship last year. What was exceptional and very helpful was that the local doctors who normally work in the clinics where we were operating also volunteered to work Saturday and Sunday to assist our humanitarian effort.

In addition, a team of three doctors and interpreters traveled to Sculeni. The remainder went to Ungheni, where the greatest number of patients were expected. The Moldovan Ministry of Health, which recommended splitting into two groups and also arranged a site visit on the Tuesday prior to the event to meet the local doctors in charge of the clinics, was instrumental in making this a success. The event was advertised on

local television and both locations had huge numbers of people waiting for us when we arrived at 9:00 AM on Saturday. We estimated about 400 people were in the hallway in Ungheni and the village of Sculeni had about 200 people waiting. The doctors in Ungheni quickly learned that many of the patients were known by the local doctors and were more in need of medication than diagnostic services. The result was a system where the American, military, and university doctors teamed with a local doctor and confirmed the diagnosis and the prescription. The medicines were dispensed by the embassy doctor and the Ministry of Health doctor, who were familiar with the local medications (some were labeled in Russian, since all had been purchased locally). The final tally after two days: at least 1,125 people were seen and received needed medications. The event was summed up by an elderly lady who stopped Col J. Michael Swope after receiving some pills, thanked him profusely, and said that this is how humanitarian aid should be dispensed, directly to the people. She then broke down in tears as she described how and why she needed the medication.

Approximately \$12,000 worth of medicines were purchased locally and we dispensed all of it. Deciding what was needed, locating it, and helping us purchase it was accomplished by the hard work of the embassy physician, Dr Liliana Shantsevaia. Without her knowledge of local suppliers, generic and non-U.S. manufactured drugs, and language, we could not have had the proper medications. She worked with the U.S. team of military and civilian doctors, dentists, and our nurse after hours to create a list of most needed medications, giving advice as to alternatives to some of the U.S. medications that were not available, and accompanying Col Swope's deputy on the actual purchase of the medicines and supplies. She also was able to secure several reductions in price due to her connections with the suppliers.

### Impact

Publicity was good, television interviews and pieces were done by Moldova's PRO TV and Moldova National TV. The pieces aired on Monday and were said to be very positive by those who saw them when broadcast. We received some very valuable information about how medicine is practiced in Moldova and were able to help the local doctors as they move toward a family practice type of medicine rather than the central hospital and specialist approach of the former Soviet Union. We learned about local generic substitutes for some high

priced, name-brand medications, and we were able to teach our Moldovan counterparts about some newer medications and methods. We also learned that the local clinics were well staffed with qualified doctors but were very inadequate in equipment and medicines. From the numbers of people who came for evaluation and treatment, it was obvious the hard economic conditions make it nearly impossible for most people to purchase medications needed to combat their chronic illnesses.

A good number of us had to leave on Sunday, 25 March (LTC Broadhurst, Maj Moy, Maj Weiss, Dr Hershey, and Dr Mumford on the 25th, LTC Meltzer on the 27th). However, the mission continued,



*L to R: child, Dr Meltzer, child's mother at Ungheni medical facility*

and Ms Lutz and Dr Fee, from EVMS, and Dr Mackler remained to push on with their individual components to the combined mission. Dr Mackler and a dental student from Chisinau (who was married to a US Embassy employee) traveled to an orphanage in Bulboaca. They were accompanied by the dean of the dental school, Professor Dr Pavelgodoroja, another faculty member, Dr Gheorghe Nicolau, and the senior dental student, Marianna Evans. They went to the orphanage supported by Col Swope's Military Liaison Team. This location was recommended to them by both Col Frank Swett and Swope. They saw 87 children over a two-day period. Their effort was such a huge success that the portable dental delivery system was loaned to the school on the condition that the dean would continue in his leadership capacity to recruit other faculty and students to visit and deliver care at other orphanages.

This was a 12-day trial period. Funds were donated to assist in the purchasing of supplies for this project so it could continue and the results will be used by Drs Mackler, Hershey, and Mumford in planning future projects in Moldova in partnership with the EVMS and the NC-Moldova Partnership Committee chaired by Secretary of State

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## Experiences in Moldova

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Elaine Marshall and North Carolina Senator Phillip Baddour.

After we left, Ms Lutz, who oversees the grant for EVMS to establish a family practice retraining program for Moldovan physicians and to open representative family practice training clinics, held several meetings with the representative from the USAID office in Kiev (Mr Perlman). They had an opportunity to discuss the progress of the medical clinic renovations in Botanica (initial family practice teaching clinic in Chisinau) and to discuss the residency rotations at this site. Dr Eric Fee presented a lecture on depression that was well attended by the faculty and residents of the SMPU (State Medical and Pharmaceutical University) in Chisinau. This lecture was followed by a lengthy Q&A period, particularly around the use of pharmaceuticals in treating depression. Dr Fee also worked at the Botanica clinic, where he saw patients and worked with residency groups. During this time, he showed them the proper use of an otoscope and how to identify and treat otitis media (six of the residents had never seen or used an otoscope).

As far as community activities go, Ms Lutz participated in a panel to judge some employee groups who presented skits to the community about how humor in the workplace can relieve stress. This was great fun and was well attended. It was held at the Bucaria Candy Factory, where the director has implemented a smoking cessation program, elder care, health care, dental care, and day care for the employees. He currently has 2,000 employees who work around the clock. He is now the new Prime Minister of Moldova. In addition, Ms Lutz attended another community activity—tree planting day! This was where members of the community brought their families to plant a tree in the park and have a picnic. Again, promoting a healthy lifestyle and family activities. She was with the mayor and planted a walnut tree.

To give one an idea of the desperate state of health care created by economic shortages, the Botanica clinic opened on January 3, 2001. By March 31, 2001, there had been a total of 4,253 patient visits to that site. This is a significant number for such a short time frame. There have also been 15 community outreach programs that have been presented by the doctors and nurses from Botanica. These include programs on geriatrics, nutrition, stress management, mental health, and pediatrics.

## Conclusion

In conclusion, our efforts to help Moldova and its citizens allowed a visit by Col Swett and Assistant Secretary of State Rodney Maddox to Col Snitko, the Moldovan military officer (a bilateral AK amputee) who received new state-of-the-art prostheses at Wake Med thanks in large part to the efforts of Rob Morrell, MD (medical director of Wake Med), and Mr Louis Brown of Brace Builders in Raleigh. We also received word by June that the pacemaker we received and forwarded to Moldova for Col Ungureanu's daughter (he was the cardiologist who confirmed our diagnosis of heart failure secondary to a defective valve in a reserve colonel assigned to the Military Liaison Team in 1999) was surgically implanted and the young journalist for whom it was intended was doing well.

The North Carolina-Moldova partnership continues to flourish and the mission of the NCNG to spearhead these efforts on the ground will be headed by Col Jay Wilkins, who is to follow Col Swope, who followed Col Swett in seeing to it that our mutual interests are served in a positive and productive manner. This means the program of inoculating 1,100 Moldovan children for immunization against hepatitis B should have been completed by the end of 2001. The North Carolina Air Guard is to give the second shot, and the final immunization should be accomplished late in the year. The "Heart to Heart Foundation" of the American Association of Family Physicians planned to deliver a huge quantity of medical supplies and equipment in late 2001. The NCNG has obtained and delivered nearly \$2,000,000 of medications and medical supplies to Moldova.

This is a living program to assist our fellow human beings who, at the moment, are less fortunate than those of us living in North Carolina. In order for it to thrive, it needs the support and commitment of our entire medical, dental, and nursing community.

Our thanks to Col Swope, Ms Francine Lutz, and Dr Stephen Mackler, for their assistance with this article. Without their thoughts and comments it would never have been accomplished.

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Major Brenda E. Moy, RN, is chief nurse, Detachment 4 (Medical), HQ STARC, of the North Carolina National Guard.

Dr Meltzer practices at Doctors' Urgent Care in Fayetteville. He also practices forensic psychiatry at Wake Mental Health and psychiatry at Wake Medical Center. He is a lieutenant colonel in the 113 Field Artillery of the North Carolina National Guard. ♦

## Charles L. Garrett, Jr, MD, Elected NCMB Secretary/Treasurer



*Dr Garrett*

Andrew W. Watry, executive director of the North Carolina Medical Board, has announced that Charles L. Garrett, Jr, MD, of Jacksonville, has been elected secretary/treasurer of the North Carolina Medical Board. Dr Garrett, who was named a member of the Board by Governor Hunt in January 2001, replaces Mr Paul Saperstein, of Greensboro, as secretary/treasurer of the Board.

Dr Garrett is director of laboratories at Onslow Memorial Hospital; managing senior partner of Coastal Pathology Associates, PA; medical director and adjunct faculty member at the School of Medical Laboratory Technicians at Coastal Carolina Community College; medical examiner of Onslow and Jones Counties; southeastern regional pathologist for the Office of the Chief Medical Examiner of North Carolina; and executive director of the Onslow County Medical Society. A native of South Carolina, he received his undergraduate education at Wofford College in Spartanburg, SC, and took his MD, *magna cum laude*, at the Medical College of South Carolina in Charleston.

Dr Garrett did his postgraduate training at the Medical University Teaching Hospitals in Charleston, South Carolina, and a fellowship at the Medical College of Virginia and in the Office of the Chief Medical Examiner of Virginia. He is certified by the American Board of Pathology. He also served in the U.S. Navy, from which he was honorably discharged as a lieutenant commander.

A fellow of the College of American Pathologists, the American Society of Clinical Pathology, and the American Academy of Forensic Sciences, Dr Garrett is active in a large number of professional organizations and served as president of the North Carolina Medical Society in 1998. He continues his work with the Medical

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## Garrett Elected

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Society today in several capacities and is a Society delegate to the American Medical Association. He is also on the Board of Directors of the AMA's Political Action Committee.

