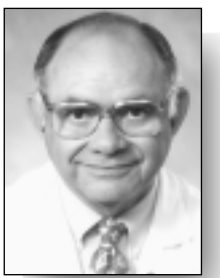
Primum Non Nocere

No. 2, 2002

forum

NC MEDICAL BOARD

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



President's Message

Walter J. Pories, MD

Karoshi

The first case of *karoshi*, or "death from overwork," was reported in 1969 with the death from a stroke of a 29-year-old, married, male worker in the shipping department of Japan's largest newspaper company. Karoshi is a socio-medical term used particularly in applications for workers' compensation in Japan, especially in cases of cardiovascular disease brought on by excessive workloads and occupational stress. According to the Japanese Ministry of Labor, the major medical causes of karoshi-deaths are heart attacks and strokes.

Anxiety About Karoshi

In Japan, the word is well known. A recent survey of 500 male, white-collar workers in top-ranking corporations in Tokyo revealed that 46 percent of respondents were anxious about their own risk of karoshi. A quarter of them experienced complaints from their families related to anxiety about the illness, and from 5 to 20 percent of the workers themselves were afraid. This fear increased with age. The report also indicated that family members are much more afraid than the workers themselves.

Although karoshi has now been reported by many industrialized nations, there are no sound epidemiological estimates. The Japanese Ministry of Labor awards compensation for 20 to 60 deaths each year from overwork. Critics, however, claim that the compensation is far less than the actual occurrence. They claim that one third of the 35,000 deaths related to cerebrovascular or cardiovascular disease in the 20 to 59 age group are work-related —- more than 10,000 each year. In 1994, the Japanese government's Economic Planning Agency in the Institute of Economics agreed that the level of compensation was low, estimating the number of karoshi deaths at around 1,000, or 5 percent of all deaths from cerebrovascular and cardiovascular disease in the 25 to 59 age group.

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From the Executive Director

Andrew W. Watry

Update

Many of the quotations I use in this space come from such obscure sources they cannot be found in *Bartlett's*. So I must attribute this quote to several elected officials who use it when describing the attitude of their constituencies: "It's not, 'What have you done for me?' It's, 'What have you done for me lately?'" We go to great lengths to chronicle output of this Board. Our Web page features an annual report, as well as licensing action information that is accessible in several different formats. However, I appreciate the context of the quotation above as it relates to elected officials. I know they are present and voting on a panoply of issues. I can find out about these diverse issues through a wide variety of sources, but it usually requires a significant investment of my own time. I would like to have a brief, consolidated summary of what has been done for me lately. In that spirit then, I would like to offer an answer to that question for those we serve: the people of North Carolina, including our licensees. Here is what we have done for you lately.

Fee Increase

The biggest recent issue is the Board's fee increase. As a result of a statutory change signed by Governor Easley in December 2001, the Board increased its annual registration fee, effective for February and future registrations, from $100 to $125 per year. If you do any comparison with other regulatory boards, the dollar value of this fee is a bargain. The Massachusetts Board, for example, has been functioning on the fee level that we just reached for the past ten years. Their fee was recently raised $75 to $200 a year. By comparison, we raised our fee—

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In This Issue of the FORUM

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forum
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Publisher
NC Medical Board

Editor
Dale G Breaden

Assistant Editor
Shannon L. Kingston

Address
1201 Front Street, Suite 100
Raleigh, NC 27609

Telephone
(919) 326-1100
(800) 253-9653

Fax
(919) 326-1130

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

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A Case in Point

We may be unfamiliar with the term "karoshi," but certainly know the syndrome. Nor are North Carolina's physicians immune. The other day at a meeting of the Medical Board, we interviewed a physician to consider whether to restore his license, a privilege that he had lost because of alcohol, substance abuse, and even an allegation of sexual misconduct.

I remembered him well. He was haggard, puffy-eyed, and disheveled at his initial interview—defensive, frightened, and ashamed. His story was a common one: eight years of the pre-med grind and medical school, a demanding six years of residency and fellowship, followed by entry into an overwhelming practice for which he had not been prepared. He certainly learned how to treat rare diseases, but he was never exposed, in the ivory towers of the medical center, to the knowledge he desperately needed: the essentials of running a small business. He knew nothing of accounting, billing, and collection. He was naive about time management, purchasing, personnel relations, marketing, commercial real estate, and dealing with legal matters.

Because he was an excellent physician with a winning personality, his practice developed rapidly and within two years he was overwhelmed with long hours of work that fused days into nights and weeks into weekends. There were always more patients to see, more charts to complete, more calls, more e-mails, more letters. There was no time to study or to play. To help him to sleep, he found solace in a drink, then two, and a sedative once in a while. Within another three years, we met him in the spiral of a broken home, estranged children, alcohol abuse, and two unfortunate affairs.

We had no choice but to suspend his license and to refer him to a long therapeutic program managed by the North Carolina Physicians Health Program.

The objective of the recent visit was to determine whether he was ready to return to limited practice. I did not look forward to the encounter. Disciplining a colleague is always painful, and, no matter how justified, the action is remembered with a feeling of shared guilt and even the hidden admission that "there but for the grace of God go I." None of us is perfect. It's hard to look someone in the eye a year after you have taken away his or her right to practice, no matter how good the reason.

To our delight and relief, he was a changed man: bright of eye, well groomed, outgoing, and jocular. His first act was to thank us! He told us that he had become a "house husband" and savored the new life. He said we had "saved his life," that he "needed that 2x4," that he finally had a chance to watch his kids play ball, that he "learned to love his wife again."

Whew! We asked him what turned the tide. He told us that the epiphany occurred when his counselor told him that he had to make some tough choices: "give your life solely to medicine and your marriage will fail. If you focus only on the family, your career will collapse. No recovery will occur until you balance these forces and assure each consistent, dedicated time and energy."

Our decision was not hard. We allowed him to return to a limited practice. He, in turn, assured us that even after we released him from his consent order, he would continue to limit his practice. He would never lose his way again. The story may have had a happy ending for him, but the problem of lost lives due to overwhelming practices continues to be a nightmare for many of our physicians.

A Lesson Learned

Karoshi is also an infectious disease. I know. I have had it and still have a chronic version. When the medical school at East Carolina was only a few years old, I asked my mentor, Dr Charles Rob, about whom I wrote in a previous *Forum* article, how he thought I was doing as the new chair. I was, of course, fishing for and expecting a compliment. To my surprise, he replied, "Walter, I have never been so disappointed with you in my life."

I was dumbstruck and blurted, "What do you mean? I'm doing my best. I just can't work any harder."

"That's your problem," he replied. "You are working seven days a week; you expect your faculty to do the same and, as a result, there hasn't been a new idea here for months. Folks are exhausted; they don't see their families and nothing is getting done."

"No physician," he went on, "should work in the office more than four days a week. There needs to be a fifth day to dream, to write, to do research, to get a haircut, to watch a kid pitch in Little League. Weekends and evenings are for families, for reading, and for play."

I had never heard of a more irresponsible idea. Neither had my faculty when I pre-

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Karoshi

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sented it to them at the next monthly meeting. How could we care for our patients? How would the work be done?

Fortunately, Dr Rob was a master at whining. Over the next few months, he whined at each meeting, he whined in the operating rooms, and he whined in the clinics. He pointed out that if we trusted our colleagues on Sundays and when we went to meetings, why not trust them on Fridays? He asked us how our research was going. He asked us how much time we were spending with our kids and spouses. Oh, he was a world-class whiner.

Finally, tired of it all, no longer able to tolerate the attacks, I agreed to try the dumb idea. "OK, you win. Just stop whining. We'll all go on four-day weeks, but we'll only do it for three months and you'll see what a stupid idea this is. Charles, you just don't understand; times have changed. Things are a lot different now."

Well, it turned out that Charles was right. Production increased sharply. The practice doubled, grants doubled, articles began to appear. Folks had time to study. Faculty, residents, and their families were far happier. For 19 years, there were no divorces among the surgical faculty or residents (with one exception, a resident who arrived in his third year and whose wife filed for divorce several months after his arrival—he had not had time to learn the culture).

Time for Change

This is why I applaud the recent decisions by the State of New York, the Accreditation Council for Graduate Medical Education, and the American Medical Association to demand that resident hours be limited to 80 hours. What amazed me were the objections: "How will we care for the patients?" "The only thing wrong with being on call every other day is that you miss half the cases"; "There is no proof that sleep deprivation interferes with resident performance"; etc.

Try to explain that response to anybody not involved with medicine! Try to defend why working 80 hours per week is not enough. Try to argue that residents, who are by definition students, should be able to score high grades on their in-service examinations without having the time or the energy to study. Could fatigue be a factor in the high rates of medical errors and malpractice suits?

How can we demand these draconian hours of our residents when we knew it was wrong as we endured it ourselves? And, equally bad, why demand it of ourselves?

It's time for change. It is time that American physicians, like those of Europe, worked reasonable hours with time to learn, to play, to be with their families. Not only will we be better parents, spouses, and citizens, we'll also be better physicians. ♦

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with no fee increase for the prior ten years—by a total of $25. There are several other such examples of fee increases by other medical boards. Using data that are a couple of years old, we find that the national average for license fees across the country is $132 a year. So we raised our fee to a level below the national mean. Now I would like to discuss what we are doing with the increase.

NCPHP Support

We immediately put all of the increased funding to use in such a way as to directly impact the Board's ability to carry out the mandates of the Medical Practice Act. As noted earlier, the Governor signed the fee bill in mid-December. By January, the Board committed to an increase of $155,000 in funding for the North Carolina Physicians Health Program (NCPHP). This represented a 38 percent increase in the amount of funding provided NCPHP by the Board. In effect, the rate of support was raised to $18 per active licensee. This translates to a total commitment of about $542,000 to NCPHP each year. There are direct returns to both patients and physicians through this investment. A formal program for early identification, intervention, and treatment of impaired professionals yields substantial public benefits. It is common knowledge that those who have a problem with chemical dependency, left untreated, could conceivably deteriorate to a point where patient care is compromised. Investment in early identification, treatment, and rehabilitation has substantial benefits in reversing this process, reducing patient error, and salvaging a valuable medical professional in the process.

Staff Enhancements

In addition, the fee increase is being used to bolster the Board's enforcement program. Two new attorneys have been added to the staff for prosecuting cases and for prosecuting them in a more timely way. There will be a direct and measurable impact on the amount of time it takes to adjudicate cases that require hearings. The addition of the two attorneys raises the number of staff attorneys in our Legal Department to five, bringing the ratio of attorneys to licensees a bit closer to that of other medical boards. Additionally, the Board has established a Compliance Department and named a director for that department, Ms Brandy Forward. The Compliance Department will be responsible for monitoring compliance with consent orders and Board orders. Additionally, this department will be responsible for selecting random samples for audit for compliance with the continuing medical education requirement.

Finally, there are plans to bring in a part-time medical coordinator to augment the services of our full-time medical coordinator, Gary Townsend, MD, JD. As we annualize our current complaint activity, we anticipate we will have received 1,000 complaints by the end of our fiscal year on October 31, representing an almost 60 percent increase in two years. The analysis of malpractice reports, complaints, and quality of care issues dictates a need for additional resources in this important area.

PREP

The other major recent development is the Board's participation in the Practitioner Remediation Enhancement Partnership (PREP). This program is an outgrowth of the Institute of Medicine report on medical errors (*To Err Is Human*). The Citizen Advocacy Center (CAC), a Washington-based group, has undertaken a pilot project funded by the Health Resources and Services Administration to develop a system for looking at ways of preventing medical errors in a non-punitive environment. I think there is general consensus that the disciplinary approach alone is not the answer to reducing medical errors. What is commonly referred to as the "blame-game" causes practitioners and others in the health care system to drive problems underground so as not to be exposed to the quasi-judicial disciplinary process of medical boards.

This pilot project looks for ways to reduce medical error in the same fashion as errors are reduced in the aviation industry: by providing incentive mechanisms for early identification of problems and by developing systems for assessment and remediation in a non-punitive context. At the same time, this pilot project does not allow for hiding or otherwise shielding practitioners who should be subject to discipline or mandatory reporting. I must add that the program is very much in its developmental stages. We have had an initial meeting to solicit input from hospitals. I am pleased to report that

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seven hospitals responded to the initial solicitation.

We are trying to design a program that meets both the requirements of the hospitals and the Board, and at the same time stays within the guidelines of both the North Carolina law and the pilot program administered by CAC. Much as is the case with the NCPHP, participating practitioners could be kept anonymous from the Board so long as they signed a contract with the hospital and actively participated in and successfully completed an assessment and remediation program. The Board would simply maintain the statistics to determine the effectiveness of the pilot effort as a disciplinary alternative. We will give you more of an update on this program as it develops.

On-Line Annual Registration

Our computer system development is providing substantial benefits to licensees as well as the Board. A paper registration system, operating through the mail, is still in use in a majority of states. It can be cumbersome and take several weeks or months to complete. Meanwhile, a licensee may have a hospital or insurance company breathing down his or her neck for confirmation. Our system enhancements are not that recent but are used by more and more licensees each month. They provide (1) 24-hour confirmation to the licensee by e-mail; and (2) on-line access to hospitals, insurance companies, and others to instantly confirm license status. The result: over 80 percent of our licensees register on line. This is the highest participation rate in the country, saving licensees valuable time in the process.

