**President’s Message**

Wayne W. VonSeggen, PA-C

**Communication Is the Key**

Among the wide variety of problems that come before the North Carolina Medical Board, by far the most common involves some sort of communication problem between the physician and patient, the physician and patient’s family, or the physician and other medical support staff. The problem usually is based on the expectation of the patient or the family that the physician (or other health care provider, such as a physician assistant or a nurse practitioner) is responsible for communicating more effectively. In reality, of all the fields of preparation in which medical personnel are usually trained, formal courses and practical training in effective communication are often neglected. While language, grammar, and medical vocabulary courses may be prerequisites, it is uncommon to see ongoing communication training and interviewing/observing techniques being taught in medical school. It is often assumed that on-the-job training will suffice to bring the student into the range of an “effective communicator.”

Physicians in an active medical practice must communicate with an astonishing assortment of individual patients across the full spectrum of ages. The choice of words and messages must take into account multiple levels of education, the ever-present life-critical emotions, and the possibility of varying mental illness or cognitive states. Often, the communication must take place in the midst of a variety of complex and unpredictable disease processes. Atop it all, the crucial information the physician must send and perceive may be affected by gender, racial, or cultural sensitivities. The physician must constantly be prepared to sort actual truth from self-serving confabulation, hearing not only words and expressed thoughts, but linking the verbal message with the objective evaluation of medical signs. It is no wonder that effective communication by physicians is such a Herculean task. The task begins each time a physician-patient relationship is formed.

**From the Executive Director**

Andrew W. Watry

**Myopia in Licensure**

The licensing of physicians in this country is still a state function handled by state licensing boards. Let’s hope it stays that way. Medical licensing boards, in many states, evolved from horse-and-buggy days. There was no prescribing over the Internet, no telemedicine, and no uniform examination for licensure. Each state asked its own examination questions, some asking for answers in a blue book. There were no HMOs, PPOs, no locum tenens placement services. There was no practice of medicine across state borders except in border communities. All of that has changed.

**Growing Federal Interest**

There are now many forces at play that are pushing for a shift in this regulatory authority. Some suggest the need for federal intervention (see below). Those of us who have been connected with medical boards for a long time are very resistant to any discussion about such a shift. We tend to feel that states are doing an effective job of protecting the public despite criticisms to the contrary. We can, however, have a tendency to be myopic in the face of these forces. One example is the application process for licensure. We require documentation of core credentials because we’ve been burned in the past when we trusted others to do it. Yet in the year 2000 we still require physicians to document their core credentials over and over again at licensing boards, hospitals, managed care organizations, and other places. All too often, we are not focusing on the more distant object and the bigger picture. That which is clearly before us is in clear focus, that which is distant more difficult to discern.

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result is called “selective listening.” You hear only what you really “attended.” The result is sort of a “Swiss cheese level” interview. Delay your judgment and advice giving until it is your turn to respond, and by then you may have reason for a completely different response. Those who interrupt often do not save time in the communication process and may be less effective because the speaker’s full message was not delivered. By taking the initiative to become a patient listener, you will experience what many veteran clinicians have learned: patients are drawn to health care providers who are good listeners.

Once you have listened (and observed for congruence), sending back your response to the patient is the second part of communication. Have a gentle answer to communicate compassion, kindness, and patience. It has been said that 90% of the friction of daily life is caused by the wrong tone of voice in our communication. Every physician hopes to empathize with the patient’s situation and help in some way. Kindness is a language that even the deaf can hear and the blind can appreciate.

Physicians must tailor their responses to build rapport with the patient through trustworthy listening, then thoughtful consideration, and delivering an informational response clearly and accurately so the patient may make a truly informed decision. Health care professionals must respond to the willing and the noncompliant, the angry patient and the fearful patient, the demanding ones and the manipulative souls who try our patience. Some may be seeking drugs, or trying to get antibiotics when you sense viral illness, or simply hoping that you’ll provide that written work excuse note they desperately need.