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

## Drs Moffatt and Norins, Mr Gupta Named to NCMB; Dr Herring Reappointed

Andrew W. Watry, executive director of the North Carolina Medical Board, has announced that Governor Easley has appointed Robert C. Moffatt, MD, of Asheville, Michael E. Norins, MD, of Greensboro, and Hari Gupta, of Morrisville, to the North Carolina Medical Board. The Governor has also reappointed Stephen M. Herring, MD, of Fayetteville, to the Board.

### Dr Moffatt

Robert C. Moffatt, MD, of Asheville, was born in Winchester, Tennessee, and took his BA degree from East Tennessee State University. He earned his MD degree at the University of Tennessee Center for Health Sciences, Memphis, and did his internship at Memorial Mission Hospital in Asheville. He completed his residency training in surgery at the University of Georgia College of Medicine and did a surgical oncology fellowship at Memorial Sloan Kettering Cancer Center. He holds certification from the American Board of Surgery, is a fellow of the American College of Surgeons, and is licensed in North Carolina, Georgia, and Mississippi.

Dr Moffatt holds appointments at Memorial Mission Hospital and St Joseph's Hospital in Asheville. His practice is focused on surgical oncology. He has served as president of the Buncombe County Medical Society and is a member of the

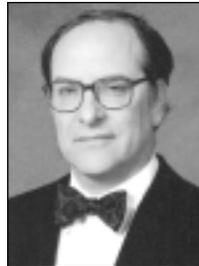


*Dr Moffatt*

North Carolina Medical Society, the American Medical Association, and numerous other professional organizations. He was also Buncombe County medical examiner for seven years. Active in community affairs, over the years he has been on the Asheville Symphony Society Board, the King College (Bristol, TN) Board of Visitors and Board of Trustees, and the Mountain Ramparts Health Planning Council. He has also served as president of the Asheville Lyric Opera. Among other honors, he was made a member of the Governor's Order of the Long Leaf Pine by Governor James B. Hunt, Jr.

### Dr Norins

Michael E. Norins, MD, of Greensboro, a native of California, received his BS degree from the University of Georgia and his MS degree in chemistry from Western Carolina University. He earned a Master of Public Health-Administration degree at the University of South Carolina and his MD at the University of North Carolina, Chapel Hill. He currently practices primary care and internal medicine in Greensboro and is medical director of LeBauer HealthCare.



*Dr Norins*

Dr Norins is an adjunct associate professor in the University of North Carolina School of Medicine. He is also an associate of the American College of Physicians and the American Society of Internal Medicine, a member of the American Medical Association, the North Carolina Medical Society, and the Greater Greensboro Society of Medicine, of which he is a past president. Among his many professional activities, he serves or has served on the Professional Advisory Committee of the Hospice of Greensboro, the Medical Peer Review Committee of Wesley Long Hospital, the Medication Assistance Program Professional Advisory Committee, the Board of the PHP-NC, and the Credentials Committee of the UHC-NC.

### Mr Gupta

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

Mr Gupta began his professional career as a programmer and systems analyst in



*Mr Gupta*

Toronto, Canada, and soon moved on to a consultant's post with the Computer Task Group in Columbus, Ohio. In 1990, he joined SAS Institute in Cary, North Carolina, beginning as a software developer and then moving to applications development. In 1996, he became consulting director for SAS Asia Pacific/Latin America, and doubled AP/LA consulting revenues for two consecutive years. In 2000, he assumed the role of general manager for SAS Global Services, building and managing a 70-member team of software consultants based in India and the United States.

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

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

### Dr Herring

Stephen M. Herring, MD, of Fayetteville, a native of Chapel Hill, North Carolina, took his BA degree at the University of North Carolina, Chapel Hill. He earned a DDS from the University of North Carolina School of Dentistry, followed by an MD from the Wake Forest University/Bowman Gray School of Medicine. He did his internship in general surgery and a residency in general surgery and plastic surgery at Bowman Gray. He is certified by the American Board of Plastic Surgery and holds licenses in both



*Dr Herring*

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

# Mitigating Malpractice Misery

Louise Andrew, MD, JD

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John-Henry Pfifferling, PhD

Director, Center for Professional Well-Being, Durham, NC



Dr Andrew

The medical malpractice experience has many adverse effects on physicians and on their practice community. Researchers report that more than 95% of sued physicians acknowledge some physical and/or emotional reactions. Given physician's general reluctance to admit emotional reactions, such prevalence is highly significant. The societal cost of defensive medicine has been estimated in the billions, and the resultant patient inconvenience or suffering due to false positives, iatrogenic complications, wasted trips to medical facilities, etc, is appalling. Our purpose in this article is to reduce the stress of litigation for physicians and their community.

## The Impact of Suit

Sued-physician responses can include the onset or exacerbation of a physical illness, such as peptic ulcer disease, cardiogenic distress, or insomnia. Emotional responses may range from anger to profound depression and even suicidal ideation. A number of medical communities relate stories of physicians who attempted suicide in reaction to the receipt or continuing stress of a suit.

Throughout the course and even following resolution of a claim for medical malpractice, the stress of the experience has continuing adverse impact on a physician's life. Sued physicians are more likely to stop seeing patients who appear to have a risk for untoward outcomes or a propensity to initiate a suit. In the wake of a claim, some physicians consider early retirement and many discourage their children from entering medicine.

After being sued, most physicians obsessively document, order more tests and consultations, and stop performing procedures that may result in complications, even when the procedures are appropriate and are performed competently. A physician facing a medical malpractice suit frequently avoids speaking with colleagues, can be shunned by colleagues or hospital administrators, and many imagine the case will damage their practice permanently. These maladaptive coping mechanisms can easily spill over into the home environment.

Being named in a medical malpractice suit initiates a host of other consequences. Since

1990, an entity making payments in settlement of a claim, except the physician on his/her own behalf, must report the provider to the National Practitioner Data Bank (NPDB.) Hundreds of thousands of reports have been made to the NPDB; the vast majority are due to payments made to settle malpractice claims. Many of these settled claims were considered non-meritorious, but were settled by insurers due to the possibly greater cost of trying the case.



Dr Pfifferling

In North Carolina payments by insurers and by those who are self-insured must be reported to the North Carolina Medical Board.

Health care institutions are required by law to query the NPDB when considering the qualifications of an applicant for staff privileges and must check their staff lists with the NPDB every two years. State medical boards and other recognized credentialing bodies may also use the NPDB as a data resource. Such bodies invariably request information regarding previous malpractice cases of each physician in the application process. Although physicians are afforded an opportunity to provide details of malpractice claims, bias or prejudice is often present, and negative histories may result in denial of credentials or state licensure. Providing these agencies the details of a case long over is time consuming, sometimes impossible, and always stress provoking.

Many insurers retain the right to settle claims on behalf of their physician insureds without the consent of the insured physician. This practice often results in payment for non-meritorious claims because the nuisance value of litigating the case is greater to the insurance company than the settlement demand. Most physicians feel the exercise of such a right is a blatant violation of their trust and their professional autonomy. Since insurance companies vary in this practice, every physician should read and thoroughly understand the coverage contract to avoid this pitfall.

## Prevention

Prevention is by far the most effective strategy in mitigating the effects of malpractice claims. Most risk management experts agree that besides knowing what situations invariably precipitate calls to an attorney,

effective communication is the most crucial deterrent to malpractice litigation. Components of effective communication include the following:

- uninterrupted listening during the critical first 60 seconds of the physician-patient interaction;
- demonstrating acknowledgement of the patient by the physician;
- setting up realistic expectations for the interaction;
- sharing responsibility regarding the outcome with the patient, family, and other providers;
- providing time-and-action-specific discharge instructions, including the expected time frame for follow-up or recovery;
- providing an opportunity for the patient to ask questions, which provides a last chance to address the patient's concerns or to show an empathetic understanding of them.<sup>1</sup>

When you are communicating well, the behavior of the person with whom you are communicating changes. True communication always leads to new behavior, and often greater compliance. People are motivated to change behavior when they sense being acknowledged. To acknowledge is to deeply listen to what another person is saying. As Itoh writes, "Your ability to communicate well depends on your ability to get the other person to talk—and your ability to listen to what the other person is saying. Listening is only listening when you hear all of what another person is saying, without judging, or denying, or comparing that person to yourself."<sup>2</sup>

Additional actions that decrease the likelihood of a malpractice claim include the practice of complete, legible, and timely documentation; maintenance of continuing education and board certification requirements; reading current, practice-relevant journals; and participating in quality assurance activities.

Understanding the typical pattern of the generation of the typical suit can help to avoid it. People seek legal advice when:

- unexpected medical results and complications occur without warning (surprises);
- injuries are perceived by the patient (or close friends) as "catastrophic," or the patient is the primary provider in the home;
- the relationship with their physician is

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## Mitigating Malpractice

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rocky, fleeting, or unsatisfying;

- communication is incomplete, disappointing or a "failure";
- subsequent providers make critical comments about received care;
- they perceive a lack of empathy shown by the physician or associated staff;
- the patient and/or family don't understand a bad outcome and cannot get an adequate explanation.

### Mitigation

Despite the best preventive measures, litigation may nonetheless occur. Physicians preparing to defend themselves must recognize that they will inevitably experience emotional reactions. Individuals confronting the litigation process should expect they will feel angry, hurt, disappointed, disillusioned, isolated, vulnerable, violated, or unjustly singled out.

Guilt is a common response, even if the physician rendered faultless care. Defendant physicians may question their competence or persistence in their profession. They may become ill, stressed, withdrawn, or depressed.

Initially, support systems may appear to be scarce. Colleagues or associates may not offer empathy or understanding, particularly if they have not yet personally experienced a medical malpractice claim. The affected medical department or hospital administration may not offer support but, instead, may take an adversarial stance. Even family and friends may be incapable of providing support or understanding initially. All of these groups may harbor the mistaken belief that bad outcomes and malpractice suits happen when physicians make mistakes or are "bad doctors."