Conclusion

These are but a few of the many recent activities of the North Carolina Medical Board. They reflect something of what we are doing lately for the people of this state and for our licensees. Other such activities will be explored in future numbers of the *Forum*. As always, we solicit your feedback and comments. ♦

North Carolina Medical Board

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

Three Attorneys Join NCMB Legal Staff

Andrew W. Watry, executive director of the North Carolina Medical Board, and Thomas W. Mansfield, JD, director of the NCMB's Legal Department, have announced the addition of three attorneys to the Board's legal staff. They are Mary B. Wells, JD; Brian L. Blankenship, JD; and Marcus Jimison, JD. They join Mr Mansfield and R. David Henderson, JD, and bring the number of attorneys on the Board's legal staff to five.

Ms Wells is a graduate of the University of Florida, Gainesville, and took her JD at the Nova University School of Law in Fort Lauderdale, Florida. At Nova, she was on the Moot Court Board and a member of the National Mock Trial Team. Until 1992, she worked in the Felony Division of the Office of the Public Defender in Clearwater, Florida, completing over 50 jury trials. From 1992 until joining the NCMB, she was a partner at Cheshire, Parker, Schneider, Wells & Bryan in Raleigh, specializing in state criminal trials and appeals. In 2000-2001, she served as chair of the Wake County Committee for Indigent Appointments; in 2001, she was selected for inclusion in the *Best Lawyers in America Consumer Guide*. Ms Wells is a member of the North Carolina Bar, the Florida Bar, the North Carolina Academy of Trial Lawyers, the Wake County Bar Association, and the North Carolina Academy of Women Attorneys.

Mr Blankenship, a graduate of High Point University, High Point, North Carolina, earned his JD from Campbell University Law School, Buies Creek, North Carolina. From 1995 to 1999, he served as a lieutenant in the Judge Advocate General's Corps of the U.S. Navy at Pensacola, Florida, and Fort Meade, Maryland. From 1999 to 2001, he managed the Personal Injury Department of Crumley and Associates' office in Asheboro. From 2001 until joining the Board, he was an assistant attorney general in the North Carolina Department of Justice, providing legal advice to the North Carolina Alcoholic Beverage Control Commission and several other state agencies. He also acted as prosecuting attorney for the Sheriff's Commission and the Criminal Justice Commission. During this time, he routinely conducted training for state and local law enforcement officers and prosecutors. Mr Blankenship also serves as a captain in the Judge Advocate General's Corps of the North Carolina Army National Guard and teaches criminal procedure at Mount Olive College.

Mr Jimison, a graduate of the University of North Carolina at Chapel Hill, received his JD from North Carolina Central University. From 1993 to 1998, he was a staff attorney with North Carolina Prisoner Legal Services, which involved, among other things, acting as an advocate for imprisoned people, litigating class actions regarding prison conditions, resolving disputes, and advising clients on legal rights. During that period, he also supervised and trained new staff attorneys. From 1998 until coming to the Board, he was director of litigation for the Land Loss Prevention Project, supervising all litigation and a staff of six attorneys. He was lead attorney in cases before state and federal courts. He has also been a presenter on numerous panels related to environmental and agricultural legal issues. Mr Jimison is a member of the North Carolina Academy of Trial Lawyers, the North Carolina Bar Association, and the American Bar Association. In 1997, he was given the Julian Pearce Award for Pro Bono Legal Services. ♦

USMLE, FLEX, and SPEX Transcript Fees

At its April 2002 meeting, the United States Medical Licensing Examination Budget Committee approved an increase in the fee charged for USMLE transcripts. Consequently, the Federation of State Medical Board's Examination and Board Action History Report (EBAHR), which is used to report USMLE, FLEX, and SPEX scores, will increase to $50 effective August 1. This increase has been published on the FSMB Web site.

On August 1, 2002, the Federation will activate its Web-based system for on-line EBAHR requests. This will expedite the processing of EBAHR requests by allowing individuals to electronically transmit their request for an EBAHR to the Federation. Additionally, individuals will be able to pay electronically for their EBAHR and designate either one or two recipients for the single $50 fee. This on-line request will be accessed from the Federation's home page (*www.fsmb.org*) by simply clicking on Transcript Requests and following the instructions.

If you have any questions regarding this matter, contact David Johnson, Director, FSMB Examination Services, at (817)868-4081 or via email: *djohnson@fsmb.org*. ♦

Fondly, Carolyn:

Letters to a Young Physician Part II

Carolyn E. Hart, MD

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

Time to Relax with Your Family

Dear W:

I hope you and your family will be at this meeting I am about to attend. It is in your part of the country and in your mother's specialty, but I imagine you are probably so busy now with your own studies and activities that you don't accompany her anymore. Maybe your folks will be here, though, and I can get news of you. Your parents are two people who know how to relax in healthy, positive ways. You have had a good example. You know already how important it is for a physician to "Take Time to Relax with Your Family."

Because they wanted to return to their desert origins after residency, your parents concluded they would never again live close to water. So, long before they could afford to do any such thing, they bought a beautiful mahogany sailboat to explore the Chesapeake Bay. They learned all about sailing and taught their closest friends as well. We had great fun on that boat. They ultimately sold it for more than they had originally paid! As a toddler, you were a very good helper and seemed to enjoy the boat, too. I wonder if you remember.

Your brother, C, was too young then to fully enjoy the boat, but I hope your parents have relaxed with him, too. When residency ends and practice starts, it can become harder to find the time to relax. Many physicians go through a time when they relax very little and that hurts them and their families. To relax with your family means to let go of worries and to have fun, not just to do dutiful things. Relaxing requires a little more time, preparation, and rest than just showing up does, and that extra time is very difficult to find. Most physicians are driven, responsible people who go to as many of our children's arts performances and sporting events as possible, but, due to fatigue and stress, may end up looking like the woman in the Allegra® ad ("Low Interest or High Pollen?")! That is certainly better than not going at all, but I would heartily recommend setting aside time for yourself and your family when you are not on call or post-call—time enough to relax and to genuinely enjoy each other. It doesn't have to be a lot of time, but it needs to be regular, reliable, and protected time. Treat yourself and your family as if, collectively, you are your favorite patient.

You might respond "Of course I will," but we all thought that when we were young and had not contended yet with the quicksand of a busy clinical day. Such a day can be fun, but it also can be mentally, physically, and emotionally exhausting, leaving you with no more words, attention, patience, or kind gestures for your own family. I recently read *Tuesdays with Morrie*, by Mitch Albom, a thoughtful little book about a successful media man who rediscovered life's beauty and his own priorities through visits with his dying mentor. I would say that you should read it, but better yet, wait and read it after a few years of practice.

"Treat yourself and your family as if, collectively, you are your favorite patient"

Your family is your inner circle. Lately, my town, Huntersville, North Carolina, has been trying to define "a family" to determine who pays what membership fee for our new aquatic/sports center. This debate began in response to several same-sex couples who had adopted children, considered themselves families, and hoped to pay the family rate at the center. Also, there were divorcees whose children visit on weekends, common law couples, adult children still living with their parents, elderly parents living with their adult children, live-in nannies and exchange students, and so on. Huntersville's commissioners eventually wrote a reasonable definition of a family, involving domicile, length of relationship, sharing of expenses, etc. It was an intriguing philosophical exercise for our times.

Here in Mecklenburg County, the physicians are a varied group, and many have experienced personal tragedies, disappointments, and other challenges. Some have been widowed, and some have very ill spouses. Some are divorced; some have a sick or special-needs child. Many have aging parents, and some have nontraditional households. These situations add stress and may magnify the tendency of many physicians to become workaholics and to be vulnerable to substance abuse, burnout, depression, and divorce. It is therefore very important that we support each other's need to have "Time to Relax with Our Families."

W, I need to go now and register for this meeting. I can't wait to find out if you are here! If so, how about getting our families out by the pool for a little R&R?

Fondly,
Carolyn

Time to Run Your Business

Dear W:

I was very sorry you and your family were not at that conference last month, but was also glad to hear how well things have been going for you. Your new girlfriend, B, sounds wonderful. I guess you didn't need my advice to "Take Time to Relax!" Not to sound like your mom, but be sure not to get too distracted by love to do your studies well. Satisfaction in your work/school progress is intertwined with happiness in your personal life and both affect each other—for better or worse. I think we all face a lifelong challenge of trying to find the right balance between work and play. This wasn't really what I wanted to talk with you about this month, because you know this concept already and you and B will just have to tinker to find the right balance for yourselves. What I do want to discuss this time is the need to watch your finances. Both personally and professionally as a physician, you will need to "Take Time to Run Your Business."

Running a business has not traditionally

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Fondly, Carolyn

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been a physician's area of focus, or even interest. In fact, many of us are a little embarrassed by the need to do so, possibly because we feel that medicine is a calling, a profession that in some ways is similar to the clergy and that doesn't belong in the marketplace. We know, though, that even the clergy have to bring home a paycheck and pay their staff, insurance, and electric bills. Medicine is no different. Physicians have also not been trained in business and financial management, so many of us are intimidated by the idea of running a business. Many physicians have therefore become corporate employees by selling their practices to hospitals or management companies, and this may or may not work out well. The relief from management responsibility is usually accompanied by some degree of loss of autonomy. I know some physicians who are very happy with this arrangement, others who have left to try to run their own practices again, and a couple who have bought their practices back from the hospital.

The percentage of physicians in self-owned practices and the percentage of employed physicians vary in rural and urban areas across the country. It is perhaps more obvious why private practitioners need business skills, but even employed physicians need to understand and participate in business to prevent more clinics from failing. In fact, the recent concerns about physicians turning away Medicare patients relate to this. If Medicare payments are not enough to at least cover the physician's expenses, no one will be able to care for more than a few Medicare patients. This will unavoidably become worse as our populace ages and lives longer. Also, insurance companies link their payments to Medicare rates, using a (usually pitiful) multiplier. Practices and hospitals can now easily falter and go bankrupt, so business management is more crucial than ever before.

Business management isn't really that hard to understand; it just takes your attention and some tenacity. For you to get a paycheck, what comes in must be greater than what goes out. (It's the opposite of the principle of weight loss!) Making a profit (paycheck) was previously much easier for medical practices, but now we are in an era of falling collections and rising overhead expenses. W, your mother's parents owned a grocery store in the Southwest and mine owned a ceiling subcontracting business in the Southeast. It helps to grow up listening to supper-table talk about collections, quality of product, and expenses, but everyone knows that is basically how a business works.

The managing partner of your practice must understand business and be committed to spending at least 10 to 15 percent of his or her time on practice management (and be compensated for this). Even more importantly, you must have a smart practice administrator who has strong business acumen and with whom the physicians agree about management of collections, quality of product, and expenses. Like it or not, the "product" is the care you provide to patients. Let's assume your product is excellent, you are a very competent physician who maintains good relationships with your colleagues, you have a kind heart and "bedside manner," and you pursue all problems with consistent diligence. Providing a terrific medical "product" like that used to be sufficient for a medical practice to succeed, but you now have to also watch the collections and expenses.

"Business management isn't really that hard to understand; it just takes your attention and some tenacity"

There is a rather alarming-looking ad often seen in the USAirways magazine, *Attache*, that says: "You don't get what you deserve; you get what you negotiate." That is unfortunately true even in medicine now, so you and your administrator must negotiate well with the managed care organizations (MCOs) for suitable contracts that arrange for payment for that good product. Have confidence that your product is something that they need! Also, negotiate well with your "vendors": your landlord, computer and copy machine companies, office supply store, accountant, lawyer, and cleaning service. Recycle and reuse supplies when possible, then reuse again. (Oh dear, I am my mother's daughter after all!) Consider charging patients small fees for non-covered services like telephone management, completion of forms and letters, etc. (You cannot do this if the service is "covered but denied," but you can if the service is not covered under the patient's policy.) More and more practices are doing this, and more and more patients understand why. The American Medical Association has several helpful books about practice/business management, including *Managed Care Contracting: Successful Negotiation Strategies* and *Smart Practices: Success in a Changing Environment*. (Go to *www.ama-assn.org.*)

W, I want you to know that managing a business is challenging but not really harder than balancing your checkbook. I still use one of those, but you may not remember them; it was a 20th century thing! The principles of good business have not changed since your grandparents opened their store years ago. As a physician today, you must maintain the quality of your "product" but also attend to the collections and expenses of your practice. You must "Take Time to Run Your Business!"

W, I know you and B must be eagerly anticipating your summer break, and I look forward to meeting her soon. Have a great vacation!

Fondly
Carolyn ♦

Physician Needed as Member of Board's PA Advisory Council

The Physician Assistant Advisory Council (PAAC) to the Medical Board is searching for a physician member. The PAAC advises and communicates with the Board on issues affecting PA practice and regulation in the state. The PAAC does not have authority to license or discipline PAs, but it provides valuable insights to the Board's PA Committee and to the full Board.