Through the maze of possible responses as you deliver your speech, you hope to negotiate a workable treatment plan and solicit their compliance. Begging and pleading sometimes works, but most often we need to balance patient demands with practical actions likely to solve their problems. By listening and responding carefully, you may learn the patient’s preferences with options of the treatment plan, and find a position on which you can both agree.

“The art of listening may be the most important element in communication.”

In any relationship, whether it is the patient’s relationship with colleagues or with loved ones, the listening process is also required. The physician cannot afford to relax the responsibility for it. Why? Because relaxing in the area of effective communication could cause a missed diagnosis, the wrong choice, delayed problem-solving, a complaint, or a possible lapse resulting in indefensible malpractice, the loss of the patient’s life or the physician’s career.

Receiving messages from the patient is a very complex undertaking. Physicians often strive to improve personal listening skills. It helps to focus not only on the words being said but also on nonverbal cues, the volume, pace, and pitch of speech that may actually give the physician additional objective information that may be more reliable than the words being spoken. Listen for congruence to assure yourself that the message and the meaning really match. Maintain the “right” level of eye contact: enough to soak up all communication cues, but not too much to be oppressive to the overly sensitive person. Be aware that the dynamic of the level of eye contact and communication style may need to be altered if the patient is emotionally labile, physically smaller than yourself, or is lying or sitting while you are standing during communication.

Allow “white space” processing time as you listen. As the patient speaks, do not interrupt or complete words or sentences for the patient. Provide a short pause of silence after the patient has spoken and before you respond in order to allow the patient to fully communicate ideas without interruption or being cut off. Listen, process, then respond. Realize that something the patient is about to say is much more important than what you are planning to say in response. Prevent yourself from “rehearsing” what you are going to say next (while the patient is talking) because, in all likelihood, you will probably miss something the patient is saying and your listening will become less effective.

The art of listening may be the most important element in communication. When the patient is talking, give total attention and try to block out any distractions. If you discover yourself with a wandering focus of attention, don’t assume that you know what the person is going to say. The
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When we communicate in our practices, we should avoid any unnecessary jocular attitude that could even remotely be interpreted as potentially insensitive on our part. Be especially sensitive to what the patient may hear when you are talking about other things, because the patient may erroneously think you are talking about or reacting to their problem. Develop sensitivities to how what is being said could be interpreted by a generally female work force in your office or hospital. Often hospitals will have a 70% female work force, so if a comment or remark is in a gray area, you may choose to omit it. If you do speak, pause to consider using the most sensitive comment, one even your clergyman’s wife would understand and appreciate.

Interactions with medical co-workers are sources of communication landmines. Never discuss a patient’s condition or diagnosis with another clinician in the exam room with the patient listening. Excuse yourself after collecting verbal and objective information, then discuss the case with the other clinician in the privacy of a separate setting, such as a nearby office or work area where the patient cannot hear you or see you while you are discussing the patient’s evaluation. Be cautious in areas of overlapping duties or scope of practice, for these are often areas in which to tread carefully and tactfully. Always request assistance from a co-worker privately, personally, and quietly. Give other employees appropriate time and space to accomplish their assigned duties without being overbearing in your presence or your pressure to get your job finished. Remember that efficiency and quality of services by medical staff are often evaluated by someone other than you in a hospital setting or clinic setting. Communicate all concerns regarding problems with the appropriate person in management. Even if you are the one to rate the work of an individual, any direct comment regarding perceived inefficiency should be reserved for private person-
al feedback sessions. Make a point of thanking those who have helped you during your work time.