Several avenues in addition to legal counsel are available to assist physicians in sharing the burden of defending a medical malpractice claim. Sharing feelings and explaining the basics of similar types of medical cases to family members can help to ease the stress and gain their understanding, support, and empathy. Strong and intrusive negative feelings should be discussed with a professional counselor. Privileged communications are possible not only with attorneys but also with spouses, clergy, and mental or other treating health professionals, including state physician assistance programs.

The malpractice carrier should be notified promptly of any claim or threat of claim, of any contact by an attorney, or any request for records. Such notification often is a condition of insurability, as well as a mechanism for dating claims. Defendants should plan to participate actively in the case and provide the defense counsel with complete details as

promptly as possible. No part of any medical record should ever be concealed or altered.

Defendants should inquire of their counsel about the opposition's deposition and trial tactics, insist on obtaining the best witnesses, assist in answering interrogatories, read the litigation documents, and carefully prepare for their testimony. They should prepare for the fact that the claim will intrude on regular life experience regardless of personal or professional schedules. It is wise to reduce non-essential professional obligations, and especially to eliminate overbooking or rigid schedules at this time. This is because there is some evidence that there is a higher likelihood of a second case being initiated in the wake of a first case.

Some physicians seek coaching from an advocate to better understand the malpractice process and prepare for deposition and possible trial. Hiring personal co-counsel (your own attorney to assist in the case and monitor the attorney hired by the insurer) may also be prudent if the insurer informs the physician that the award or settlement amount may exceed policy limits, or if the insurer's attorney does not appear skillful, or to represent the best interest of the physician.

After a trial, the physician defendant should prepare for each possible outcome before the verdict is given. He or she must understand and accept that settlement is not an admission of negligence. The amount of any settlement is not proportional to the degree of culpability (if any) in the case, but to the relative expense of litigating the case to its conclusion, the costs incurred by the medical outcome, and emotional or cultural factors weighed by the jury.

Unfortunately, even dismissal of a case does not completely remove the stigma or stress of litigation. Litigation stress may mimic post-traumatic stress and undermine personal ease for years. Litigating a malpractice case typically takes years, and the process may be even more stressful than the outcome if the defendant is not prepared, educated, and supported throughout the case. Since cases proceed by fits and starts, there will be recurrent painful reminders of the claim, which some have likened to vicarious re-traumatization.

Prior to settlement of a claim, the physician defendant and attorney should explore whether avoidance of NPDB reporting is possible under the circumstances of the case. Also, with the attorney's assistance, a summary of the claim should be created, which usually includes the terms of the judgment, settlement, or dismissal. This document, along with appropriate copies of the claim and settlement or dismissal, can be submitted for future credentialing and licensing application purposes.

### Learning

Regardless of the outcome, successfully confronting a malpractice suit can provide a growth experience. The knowledge gained from researching and defending the case can often be used to help change the environment and circumstances that have contributed to the suit (for example, upgrading diagnostic or treatment services available at the institution). Neutral third parties, such as the defense attorney, counselor, or law clerks, may provide insight regarding demeanor or habits exhibited by the physician under stress, which may be similar to the behavior that prompted initiation of the claim! Better communication and coping skills can be learned from a coach who has been consulted because of the stress of the claim process. Analyzing and altering negative or abrasive behavior will improve all facets of life.

After the case is concluded, a sued physician may want to share the experience with others facing litigation or those facing similar stresses, such as disciplinary proceedings, divorce, serious illness, or practice dissolution, in a peer setting or a support group. Physician defendants can and are now motivated to educate the public regarding the limitations and constraints of medicine in general. The stress of dealing with medical malpractice litigation may additionally motivate society to look at alternative ways to manage errors, ambiguity, and the unavoidable risk associated with medical practice.

The practice of medicine includes the constant threat of medical malpractice litigation. When confronted with a malpractice claim, the physician should immediately begin building a personal support system including the best counsel available. Facing a medical malpractice suit is a tremendous challenge, but successfully negotiating the process enhances physicians' coping skills and may ultimately improve their practice of medicine.

### References

1. The Bayer Institute for Health Care Communication offers a useful mnemonic for these components: "4E: we engage, empathize, educate, and enlist patients in management of their illness." For further information, call 800-800-5907.
2. Mamoru Itoh. *I Want to Tell You About My Feelings*. p 57. Morrow, 1992.

### Bibliography

Andrew, LB, Pfliffering JH: *How to Start a Litigation Stress Support Group*. Monograph published by the Center for Professional Well-Being, Durham, NC, 1995.

Andrew, LB: *Learning Through Personal Assault: Litigation Stress*. Monograph. Medical Chirurgical Society of Maryland, 1992

Charles, SC, Pyskoty CE, Nelson A: Physicians on Trial—Self-Reported Reactions to Malpractice Trials. *West J Med*, 1988; 148(3): 358-60. ♦

## The Art of Medicine

# An Image of Tradition and Hope

Walter J. Pories, MD, President, NCMB  
 Professor of Surgery and Biochemistry, ECU School of Medicine

Most physicians are familiar with the poignant painting *The Doctor*, by Sir Luke Fildes, one of England's finest portrait painters. Fildes lost his oldest son in 1877 on the worst of nights: Christmas Eve. The boy was attended by a physician named Dr Murray, who stayed long into that holy night to devote his full attention to the child.

Several years later, Fildes was commissioned to paint a medical scene. He knew what he wanted to paint but could not bring himself to even start the scene for another four years. Finally, Fildes paid tribute to Murray with *The Doctor*, a wonderful portrait of him attending the painter's son.

A fine engraving of the painting, in the collection of the Dittrick Medical History Center at Case Western Reserve University, is reproduced below and shows the scene quite well: the child, with his arm floppy and extended; the mother, hunched crying over the table; her grim husband, holding himself

together; and, of course, Dr Murray, watching, praying perhaps, but certainly discouraged. His armamentarium is spent; he knows nothing else to do.

Most of us, as physicians, have endured such long nights. We struggled, gave our best: assessed, diagnosed, and treated, but without avail. Despite all the right steps, the patient continued to fail. Over and over, we asked ourselves, "Is there anything else I should be doing?"

I have been there in the OR, helpless in the face of a broken liver; in the ICU, straining to see any sign of urine in the catheter; and on the wards, scanning the computer for more favorable numbers. And I have comforted my colleagues when they have had similar nights. Physicians are not good losers.

When that time comes, and I assure you it will, remember this wonderful image. Because, as we look at Dr Murray with every

arrow spent, we do not see failure but, rather, a physician who rose to the highest traditions of our profession. Doctors comfort and support, hold the patient's hand, and even cry. I have. Our patients know we are not gods, nor do they expect us to be. "No, just do the very best you can, doctor." And this is what those families remember as well.

There is one more aspect of the picture. Despite the fact that the painter's son actually died during the night, notice that Fildes painted the arrival of dawn. To Fildes, the child is living to see another day.

That emotion is called hope. Fildes kept that for his son and, perhaps, for himself. We need to remember that message: always retain hope and never, ever, take that out of the picture.

The print accompanying this article is reproduced with permission of the Dittrick Medical History Center, Case Western Reserve University. ♦



The Doctor, by Sir Luke Fildes (1844-1927)

## NCMB Revises Five Position Statements

At its meeting on March 21, 2002, the North Carolina Medical Board completed work on and approved revision of five of its position statements. They are presented below in marked versions to clearly indicate the changes made. Added language has been underlined. Deleted language has been lined through.

### SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS AND OTHERS WITH WHOM SIGNIFICANT EMOTIONAL RELATIONSHIPS EXIST\*

- It is the position of the North Carolina Medical Board that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. The Board strongly believes that such treatment and prescribing practices are inappropriate and may result in less than optimal care being provided. A variety of factors, including personal feelings and attitudes that will inevitably color judgment, will compromise the objectivity of the physician and make the delivery of sound medical care problematic in such situations, while real patient autonomy and informed consent may be sacrificed.

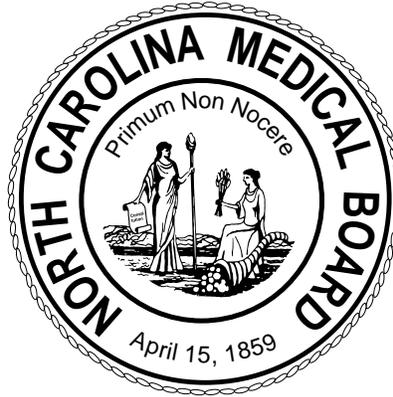
- When a minor illness or emergency requires self-treatment or treatment of a family member or other person with whom the physician has a significant emotional relationship, the physician must prepare and keep a proper written record of that treatment, including but not limited to prescriptions ~~written for controlled substances~~ and the medical indications for them. Record keeping is too frequently neglected when physicians manage such cases.

- The Board expects physicians to delegate the medical and surgical care of themselves, their families, and those with whom they have significant emotional relationships to one or more of their colleagues in order to ensure appropriate and objective care is provided and to avoid misunderstandings related to their prescribing practices.

*\*This position statement was formerly titled, "Treatment of and Prescribing for Family Members."*

(Adopted May 1991)

(Amended May 1996; May 2000; March 2002)



### LASER SURGERY

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

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

Lasers are employed in certain hair-removal procedures, as are various devices that (1) manipulate and/or pulse light causing it to penetrate human tissue and (2) are classified as "prescription" by the U.S. Food and Drug Administration. Hair-removal procedures using such technologies should be performed only by a physician or by a licensed health care practitioner working within his or her professional scope of practice and with appropriate medical training functioning under the supervision, preferably on-site, of a physician who bears responsibility for those procedures.

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

Surgery, which involves the revision, destruction, incision, or structural alteration

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

(Adopted July 1999)

(Amended January 2000; March 2002)

### WRITING OF PRESCRIPTIONS

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

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

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

- No prescription for controlled substances or mind-altering chemicals should be issued by a practitioner for his or her personal use.