The members of the PAAC are nominated by the PA Committee and appointed by vote of the full Board for terms of two years. They may be reappointed by Board action. The PAAC's members represent the leadership of the North Carolina Academy of Physician Assistants, the PA Section of the North Carolina Medical Society, and each PA training program in North Carolina. They also include other PA and physician members chosen for their particular expertise on issues facing the Board.

This group typically meets twice a year, in April and in October. You may view a list of the current members at the Board's website, *www.ncmedboard.org/paac02.htm*. If you are a North Carolina licensed physician and would be willing to serve on the PAAC, please send your request to: NCMB, c/o Robin Hunter-Buskey, PA-C, 1201 Front Street, Suite 100, Raleigh, NC 27609. ♦

No One Is Immune: Loss, Grief, and Bereavement

*Patricia S. Merriman, PhD**

Dr Merriman

No one escapes the process of grief in his or her lifespan. Grieving affects cognition, emotions, and the senses at all levels. *Grief is not a disease or disorder*. It is a natural process of reacting to loss. It includes raw core feelings likened to a "broken heart."[1] On the other hand, grief is a major stressor, depressing the immune system with consequent health and emotional symptoms. A useful assessment metaphor is that the intensity of a grief reaction is proportional to the degree that the heart and soul of a patient was attached, like an umbilical cord, to that which was lost. This metaphor not only applies to deceased loved ones, but also to career losses, lost body parts, divorces, pet losses, geographic relocations, natural disasters, horrific trauma, and terrorism such as September 11. All losses are embedded in the patient's pre-loss identity.

A hospice social worker recently cited the following statistic: for each death in the United States, on average 8 persons are intimately impacted and 16 others are significantly related to the deceased or the mourners.[2] Multiply this times your local death rate, or the gross numbers lost at the World Trade Center or during Hurricane Fran, and the ripple effect on a community becomes incalculable. This ripple effect is seen in physicians' offices, in clinics, in hospitals, and by emergency workers.

Grief is a stressor. It produces a stress reaction in the body compromising the autonomic, neuroendocrine, and immune systems.[3] Neuroendocrine changes from baseline to two months post-loss are a significant predictor of long-term chronic health problems. Elevated epinephrine and cortisol predict greater hopelessness and poorer self-reported health problems at the end of two years post-loss. Using the DST, dexamethasone suppression test, to measure the relationship of bereavement to nonsuppression of cortisol, researchers found significant nonsuppression rates in younger samples, particularly children (mean age=13) who had recently suffered the loss of one parent. From 10 to 15 percent of the adults studied had high rates at one month post-loss, with significant increases at six months, especially those diagnosed with complicated grief and depression. Adult subjects with depression and grief reactions had significantly blunted CRH (corticotropin-releasing hormone) compared to "normal" grievers.[4] There is consistent research evidence that grief also produces negative changes in CD4(t-helper), CDB(t-suppressor), and NK(natural killer) cells. Kemeny, et al,[5] describe a rapid CD4 cell loss over three to four years in patients with grief and depression, with a baseline beginning at two years post-loss.

Normal grief, as defined by Lindemann,[6] Bowlby,[7] and others as early as the 1940s, has some distinct phases. The durations are arbitrary according to the type of loss, premorbid health history, coping capacity, and social supports available. The acute phase, covering three to six months, is followed by a longer mid-period covering a year or more. Recovery is usually in the range of two to three years. During these times, somatic, affective, and cognitive symptoms may manifest as detailed in the list below, derived from Lindemann.[8]

Symptoms of Normal Grief

- Somatic distress: waves of feeling lasting 20 minutes to an hour—tightness in the throat, choking, shortness of breath, sighing, an empty feeling in the abdomen, muscle weakness, and something described as "mental pain" or pangs in the heart area. These symptoms can mimic anxiety and panic attacks. Patients may adopt the illness of the deceased. Headaches, nausea, sudden weight changes, GI upsets, and chronic fatigue are frequent complaints.
- Preoccupation with image of the deceased: smell, touch, auditory, and visual "hallucinations"; sensing the immediate presence of the deceased in the room; imitation of traits and gestures of the deceased. Children may create an "imaginary" friend. Note: these are common in the early phases of grief.
- A sense of unreality: a "not really happening" phenomena—the illusion that people are shadowy, small, removed, and distant. Hostile reactions, irritability, and finding control difficult; awkward dependency coupled with isolation desires; emotional lability coupled with appropriate crying and sadness.
- Loss of patterns of conduct: rapid speech, restlessness, aimless "searching behaviors," a lack of capacity to initiate; failures in self-care, bathing, paying the bills, etc. All work is an effort. Accident proneness.
- Guilt feelings: fears of neglecting the deceased ("I didn't do enough"); failures of closure on the relationship.
- Sleep disorder: nightmares; flashes of the deceased as terminal, mutilated, etc; fears of aloneness.

Since the 1970s, bereavement studies have indicated a negative impact on the health of the bereaved. Parkes, et al,[9] describe a 40 percent increase in mortality and morbidity from various illnesses during the first six months of grieving. Controlling for more factors has lowered these odds, but not the fact that the first year of grieving is highly stressful, forcefully demanding changes from patients. Recent hypotheses[10] suggest that heart attacks post-loss may relate to cytomegalovirus or chlamydia pneumoniae, immunological decrements, correlating with earlier research on widowers and the metaphor that grief feels like a "broken heart."[11]

Knowing the signs of *normal grief* in the early phases is most important for physicians because patients will present with statements like: "I feel like I am going crazy"; "My head hurts, but not like a headache"; "I ache in my chest, is it a heart attack?" "I feel like a stick of wood, yet find myself going from room to room, forgetting and getting nothing done." My clinical experience with patients corroborates those of Parkes,[12] who found that 50 to 70 percent of his patients described "hallucinations" of sound, sight, or touch of the deceased within the first three to six months post-loss. Patients experience the paradox of admitting the "craziness" of these sensations while acknowledging their comforting aspects. These comments may also be accompanied by physical ailments, from lingering colds to rashes to reoccurrences of previously remitted illness, in the first year of bereavement. Episodes are acute, feel awful, but resolve quickly; seldom are medications necessary. Sleep disorders are a given. Sleep usually rebounds every three days if patients persist with good habits.

Normalizing the "crazy feelings" in the early phases of grieving helps them resolve. Assurance from physicians that the feelings and cognitions are normal honors the

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deceased and the mourner while at the same time implying that there will be a shift toward a recovery phase. The progress of grief resolution can be fast or slow, but it is always a hard and painful process. Progress in resuming a healthy lifestyle in the second to third year presumes that, pre-loss, the patient had good health, adequate income, support systems, and positive coping mechanisms. Without any one of these, the degree of pathology increases even for anticipated losses.

Type of Death

The type of death influences the experiences of the bereaved. Anticipated death gives time for anticipatory grieving, giving up the life of the ill person a little at a time. It also allows for community support, legal preparations, and time to say "good-bye." When death is sudden, though non-violent (eg, heart attacks, SIDS, and stillbirths), the grief reconciliation process involves the memory of an intact body. Still, it is difficult to resolve the lack of time to say "good-bye." Grieving deaths resulting from violence, suicide, accidents, war, and terrorism involves flashbacks of mutilated bodies, horrific images, information gaps, and, not infrequently, no body to bury or memorialize. This process has been elucidated in our daily newspapers and on television since the terrorist events of September 11.

Without resolution of grief, the patient moves into a pathological or complicated grief pattern with continued dysfunctional health consequences.[13] Negative life events prior to and immediately after a loss or multiple losses predicates a longer duration of healing and the increased likelihood of prolonged health and emotional problems.

Symptoms of Pathological or Delayed Grief

- Overzealous activities; imitating the deceased without a sense of loss; wooden affect, robot-like feelings; inability to speak of the deceased; hidden or overt anger unmitigated by time or therapy.
- Alteration in friendships, from isolation to inappropriate social choices; promiscuity, gambling, and substance abuse; manufactured gaiety.
- "Queen Victoria" syndrome: keeping the rooms, clothing, and routine the same as on the day of death. (Prince Albert's clothes and shaving gear were set out each morning for years after his death.)
- Recognized medical illness, often moving into chronic conditions such as heart disease, ulcerative colitis, rheumatoid arthritis, and asthma. This seems to be a time of autoimmune response, metaphorically, a body fighting itself.
- Symptoms of the deceased's last illness.
- Agitated depression, suicidal tendencies, post-traumatic stress syndrome.

Unresolved or delayed grief has negative effects on health. Patients with low resilience for grieving have often been abused, especially as children, are unstable economically, have experienced multiple losses, had prior psychiatric and physical illnesses. They number the very elderly, the very young, and adolescents as a special category. Five to twenty-five percent of the population will sustain death, health, or psychiatric problems with complicated grief as a mediating variable.[14] Depressions that persist beyond the first year are a clinically significant category.

In my 20 years experience as a clinical psychologist receiving referrals from physicians, it seemed that unresolved grief was the nexus of many "common" yet unremitting emotional and physical symptoms. In these referrals, anxiety, depression, and sleep disorders were common denominators underlying a myriad of health complaints. Rape and incest survivors often presented with addictive disorders, including obesity. A man who lost an eye in an industrial accident experienced a sudden onset of respiratory illnesses. Years after an abortion, women experienced suicidal ideation or attempts related to either the anticipated natal date or the date of the abortion. The loss of a three-day-old baby with a heart malformation, a year later, led to the mother's year-long struggle with pericarditis. After being displaced by "the younger woman," a prominent clergyman's divorced wife experienced acute onset rheumatoid arthritis. Men often experience "heart" problems after career losses or promotions that separate them from their peers and work-related dreams. One breast surgeon conjectured that the autoimmune responses to silicone implants were more related to the fact of mastectomy, loss of valued body parts, than to the implants.

Social, environmental, and *déjà vu*-type experiences months and years later can bring back a resurgence of grief effects, often in the form of physical illness, emotional lability, or suicidal tendencies. Often, the caretaker or "strong one" in a family system has a delayed grief reaction. It often occurs years later, when the survivor reaches the same age as the deceased at death, or has a similar life crisis or illness. Parents who lose children to accidents or illness tell me there is always a "doughnut" hole of pain in the gut that never seems to resolve. Anniversary reactions are common in unresolved grief. There has never been a patient who had an abortion, miscarriage, or stillborn who did not remember the "due date" or the "death date" and the name chosen for the missing child.[15] These patients do not feel they can grieve or have rituals honoring the deceased because society, their families, co-workers, and physicians want them "to get on with life." Similar reactions are heard from survivors of AIDS, rape, and incest. At the extremes are those survivors of war, terrorism, and natural disasters who feel like "no one understands."[16] They are grieving "ambiguous losses, the lost that are never found...where there is no tangible evidence of death."[17] Currently, one has only to remember the years of the Agent Orange controversy and the present concerns with the toxicity of the Twin Towers implosions to recognize that more than psychological stressors compound any resolution of grief.

Recovery

What does recovery look like? Distress does not decrease in a straight line. There are great fluctuations over several years' time. Gradually, physicians will find patients experiencing more good days than bad days. They will resume expression of a full range of emotions, often commenting that they caught themselves singing in the shower or laughing at TV. They will remember more times with the deceased without painful feelings and images. There will be a shift from "gone forever" to "the gift of the time lived." If necessary, there will be forgiveness of self and others. The patient will resume or seek new attachments with an enlarged support system. Research studies[18] indicate that resilient patients with a good coping capacity have the following characteristics: proactive problem solving techniques, good use of resources, social supports, goal-directed lives, religious faith,[19] regular exercise, good diets, very low use of substances, and daily time spent in pleasure or relaxation. In addition, they are seldom ill or miss work.

Practice Recommendations

During the initial visit, patients should fill out a Loss Assessment Form. This is similar to the stress rating scales devised by Holmes and Rahe[20] in 1967 and still in use. These data give the physician a baseline and sensitize patients and staff to the likelihood that patients have had multiple losses, the timing of anniversary reactions, as well as the types of traumatic experiences in the patients' past history.

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Loss Assessment Form

LOSSES	RELATIONSHIP Parent, Child, Friend, Other	DATES
Deaths		
Divorce		
Suicide		
Miscarriage/Stillbirth		
Abortion		
Murder		
Pet Death... within last year		
Job Loss... within last 2 years		
Geographic Relocation		
Accidents: airplane, automobile, work related, sports or hobby related		
Trauma Type: environmental, flood, fire, hurricane, war, refugee camp, etc.		
Other Trauma: rape, incest, torture, etc		

The following suggestions may facilitate "being on top" of patients' complaints and symptoms related to recent losses or complicated grief reactions.