Physicians must be aware of the methods used in their practice: greeting, identifying, processing, and referring patients, dismissing patients from the practice, handling correspondence, preparing for procedures, and reviewing laboratory and radiological reports received by office staff. Communication lapses in those areas may allow problems such as the following frequently observed errors:

- overlooking recently acquired medication allergies;
- failing to ask about concurrent use of OTC medications or herbal remedies patients may be using;
- allowing reports to be refiled in the patient’s chart without clinician review and dating;
- operating on the wrong limb by failing to devise a foolproof method for identifying and preventing such errors;
- operating at the incorrect spinal level by failing to verify the correct level before surgery is started;
- assuming instead of verifying and documenting true statements.

Policies and procedures within the practice should include anticipating the potential for miscommunication. “Policies and procedures within the practice should include anticipating the potential for miscommunication.”

“Policies and procedures within the practice should include anticipating the potential for miscommunication.”

Resources on Improving Communication in Medical Practice
1. American Academy on Physician and Patient, McLean, VA.
2. Listening, The Art of Understanding Others, Great Performance, Inc. 14964 N.W. Greenbrier Parkway, Beaverton, OR 97006.

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Following are a few examples of heightened federal interest in the regulation of medicine.

- With wasteful redundancy, we now have two federal data banks tracking physicians: the National Practitioner Databank (NPDB) and the Health Insurance Portability Databank (HIPDB). Details of these data banks may be found at www.NPDB-HIPDB.com.

- In a report of the Joint Working Group on Telemedicine, appointed by Congress, the authors identified state-based medical licensing as a significant barrier to the diffusion of telemedicine. Four bills were introduced in Congress in 1999, each requiring the Secretary of Health and Human Services to submit a report on state progress to facilitate the provision of telemedicine services by eliminating unnecessary requirements, adopting reciprocal licensing agreements, and implementing uniform requirements.

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1-800-253-9653

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- The General Accounting Office has been asked to examine on-line doctor consultation, which is viewed by some congressmen as highly unethical and prone to serious problems.
- The Clinton administration has been credited with efforts to police rogue Internet pharmacy operators and rogue physicians. The administration’s proposal would expand Food and Drug Administration powers to investigate these sites.

These are but a few markers of substantially increased federal interest in medical regulatory issues.

A Daunting Task

The medical boards have a daunting task to fairly and appropriately address these regulatory issues in the coming years. One thing is clear in all jurisdictions: the public generally expects medical licensing boards to do a better job. This is clearly communicated to all of my colleagues through media contacts, public inquiries, review of the literature, and legislative contacts.

We do have mechanisms at our disposal to help us focus on the more distant objects. The most significant mechanisms are organizations we use for daily communication among ourselves: the Federation of State Medical Boards of the U.S. (FSMB), which is the national voluntary organization of medical boards, and the Administrators in Medicine (AIM), an organization of medical board directors working jointly with and through the FSMB.

The most significant long range challenge facing medical boards, in my opinion, is the issue of interstate cooperation. The public and our licensees expect more permeable borders. We need to devise mechanisms to make licensee mobility between jurisdictions less of a headache. We need to improve mechanisms of communication among jurisdictions so that there is quick and timely notification of other jurisdictions when problems occur. The public expects more convenient access to consumer information about physicians to enable more informed choices. Finally, we need more standardization. Here are some initiatives taking place to address some of these issues.

- FSMB Board Action Data Bank: Web-based notification of all 64 licensing jurisdictions for disciplinary action taken by boards.
- FSMB recommendations for helping states develop effective physician profile systems for making public information more available about licensees. Our own NCMB Web site is highly rated as a useful consumer site by a national consumer group.
- FSMB Model Medical Practice Act: guidance to states on state-of-the-art statutory authority to help boards do a better job. This was used in North Carolina to help fashion the current House Bill 1049, which will make substantial improvements to our Medical Practice Act and will come forward in the Short Session of 2000.
- Post Licensure Assessment: a program to help identify assessment mechanisms for licensees with deficits in clinical knowledge and to help develop appropriate remediation mechanisms. This is a collaborative effort between the FSMB and the National Board of Medical Examiners.
- Interstate Compacts: although not being formally considered by medical boards at the moment, most are aware of the work of nursing boards to form interstate compacts much like those devised for drivers’ licenses. A license from one state is recognized in another provided there are agreements as to who the public can complain to, who investigates, and who assumes the substantial costs of the disciplinary process. This approach is often referred to as mutual recognition. Medical boards are discussing various options for improving interstate mobility of licensees.
- Internet prescribing: boards are working with different enforcement agencies to deal with issues surrounding prescribing on the Internet.
- The FSMB home page provides useful information, links to state boards, and other resources, at www.fsmb.org.