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

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

- A physician who prescribes controlled

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

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

### ACCESS TO PHYSICIAN RECORDS\*

A physician's policies and practices relating to medical records under their control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care when such a transfer is requested by the patient or anyone authorized by law to act on the patient's behalf. Such policies and practices should conform to applicable federal and state laws governing health information.

It is the position of the North Carolina Medical Board that notes made by a physician in the course of diagnosing and treating patients are primarily for the physician's use and are therefore the property of that physician. Moreover, the resulting record is a confidential document and should only be released with proper written consent or authorization of the patient. Each physician has a duty on the request of a patient to release a copy or a summary of the patient's record in a timely manner to the patient or anyone the patient designates. If a summary is provided, it should include all the information and data necessary to allow continuity of care by another physician.

The physician may charge a reasonable fee for the preparation and/or the photocopying of the materials.<sup>1</sup> To assist in avoiding misunderstandings, and for a reasonable fee, the physician should be willing to review the materials with the patient at the patient's request. Materials should not be held because an account is overdue or a bill is owed.

~~Should it be the physician's policy not to include in either the copied or the summarized record those materials that were provided by other physicians regarding the patient's former or current care, he or she should advise the patient of that fact and of ways those materials might be obtained.~~

Physicians should not relinquish control over their patients' medical records to third

parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure patients' access to their records.<sup>2</sup> This provision does not apply if the primary custodian of the records is a hospital or other health care facility.

Should it be the physician's policy to complete insurance or other forms for established patients, it is the position of the Board that the physician should complete those forms in a timely manner. If a form is simple, the physician should perform this task for no fee. If a form is complex, the physician may charge a reasonable fee.

To prevent misunderstandings, the physician's policies about providing copies or summaries of patient records and about completing forms should be made available in writing to patients when the physician-patient relationship begins.

When responding to subpoenas for medical records, unless there is a court or administrative order, physicians should follow the recommendations set out in the *North Carolina Medico-Legal Guidelines*.<sup>3</sup>

- .....
1. This is subject to some exceptions, including, but not limited to: (1) records sought with respect to claims for personal injury and Social Security disability, which are governed by the maximum fees set forth in NC Gen. Stat. 90-411; (2) records sought in worker's compensation cases, which are subject to fees established by the North Carolina Industrial Commission; and (3) NC Gen. Stat. 44-49, governing medical liens for physicians in personal injury cases.
  2. See also Position Statement on Departures from or Closings of Medical Practices.
  3. Link: *The North Carolina Medico-Legal Guidelines*.

\*This statement will be updated as required in keeping with federal laws and regulations.

(Adopted November 1993)  
(Amended May 1996; September 1997;  
March 2002)

### THE PHYSICIAN-PATIENT RELATIONSHIP

The North Carolina Medical Board recognizes the movement toward restructuring the delivery of health care and the significant needs that motivate that movement. The resulting changes are providing a wider

range and variety of health care delivery options to the public. Notwithstanding these developments in health care delivery, the duty of the physician remains the same: to provide competent, compassionate, and economically prudent care to all his or her patients. Whatever the health care setting, the Board holds that the physician's fundamental relationship is always with the patient, just as the Board's relationship is always with the individual physician. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care. Therefore, it is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk. This is true whether such an act is entirely self-determined or the result of the physician's contractual association with a health care entity. The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

### *Elements of the Physician-Patient Relationship*

The North Carolina Medical Board licenses physicians as a part of regulating the practice of medicine in this state. Receiving a license to practice medicine grants the physician privileges and imposes great responsibilities. The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to the physician in a vulnerable condition, believing the physician has knowledge and skill that will be used for their benefit.

Patient trust is fundamental to the relationship thus established. It requires that

- there be adequate communication between the physician and the patient;
- the physician report all significant findings to the patient or the patient's legally designated surrogate/guardian;
- there be no conflict of interest between the patient and the physician or third parties;
- intimate details of the patient's life shared with the physician be held in confidence;
- the physician maintain professional

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## NCMB Revises Statements

*continued from page 15*

knowledge and skills;

- there be respect for the patient's autonomy;
- the physician be compassionate;
- the physician be an advocate for needed medical care, even at the expense of the physician's personal interests; and
- the physician provide neither more nor less than the medical problem requires.

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust—communication, patient primacy, confidentiality, competence, patient autonomy, compassion, selflessness, and appropriate care—are foremost in the hearts, minds, and actions of the physicians licensed by the Board.

This same fundamental physician-patient relationship also applies to mid-level health care providers such as physician assistants and nurse practitioners in all practice settings.

### **Termination of the Physician-Patient Relationship**

The Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in compliance with the physician's obligation to support continuity of care for the patient. The decision to terminate the relationship must be made by the physician personally. Further, termination must be accomplished by appropriate written notice given by the physician to the patient, the relatives, or the legally responsible parties sufficiently far in advance (at least 30 days) to allow other medical care to be secured. Should the physician be a member of a group, the notice of termination must state clearly whether the termination involves only the individual physician or includes other members of the group. In the latter case, those members of the group joining in the termination must be designated.

(Adopted July 1995)

(Amended August 1998; January 2000; March 2002) ♦

## North Carolina Medical Board Releases 2001 Annual Board Activity Report

In a recent announcement, the North Carolina Medical Board issued the Board's 2001 Annual Activity Report. The report focuses on actions taken by the Board during 2001 and on a wide range of information relating to the work of the Board.

Though all the data in the report are important in understanding the scope of the Board's responsibility in protecting the health, safety, and welfare of the people of North Carolina, the announcement called particular attention to several details in the report.

Altogether, the Board took 219 formal actions related to 123 individuals in 2001, compared to 222 actions related to 116 individuals in 2000. That total includes both prejudicial and non-prejudicial actions. (Non-prejudicial actions are those that initially derived from a disciplinary action but do not reflect a new action—such as the extension of a temporary license for a person who is practicing satisfactorily.) Prejudicial actions numbered 118 against 87 persons (76 physicians, 10 physician assistants, and 1 EMT). (In 2000, the numbers were 122 actions against 74 persons—66 physicians and 8 physician assistants.) Non-prejudicial actions numbered 101 related to 57 persons (49 physicians and 8 physician assistants). (In 2000, the numbers were 100 actions related to 62 persons—53 physicians, 8 physician assistants, and 1 nurse practitioner.)

The Board also revoked 8 licenses, denied 5, and suspended 13 (8 of which were stayed on specific conditions). Five licenses were summarily suspended.

The Annual Report contains two sections. In Section A can be found general information about the number of physicians (26,581—18,740 of whom are in-state), physician assistants (2,216), and nurse practitioners (1,926) regulated by the Board. Data on the Board's licensing activities, complaints received by the Board, and other details about the Board's disciplinary processes are included. Also presented are data on the causes of disciplinary action and the most common elements found in consent orders issued by the Board. Finally, there is a brief summary of activity by the North Carolina Physicians Health Program. In each case, the figures for 2001 are accompanied by comparable figures for 2000. This section of the report gives some sense of the scope of the Board's work.

Section B contains four segments focused on data about various actions, both prejudicial and non-prejudicial, related to the Board's disciplinary role: (I) a summary of specific Board actions, both prejudicial and non-prejudicial, with comparative figures for 2001 and 2000; (II) an expanded version of the summary that includes the names and locations of those concerning whom actions were taken in 2001; (III) an alphabetical list, with locations, of those against whom prejudicial actions were taken in 2001, and an alphabetical list, with locations, of those about whom non-prejudicial acts were taken in 2001; (IV) and an alphabetical list of all those concerning whom actions were taken in 2001. Segment I of Section B is presented below.

The full report is available to the public in Word and bookmarked PDF format on the Board's Web site at [www.ncmedboard.org](http://www.ncmedboard.org). Consumers can obtain valuable information on the Board's Web site, including copies of all public orders relating to each of the Board's actions. It is a rich resource for all the citizens of North Carolina seeking information about the Board's work and its licensees.

### **BOARD ACTION REPORT: SECTION B**

#### **I. NCMB Board Action Summary—2001**

*[Comparative Figures for 2000 appear in brackets and italics.]*

#### **Part 1—2001 Actions By Category**

##### **PREJUDICIAL ACTIONS:**

**License Denied: 5 Actions (5 physicians)**  
*[2000: 2 Actions (1 physician, 1 PA)]*

**Annulments: NONE**  
*[2000: None]*

**Revocations: 8 Actions (8 physicians)**  
*[2000: 3 Actions (3 physicians)]*

**Suspensions: 13 Actions [8 stayed; 8 by CO] (12 physicians, 1 PA)**  
*[2000: 11 Actions [3 stayed; 6 by CO] (10 physicians, 1 PA)]*

**Summary Suspensions:  
5 Actions (5 physicians)**  
*[2000: 7 Actions (7 physicians)]*

*continued on page 17*

## 2001 Annual Board Report

*continued from page 16*

### Miscellaneous Board Orders:

1 Action (1 physician)

[2000: NONE]

### Consent Orders: 48 Actions —

45 Persons [12 modifying previous COs] (41 physicians, 3 PAs, 1 EMT)

[2000: 53 Actions — 49 persons [12 modifying previous COs] (43 physicians, 6 PAs)]

[More than one CO may be executed with a practitioner during the year. Note that COs limit and/or restrict the practitioner in some way. They may also result in the revocation, suspension, or surrender of a license, the dismissal of charges as a result of other action taken, and/or the issuance of a temporary/dated license. Such results are reflected in the appropriate sections of this report. In some cases, a CO may modify a previous CO in some way.]