1. Review the intake Loss Assessment Form prior to patient visits; update the form when necessary. At each visit, have the patient fill out a small form indicating the positive and sad or unpleasant events that have happened since the last visit.
2. Provide information about terms on autopsy, medical, and police reports. Often this allays guilt feelings over not having done "enough." (Her obstetrician told a woman that her stillborn had to be "decapitated" in order to save the mother's life. She had never asked why and suffered 30 years of tortuous dreams until the hospital reports were obtained and explained to her.)
3. Inquire about suicidal and self-harming intent, including accident proneness. Distinguish between longing for the deceased, eg, "I wish I could join my husband," and intent, plan, and methods. (Teenage boys are known to drive their trucks into trees, mourning unrequited love.)
4. Assess daily routine, health habits, exercise,and nutrition. Emphasize the necessity of routine while normalizing the acuteness and "craziness" of grief's affective fluctuations.
5. Assess medication compliance. In the acute phases of grieving, patients often forget their customary medications and/or double up.
6. Assess depression and anxiety. Assess the extent of sleep disorders.
7. See the patient more often in the first year of grieving; you may be the easiest person to talk to. Notations in a journal memorialize the event or person, provide catharsis, and may be helpful to the physician on subsequent visits.
8. Make referrals to a hospice, AARP, and other community bereavement support groups: SIDS, Compassionate Friends, and groups for families of the murdered, AIDS, etc. Some funeral homes provide similar short-term counseling.
9. Make referrals to psychiatrists, psychologists, and social workers for consultation and therapy, especially in cases with preexisting problems, or instances of multiple losses or trauma.
10. Make referrals to pastoral counselors. In religious families, a member of the clergy may be the best person to guide the entire family as each person grieves in her or his own way. The need for absolution is frequent in cases of real or imagined guilt. Clergy can aid families in memorializing rituals or posthumous funerals years after a loss, particularly in cases where there has been no body to bury.

Conclusion

In summary, grief reactions have strong physical and emotional sequelae. The degree of attachment and the intensity of the context, anticipated to horrific, has significant impact on the trajectory of any individuals' grief recovery. Unfortunately, many grieving persons feel that their symptoms are "so weird" that they avoid attending a group. On the other hand, there is comfort in having the information that a group exists in case they want to go at a later time. Persons with complicated grief from multiple or traumatic events will need medical and counseling professionals working together to prevent "doctor shopping," substance abuse, and prescription duplication or misuse for medical conditions exacerbated by grief.

NOTES

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To E-mail or Not to E-mail Patients— That Will No Longer Be the Question

Julian Blumenfeld, MD
President, JBMD Consulting, LLC

Dr Blumenfeld

Are you and your staff overwhelmed with patient phone call interruptions? Is your office staff distracted by phone call appointments when making an in-person appointment? Do you hire additional staff just to handle the flood of daily phone calls? Are you encountering phone tag with your patients when trying to contact them for important information? These scenarios will soon be a vestige of twentieth century technology.

Customer service in general is undergoing a dramatic transformation. Just try speaking to a real person on the other end of a 1-800 number. Both large and small corporations know all too well that Internet technology available today will save them big bucks for tomorrow. Routine customer service needs are being handled by menus of voice prompts that are directing customers to on-line (Internet) services. On-line services typically cost just pennies per transaction as compared to $10-plus for an in-person customer transaction. Yet, medical practices have been slow to incorporate information technology or on-line services.

Electronic mail (e-mail) will play a key role in increasing communication efficiency and reducing operational costs for medical practices. This is not my personal prediction. It is already happening. Kaiser Permanente of Southern California has recently offered all physicians the option to e-mail patients. The Kaiser Web site now provides a "members only" site to e-mail doctors and to refill prescriptions on line. Blue Cross of California is encouraging its 50,000 plus physician members to incorporate e-mail communications in their office practices. In fact, Blue Cross of California has contracted with an outside vendor to provide secure and comprehensive electronic communications for their physician members for free.

So, what are the features of electronic patient communication (ie, e-mail) that will allow it to fulfill high expectations? E-mail is asynchronous, informal, and text oriented. Asynchronous communication allows each person to communicate at his or her own convenience. Your staff could answer routine e-mails (ie, patient appointments, prescription refills, common insurance questions) when the office routine is less hectic or at designated times. Furthermore, your patients can receive answers or submit requests at their convenience as well. E-mail is also informal but permanent. It can serve as useful documentation for every communication. Since it is text oriented, it lacks an emotional context. We all know that angry, emotional phone calls in the middle of a busy day can upset the staff as well as the physician. Reading an e-mail regardless of its emotional tone allows for a thoughtful and professional response.

Yes, you are thinking, but what about the concerns for such electronic patient communications? The most frequent concern physicians express to me is the fear of being bombarded with lengthy and numerous e-mails. What about the confidentiality or security issues of electronic communications? What legal and ethical impact will it have on my practice? And when it is all said and done, will it make my already hectic and stressful practice easier?

The key to successfully integrating e-mail communications into medical practice is to follow carefully thought out guidelines. Do not just start e-mailing your patients. Your staff and physician partners need to discuss carefully all aspects of electronic communications. The American Medical Association now offers comprehensive guidelines for e-mailing patients written by a team of computer experts. All concerns are addressed by a team of computer informatic specialists. Also, outside vendors are available to integrate e-mail and other information technologies into your practice.

"So far, physicians incorporating e-mail in their practices have not experienced abuses."

So far, physicians incorporating e-mail in their practices have not experienced abuses. As with any office procedure, you can set the policy for e-mail communications. Patients should sign an informed consent outlining the role and limitations of your e-mail services. Structuring e-mail communications is paramount. For example, patients need to properly identify and title all e-mail communications. Patients may be asked to limit their e-mail to five or six lines. Other patient instructions may be needed so that these services improve your efficiencies.

Electronic communications will improve patient-physician communication, enhance patient satisfaction, and even provide better patient education. Sophisticated use of e-mail can allow patient monitoring for chronic illness. Asthmatic, diabetic, and hypertensive patients can keep in touch more closely and conveniently with office staff via electronic communications. In the near future, physician offices will electronically transmit important notices, such as: pre-op, post-op instructions; informed consents; new medication guidelines; and even new office announcements and promotions.

So now you ask, what about reimbursement? For some fee-for-service insurance plans, a fee can be charged directly to the patients for e-mail involving medical advice or medication changes. Industry surveys show that most patients are willing to pay the equivalent of a co-pay per e-mail. For capitated plans, e-mail may be able to reduce office visits for certain cases.

Indeed, the world is changing! But if prepared, physician practices can incorporate information technology to improve patient care, reduce costs, and, at the same time, make our daily lives a lot easier.

Dr Blumenfeld practiced allergy and immunology for over 12 years. He is now committed full time to fostering communication skills and strategies for health care professionals. He may be contacted by mail at PO Box 473001, Charlotte, NC 28247-3001; by telephone at (704)281-3216; and by e-mail at jbmdcon@msn.com.

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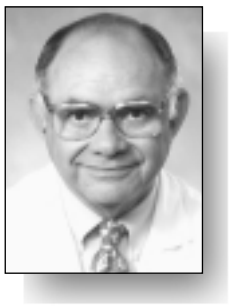
*Dr Merriman is a licensed clinical psychologist who moved to North Carolina seven years ago. She took her doctorate in psychology at Ohio State University and holds a bachelor of science in social work and a master of arts in sociology from that university. She did postdoctoral study in clinical psychology at Wright State University and a fellowship in occupational mental health at Duke University School of Medicine. In Ohio, she had a traditional clinical practice for 20 years and, as an adjunct professor, taught death and dying classes to health care professionals at Wright State. She also proctored medical students at Wright State University Medical School, with an emphasis on grief issues. In North Carolina, she has worked in managed care programs. In 1996, she taught speech and hearing therapists in the Gaza Strip for Marquette University. In recent years, she has worked part time with Cornucopia House Cancer Support Services in Chapel Hill. Now retired, she volunteers at hospice and at Cornucopia House. ♦

Awards and Appointments



Dr Pories

Walter J. Pories, MD, president of the North Carolina Medical Board, received the "Distinguished Alumnus Award in Recognition of Outstanding Achievement and Service" from Wesleyan University, Middleton, Connecticut, at the school's commencement in May 2002. In making the award, the University cited Dr Pories as an eminent surgeon, visionary biochemist, and national leader in surgical research. "You came to this country to escape the Holocaust, attended Wesleyan on a full scholarship, and, while still in medical school, began the seminal research on human nutrition that has made you a legend in your field. Chief among your accomplishments are your discovery of an elegant surgical technique for extreme obesity and your ground-breaking research in adult-onset diabetes, which have given new hope to sufferers worldwide." The citation concluded: "You have said that Wesleyan changed your life. For the untold lives you have changed and made better, Wesleyan is proud to proclaim you a Distinguished Alumnus."

Ms Hunter-Buskey

Robin N. Hunter-Buskey, PA-C, of Gastonia, a member of the North Carolina Medical Board, has been named to the Bylaws Committee of the Federation of State Medical Boards of the United States. Ms Hunter-Buskey was appointed by Ronald C. Agresta, MD, of New York, who took office as president of the Federation in April 2002. She will serve a one-year term. The Bylaws Committee is charged to make recommendations to the Federation's House of Delegates on needed changes to the organization's bylaws. (Last year, several current and former members of the Board served on Federation committees, including Elizabeth P. Kanof, MD, on the Special Committee on Questionable and Deceptive Health Care Practices; John Foust, MD, on the Special Committee on Professional Conduct and Ethics; and Charles E. Trado, MD, on the Special Committee on Communication. The Board's executive Director, Andrew W. Watry, also served on the Special Committee on Communication.)

Dr Barrett

George C. Barrett, MD, who served as president of the Federation of State Medical Boards in 2000-2001 and who stepped down as immediate past president of the Federation in April 2002, has been named to continue as a member of the Federation's Post-Licensure Assessment System: Assessment Center Program Committee. He also continues as a Federation representative to the Educational Commission for Foreign Medical Graduates and the National Board of Medical Examiners. Dr Barrett is a member and past president of the North Carolina Medical Board.

Mr Watry

Andrew W. Watry, executive director of the North Carolina Medical Board, has been honored by the National Committee for Employer Support of the National Guard and Reserve of the Department of Defense for his cooperation in facilitating the service of those Board employees who are members of the Guard and the Reserve. The citation reads: "The National Committee for Employer Support of the National Guard and Reserve Recognizes Andrew W. Watry, North Carolina Medical Board, on behalf of the men and women of America's Reserve forces, for outstanding service to the national defense through continuing support of the National Guard and Reserve." The certificate of award was presented at a special ceremony at the Board's offices on May 13, 2002, by Colonel Marsha Lilly.

Ms Meelheim

H. Diane Meelheim, MSN, JD, director of the North Carolina Medical Board's Operations Department, has been appointed to a special committee of the Federation of State Medical Boards that will evaluate the Federation's leadership structure. (Last year, she served on the Federation's Special Committee on License Portability and its Advisory Council of Board Executives.) She has also been selected to serve on a new committee of the Educational Commission for Foreign Medical Graduates that will examine development of a system for uniform evaluation of foreign medical schools. In April 2002 in San Diego, Ms Meelheim was given the Administrators in Medicine's "George S. Palmer, MD, Award" at the group's annual meeting. The Administrators in Medicine (AIM) is the national organization for state medical and osteopathic board executives. Ms Meelheim recently completed a two-year term as president of AIM. The award reads: "Administrators in Medicine hereby presents H. Diane Meelheim with the George S. Palmer, MD, Award For Excellence in recognition of Online Licensing and her support of State Medical & Osteopathic Boards in their role of protecting the public." (North Carolina has been honored several times over the years by AIM. Also receiving AIM awards have been Bryant L. Galusha, MD; Andrew W. Watry; Bryant D. Paris, Jr; and Dale G. Breaden.) ♦

the UNC journal of medicine, literature, and visual art

Vincent J. Kopp, MD - Assoc Prof, Anesthesiology and Pediatrics; Adjunct Assoc Prof, Social Medicine
School of Medicine, University of North Carolina, Chapel Hill
Joseph Zanga, Jr, MSII - School of Medicine, University of North Carolina, Chapel Hill

The sixth edition of *iris: the UNC journal of medicine, literature, and visual art* is scheduled for publication this summer. Work on the seventh edition will begin in August. This article reviews the past and looks at the future of this unique University of North Carolina at Chapel Hill publication. Dedicated to ". . .efforts to foster a community of creative conversation about the meaning of health care and the experience of illness, disability, and wellness," the journal stands out as an accomplished production dedicated to building community among people who share what is best and most human about medicine through art.

Why *iris: the UNC journal of medicine, literature, and visual art?*

David Rothman's seminal book, *Strangers at the Bedside*, tells the now familiar story: modern medical encounters are no longer just between doctors and patients. They occur in a social and cultural milieu where multiple "strangers" move, when required, from the background into the foreground of medical care. The now metaphorical "bedside," once the sole domain of the doctor-patient relationship, has become crowded with strangers, each with a different definition of the patient's best interests.

Until the past two decades, the doctor-patient relationship signified one physician taking care of multiple patients, one patient at a time. The patient held center stage. Doctors treated a specific known person, not a client or consumer purchasing medical services. Crowded from the bedside by a myriad of specialist physicians and nurses, pharmacists, researchers, insurance company case managers, ministers, lawyers, judges, patient proxies, professional caretakers, consumer advocates, alternative medicine proponents, and entrepreneurial capitalists—all claiming legitimate roles in medical care—the primary physician, that mythical "my doctor" of the classic doctor-patient relationship, must share medical knowledge and responsibility with an expanded spectrum of individuals and institutions. At the same time, the caring physician and the ideal, compliant patient of tradition also became strangers to each other as medicine changed.