If We Don’t Lead...  

Medical boards are doing a lot more in the year 2000 than they were 10 or 20 years ago to focus on the more distant interstate and intrastate issues. Boards are committed to improving disciplinary mechanisms, improving communication mechanisms, making it easier for physicians to move from state to state, making it easier for consumers to find out about their physicians in their own state, as well as in other states, and appropriately protecting the public and accommodating new technologies such as telemedicine and proper forms of Internet prescribing, all of which make state borders much more permeable than in years past.

Someone once said “Lead, follow, or get out of the way.” We are uniquely positioned in a leadership role. One of our Board members, George Barrett, MD, from Charlotte, has been elected president of the FSMB. The Board’s assistant executive director, Diane Meelheim, has been elected vice president of AIM and is a candidate for president of that organization.

Various representatives from your Board are tapped to help work with other states to develop solutions to these important issues. We need to be vigilant and a part of the solution to these important issues, because what happens outside our borders can be every bit as important as what happens within them. We are doing what we can to help bring distant objects in licensure into focus as well as to deal with issues at home. We need to maintain the momentum of the changes described above because they are good for the public and because, if we don’t lead, we may be forced to follow or get out of the way.

Any comment you may have concerning these issues would certainly be welcomed. If you choose to send e-mail, please address it to info@ncmedboard.org. Thanks.

On-Line Registration: It’s on the Way

Good news! Physicians will soon be able to register their North Carolina medical licenses on line, which will include payment of the registration fee by credit card. This system will significantly reduce the administrative burden that pen and paper registration places on the physician and the Board. It will allow immediate feedback and much more timely confirmation.

Watch the Board’s Web site (www.docboard.org/nc) and the Forum for details.
The first house call I ever made was as an intern assigned to the Nashville General Hospital’s emergency room. A man about my age, then 27, came into the ER after midnight, having had a single shaking chill and cough productive of rusty sputum. His examination confirmed fever and localized rales. I treated him with IV penicillin and sent him home. After a 24-hour stint in the ER, residents worked in the Screening Clinic, affectionately named the Screaming Clinic — my assignment for the rest of the day.

**Beginnings**

The decision to send that man home weighed on me during those outpatient hours. I had a similar experience that year with a young man who presented with epididymitis. I had written him a prescription for an appropriate antibiotic and sent him home. He returned three days later during my rotation with excruciating pain, fever, scrotal swelling and an overwhelming illness because he could not afford to get an inexpensive generic prescription filled and because I had not been smart enough to ask him whether he could buy the medication.

I had visions of my patient returning moribund to the ER. . . I needed to be assured he would have adequate treatment."

"I made phone calls during the week to set up weekend appointments in places like Jackson and Maryville, small towns at the edge of the Smokies where patients lived. I could leave Nashville early on a Sunday morning, swing by a hospital in Knoxville, review charts and autopsy records on microfiche in mid-morning, and arrive in the foothills by early afternoon after church was out.

I would unload several boxes from the car and settle in at the kitchen table. After the patients signed permission forms, I would draw their blood into test tubes, save some with anti-coagulant and let some clot. The clotted samples I then had to spin, either with a hand-cranked centrifuge or a tabletop electric unit on the floor to keep the vibration down; pipette the sera; and package it up for the long ride home, arriving well after dark. I met a lot of nice folks. Through these contacts, I tracked down a mortician named Mr Pickle who looked up in his funeral records the death information on the matriarch of the family, from whom four of nine children had acquired the unusual neurological disease by autosomal dominant transmission.