### Denials of Reconsideration/Modification:

NONE

[2000: 1 Action (1 physician)]

**Surrenders:** 27 Actions [4 from COs] (20 physicians, 7 PAs)

[2000: 21 Actions [3 from COs] (18 physicians, 3 PAs)]

### Court Appeals: NONE

[2000: 1 Action (1 Physician)]

**Temporary/Dated Licenses Issued (via Consent Order):** 9 Actions (8 physicians, 1 PA)

[2000: 22 Actions (19 physicians, 3 PAs)]

**Temporary/Dated Licenses Allowed to Expire:** 1 Action (1 physician)

[2000: 1 Action (1 physician)]

### NON-PREJUDICIAL ACTIONS:

**Dismissals:** 5 Actions [0 by reversal, 1 with inactive status, 2 by CO, 2 with RTL termination] (5 physicians)

[2000: 7 Actions [3 by reversal, 2 due to inactive status, 2 by surrender] (7 physicians)]

**Temporary/Dated Licenses Extended:** 51 Actions—29 Persons (24 physicians, 5 PAs)

[Several extensions are often issued to a practitioner during the year.]

[2000: 58 Actions—39 persons (32 physicians, 7 PAs)]

**Temporary/Dated Licenses Became Full and Unrestricted:** 22 Actions (19 physicians, 3 PAs)

[2000: 16 Actions (15 physicians, 1 PA)]

**Consent Orders Lifted:** 23 Actions (20 physicians, 3 PAs)

[2000: 19 Actions (17 physicians, 1 PA, 1 NP)]

### Revocations Reinstated: NONE

[2000: NONE]

## Part 2 — 2001 Total Actions and Breakdown

— TOTAL —

219 Board Actions of all Types Relating to 123 Persons

[2000: 222 Actions for 116 persons]

**118 Prejudicial Actions Related to 87 Persons (76 Physicians, 10 PAs, 1 EMT)**  
[2000: 122 Actions Related to 74 Persons (66 Physicians, 8 PAs)]

**101 Non-Prejudicial Actions Relating to 57 Persons (49 Physicians, 8 PAs)**

[2000: 100 Actions Related to 62 persons (53 Physicians, 8 PAs, 1NP)]

— BREAKDOWN —

Some individuals fall in both the Prejudicial and Non-Prejudicial categories of action noted immediately below. However, duplicate names within each category are eliminated for the calculation of that category's total (eg, a total of 76 individual physicians had 105 prejudicial actions taken against them). The Combined Total segment eliminates all duplicates in both categories and simply presents the total number of individuals concerning whom any action was taken.

### PREJUDICIAL TOTALS: 2001

76 Physicians (105 actions)

10 PAs (12 actions)

1 EMT (1 action)

87 Persons (118 actions)

### NON-PREJUDICIAL TOTALS: 2001

49 Physicians (79 actions)

8 PAs (22 actions)

57 Persons (101 actions)

### PREJUDICIAL TOTALS: 2000

66 Physicians (107 actions)

8 PAs (15 actions)

74 Persons (122 actions)

### NON-PREJUDICIAL TOTALS: 2000

53 Physicians (89 actions)

8 PAs (10 actions)

1 NP (1 action)

62 Persons (100 actions)

### COMBINED TOTAL OF PERSONS, WITHOUT DUPLICATIONS:

	2001		2000
Physicians	109	Physicians	102
PAs	13	PAs	13
NPs	0	NPs	1
EMTs	1	EMTs	0
	123		116 ♦



# Save the Date!

## NCPHP 2002 Addictions Conference VII

Mid Pines Inn & Golf Club and Pine Needles Conference Center

### Scheduled Speakers and Tentative Topics

**Earnie Larsen**

*on relationships and Stage II recovery*

**Jeff Georgi**

*on spirituality in recovery*

**Robert Vanderberry, MD**

*from the AA Big Book: "On Wives" and "The Family Afterward"*

**Wayne Sotile, PhD and Mary Sotile, MA**

*on resilient physicians and medical families: the true heroes*

Success in recovery is directly relative to the strength of your family support system, and as you can see, the theme of our 2002 conference is designed to interest and include spouses and family members. There will be plenty of activities available—not just golf!—so plan now to bring your "significant others" to Southern Pines.

# NORTH CAROLINA MEDICAL BOARD

## Board Orders/Consent Orders/Other Board Actions

### November - December, 2001/January 2002

## DEFINITIONS

#### **Annulment:**

Retrospective and prospective cancellation of the authorization to practice.

#### **Conditions:**

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

#### **Consent Order:**

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

#### **Denial:**

Final decision denying an application for practice

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

#### **NA:**

Information not available.

#### **NCPHP:**

North Carolina Physicians Health Program.

#### **RTL:**

Resident Training License.

#### **Revocation:**

Cancellation of the authorization to practice.

#### **Summary Suspension:**

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

#### **Suspension:**

Temporary withdrawal of the authorization to practice.

#### **Temporary/Dated License:**

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

#### **Voluntary Dismissal:**

Board action dismissing a contested case.

#### **Voluntary Surrender:**

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

### ANNULMENTS

NONE

### REVOCATIONS

#### **GRANDSTAFF, Stephen Wade, MD**

Location: Fairbanks, AK  
 DOB: 3/20/1962  
 License #: 0000-38345  
 Specialty: FP (as reported by physician)  
 Medical Ed: Wayne State University (1988)  
 Cause: Felony convictions in Alaska [73 felony counts: 2 related to sexual assault, 3 to theft, and 68 to drugs].  
 Action: 12/19/2001. Notice of License Revocation entered.

### SUSPENSIONS

#### **PETERSON, William, MD**

Location: Washington, DC  
 DOB: 1/15/1949  
 License #: 0096-01432  
 Specialty: N/CN (as reported by physician)  
 Medical Ed: Hahnemann Medical College (1975)  
 Cause: Hearing on 10/18/2001 regarding the Board's Notice of Charges and Allegations against Dr Peterson dated 8/02/1999. The Board finds Dr Peterson provided medical treatment to Patient A on numerous occasions in 1998 and 1999 while engaged in a personal and sexual relationship with her. While on call in the 12 months or so prior to the August 1999 summary suspension of his license he refused to answer pages from the hospital on numerous occasions. In July 2001, Dr Peterson completed a five-day assessment at Palmetto Addiction Recovery Center. The final diagnosis included a history of alcohol abuse, adjustment disorder with disturbance of mood, major depressive disorder in partial remission, and narcissistic and dependent personality traits. The Center recommended he sign a 6-12 month diagnostic monitoring contract to verify his status with regard to substance abuse, that within one year he attend a course in ethics and professional boundaries, that he see a psychiatrist approved by the NCPHP, with quarterly reports to NCPHP on his status and mood disorder, that he comply with all treatment recommendations, and that he regularly attend Caduceus meetings. Because he lives in Washington, DC, he signed a Treatment Program Agreement on 8/27/2001 with the Physician Health Committee of the Medical Society of DC (PHCMSDC) that incorporates the recommendations noted. As of this date, Dr Peterson has substantially complied with the requirements of his NCPHP and PHCMSDC contracts.  
 Action: 12/20/2001. Findings of Fact, Conclusions of Law, and Order of Discipline issued: the Order of Summary Suspension of Dr Peterson's license is dissolved; Dr Peterson's license is indefinitely suspended as of 8/12/1999; the suspension is stayed, as

of the date of this order, so long as Dr Peterson complies with the following: he shall maintain and abide by his contract with NCPHP; he shall maintain and abide by his contract with PHCMSDC; must comply with other conditions.

#### **TRUMP, Benjamin Franklin, MD**

Location: Baltimore, MD  
 DOB: 7/23/1932  
 License #: 0000-14971  
 Specialty: PTH (as reported by physician)  
 Medical Ed: University of Kansas (1957)  
 Cause: In May 1998, Dr Trump surrendered his license to the Maryland Board to avoid possible issuance of charges for violation of the Disposition Agreement he had entered into with the Maryland Board in July 1997. In September 1998, the Maryland Board reinstated his license on conditions. Dr Trump's surrender of his Maryland license is grounds for action by the North Carolina Medical Board.  
 Action: 11/11/2001. Dr Trump's North Carolina medical license is indefinitely suspended.

See Consent Orders:

**HODA, Syed Tanweeful, MD**  
**ROSS, Michael Reiff, MD**

### SUMMARY SUSPENSIONS

NONE

### CONSENT ORDERS

#### **BRIDGES, Michael Howard, MD**

Location: Greensboro/High Point, NC (Guilford Co)  
 DOB: 6/12/1966  
 License #: 0096-00463  
 Specialty: IM/PD (as reported by physician)  
 Medical Ed: Wright State University (1992)  
 Cause: On application for reissuance of Dr Bridges license, which he surrendered on 5/02/2001. A series of erratic behaviors had brought his ability to practice into question and he ceased practice, going for assessment to the Ridgeview Center in Atlanta in March 2001. There he was diagnosed with Bipolar I Disorder and remained for several weeks of treatment. Since completing his treatment, he has obtained outpatient psychotherapy and medication. Dr Bridges understands the risks associated with discontinuing his medication, has responded well to treatment, and no longer experiences manic or depressive symptoms. He has signed and is complying with a contract with NCPHP.  
 Action: 1/23/2002. Consent Order executed: Dr Bridges is issued a license to expire on the date shown on the license [7/23/2002]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind-or-mood-altering substances and all controlled substances, and he shall refrain

from the use of alcohol; he shall notify the Board within 10 days of the issuance of any prescription to him for any such substances and include identification of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall provide a copy of this Consent Order to his current and all prospective employers and to all colleagues with whom he shares call; must comply with other conditions.

**CLONINGER, Kenneth Lee, Jr, MD**

Location: Greensboro, NC (Guilford Co)  
 DOB: 2/09/1935  
 License #: 0000-14122  
 Specialty: NS (as reported by physician)  
 Medical Ed: University of Maryland (1961)  
 Cause: On Dr Cloninger's request for retroactive reinstatement of his license. Dr Cloninger failed to register his medical license within 30 days after certified notice and the Board, therefore, placed his license on inactive status on 7/05/2000. He continued to practice until 2/22/2001, when he first learned his license was inactive. He did not resume practice until the Board approved his reinstatement application on 7/19/2001. He asked the Board to reinstate his license to 7/05/2000 so there would be no lapse in his authority to practice. Dr Cloninger's failure to timely comply with the registration requirements was due, in large part, to his failure to timely review communications from the Board. He now appears to appreciate the importance of communications from the Board.  
 Action: 11/30/2001. Consent Order executed: Dr Cloninger's license is reinstated effective 7/05/2000; Dr Cloninger is reprimanded.