"Until the past two decades, the doctor-patient relationship signified one physician taking care of multiple patients, one patient at a time"

Yet a mysterious thing happened: health care technology and service improvements did not change the personal needs inherent to the medical encounter. Despite better diagnostic procedures and effective treatments, patients and providers experienced alienation and frustration. Each group struggled with the Byzantine, depersonalized environment of modern medical care. Patients lost their sense of being cared for; provider's questioned whether they were caring for the patient or their new corporate and institutional masters' bottom lines.

Some dimension of human connection in medicine was diminished by progress. Public and private expressions of dissatisfaction, hurt, confusion, and injustice mounted. Calls for medicine to return to time-honored, core values increased in frequency and loudness.

Enter the latest group of bedside strangers: artists. Poets, novelists, playwrights, painters, and photographers, many of whom were patients or family members or medical care providers in their own right, took medicine as a subject. Gifted with perception and expressive ability, they turned medicine inside out, sometimes to make better sense of their individual medical experiences, sometimes to express dissatisfaction with medicine's social impact on the lives of inarticulate others. In so doing, artists forged words and images that revealed the internal workings of modern medicine and the health care industry it spawned. Contemporary writers like Reynolds Price, Margaret Edson, Donald Hall, Alan Shapiro, and Audrey Shafer—to name a handful—came to contribute substantively to a small but growing corpus of literature and art focused on medical ambiguities and paradoxes as compelling subjects for art and interpretative documentation.

The Founding of *iris: the UNC journal of medicine, literature, and visual art*

Though it serves the whole UNC Health System and Health Affairs community, *iris: the UNC journal of medicine, literature, and visual art* began with a small group of UNC-CH medical students—chief among them Deepu Gowda, then a second-year medical student. This group of students saw the same interconnected facts Rothman documented. As a group, they decided to act on their perceptions by starting the journal.

The students learned through courses and patient contact that the impulse to make sense of intense, personal medical experiences was not confined to sophisticated and famous artists. They knew average patients and family members turned to creative expression to reveal (or extract) meaning from suffering, to record the joy of recovery, to leave a record of their human plight. They felt themselves, along with other health care providers—especially those who see patients die, in need of a way to express their plights, record their acts of personal courage or efforts at personal reconciliation, through literature and art.

In short, these students recognized that many patients, family members, and medical providers populating the UNC Health System shared common experiences and that these could be effectively approached through art.

Gowda began exploring the idea of a journal of medicine, literature, and art in 1996 after participating in a medicine and literature seminar conducted by Drs Robert Coles and Robert Bashford through the UNC-CH Department of Psychiatry. Gowda approached me afterward for assistance. He had worked with me as a student research assistant in the Department of Anesthesiology on an ethics project in 1995. I, too, had participated in the seminar and he knew of both my interest and my past experience establishing the UNC-CH undergraduate literary magazine, *Cellar Door*, in 1972-73. I told him I would be glad to help but that there were four ingredients required to launch and sustain a successful student-run journal: a clear mission, reliable financial support, a home within the institution, and dedicated staff. I told him, too, I was skeptical medical students would be able to sustain a journal over the long haul. Gladly, I have been proven wrong.

Based on our discussions, he and his fellow students moved to publish a first edition in 1997. The first group of four editors included Gowda, Winny Hung, Seth Hawkins, and Joe Scattoloni, all UNC-CH medical students. They expertly executed their plan. The first volume of *iris: the UNC journal of medicine, literature, and visual art* was published on time and on budget in 1997.[1] With student government funds adequate to begin, the first volume was produced using computer, graphic, and editori-

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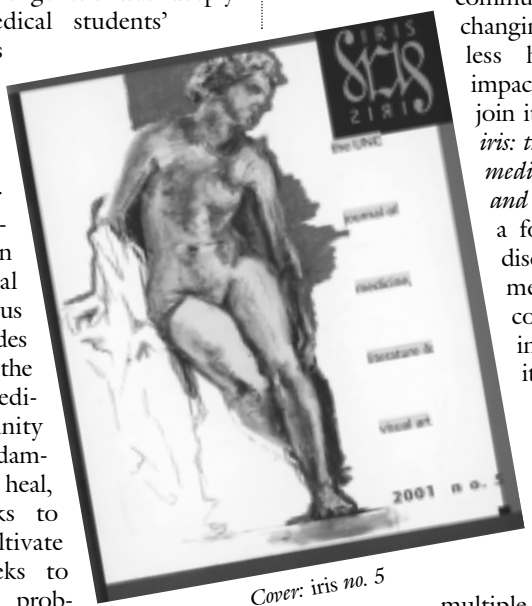
al staff support provided by the Department of Anesthesiology, chaired by Dr Philip Boysen. During production, the students secured the journal's institutional home for the next five years in the Department of Social Medicine. Nancy M.P. King, JD, served as faculty advisor through 2001. I became faculty advisor in 2001 after serving on the first Editorial Advisory Board along with Robert Coles and Doris Betts.

Growth and Evolution of a Community Journal

While the journal's genesis was deeply rooted in the medical students' humanistic attitudes about medicine and their desire to recover and reinforce traditional medical values for themselves throughout medical education into their individual careers, the real genius of their journal resides in their acting on the recognition that medicine is a community affair, one that may damage as it seeks to heal, exclude as it seeks to improve, and cultivate falseness as it seeks to resolve fundamental problems. By creating a journal in which patients and providers meet on the common ground of the printed page, they began to forge a new community within the UNC Health Care System, one predicated on the common need for artful expression, not the patterns of dominance and dependency typically fostered by medical care.



Cover: iris *no. 5*

Under faculty advisor Nancy M.P. King, JD, and Beth Dolan Kautz, then senior fellow in literature and medicine in the Department of Social Medicine, *iris: the UNC journal of medicine, literature, and visual art* grew and evolved into a true community journal, functioning under a mission statement that in part reads:

> Experiences involving illness, caring for the ill, and wellness have profound effects that are often difficult to assimilate. The creative arts provide all those who experience illness and healing the means of expression, communication, and mutual understanding that is unavailable through medicine, science, or scholarship alone. Literature and art uniquely merge emotional, aesthetic, and moral perspectives; help link experience, interpretation, and critical reflection; and increase our ability to understand the many kinds of suffering and healing that are experienced by those involved in health care, whether as providers or as patients.
>
> UNC and Chapel Hill—the university, the hospital and local health care system, and the people who staff them and are served by them—are the focus of our efforts to foster a community of creative conversation about the meaning of health care and the experience of illness, disability, and wellness. This community is constantly changing but it nonetheless has a powerful impact on those who join it, however briefly. *iris: the UNC journal of medicine, literature, and visual art* provides a forum for creative discourse among the members of this community, both inside and outside its pages.[2]

The first edition's release in fall 1997 was the occasion for a reception attended by editorial staff, multiple contributors, supporters, and guests. In his congratulatory comments, Jeffery Houpt, MD, dean of the UNC-CH School of Medicine and vice-chancellor for health affairs, commended the students for their vision, achievement, and community consciousness.

After completion of scheduled introductory comments, contributors read or explained their displayed artwork to the assembled crowd. Afterward, as refreshments were served, a remarkable scene developed. Physicians, nurses, families, patients, and guests mingled with the ease that comes only after communication barriers have been knocked down. Genuine awe, respect, and tenderness marked the witnessed exchanges among people who had, moments earlier, shared only a place in the pages of a journal. This event inaugurated what was to become another *iris* feature: the annual gathering for the purpose of presenting medical art produced by UNC patients, faculty, students, and community artists and published in the journal.

After the first issue's release, the journal's editorial staff recruited other students from the other health professions schools to serve on the second and subsequent volumes' editorial staffs. This eclectic staffing pattern remains a feature of the journal's operations to date. This said, School of Medicine students have held the majority of editorial positions through the current issue. The seventh edition will be the first headed by a non-medical student co-editor, more evidence that the journal has reached broadly into the local health education community.

Stepping into the Future

Financial support for *iris* is narrowly based. Past and current funding sources include the Medical Foundation Loyalty Fund, the UNC-CH Student Government Association, the UNC-CH Graduate and Professional Student Federation, the Office of the Dean, the Departments of Social Medicine and Anesthesiology, and private donations. The Whitehead Society, the UNC-CH's SOM student government organization, recently joined the donor list with a small commitment of funds to *iris*. No large private grants or prizes have yet been sought. The need exists to build an enduring financial base for future operations. Endowment funds must be sought as a needed source of financial support in the future.

Since inception, the journal's production costs have increased from approximately $6,000 to $7,200, a 20 percent increase in six years. This change reflects an increase in the number of volumes printed and distributed (1,500 to 2,000) and the use of color for covers and graphics. While the exact number of submissions per year is not recorded, the number of combined literary and graphic pieces published per issue has ranged from 32 to 37. The total number of pages per issue has ranged from a low of 59 (*iris* no. 1) to a high of 80 (*iris* no. 2). A switch from a one-color to four-color cover format came with *iris* no. 3. The eight-page color block format currently in use inside was introduced with *iris* no. 4. With improved graphics presentation capability and quality came increased production costs. This change resulted in a more visually appealing publication with a graphics-to-literature ratio increasing from 9:24 (*iris* no. 1) to 15:16 (*iris* no. 5).

"The creative arts provide all those who experience illness and healing the means of expression, communication, and mutual understanding"

The *iris* Web site was created by medical student James Pearson in 1999 for the

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fourth edition. Beginning with *iris* no. 6, the entire content of the journal will be viewable on line through the School of Medicine Web site address (*www.med.unc.edu/iris/*) in addition to being available in print. In the future, back issues will become available as well. If future funding or generous gifts allow the staff to do so, compilation of past editions of *iris* into a collection on compact disc would be a worthy goal.

The common denominators of the graphics and literature published in *iris* are medical themes, artistic merit, and accessibility to a broad audience. Through mixing work done by amateur and professional poets, writers, photographers, and graphic artists, *iris* keeps a vibrant quality, full of honesty, integrity, authentic emotion, and artful expression.

The journal's editors eschew intensely personal but weak art. They also carefully avoid works that might be offensive to the broader community of readers. The editors do not intend to shock the community with brutal pictures or stories dealing with medicine's realities or shortcomings. Indeed, it is an *iris* editorial goal to present honest, dignified art that is valuable as well as valued by the hybrid community it serves. In *iris*, a sick child's first (and sometimes last) poem may appear next to an accomplished photographer's searing images. The child and photographer must feel equally comfortable with their *iris* work.

Though *iris* is printed in English, future inclusion of original literature in other languages (especially Spanish), with accompanying English translations, would be an innovative step toward further broadening the journal's editorial mission to reflect the changing demographics of its community audience.

Medical Humanities Education in Relation to *iris: the UNC journal of medicine, literature, and visual art*

Physicians of the past did not separate humanistic concerns from either medical education or practice. University trained physicians obtained broad preparatory educations before studying medicine, while apprenticeship-trained physicians saw firsthand the conditions of patients' lives as they learned empirical methods of healing. Sir William Osler wrote to young physicians in "The Searcher for Knowledge":

> Nothing will sustain you more potently in your humdrum routine, as perhaps it may be thought, than the power to recognize the true poetry of life—the poetry of the common place, of the ordinary man, of the plain, toil worn woman, with their loves and joys, their sorrows and griefs.[3]

Osler taught medical students that engagement with patients—not just their pathology but also the "poetry" of their lives—can sustain and renew them as physicians confronting medicine's mundane face.

William Carlos Williams, the archetypal physician-poet, knew this, too. He took Osler's lesson and made it a key element of his personal aesthetic. Drawing on events from his patients' lives, he created poems and stories that helped define his poetic creed: "No ideas but in things." One hears in "The Practice," a chapter in Williams' *Autobiography*, echoes of Osler's words.

> It's the hum-drum, day-in, day-out, everyday work that is the real satisfaction of the practice of medicine; the million and a half patients a man has seen on his daily visits over a forty-year period of weekdays and Sundays that make up his life. I have never had a money practice; it would have been impossible for me. But the actual calling on people, at all times and under all conditions, the coming to grips with the intimate conditions of their lives, when they were being born, when they were dying, watching them die, watching them get well when they were ill, has always absorbed me.[4]

It is perhaps harder to see "the poetry" or the "real satisfaction" in the "hum-drum" of medicine than it once was. Indeed, the lessons Osler, Williams, and others teach are often neglected in modern medical education. While it is fashionable to include medical humanities education in health education curricula, the efforts are often heroic and overwhelmed by competing expectations. To sit in medical school or other health education school lecture halls is to learn that the real progress in medicine is to be gained from "high tech" rather than "high touch" advances in medicine. Genomics and proteomics, medical technology and bioinformatics, economic and health policy management will produce the perfect convergence of solutions needed to eliminate human suffering and sustain the medical-industrial complex required to achieve health perfection, if not endless profits. How can the quaint notions of an Osler or a Williams compete with such an unrelenting message in the minds of young students?