**Over the Years**

It was a few more years into my practice in Charlotte when I made a house call to a neighborhood off Wilkinson Boulevard one spooky winter night about 10 years ago. The wife was so sick she couldn’t drive to the hospital, and even if she had had strength, she couldn’t leave home. Her husband was confined to bed with COPD and steroid-associated osteoporosis so severe he broke ribs rolling over in bed. Further, they had small children and there was no one to care for them. I went by the office, found some antibiotic samples, some promethazine for injection and some IV fluids. I found the house, and a girl answered the door. The room felt like a sauna and my glasses fogged over as I entered the house. She led me to the lowest level of the tri-level home, where her father’s hospital bed occupied the center of the family room. Her mother was lying on a sofa in the corner, naked, drenched from sweating and drinking ice water from a Mason jar.

“She could not be persuaded to come in for an office visit for any reason, so I administered flu shots to her at her house every October.”

“Her mother was lying on a sofa in the corner, naked, drenched from sweating and drinking ice water from a Mason jar. Her exam showed no serious findings. I administered an intramuscular injection of promethazine and oral acetaminophen, assured myself that her gastroenteritis was improving and that she was able to keep fluids down. She was able to avert an ER visit.

On call, I have twice pronounced people dead in their beds at home. I subsequently called on the elderly spouse of one of those patients many times. She lived in a single room in a large house in a prestigious neighborhood. She had a housekeeper who helped her move from her bed to a chair to the bathroom, a circuit she traveled several times per day on swollen legs and arthritic knees. I admitted her once for a perirectal abscess, the only time in her more than 90 years she had been hospitalized. Her backdoor was always unlocked, so you always had to go into the house and call loudly to ask permission to come in to visit. She could not be persuaded to come in for an office visit for any reason, so I administered flu shots to her at her house every October. She always graciously offered for me to join her with a bourbon and water when I would come to see her after office hours before supper. I never did. She, like her husband, died at home.

Older, disabled folks with no means of transportation can benefit particularly from home visits. I saw another patient, elderly and demented with abdominal pain. She was on warfarin and her daughter was worried. My exam table was her sofa. Her daughter was our chaperone. Her belly was soft, bowel sounds were active, she was not impacted, and her stool occult blood test

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House Calls

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was negative. That visit saved Medicare a $200 ambulance ride, hours in an emergency room and an expensive workup. The family seemed to appreciate my visit. Alas, the patient had forgotten me in the time it took to close the front door behind me.

Another woman was not so lucky. She was young, maybe 20, an au pair from Germany. A few hours after a visit with her Bavarian boyfriend, she began to have severe abdominal pain and vomiting. She felt guilty, wondering if the illness was caused by sex. She had an acute abdomen; a surgeon found a mesenteric hernia.

Not all my house calls have been inside. My uncle took me once to see the daddy of an employee of his. He was a farm worker with “high blood” (hypertension) and “the gouch” (gout). It was hot summer and he sat in a springy metal lawn chair under a tree in his side yard littered with old tires and rusty plows and a wood pile already growing taller for the coming winter. His socks were mostly holes and I checked him for CHF while he smoked. I left him with a sermon on not smoking, not eating salt and taking his medicines on schedule.

“It’s the doctor, it’s the doctor!”

If there is a business about medicine, this is it, the service of house calls. House calls have distinguished the lives of countless physicians and their patients for generations. Observations of the starched lace doilies on the arms of overstuffed couches in old farmhouses may be as important to the practice of good medicine as knowledge of the latest ARB (angiotensin II receptor blocker). In other houses in other neighborhoods, the vinyl seats are covered with towels. I have sat there, or on the edge of a bed, and tried to know these patients better. The long years of my adolescence prolonged by my fancy education and years of training left me ignorant of what real people do and who they are. I am trying to re-educate myself. It would be theater, if it were imaginary. When I have visited a patient at home, I have been privileged to look inside another stratum of society, if only through a doorway opened for a few moments. Many physicians, whether by specialty or choice, will never have that experience, even once.