**CONNINE, Tad Robert, MD**

Location: Charlotte Hall, MD  
 DOB: 1/19/1964  
 License #: 0099-00193  
 Specialty: RO (as reported by physician)  
 Medical Ed: University of South Florida (1992)  
 Cause: On application for reinstatement of license, which was surrendered 7/10/2000. From July 2000, Dr Connine underwent four months of inpatient substance-abuse treatment in Louisiana. He then completed four months of inpatient treatment in Maryland. Dr Connine admits he has abused and been dependent on mind-or-mood-altering substances, and that such abuse and dependence render him unable to practice with reasonable skill and safety. He also admits Alabama and Georgia have suspended or revoked his medical license in those states. He has a contract with NCPHP, with which it appears he has complied, and he has maintained his sobriety since July 2000, regularly attending AA meetings.  
 Action: 11/11/2001. Consent Order executed: Dr Connine is issued a license to expire on the date shown on the license [1/31/2002]; he shall not work more than 40 hours a week; he shall attend AA, NA, and/or Caduceus meetings as recommended by NCPHP; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use or possession of all mind-or-mood-altering substances and all controlled substances, and he shall refrain from the use or possession of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

**HAYMOND, Alvin Henry, Jr, Physician Assistant**

Location: Charlotte, NC (Mecklenburg Co)  
 DOB: 9/27/1966  
 License #: 0001-03394  
 PA Education: Kettering College of Medical Arts (2001)  
 Cause: On application for a PA license. Mr Haymond began work as a PA in the emergency department of the Carolinas Medical Center in Charlotte in May 2001 even though he had not obtained a PA license from the Board or submitted a PA Intent to Practice Form. In July 2001, he submitted an application for a PA license to the Board. In September 2001, he met with members of the Board to discuss these matters.  
 Action: 11/05/2001. Consent Order executed: the Board issues Mr

Haymond a PA license; he is reprimanded for practicing as a PA before obtaining a license and submitting a PA Intent to Practice Form.

**HODA, Syed Tanweerful, MD**

Location: Inner Grove Heights, MN  
 DOB: 2/05/1966  
 License #: 0097-00590  
 Specialty: IM/FP (as reported by physician)  
 Medical Ed: Dow Medical College, Karachi, Pakistan (1991)  
 Cause: Dr Hoda admits and the Board finds that Dr Hoda, as an independent contractor, provided medical services through Virtual Medical Group.com, LLC (VMG), a business corporation in Morrisville, NC, that renders medical services, including prescriptions, via the Internet. From May through October 2001, Dr Hoda prescribed medications, including Viagra®, Cipro®, Zoloft®, Paxil®, and others, without physical examination of the patients and without any prior physician-patient relationship between himself and the patients. During the same time, VMG, through Dr Hoda, rendered medical care to patients in North Carolina, thus engaging in the unauthorized practice of medicine. Dr Hoda allowed VMG to bill patients for medical services rendered by him and accepted part of those fees as his compensation. The remainder of the fees was used to pay other expenses of VMG. Dr Hoda, therefore, engaged in unprofessional conduct, assisted in the unauthorized practice of medicine, and split fees generated from his practice of medicine. There is no evidence Dr Hoda's prescribing irregularities caused any detrimental effect to any patient. A representative of VMG indicated to Dr Hoda, prior to his engaging in these activities, that the Board was aware of VMG's activities; he did not realize his actions violated the standards of care and professional ethics enforced by the Board. He stopped writing prescriptions via the Internet for residents of North Carolina on 11/05/2001 and has cooperated fully with the Board.  
 Action: 1/31/2002. Consent Order executed: Dr Hoda's license is suspended for 60 days as of 2/01/2002. Suspension is stayed on the following conditions: Dr Hoda shall not prescribe medication for any person without first performing a physical examination thereof unless a prior physician-patient relationship exists that might permit, depending on good medical practice, issuing a new prescription without an examination (which condition shall be waived in the event and to the extent any licensing board, or legislative or regulatory body, promulgates or enacts standards that permit such practices; he shall never assist VMG or any other entity in the unauthorized practice of medicine; he shall not permit VMG to bill patients for any medical services rendered by him to North Carolina residents after 11/05/2001; must comply with other conditions.

**MINDER, Joseph Kamel, MD**

Location: Matthews, NC (Mecklenburg Co)  
 DOB: 3/23/1952  
 License #: 0000-39307  
 Specialty: U/OS (as reported by physician)  
 Medical Ed: American University of Beirut, Lebanon (1978)  
 Cause: Regarding the Board's Notice of Charges and Allegations against Dr Minder dated 6/12/2000. Dr Minder admits and the Board finds that he failed to pay his rent on time and his landlord, another physician with whom he was in dispute over the lease, changed locks and denied Dr Minder access to his medical office. His landlord told him he could get his records and other items from the office, and he retrieved these items 10 days later after making a rent payment under duress. As a result of this situation, at least eight patients with chronic conditions who were scheduled before the office was locked were unable to see Dr Minder. Dr Minder gave no notice to some patients about his not being able to keep appointments, but was able to give notice to others. At least one patient came to his office at the time of her appointment and found it locked. She was unable to obtain any information about where Dr Minder might be seeing patients. Some days later, a patient representative called Dr Minder on behalf of eight of her clients who were Dr Minder's patients telling him these patients, who had appointments, needed follow up. Although these patients needed personal visits, Dr Minder responded that they were doing well, had no new problems, and follow up by telephone would be sufficient. Minimal standards of care require a physician who is unable to see patients make reasonable attempts to notify patients with appointments and attempt to arrange and

assist patients in arranging continuing care with other physicians. Dr Minder's effort to notify patients with pending appointments was incomplete, due in part to circumstances beyond his control, and he suggested instead an inappropriate and insufficient means of follow up. Dr Minder's failure to attempt to contact all his patients with pending appointments and failure to offer more than telephone follow up did not meet minimal standards and was unprofessional conduct.

Action: 12/20/2001. Consent Order executed: Dr Minder is reprimanded.

**RIDDLE, William Mark, MD**

Location: Faison, NC (Duplin Co)

DOB: 3/20/1956

License #: 0000-39871

Specialty: FP/ADDM (as reported by physician)

Medical Ed: East Carolina University School of Medicine (1985)

Cause: On request for modification of Dr Riddle's Consent Order of 3/29/2001 to allow him to apply for DEA registration. Dr Riddle surrendered his license on 9/11/1997 after being confronted about his diversion and abuse of hydrocodone. He was issued a temporary license with conditions under a Consent Order on 10/12/1998. That Order was modified on 9/27/1999 to limit his work per week to 40 hours. He surrendered his license again on 11/18/1999 after he was confronted about violating his Consent Order by self-prescribing tramadol HCl and working over 40 hours a week. On 6/14/2000, Dr Riddle was issued a temporary license subject to conditions under a Consent Order, and on 3/29/2001 that Consent Order was modified to limit his work to no more than 30 hours per week. He has been working as a case manager with Virginia Monitoring, which monitors compliance of practitioners in Virginia who are recovering from alcohol and substance abuse and he now seeks to modify the Consent Order to allow him to apply for DEA registration so he may prescribe scheduled substances for his patients. He has met regularly with an addiction specialist to discuss the causes of his relapse and formulate a stronger relapse prevention plan. He reports he has not used alcohol or prescription medication, other than that prescribed by someone else, since 11/10/1999; he is compliant with his NCPHP contract; NCPHP, Virginia Monitoring, and his addiction specialist have regularly screened him and all tests have been negative for use of alcohol or drugs, other than those prescribed by someone else; he reports he has been active in AA and Caduceus.

Action: 11/11/2001. Consent Order executed: Dr Riddle is issued a dated license to expire on the date shown on the license; he shall practice only in a setting approved in writing by the Board's president; he may not work more than 40 hours a week plus additional hours in which he takes call every fifth night; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of any prescription drugs, any controlled substances, and any mind-or-mood-altering substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall attend AA, NA, and/or Caduceus meetings as recommended by NCPHP; he may, with the permission of the DEA, register to prescribe controlled substances; when granted DEA registration, he shall keep a log of all controlled substances he prescribes, orders, or administers and shall submit a copy of the log to the Board when requested; he shall not purchase, administer, prescribe, dispense, or order any controlled substances until his DEA registration has been reinstated; he may not be a primary or back-up physician for PAs or NPs; he shall obtain and document to the Board 50 Category I CME hours relevant to his practice each year; he shall provide a copy of this Consent Order to all current and prospective employers; must comply with other conditions.

**ROSS, Michael Reiff, MD**

Location: Columbus, OH

DOB: 9/08/1955

License #: 0098-01757

Specialty: GP/OBG (as reported by physician)

Medical Ed: University of Maryland (1990)

Cause: Regarding the Board's Notice of Charges and Allegations against Dr Ross dated 10/26/2001. As an independent contractor, Dr Ross provided services through Virtual Medical Group (VMG), a business corporation of Morrisville, NC, that renders medical services, including prescriptions via the Internet. On various dates in June through October 2001, Dr Ross prescribed medications, including ciprofloxacin hydrochloride, an antibiotic used to treat infections, including anthrax. He also prescribed various medications for non-acute conditions. He authorized these prescriptions without a physical examination of the patients and without any prior physician-patient relationship. Upon reflection, Dr Ross recognizes this is a potentially dangerous practice. During the same time, VMG, through Dr Ross, rendered medical care in North Carolina, thus engaging in the unauthorized practice of medicine. Dr Ross also split fees he generated from practicing medicine with VMG by permitting VMG to bill patients for medical services rendered by him, a portion of the fees being used to pay Dr Ross and the remainder to pay other VMG expenses. There is no evidence Dr Ross caused any detrimental effect to any patient by his prescribing irregularities. He asserts representatives of VMG told him before he engaged in the activities described here that the Board was aware of VMG's activities and the physicians associated with it and acquiesced in such activities. Dr Ross ceased his participation in these activities immediately on learning they violated standards of care and professional ethics enforced by the Board. He has given notice to VMG of termination of his contractual relationship with VMG and he has cooperated fully with the Board's investigation and has volunteered to cooperate in any manner with the Board and other authorities in any investigation of VMG.