The publication of journals like *iris* can serve as antidotes, at least on an individual level, to the often-hyperbolic claims that fill contemporary lecture halls, seminar rooms, scientific journals, and newspapers. By addressing the human content of specific individual lives that will never know the promises of a medical utopia, medical humanities journals like *iris* help restore balance where failures, paradoxes, and partial successes are too easily overlooked. With art as the record of patients' struggles and desires—and proof of medicine's imperfect command over life—health professionals can acquaint themselves with the true spectrum of medicine's limitations and promises.

> ***"Journals like iris help restore balance where failures, paradoxes, and partial successes are too easily overlooked"***

Viewed in relation to at least one remaining traditional goal of medicine—the duty to help a patient convert hope for improved health into a discrete cure or sustainable state of care—a medical humanities education, supplemented with exposure to a journal devoted to building a hybrid community, can help clarify what patients value in their contact with medicine, as well as delimit health care's place in society. After all, patients are only patients relative to health care's agendas and goals, and these are not a patient's exclusive concerns. At all other times, patients are people with lives full of want, need, confusion, suffering, heroism, joy, and, one hopes, love.

Learning or being reminded of this about people helps health care providers become more human themselves. What better incentive is there to encourage medical humanities education than the knowledge that one will inevitably be a patient to some future health care provider?

Dr Kopp may be contacted by mail at: CB#7010, 223 Burnett-Womack Bldg, Chapel Hill, NC 27514-7010. Telephone: 919-966-5136. E-mail: *vkopp@aims.unc.edu.*

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Adversarial Relationship Is Really a Choice

J. Thomas Readling, Special Agent
Medicaid Investigations Unit
Office of the North Carolina Attorney General

I recently sat through a three-day Medical Board hearing. I noted the many times the actions of law enforcement or our regulatory boards were referred to, implying them to be adversarial and standing in opposition to "pain relief" or medical "progress." I cannot speak for all law enforcement, but I can speak to these issues based on my experience. From my perspective, these accusations are baseless and serve only to give "victim" status to the accused. The fact remains that some doctors do come to the attention of "the government" and some of the "whys" will be explored.

As to my background, I am currently a law enforcement officer. As such, I have been actively involved in the investigation of prescription drug abuse and health care professionals since 1975. In this capacity, I have worked closely with the regulatory boards and other law enforcement agencies. With rare exception, I have found any significant investigation of a health care professional to have been "self-induced."

Before delving into problem areas, I feel it is necessary to stress that I am not opposed to pain management or the responsible use of opioids in pain treatment. In addition, I know of no professional investigator or organization that opposes pain relief. Effective pain management is a worthy goal, but it does have its risks.

I liken the use of opioids in pain management to the use of a high-risk power tool. In the hands of a skilled craftsman who operates the tool within the safety guidelines, beautiful articles can be produced. But if the tool is used by someone who is not skilled or ignores the safety issues, the tool may not produce the desired result and it may injure the user and/or those around him or her.

It seems an appropriate reminder that the abuse of pharmaceutical drugs far exceeds the abuse of illicit drugs in this country. In order for this abuse to occur, the various substances must first be obtained. Numerous controlled substances are diverted by means of theft and prescription forgery, but a vast number come courtesy of a physician's signature.

Abuse of a legally obtained substance, by itself, is not a crime. But substance abuse is closely associated with criminal activity, which makes it the business of law enforcement. Substance abuse is also a health issue, which makes it the business of our health care professionals. We, law enforcement and health care, share common ground in this respect, although we often come to the problem from different perspectives.

That drugs need to be "controlled" at all is a reflection of our society. In an ideal world, every patient would speak only the truth to a physician and would only take pharmaceutical drugs as directed. But people will always be people and, as much as we desire a utopia, we all must function in the real world. As a prescribing practitioner, you are a significant part of the first line of defense in the world of prescription drug abuse. The results of a prescription pad in the wrong hands can be as lethal as a firearm. To be ignorant of the problem or to ignore it becomes problematic to both health care and law enforcement. It may also be a precursor to action by law enforcement, a regulatory board, or both.

A patient attempting to use a physician as a source for drugs often relies on the physician's ignorance, trust, heavy schedule, or laziness. This is particularly true in patients whose complaints cannot be positively verified through testing. Drug seeking individuals will often include the proverbial use of "headaches" or other non-specific pain complaints as a means to obtain controlled substances.

In these types of scenarios, you, the physician, become both the target and the means of supply. Make no mistake, those who choose to utilize this method to obtain drugs can be very clever and often have enough knowledge of medicine to fool even the most wary physician. I have interviewed suspects who have researched their desired medication and often know more about the drug than the prescribing physician. I have even known some who have been skilled enough to manufacture false medical histories to establish a "medical" need for the drug they are seeking.

Which brings me to the point. Law enforcement and regulatory investigators know this, and I do not know any who would hold a physician responsible for being victimized on an occasional basis. A majority of these "cons" are often discovered simply by the responsible practice of medicine. After several visits, things are just not as they should be or information has been received by the physician that identifies the person as a perpetrator.

When the physician has become a victim of theft or deception, law enforcement stands as an ally of the medical profession. While it can be time consuming, a physician who takes definitive action against those seeking to deceive him or her in order to obtain drugs will soon develop a reputation within the drug community as one to avoid.

On the other hand, those physicians who are liberal in their prescribing habits and who do not take the time or make the effort to be discerning will soon develop a reputation as an "easy mark" and may be inundated with drug seekers. They will know what complaints to give and the "magic" words they need to say to this type of physician in order to obtain the desired controlled substance. When this happens, it won't be long before the physician comes to the attention of law enforcement, a regulatory board, or both.

These typically fall into one or more of the following categories. First, there is the doctor who operates a "script mill." This operation is financially driven and the physician relies on the "patient complaint" as his shield against prosecution. This type of doctor is a licensed drug dealer, no more, no less.

Next, we find the physician who has not maintained an active medical education or has remained ignorant as to substance abuse trends. There have been times when merely discussing the matter with this physician has brought about a marked change in the physician's practice and the doctor closes the door to those who were using him or her.

Law enforcement has occasionally determined a physician has become involved in immoral or illegal activity to the point where the practitioner is being blackmailed. Prescriptions and drugs have been traded for sex, silence, or any number of other reasons. Abusing the privilege of practicing medicine to this extent leaves law enforcement or a regulatory board little choice.

The list goes on, but the final one I will discuss is the physician who is agenda driven. While drive and motivation are wonderful things, they can lead to dire consequences when not properly channeled. This is particularly true when controlled substances are involved.

There have been times when I have seen a physician's agenda become more important than the standards of practice or the potential misuse of drugs. This type of activity is commonly fueled by either an ego or a blind dedication to a cause. While some good

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may come from this physician's activity, it more often than not will also leave a wake of destruction.

Sometimes, law enforcement or a regulatory board can deal with this type of physician through dialogue and/or education, and the matter can be resolved. But these times are rare. When someone is absolutely convinced they are right, no amount of persuasion or presentation of fact will yield positive results. Some type of legal action then becomes inevitable.

It is also important to recognize the cost of prescription drug abuse. Breaking and entering, larceny, armed robbery, prostitution, "fencing," and the sale and delivery of controlled substances are just a few of the associated crimes. You, as a taxpayer, incur the cost of investigation, prosecution, and incarceration.

But the costs go far beyond those noted above. The more "hidden" costs include all of the related health care expenditures, the increased costs of social services, drug treatment, and more. These costs must also include lost productivity, injury, physical and sexual abuse, and often death.

When investigating a physician, it is not uncommon to speak with one or more doctors who have either questioned the activity of the "suspect" physician or have some direct knowledge of the physician's activities. Most desire to either remain silent or speak off of the record because they do not want to become involved. As a health care professional, a registrant, and a taxpayer, you are already "involved."

We, law enforcement and regulatory investigators, are not your enemy unless you choose for us to be. We have a common foe, and much more can be accomplished through a spirit of mutual cooperation than through an atmosphere of distrust.

I encourage both professions to recognize the assets and limitations each of us bring to the table. We need to respect the other's position. But more importantly, we need to acknowledge the scope of the problem. ♦

Don't Assume Your Office Is Ready for HIPAA. . .

Sharon F. Vogt, Health Insurance Specialist
Policy & Provider Relations Branch
Division of Health Plans & Providers
*CMS Region IV**

Don't assume your office is ready for HIPAA; find out who in your office is coordinating HIPAA-readiness and ask. Even if you have a billing agency, you—the provider—are responsible for submitting an extension for HIPAA transactions compliance, required by October 16, 2002.

If you bill Medicare and won't be ready to transmit standard electronic claims and transactions this October, you must fill out an extension form and submit it to CMS. Go to *http://www.cms.gov/hipaa* to fill out the compliance plan, submit it electronically, and get an instant confirmation of the extension. The last day to file is October 15.

Medicare will no longer accept paper claims (with a few exceptions) beginning October 16, 2003. Contact your Medicare carrier for electronic data interchange information (EDI) and free software. By April 2003, you should begin testing your transactions with your business partners. Also in April, privacy compliance is required. For more information, e-mail *HIPAAinfo@cms.hhs.gov*.

*Contact Ms Vogt by mail at CMS, Attn-Sharon Vogt, DHPP, AFC Suite 4T20, 61 Forsyth Street, Atlanta, GA 30303-8909; by telephone at (404)562-7377; by fax at (404)562-7386; by e-mail at *SVogt@cms.hhs.gov*. ♦

From NCDHHS Division of Medical Assistance

ATTENTION ALL PRESCRIBERS: Valid DEA Numbers Required on Pharmacy Prescriptions

Ann Slade, Drug Utilization Review Coordinator, Program Integrity

The Division of Medical Assistance requires DEA numbers on all recipient pharmacy claims. Providers must have their DEA number on file. Failure to do so may result in denied claims. If a prescriber does not have a DEA number and needs to issue prescriptions to Medicaid recipients, the prescriber should contact the Drug Utilization Review Section at (919)733-3590.

A prescriber identification number (ID) will be issued in lieu of the DEA number. The ID number, following the same format as the DEA number, will always begin with a Z (for example, ZF1234567). Prescribers will need to enter this number on their Medicaid prescriptions. This number is referred to as a *Prescriber Medicaid Identification Number* only, and should not be referred to as a DEA number.

If EDS Provider Enrollment does not have your updated information, please provide this information for each prescriber in your practice. Please send to the following address:

EDS Provider Enrollment Unit
PO Box 300009
Raleigh, NC 27622
Fax: (919)851-4014
EDS: (800)688-6696 or (919)851-8888 (Provider Enrollment Section)

Please include:

1. Provider Name
2. Medicaid Provider Number
3. Street Address
4. City, State, Zip Code
5. Telephone Number
6. DEA Number OR Prescriber Medicaid Identification Number

[Ms Slade may be reached at the Division of Medical Assistance, (919)733-3590, extension 229.] ♦

A Brief Introduction to the Sexual Abuse/Assault and Physical Abuse Guidelines for the Evaluation of Children: Emergency Department Setting

V. Denise Everett, MD, Chair
Child Abuse Committee, North Carolina Pediatric Society

In an effort to ensure that children suspected of having been sexually or physically abused receive non-traumatizing, medically appropriate evaluations, the Committee on Child Abuse and Neglect of the North Carolina Pediatric Society developed guidelines that outline appropriate techniques and measures that should be utilized for the evaluation of child maltreatment cases. These guidelines, which appear on the next two pages of the *Forum*, were prepared in response to requests from medical practitioners evaluating children for maltreatment in acute care settings for guidance as to examination techniques, appropriate laboratory testing, evidence collection, and appropriate referrals and follow-up.

It has taken years for the Committee to complete these guidelines in an effort to obtain unanimous consensus. Once completed, they were reviewed and approved by the North Carolina College of Emergency Physicians and the North Carolina Hospital Association. We hope emergency departments, clinics, private practices, and acute care settings across the state will post these guidelines in readily accessible areas for quick reference.

Individual copies of these guidelines, along with the list that appears below of regional centers specializing in evaluation of child maltreatment, may be obtained by telephoning the North Carolina Pediatric Society at (919)839-1156, or visiting our Web site at *www.ncpeds.org*.