I won’t claim that this is always fun. When the weather is rainy, and the hour is late, my motivation for cheerful service is near zero. Sometimes I am looking for a house I can’t find on a pitch black night, and wondering whether a drive-by shooting will catch me in the crossfire, and I see someone in back-lit silhouette through a half-opened door, waving at me, excited, telling the family, “It’s the doctor, it’s the doctor!” Then, I get a second wind. This is important work, if not so much for me, for my patient up those steps, inside that door. At the end of my visit, as I leave, hesitant on the stoop and peering into the night, I wonder, “When I am old and sick and dying and covered by Medicare, will my doctor come to see me at home?”


NCMB Adopted Position Statement on Advertising and Publicity in November

In November 1999, the North Carolina Medical Board adopted a Position Statement on Advertising and Publicity. That statement is contained in the Board’s printed packet of statements and has been posted on the Board’s Web page, but it did not appear in the list of position statements published in the last number of the Forum for 1999. It is presented below.

Advertising and Publicity

It is the position of the North Carolina Medical Board that physician advertising or publicity that is deceptive, false, or misleading is unprofessional conduct. If patient photographs are used, they should be of the physician’s own patients and demonstrate realistic outcomes. The key issue is whether advertising and publicity, regardless of format or content, are true and not materially misleading.

Information conveyed may include:

a) the educational background of the physician;
b) the basis on which fees are determined, including charges for specific services;
c) methods of payment;
d) any other non-deceptive information.

Advertising and publicity that create unjustified medical expectations, that are accompanied by deceptive claims, or that imply exclusive or unique skills or remedies must be avoided. Similarly, a statement that a physician has cured or successfully treated a large number of patients suffering a particular ailment is deceptive if it implies a certainty of results and/or creates unjustified or misleading expectations.

Consistent with federal regulations that apply to commercial advertising, a physician who is preparing or authorizing an advertisement or publicity item should ensure in advance that the communication is explicitly and implicitly truthful and not misleading. Physicians should list their names under a specific specialty in classified telephone directories and other commercial directories only if they are board certified or have successfully completed a training program in that specialty accredited by the Accreditation Council for Graduate Medical Education or approved by the Council on Postdoctoral Training of the American Osteopathic Association.

(Adopted 11/1999)
Governor Hunt Appoints Dr Barrett to NCMB, Reappoints Dr Kanof

Andrew W. Watry, executive director of the North Carolina Medical Board, has announced that Governor James B. Hunt, Jr., has appointed George C. Barrett, MD, of Charlotte, and reappointed Elizabeth P. Kanof, MD, of Raleigh, to the Board. Their terms will run for three years.

Dr Barrett was a member of the North Carolina Medical Board from 1992 to 1998, chaired most of the Board's committees at one time or another, and was president of the Board in 1996-97. In April 2000, he became president of the Federation of State Medical Boards of the United States. He will serve in that position until mid-April, 2001. Dr Barrett has been a member of the Federation's Board of Directors and has served as that organization's vice president and president elect.

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

He is certified by the American Board of Radiology, with a medallion in nuclear medicine. In 1986 and 1989, he pursued advanced studies in bioethics at the Kennedy Institute of Georgetown University in Washington, DC. He is a fellow of the American College of Radiology and a member of the North Carolina Medical Society; the Mecklenburg County Medical Society; and numerous other professional organizations. In April 1999, he received the 1999 Distinguished Service Award of the University of North Carolina at Charlotte, which is the most prestigious non-academic tribute offered by that university.