Action: 12/20/2001. Consent Order executed: Dr Ross' license is suspended for 60 days; suspension is stayed on the following conditions: Dr Ross shall not prescribe medication for any person in North Carolina without first physically examining that person; he shall not assist VMG or any other entity, in any manner, in the unauthorized practice of medicine; he shall not split fees with a business corporation (that is, fees generated from the practice of medicine with a business corporation on a percentage basis); he shall obey all laws; he shall obey all regulations related to the practice of medicine; he shall notify the Board in writing of any change in his residence or practice within 10 days of the change; must comply with other conditions.

**SKWERER, Robert Gordon, MD**

Location: Charlotte, NC (Mecklenburg Co)/New Bern (Craven Co)

DOB: 7/29/1956

License #: 0099-00134

Specialty: P/N (as reported by physician)

Medical Ed: State University of New York Medical College, Brooklyn (1982)

Cause: On Dr Skwerer's application for reissuance of his license, surrendered on 7/20/2001. Dr Skwerer began to experience symptoms of depression in 1999, for which he sought treatment. Notwithstanding his treatment, he began treating himself using Dexedrine®, a controlled substance, obtained by prescribing it for himself in the names of family members. He also experienced insomnia, treating it by using various other controlled substances obtained in the same way. Following surrender of his license, he successfully completed a three-month inpatient treatment program for his depression and substance abuse. He has entered into a contract with the NCPHP and the NCPHP reports he has been compliant. He has a local psychiatrist to treat and manage his depression.

Action: 1/24/2002. Consent Order executed: Dr Skwerer is issued a license to expire on the date shown on the license [7/24/2002]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind-or-mood-altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within ten days of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall maintain a relationship with a physician to follow and treat him for depression; must comply with other conditions.

**STROUD, Joan Marie, Physician Assistant**

Location: Gastonia, NC (Gaston Co)  
 DOB: 4/24/1956  
 License #: 0001-01476  
 PA Education: Pennsylvania State University (1980)  
 Cause: Regarding application for reinstatement of license. Ms Stroud has a history of alcohol abuse. Her alcohol abuse led her to surrender her PA license on 5/24/2001 and since that time she has sought and obtained in-patient treatment for her alcohol abuse and related psychological issues. She has a contract with NCPHP and reports she has maintained sobriety since 4/20/2001.

Action: 1/09/2002. Consent Order executed: Ms Stroud is issued a PA license to expire on the date shown on the license [5/14/2002]; unless lawfully prescribed for her by someone other than herself, she shall refrain from the use or possession of all mind-or-mood-altering substances and all controlled substances, and she shall refrain from the use or possession of alcohol; she shall notify the Board within one week of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, she shall supply bodily fluids or tissues for screening to determine if she has used any of the substances noted above; she shall provide a copy of this Consent Order to each of her supervising physicians, colleagues with whom she works or shares call, and to all present and future employers; she shall maintain and abide by a contract with the NCPHP; she shall regularly attend meetings of AA and Caduceus, and shall meet regularly with her therapist; must comply with other conditions.

**VAUGHN, Tom Jimison, Jr, MD**

Location: Mount Airy, NC (Surry Co)  
 DOB: 3/30/1941  
 License #: 0000-23092  
 Specialty: OBG (as reported by physician)  
 Medical Ed: University of Virginia (1975)  
 Cause: On application for reinstatement of Dr Vaughn's license. In October 2000, Dr Vaughn called in prescriptions for Ativan®, Darvocet®, and hydrocodone cough syrup with his wife's name as the patient and the names and DEA numbers of the partners in his medical practice as the prescribing physicians without the consent of those partners; those prescriptions were actually for his use; on 10/02/2000, he signed a contract with the NCPHP and, at NCPHP's request he obtained an assessment at a drug treatment facility and was diagnosed with polydrug dependency; on 12/05/2000, he surrendered his North Carolina medical license. Dr Vaughn now reports he successfully completed a three-month drug dependency treatment program and has fulfilled the aftercare recommendations of the program; NCPHP reports he has complied with his NCPHP contract.

Action: 11/09/2001. Consent Order executed: The Board issues Dr Vaughn a license to expire on the date shown on the license [4/30/2002]; he shall maintain and abide by a contract with the NCPHP; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind-or-mood-altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall attend AA, NA, and/or Caduceus meetings as recommended by NCPHP; he shall not perform any office-based surgery unless approved in writing by the Board's president; he shall provide a copy of the Consent Order to all current and prospective employers; he shall obtain and document to the Board 50 hours of Educational Provider-Initiated CME relevant to his practice by 1/31/2002; must comply with other conditions.

**MISCELLANEOUS ACTIONS**  
NONE**DENIALS OF RECONSIDERATION/MODIFICATION**  
NONE**DENIALS OF LICENSE/APPROVAL****COLEMAN, Robert Stanley, Jr, MD**

Location: Aiken, SC  
 DOB: 1/31/1963  
 License #: NA  
 Specialty: IM (as reported by physician)  
 Medical Ed: Ross University School of Medicine, Dominican Republic (1995)  
 Cause: Failed to satisfy the Board of his qualifications in several respects: he has engaged in immoral or dishonorable conduct within the meaning of the applicable statutes; he has made false statements or representations to the Board or willfully concealed material information from the Board in connection with his application for a license; he has engaged in unethical conduct and conduct contrary to honesty, justice, or good morals within the meaning of the applicable statutes; he has not satisfied the Board he is of good moral character within the meaning of the applicable statutes.

Action: 1/10/2002. Dr Coleman's application for a license denied. He may request a public hearing within 10 days of receiving notice of this denial. [No hearing has been requested.]

**GALEA, Lawrence Joseph, MD**

Location: Charlotte, NC (Mecklenburg Co)  
 DOB: 10/19/1948  
 License #: (0000-27046—temporary, allowed to expire 1/31/2001)  
 Specialty: FP/GP (as reported by physician)  
 Medical Ed: University of Cincinnati (1980)  
 Cause: Dr Galea violated his Consent Order of 7/21/2000 by failing to meet with the Board at its January 2001 meeting and by failing to obtain and document required CME.

Action: 11/05/2001. Application for North Carolina medical license denied. He may request a public hearing within 10 days of receiving notice of denial.

**HOLT, Thomas, MD**

Location: Warrenton, NC (Warren Co)  
 DOB: 11/05/1913  
 License #: [0000-05240: inactive]  
 Specialty: OTO/OPH (as reported by physician)  
 Medical Ed: Medical College of Virginia (1938)  
 Cause: Regarding Dr Holt's application for reactivation of an inactive license. Dr Holt failed to satisfy the Board of his qualifications in that he has engaged in unprofessional conduct. Specifically, he has acknowledged prescribing medicine for his own use.

Action: 1/02/2002. Dr Holt's application for reactivation of inactive license denied. He may request a public hearing within 10 days of receiving notice of this denial.

**KING, Delf Omar, MD**

Location: Norwich, NY  
 DOB: 8/30/1943  
 License #: None  
 Specialty: AN (as reported by physician)  
 Medical Ed: University of Western Ontario, Canada (1973)  
 Cause: False statements or representations in connection with the application for license; unethical conduct; not satisfying the Board he is of good moral character within the meaning of the statutes. On his application, Dr King failed to note his 1994 arrest for menacing, his 1982 conviction for driving while impaired, and his 1995 conviction for trespassing.

Action: 8/02/2001. Application for North Carolina medical license denied. He may request a public hearing within 10 days of receiving notice of denial.

**NORRIS, Dolly Frances, MD**

Location: Carrboro, NC (Orange Co)  
 DOB: 10/03/1966  
 License #: (0096-01782—annulled)  
 Specialty: GP (as reported by physician)  
 Medical Ed: Uniformed Services University of Health Sciences (1992)  
 Cause: Dr Norris failed to satisfy the Board as to her qualifications for a license in the following respects: she engaged in immoral or dishonorable conduct; she made false statements or representations to the Board or willfully concealed material information in connection with her license application; she engaged in unethical conduct and conduct contrary to honesty, justice, or good morals; by false representations she obtained or attempt-

ed to obtain something of value; she had a license denied by another state; and she has not satisfied the Board she is of good moral character.

Action: 11/01/2001. Application for North Carolina medical license denied. She may request a public hearing within 10 days of receiving notice of denial.

#### SURRENDERS

##### **BOYD, Gwendolyn McNeill, MD**

Location: Ithaca, NY  
 DOB: 7/05/1948  
 License #: 0000-21744  
 Specialty: OBG/OM (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1977)  
 Action: 1/13/2002. Order issued accepting Dr Boyd's voluntary surrender of her license and dismissing without prejudice all charges outstanding against her. [The Board issued a Notice of Charges and an Order of Summary Suspension against Dr Boyd on 2/09/2000. On 2/14/2000, she submitted a letter of license surrender to the Board.]

##### **HARVEY, Bertha Bowen, MD**

Location: New Bern, NC (Craven Co)  
 DOB: 7/15/1957  
 License #: 0000-31994  
 Specialty: P (as reported by physician)  
 Medical Ed: Medical University of South Carolina (1982)  
 Action: 11/15/2001. Voluntary surrender of North Carolina medical license.