LIST OF REGIONAL CENTERS SPECIALIZING IN THE EVALUATION OF CHILD MALTREATMENT

NOTE: CENTERS ARE NOT LIMITED TO THE COUNTIES LISTED BELOW AND THERE IS OFTEN OVERLAP IN COVERAGE

HOME COUNTY: **BUNCOMBE**
CONTACT PERSON: CYNTHIA J. BROWN, M.D.
TELEPHONE NUMBER: (828) 213-1740
COUNTIES SERVED (20): Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, Mitchell, McDowell, Polk, Rutherford, Swain, Transylvania, Watauga, Yancey

HOME COUNTY: **FORSYTH**
CONTACT PERSON: SARA SINAL, M.D.
TELEPHONE NUMBER: (336) 716-2588
COUNTIES SERVED (10): Alexander, Alleghany, Ashe, Davidson, Davie, Forsyth, Stokes, Surry, Wilkes, Yadkin

HOME COUNTY: **MECKLENBURG**
CONTACT PERSON: MARY ROGERS, M.D.
TELEPHONE NUMBER: (704) 355-3156
COUNTIES SERVED (11): Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanley, Union

HOME COUNTY: **GUILFORD**
CONTACT PERSON: ANGELA STANLEY, M.D.
TELEPHONE NUMBER: (336) 832-7324
COUNTIES SERVED (5): Caswell, Guilford, Montgomery, Randolph, Rockingham

HOME COUNTY: **WAKE**
CONTACT PERSON: V. DENISE EVERETT, M.D.
TELEPHONE NUMBER: (919) 350-7810
COUNTIES SERVED (12): Durham, Edgecombe, Franklin, Granville, Harnett, Johnston, Lee, Nash, Vance, Wake, Warren, Wilson

HOME COUNTY: **DURHAM**
CONTACT PERSON: KAREN ST. CLAIRE, M.D.
TELEPHONE NUMBER: (919) 419-3474, ext. 233
COUNTIES SERVED (14): Alamance, Chatham, Durham, Franklin, Granville, Halifax, Johnston, Lee, Nash, Orange, Person, Vance, Wake, Warren

HOME COUNTY: **CUMBERLAND**
CONTACT PERSON: HOWARD LOUGHLIN, M.D.
TELEPHONE NUMBER: (910) 678-7296
COUNTIES SERVED (15): Bladen, Brunswick, Columbus, Cumberland, Duplin, Harnett, Hoke, Moore, New Hanover, Onslow, Pender, Richmond, Robeson, Sampson, Scotland

HOME COUNTY: **PITT**
CONTACT PERSON: ELAINE CABINUM-FOELLER, M.D.
TELEPHONE NUMBER: (252) 758-1200
COUNTIES SERVED (25): Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare Edgecombe, Gates, Greene, Hertford, Hyde, Jones, Lenoir, Martin, Northhampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne, Wilson

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN
North Carolina Pediatric Society

NCCEP North Carolina College of Emergency Physicians

NCHA

SEXUAL ABUSE/ASSAULT GUIDELINES FOR THE EVALUATION OF CHILDREN *EMERGENCY DEPARTMENT SETTING*

When it is suspected or known that a child may have been sexually abused, it is critical that a referral be made to a physician/licensed medical provider with experience in the evaluation of child maltreatment. If a physician/licensed medical practitioner who has experience in evaluating child maltreatment is available either within or outside the ED at the time of presentation, **the child should be referred to this person at this time.** If no such expert is immediately available, the child should receive a **screening exam** in the ED that focuses on **acute problems** (e.g. trauma, vaginal discharge) and, if needed, evidence collection. Once this focused exam is completed and no acute management proves necessary, the child should be referred to a physician/licensed medical practitioner with experience in the evaluation of child maltreatment for full evaluation as soon as possible.

We recommend the following approach for this screening evaluation:

1) As much information as possible should be obtained from the parent or person accompanying the child, ***out of the presence of the child***. A detailed interview of the child should **not** be attempted, especially with an uncooperative or frightened child. ***Be aware that children may be hesitant to answer questions regarding sexual abuse, especially if asked in the presence of the parent/caretaker***. Document in detail the child's statements and affect during the interview and exam.
2) Current American Academy of Pediatrics' Guidelines for the Evaluation of Sexual Abuse of Children state that Rape Kits are most productive if performed within 72 hours of the alleged incident. (Note: **Bedding and clothing can yield evidence up to 5 days post-assault**. A purple-topped tube of blood from the victim should also be submitted for DNA identification.)
3) **If needed**, cultures for gonorrhea (vaginal/penile and rectal) should be obtained using cotton swabs; cultures for chlamydia (vaginal/penile and rectal) should be obtained using a Dacron wire swab. All swabs should be premoistened slightly with sterile, non-bacteriostatic normal saline. **Gonorrhea and chlamydia cultures, rather than rapid testing methods (i.e. DNA probes) must be performed to be admissible in court.**
4) Reminder: **A SPECULUM SHOULD NEVER BE USED ON A PRE-PUBERTAL FEMALE.** Vaginal or introital cultures for gonorrhea and chlamydia are appropriate for a prepubertal female, rather than attempting cervical cultures. If a speculum exam is warranted for any reason, the child should be examined under general anesthesia/conscious sedation.
5) Reminder: **A CHILD (beyond infancy) SHOULD NOT BE PHYSICALLY RESTRAINED FOR THE PHYSICAL EXAMINATION.**
6) Reminder: **A NORMAL EXAM DOES NOT RULE OUT SEXUAL ABUSE/ASSAULT.**
7) **In most cases, the "Final Diagnosis" will not be made in the Emergency Department setting**. Therefore, the coding diagnosis should reflect this when the child is referred to a specialist. Use "Preliminary Diagnoses" (e.g. alleged sexual assault) in order to allow further evaluation by a physician/licensed practitioner experienced in the evaluation of child maltreatment.

The child should be referred to the appropriate physician/licensed medical practitioner experienced in the evaluation of child maltreatment in your particular region of the state to ensure that the child's medical and mental health needs will be met, unless the child is released in the care of a Child Protective Services' worker. The practitioner in the Emergency Department examining the child should immediately contact the referral physician/licensed medical practitioner and inform him/her of the history and the results of the initial examination with a detailed description of any findings noted.

Reporting: It is the responsibility of the practitioner in the Emergency Department to report every case of suspected child abuse or neglect to the county Department of Social Services (DSS). Law enforcement should also be contacted. DSS may accept the report, screen out the report, and/or forward the report to the District Attorney. The report to DSS and the plan of action should be documented in the child's medical record.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN
North Carolina Pediatric Society

NCCEP North Carolina College of Emergency Physicians

NCHA

PHYSICAL ABUSE
GUIDELINES FOR THE EVALUATION OF CHILDREN
EMERGENCY DEPARTMENT SETTING

When it is suspected or known that a child may have been physically abused, it is critical that a referral be made to a physician/licensed medical provider with experience in the evaluation of child maltreatment. These guidelines apply to all children.

A child should be evaluated in the Emergency Department setting if concerns arise regarding the possibility of physical abuse or there are physical injuries that may be due to abuse and a licensed medical provider who has experience in evaluating child maltreatment is not available at the time of the visit. In this case, a thorough physical examination, including the anogenital area, should be performed in the Emergency Department.

We recommend the following approach:

1) Obtain and carefully document the history from each person accompanying the child, ***out of the presence of the child***. Furthermore, each caretaker should be interviewed out of the presence of the other. Always document who was present during the interview, who was present with the child during his or her interview and examination, as well as the affect of each person. Be aware that children are unlikely to discuss abuse in the acute setting. **Do not ask the child questions related to child abuse in the presence of a parent/caretaker, as that individual may be a perpetrator.**
2) Completely examine the child, including the ano-genital area, inside the mouth, between digits, etc. Document any lesions/injuries with photographs (permission not required), if possible, and drawings, being sure the site of the injury is clear. Note the developmental stage of the child.
3) Use skeletal surveys, if a child under 2 years of age has suspicious fractures or injuries. **Do not use "babygrams" (i.e. whole-body x-rays) because of the high rate of false negatives.**
4) Obtain the medical record, if possible, and look for repeated visits for injuries and other signs of possible maltreatment, regardless of whether or not a plausible explanation is given.
5) Hold the child or admit him/her to the hospital if there is any question about the safety of the child, until a child protective services worker comes and takes over this aspect of management. N.C. General Statute 7A-549 (Twelve Hour Custody) states that any **"physician or administrator of a hospital, clinic or other medical facility to which a suspected abused juvenile is brought for medical diagnosis or treatment, shall have the right, when authorized by the chief district court judge or his designee, to retain physical custody of the juvenile . . ."**

The child should be referred to the appropriate physician/licensed medical practitioner with experience in the evaluation of child maltreatment in your particular region of the state to ensure that the child's medical and mental-health needs will be met, unless the child is released in the care of a Child Protective Services worker. The referral physician/licensed medical practitioner should be immediately contacted and informed of the history and results of the initial examination.

Reporting: It is the responsibility of the practitioner in the Emergency Department to report every case of suspected child abuse & neglect to the county Department of Social Services (DSS). Law enforcement should also be contacted.
A report must also be made to be appropriate county DSS if:

1) there are concerns regarding the child's home environment.
2) the family fails to follow through with the referred physician/licensed medical practitioner.

DSS may accept the report, screen out the report, and/or report it to the District Attorney. The report to DSS and the plan of action should be documented in detail in the child's medical record.

NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
February - March - April 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/license.

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

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

NA:
Information not available.

NCPHP:
North Carolina Physicians Health Program.

RTL:
Resident Training License.

Revocation:
Cancellation of the authorization to practice.

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

Suspension:
Temporary withdrawal of the authorization to practice.

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

Voluntary Dismissal:
Board action dismissing a contested case.

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

ANNULMENTS

NONE

REVOCATIONS

NONE

SUSPENSIONS

ECHOLS, Ruthetta Whitfield, Physician Assistant
Location: Stella, NC (Carteret Co)
DOB: 9/12/1951
License #: 0001-00914
PA Education: Hershey Medical Center of Pennsylvania State University (1980)
Cause: While working at Emerald Isle Primary Care under the supervision of Dr Arthur Hemmerlein, Ms Echols received a call asking her to come to the home of an EIPC patient to treat a laceration. She went to the home and treated the laceration. On three other occasions, she made house calls on EIPC patients to provide medical care. Ms Echols and Dr Hemmerlein did not have a written statement describing Ms Echols' scope of practice or otherwise giving her permission to make house calls. Therefore, by making those house calls, she was in violation of the Administrative Code sections relating to physician assistants, which state physician assistants may only perform those duties delegated by their supervising physician(s).
Action: 3/28/2002. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Ms Echols' license is suspended for 30 days, which suspension is stayed.

See Consent Orders:
HOLMES, Joseph Nathan, MD
TEEL, Gregory Tyrone, MD

SUMMARY SUSPENSIONS

NONE

CONSENT ORDERS

DEVANE, Evelyn Johnson, Nurse Practitioner
Location: Rose Hill, NC (Duplin Co)
DOB: 10/01/1953
Approval #: 0002-00298
NP Education: East Carolina University (1980)
Cause: During 1997, 1998, and 1999, Ms DeVane inappropriately obtained prescriptions through which she secured hydrocodone for her personal use. As a result, her nursing license was suspended for a period of not less than six months in February 2000, during which time she was not permitted to perform medical acts as a nurse practitioner. She has not performed medical acts since February 2000 and does not intend to do so until approved by the Board.
Action: 3/18/2002. Consent Order executed: Ms DeVane shall not perform medical acts as a nurse practitioner until she has appeared before the Board and received its approval, which the Board is under no obligation to grant; if approved, Ms DeVane shall take steps to assure she fully communicates with her primary physician regarding prescriptions and prescription refills she obtains from any source; unless lawfully prescribed for her by someone other than herself, she shall refrain from the use of all mind-or-mood-altering substances and all controlled substances; she shall maintain a record of all controlled prescriptions she receives as prescriptions or provides for patients, which record shall be in a notebook maintained for inspection by a representative of the Board; must comply with other conditions.

FABER, Steven Mark, MD
Location: Elizabeth City, NC (Pasquotank Co)
DOB: 7/06/1955
License #: 0000-35892
Specialty: GE/IM (as reported by physician)
Medical Ed: University of Genoa, Italy (1983)
Cause: Dr Faber failed to fully disclose to four patients on whom he had performed the "Stretta Procedure" that he had limited training in doing the procedure and that he had never performed it on a patient. The patients consented, but the Board did not consider that consent to be informed. Dr Faber, for a period of time, recommended his patients buy vitamins and supplements sold at his practice. These vitamins and supplements were sold at a profit, not at cost, and Dr Faber did not tell his patients about his financial interest in their sale. Dr Faber now fully informs patients concerning his experience with the Stretta Procedure and no longer has a financial interest in the sale of vitamins and minerals.
Action: 2/28/2002. Consent Order executed: Dr Faber is reprimanded; he shall not accept compensation for the sale of vitamins and supplements to his patients.

HOLMES, Joseph Nathan, MD
Location: Salisbury, NC (Rowan Co)/Charlotte, NC (Mecklenburg Co)
DOB: 10/07/1956
License #: 0000-37854
Specialty: IM (as reported by physician)
Medical Ed: Texas Tech University (1986)
Cause: On information that Dr Holmes violated boundaries with one of his patients. The Board finds and Dr Holmes admits that from 9/1999 until 3/2000 he engaged in a sexual relationship with one of his patients. On being informed of the Board's concerns, Dr Holmes obtained an assessment at the Professional Renewal Center (PRC). Following assessment, he successfully completed seven weeks of treatment at the PRC to address his boundary violations and depression. He regularly attends individual and group therapy sessions with Dr Gullick

that focus on boundary violations and Dr Holmes' sexual misconduct. He has obtained a local physician to treat and manage his depression and has entered into a contract with the NCPHP. The NCPHP reports Dr Holmes has complied with his NCPHP contract.