##### **MATHEW, Roy Jacob, MD**

Location: Durham, NC (Durham Co)  
 DOB: 7/02/1945  
 License #: 0000-29624  
 Specialty: P/ADDM (as reported by physician)  
 Medical Ed: Trivandrum, India (1969)  
 Action: 9/17/2001. Voluntary surrender of North Carolina medical license.

##### **MAYFIELD, Kelli Burgin, MD**

Location: Shelby, NC (Cleveland Co)  
 Ellenboro, NC (Rutherford Co)  
 DOB: 8/15/1963  
 License #: 0095-00998  
 Specialty: FP (as reported by physician)  
 Medical Ed: East Tennessee State University (1993)  
 Action: 1/24/2002. Voluntary surrender of North Carolina medical license.

##### **NELSON, David Stephen, MD**

Location: Winston-Salem, NC (Forsyth Co)  
 DOB: 12/16/1935  
 License #: 0000-13186  
 Specialty: EM/GS (as reported by physician)  
 Medical Ed: Bowman Gray School of Medicine (1961)  
 Action: 1/16/2002. Voluntary surrender of North Carolina medical license.

##### **WADDELL, Roger Dale, MD**

Location: Aberdeen, NC (Moore Co)  
 DOB: 11/17/1954  
 License #: 0000-30105  
 Specialty: GP (as reported by physician)  
 Medical Ed: University of Colorado (1981)  
 Action: 11/30/2001. Voluntary surrender of North Carolina medical license.

#### COURT APPEALS

NONE

#### CONSENT ORDERS LIFTED

##### **JORDAN, Richard Liming, MD**

Location: Jacksonville, NC (Onslow Co)  
 DOB: 6/14/1946  
 License #: 0000-19612  
 Specialty: FP (as reported by physician)  
 Medical Ed: Vanderbilt University (1971)

Action: 11/15/2001. Order issued lifting Consent Order of 7/19/2001.

##### **LOVE, David William, MD**

Location: Clyde, NC (Haywood Co)  
 DOB: 8/31/1960  
 License #: 0000-31326  
 Specialty: FP (as reported by physician)  
 Medical Ed: University of Florida (1984)  
 Action: 11/11/2001. Order issued lifting Consent Order of 2/22/2001.

##### **PERERA, Menerigamage Nimal Anandakum, MD**

Location: Mooresville, NC (Iredell Co)  
 DOB: 6/23/1948  
 License #: 0094-01299  
 Specialty: FP/GP (as reported by physician)  
 Medical Ed: University of Colombo, Sri Lanka (1977)  
 Action: 11/09/2001. Order issued lifting Consent Order of 9/19/1997.

#### TEMPORARY/DATED LICENSES:

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

##### **CONNINE, Tad Robert, MD**

Location: Charlotte Hall, MD  
 DOB: 1/19/1964  
 License #: 0099-00193  
 Specialty: RO (as reported by physician)  
 Medical Ed: University of South Florida (1992)  
 Action: 1/24/2002. Temporary/dated license extended to expire 4/30/2002.

##### **COYNE, Mark Dennis, MD**

Location: Stoney Creek, NC (Guilford Co)  
 DOB: 8/12/1949  
 License #: 0000-33493  
 Specialty: EM/OS (as reported by physician)  
 Medical Ed: Chicago Medical School (1983)  
 Action: 11/15/2001. Temporary/dated license extended to expire 11/30/2002.

##### **GUALTEROS, Oscar Mauricio, MD**

Location: Pinehurst, NC (Moore Co)  
 DOB: 5/11/1964  
 License #: 0099-00236  
 Specialty: IM (as reported by physician)  
 Medical Ed: University of Navarra, Spain (1991)  
 Action: 1/24/2002. Temporary/dated license extended to expire 7/31/2002.

##### **MARTIN, Carol Ann, MD**

Location: Raleigh, NC (Wake Co)  
 DOB: 10/14/1952  
 License #: 0099-01651  
 Specialty: P (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1978)  
 Action: 12/19/2001. Full and unrestricted license reinstated.

##### **PRESSLY, Margaret Rose, MD**

Location: Sylva, NC (Jackson Co)  
 DOB: 5/05/1956  
 License #: 0000-34548  
 Specialty: FP (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1990)  
 Action: 11/15/2001. Temporary/dated license extended to expire 5/31/2002.

##### **RIDDLE, William Mark, MD**

Location: Faison, NC (Duplin Co)  
 DOB: 3/20/1956  
 License #: 0000-39871  
 Specialty: FP/ADDM (as reported by physician)  
 Medical Ed: East Carolina University School of Medicine (1985)  
 Action: 12/20/2001. Temporary/dated license extended to expire 6/30/2002.

##### **SAPPINGTON, John Shannon, MD**

Location: New Bern, NC (Craven Co)

DOB: 1/30/1962  
 License #: 0094-00628  
 Specialty: P/CHP (as reported by physician)  
 Medical Ed: University of Texas (1989)  
 Action: 11/15/2001. Temporary/dated license extended to expire 12/31/2001.  
 12/19/2001. Temporary/dated license extended to expire 4/30/2002.

**SHAFTNER, Kimberly K., MD**  
 Location: Princeton, NC (Johnston Co)  
 DOB: 12/09/1954  
 License #: 0000-25426  
 Specialty: FP/AN (as reported by physician)  
 Medical Ed: Ohio State University (1980)  
 Action: 12/19/2001. Temporary/dated license extended to expire 12/31/2002.

**SHERMAN, Randall Lester, MD**  
 Location: Elizabeth City, NC (Pasquotank Co)  
 DOB: 6/13/1949  
 License #: 0000-33891  
 Specialty: NS (as reported by physician)  
 Medical Ed: University of Oklahoma (1978)  
 Action: 12/19/2001. Temporary/dated license extended to expire 1/31/2003.

**YOUNG, Richard Lane**  
 Location: Sunset Beach, NC (Brunswick Co)  
 DOB: 8/12/1951  
 License #: 0000-31090

Specialty: ORS (as reported by physician)  
 Medical Ed: Medical University of South Carolina (1979)  
 Action: 11/15/2001. Temporary/dated license extended to expire 11/30/2002.

See Consent Orders:  
**BRIDGES, Michael Howard, MD**  
**CONNINE, Tad Robert, MD**  
**SKWERER, Robert Gordon, MD**  
**STROUD, Joan Marie, Physician Assistant**  
**VAUGHN, Tom Jimison, Jr, MD**

DISMISSALS

**DINGMAN, Stephen Michael, MD**  
 Location: Durham, NC (Durham Co)  
 DOB: 9/26/1963  
 License: Resident Training License  
 Specialty: NS (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1999)  
 Action: 12/20/2001. Order dismissing without prejudice the Board's Notice of Charges and Allegations of 8/20/2001. [Having resigned his residency position at UNC, Dr Dingman no longer holds a resident training license from the North Carolina Medical Board and is, therefore, no longer under the jurisdiction of the North Carolina Medical Board. The Notice of Charges and Allegations of 8/20/2001 is a public document and is available on the Board's Web site.]

## North Carolina Medical Board Meeting Calendar, Application Deadlines, Examinations April 2002 -- September 2002

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

**North Carolina Medical Board** **April 17-18, 2002**  
 April Meeting Deadlines:  
 Nurse Practitioner Approval Applications March 4, 2002  
 Physician Assistant Applications March 25, 2002  
 Physician Licensure Applications April 2, 2002

**North Carolina Medical Board** **May 15-17, 2002**  
 May Meeting Deadlines:  
 Nurse Practitioner Approval Applications April 1, 2002  
 Physician Assistant Applications April 22, 2002  
 Physician Licensure Applications April 30, 2002

**North Carolina Medical Board** **June 19-20, 2002**  
 June Meeting Deadlines:  
 Nurse Practitioner Approval Applications May 6, 2002  
 Physician Assistant Applications May 27, 2002  
 Physician Licensure Applications June 4, 2002

**North Carolina Medical Board** **July 17-19, 2002**  
 July Meeting Deadlines:  
 Nurse Practitioner Approval Applications June 3, 2002  
 Physician Assistant Applications June 24, 2002  
 Physician Licensure Applications July 2, 2002

**North Carolina Medical Board** **August 21-22, 2002**  
 August Meeting Deadlines:  
 Nurse Practitioner Approval Applications July 8, 2002  
 Physician Assistant Applications July 29, 2002  
 Physician Licensure Applications August 6, 2002

**North Carolina Medical Board** **September 18-20, 2002**  
 September Meeting Deadlines:  
 Nurse Practitioner Approval Applications August 5, 2002  
 Physician Assistant Applications August 26, 2002  
 Physician Licensure Applications September 3, 2002

**Residents Please Note USMLE Information**

### United States Medical Licensing Examination Information (USMLE Step 3)

The May 1999 administration of the USMLE Step 3 was the last pencil and paper administration. Computer-based testing for Step 3 became available on a daily basis in November 1999. *Applications may be obtained from the office of the North Carolina Medical Board by telephoning (919) 326-1100.* Details on administration of the examination will be included in the application packet.

### 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.

## CHANGE OF ADDRESS FORM

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

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

Full Legal Name of Licensee: \_\_\_\_\_

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

(Check preferred mailing address)

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

\_\_\_\_\_

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

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

\_\_\_\_\_

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

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

## Overburdened by Paperwork? Complete your annual registration on line!

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"This was an incredibly easy renewal process. Thank you for access to this site in our busy lives. It makes this yearly task so much easier!"

"You must hear this a lot, but the online registration is wonderful!"

"This registration was very simple and well done. The instructions were great for a novice like me."

"No one has any excuse not to register in a timely manner. Thank you for making what could be a very painful process extremely easy."



"...renewal was a breeze."

"This is fantastic; I much prefer it to snail mail or fax!"

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"Easy to use and very quick!!! 'Amen' to progress."

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