Action: 3/09/2002. Consent Order executed: Dr Holmes license is suspended indefinitely effective 7/14/2001. That suspension is stayed effective 10/15/2001, subject to the following terms and conditions. Dr Holmes shall ensure a female chaperone who has read this Consent Order is present when he examines a female patient; the chaperone shall document she was present and no boundary violations occurred; he shall maintain and abide by a contract with the NCPHP; he shall continue his therapy with Dr Gullick or another licensed counselor approved by the president of the Board, and he shall comply with the counselor's recommendations; he shall direct the counselor to provide quarterly reports to the Board on his progress; he shall maintain a relationship with a physician to follow and treat his depression; he shall provide a copy of this Consent Order to all current and prospective employers; must comply with other conditions.

KING, Delf Omar, MD
Location: Norwich, NY
DOB: 8/30/1943
License #: 2002-00191
Specialty: AN (as reported by physician)
Medical Ed: University of Western Ontario (1973)
Cause: Dr King was convicted of driving while ability impaired in 1982 in New York. In 1994, he was charged with menacing in the second degree, which charge was reduced to trespassing. He was convicted of that charge. In January 2001, he filed an application form for a license with the North Carolina Board and failed to note these convictions in response to questions on the form relating to such matters. As a result, his license application was denied. At a hearing in December 2001, he acknowledged he incorrectly answered the questions and apologized to the Board. He has never been the subject of any disciplinary actions or investigations at his hospital; he holds licenses in Georgia, New York, Maryland, Ontario, and Quebec; and he has never been the subject of any disciplinary actions by any licensing agency or by any professional society.
Action: 2/25/2002. Consent Order executed: Dr King is issued a full and unrestricted license; he is reprimanded for failing to disclose material information in his application for a license; the Consent Order shall remain in effect until ordered otherwise by the Board.

O'DONNELL, Robert William, MD
Location: Supply, NC (Brunswick Co)
DOB: 1/30/1942
License #: 0000-29636
Specialty: P/ADP (as reported by physician)
Medical Ed: University of Maryland (1974)
Cause: Dr O'Donnell surrendered his license in 1993 due to difficulties with alcohol abuse and other things, the details of which are set forth in Consent Orders dated 1/26/1995 and 2/17/1997. Pursuant to an order of 2/22/2001, the Board relieved him of any continuing obligations under those Consent Orders. The Board and Dr O'Donnell believe it would be beneficial to reinstate certain provisions of the prior Consent Orders.
Action: 4/13/2002. Consent Order executed: unless lawfully prescribed for him by someone other than himself, Dr O'Donnell 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 continue his therapy with Drs Norris and Peters or such others as may be approved by the president of the Board and he shall comply with all recommendations made by them; he shall direct his therapists to provide quarterly reports of his progress to the Board; he shall attend AA and Caduceus meetings as recommended by his therapists; except for minor emergencies, he shall not treat, medically or surgically, or prescribe for family members or others with whom he has a significant emotional relationship; must comply with other conditions.

TEEL, Gregory Tyrone, MD
Location: Atlanta, GA
DOB: 4/04/1956
License #: 0000-30773
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1984)
Cause: Dr Teel admits and the Board finds that Dr Teel, 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 March 2000 to February 2001, Dr Teel prescribed various medications for non-acute conditions 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 Teel, rendered medical care to patients in North Carolina, thus engaging in the unauthorized practice of medicine. Dr Teel 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 Teel, 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 Teel's prescribing irregularities caused any detrimental effect to any patient. A representative of VMG indicated to Dr Teel, prior to his engaging in these activities, that the Board was aware of VMG's activities. In February 2001, he became concerned about potential harm to patients resulting from his participating in these activities and he voluntarily ceased and terminated his employment with VMG. He has cooperated fully with the Board and has volunteered to cooperate with the Board and other authorities in any investigation of VMG.
Action: 2/21/2002. Consent Order executed: Dr Teel's license is suspended for 60 days. Suspension is stayed on the following conditions: Dr Teel shall not prescribe medication for any person in North Carolina without first performing a physical examination; he shall not assist VMG or any other entity in the unauthorized practice of medicine; he shall not split fees generated from the practice of medicine on a percentage basis with any business corporation; must comply with other conditions.

MISCELLANEOUS ACTIONS
NONE

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

DENIALS OF LICENSE/APPROVAL

GALEA, Lawrence Joseph, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 10/19/1948
License #: [0000-27046]
Specialty: FP/GP (as reported by physician)
Medical Ed: University of Cincinnati (1980)
Cause: Failed to comply with paragraphs 7 (meet with the Board in January 2001) and 8 (meet certain CME reporting requirements) of his Consent Order of 7/21/2000 with the Board.
Action: 2/21/2002. Findings of Fact, Conclusions of Law, and Order issued following a hearing held 11/16/2001: Dr Galea's application for a license is denied.

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 denial of Dr Holt's application for reactivation of an inactive license. Dr Holt requested a hearing on this matter, which was held 2/21/2002. Following the hearing, the Board determined Dr Holt failed to prove his qualifications for a license to the Board's satisfaction.
Action: 2/28/2002. Findings of Fact, Conclusions of Law, and Order issued: Dr Holt's application for reactivation of his license is denied.

SURRENDERS

BOWMAN, James Thomas, MD
Location: North Wilkesboro, NC (Wilkes Co)
DOB: 11/16/1951
License #: 0000-21742
Specialty: FP (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1977)
Action: 3/04/2002. Voluntary surrender of North Carolina medical license.

HAMBLETON, Scott Lewis, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 4/15/1963
License #: 2000-00444
Specialty: FP/EM (as reported by physician)
Medical Ed: University of Tennessee, Memphis (1994)
Action: 2/13/2002. Voluntary surrender of North Carolina medical license.

MASSENBURG, O'Laf Sorento, Physician Assistant
Location: Winston-Salem, NC (Forsyth Co)
DOB: 2/10/1960
License #: 0001-01117
PA Education: Bowman Gray (1988)
Action: 4/19/2002. Voluntary surrender of North Carolina physician assistant's license.

SULLIVAN, Timothy Andrew, MD
Location: Laurinburg, NC (Scotland Co)
DOB: 7/07/1965
License #: 2000-00633
Specialty: N (as reported by physician)
Medical Ed: East Virginia Medical School (1995)
Action: 3/26/2002. Voluntary surrender of North Carolina medical license.

WARD, David Townsend, MD
Location: Winston-Salem/Kernersville, NC (Forsyth Co)
DOB: 4/07/1960
License#: 0095-00473
Specialty: OTR (as reported by physician)
Medical Ed: West Virginia University (1986)
Action: 2/21/2002. Voluntary surrender of North Carolina medical license.

WOLEBEN, Martyn Dean, MD
Location: High Point, NC (Guilford Co)
DOB: 11/13/1956
License #: 0097-00428
Specialty: OBG (as reported by physician)
Medical Ed: University of Mississippi School of Medicine (1988)
Action: 2/19/2002. Voluntary surrender of North Carolina medical license.

COURT APPEALS
NONE

CONSENT ORDERS LIFTED

CHEEK, John Christopher, MD
Location: Smithfield, NC (Johnston Co)
DOB: 3/03/1957
License #: 0097-01906
Specialty: GP/CN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1984)
Action: 3/09/2002. Order issued lifting Consent Order of 12/08/1997.

HENDRICKS, David Martin, MD
Location: Goldsboro, NC (Wayne Co)
DOB: 5/20/1951
License #: 2000-00454
Specialty: AN/OS (as reported by physician)
Medical Ed: Medical University of South Carolina (1988)
Action: 3/09/2002. Order issued lifting Consent Orders of 4/14/1999 and 1/08/2001.

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: 2/17/2002. Order issued lifting Consent Orders of 12/17/1999, 4/19/2000, and 8/8/2000.

McCURDY, Donald Pittard, MD
Location: Birmingham, AL
DOB: 1/29/1946
License #: 0000-21824
Specialty: OPH (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1977)
Action: 2/10/2002. Order issued lifting Consent Order of 3/23/1999.

ZABENKO, Robert Tracy, DO
Location: Fort Polk, LA/Fayetteville, NC (Cumberland Co)
DOB: 12/05/1958
License #: 0098-00166
Specialty: OBG/OS (as reported by physician)
Medical Ed: University of Health Sciences College of Osteopathic Medicine (1994)
Action: 3/09/2002. Order issued lifting Consent Order of 1/08/2001.

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

BJORK, Paul Edward, Jr, MD
Location: Hamlet, NC (Richmond Co)
DOB: 3/06/1954
License #: 0000-36146
Specialty: GN (as reported by physician)
Medical Ed: University of South Carolina (1983)
Action: 3/20/2002. Temporary/dated license extended to expire 4/30/2002.
4/17/2002. Temporary/dated license extended to expire 10/31/2002.

CHEEK, John Christopher, MD
Location: Smithfield, NC (Johnston Co)
DOB: 3/03/1957
License #: 0097-01906
Specialty: GP/CN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1984)
Action: 2/20/2002. Full and unrestricted license reinstated.

CLAYTON, Thomas Vann, MD
Location: Andrews, NC (Cherokee Co)
DOB: 9/20/1956
License #: 0000-30895
Specialty: FP/FPG (as reported by physician)
Medical Ed: St George's, Grenada (1983)
Action: 3/20/2002. Temporary/dated license extended to expire 4/30/2002.
4/17/2002. Full and unrestricted medical license reinstated.

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 Southern Florida (1992)
Action: 4/18/2002. Temporary/dated license extended to expire 10/31/2002.

DIAMOND, Patrick Francis, MD
Location: Burgaw, NC (Pender Co)
DOB: 5/15/1946
License #: 0098-00042
Specialty: FP (as reported by physician)
Medical Ed: Autonomous University Tamaulipas, MX (1987)
Action: 2/20/2002. Temporary/dated license extended to expire 2/28/2003.

DECLERCK, Paul A., MD
Location: Kinston, NC (Lenoir Co)
DOB: 10/07/1947
License #: 0000-24240
Specialty: FP (as reported by physician)
Medical Ed: University of Brussels, Belgium (1975)
Action: 3/20/2002. Temporary/dated license extended to expire 4/30/2002.
4/18/2002. Temporary/dated license extended to expire 7/30/2002.

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: 4/17/2002. Temporary/dated license extended to expire 8/31/2002.

SKWERER, Robert Gordon, MD
Location: New Bern, NC (Craven Co)
DOB: 7/29/1956
License #: 0099-00134
Specialty: P/N (as reported by physician)
Medical Ed: State University of New York, Brooklyn (1982)
Action: 4/17/2002. Temporary/dated license extended to expire 11/30/2002.

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)
Action: 4/18/2002. Full and unrestricted medical license reinstated.

WASHINGTON, Clarence Joseph, III, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 1/11/1947
License #: 0000-32295
Specialty: GYN (as reported by physician)
Medical Ed: University of Michigan (1974)
Action: 3/20/2002. Temporary/dated license extended to expire 4/30/2002.
4/18/2002. Full and unrestricted medical license reinstated.

ZABENKO, Robert Tracy, DO
Location: Fort Polk, LA/Fayetteville, NC (Cumberland Co)
DOB: 12/05/1958
License #: 0098-00166
Specialty: OBG/OS (as reported by physician)
Medical Ed: University of Health/Science College of Osteopathic Medicine (1994)
Action: 2/20/2002. Full and unrestricted license reinstated.

DISMISSALS
NONE

North Carolina Medical Board
Meeting Calendar, Application Deadlines, Examinations
August 2002 -- January 2003

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

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
North Carolina Medical Board	**October 16-17, 2002**
October Meeting Deadlines:	
Nurse Practitioner Approval Applications	September 2, 2002
Physician Assistant Applications	September 23, 2002
Physician Licensure Applications	October 1, 2002
North Carolina Medical Board	**November 20-22, 2002**
November Meeting Deadlines:	
Nurse Practitioner Approval Applications	October 7, 2002
Physician Assistant Applications	October 28, 2002
Physician Licensure Applications	November 5, 2002
North Carolina Medical Board	**December 18-19, 2002**
December Meeting Deadlines:	
Nurse Practitioner Approval Applications	November 4, 2002
Physician Assistant Applications	November 25, 2002
Physician Licensure Applications	December 3, 2002
North Carolina Medical Board	**January 22-24, 2003**
January Meeting Deadlines:	
Nurse Practitioner Approval Applications	December 9, 2002
Physician Assistant Applications	December 30, 2002
Physician Licensure Applications	January 6, 2003

☛ **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.

Important

Please Note

The mailing address of the North Carolina Medical Board is:

North Carolina Medical Board
1201 Front Street, Suite 100
Raleigh, North Carolina 27609-7533

For some time, the NCMB has received mail directed both to its street address, noted above, and to a Post Office box. By October, its Post Office box will be closed. Should your records include the NCMB's old PO box number, you will want to remove it now to avoid misdirecting future mail. Replace it with the street address above.

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