Dr Kanof, a native of New York, received her BA from Mount Holyoke College and her MD from New York University. She did an internship at Kings County Hospital Center and residencies in dermatology at New York University-Bellevue Medical Center and Duke University Medical Center. She is a fellow of the American Academy of Dermatology and a diplomate of the American Board of Dermatology. She holds appointments as assistant clinical professor of dermatology at the Duke University School of Medicine and as adjunct clinical professor of dermatology at the University of North Carolina School of Medicine.

Very active in organized medicine, Dr Kanof served as president of the Wake County Medical Society in 1984 and of the North Carolina Medical Society in 1994. She has served on or chaired numerous Medical Society committees and currently serves as a Medical Society delegate to the American Medical Association. Over the years, she has also been a participant in a wide range of community and charitable groups.

She has published several articles and, in 1996, was co-author of “Overcoming Barriers to Physician Involvement in Identifying and Referring Victims of Domestic Violence,” published in the Annals of Emergency Medicine.

Dr Kanof has served on the Board's Malpractice, Physician Assistant, Physicians Health Program, Policy, and Liaison Committees, and has been chair of its Complaints, Scope of Practice, and Alternative Medicine Committees. Dr Kanof is currently vice president of the Board and has served as the Board’s secretary-treasurer.

General Reminders for Physician Assistants from the NCMB Licensing Department

1) Keep us informed of any address changes, in writing. (This should not be included with your annual registration forms, as registration is a SEPARATE department.) Please mark to the attention of Erin Gough.

2) To change or add a Primary Supervising Physician, you must submit an Intent to Practice Form BEFORE you may begin work for that physician. If you simply dropped a Primary Supervising Physician and are no longer working for him/her, notify us in writing.

3) Save all written correspondence to and from the Board, including, but not limited to, Intent to Practice Acknowledgement letters.

4) For a list of required materials to keep on site, and a list of suggested materials to keep on site, go to: www.docboard.org/nc. Click on “licensing”, and scroll down until you see the link to the Intent to Practice Form. The instruction page for this form lists materials to keep on site.

5) If you would like to see the current PA regulations, go to our Web page (see #4), click on “Rules,” and scroll down to p. 50. PA rules begin here.

6) There is a $15.00 fee for each written PA licensure verification. Please send a check or money order along with your request, payable to NC Medical Board.

7) If you currently hold a temporary PA license, you are required to notify the Board of your NCCPA scores within 15 days upon the receipt of scores.

Please don't rely on others to see that these things are in order. It is your responsibility as a physician assistant licensed by this Board to follow the regulations and to make sure that the appropriate materials are on file at your work site(s) and at the Board's office. I am available to answer your questions Monday-Friday, from 2:30-5:00pm.

North Carolina Medical Board
Web Site:
www.docboard.org/nc
E-Mail:
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Reflections of the NCMB’s First Public Member

Mrs Martha K. Walston
Member, NCMB

In January 1982, I was approached by Governor James B. Hunt, Jr, and asked to accept an appointment as the first public member of the North Carolina Board of Medical Examiners (as the North Carolina Medical Board was then known). Since I knew absolutely nothing about the Board, I sought the advice of my brother, Dr John A. Kirkland, who is a practicing physician. He referred me to a long time friend, Dr Edwin A. Rasberry, Jr, who is a physician from Wilson and had served on the Board. Dr Rasberry told me about the workings of the Board and encouraged me to serve. I had had much good experience with the medical profession over the years because of a disability with one of our children. I decided to accept the appointment, seeing service on the Board as a way of expressing my appreciation.

Back then, the Board meetings were held all over the state, and the first meeting I attended was in Charlotte. Needless to say, it was a long drive not knowing much about what I was venturing into. I sat in that meeting for four long days trying to understand and absorb what was taking place. On the last day, the president asked me what I thought about the Board. I first told the members that it was evident they were all dedicated and extremely hardworking, but I did think it was possible for a public member to make a contribution. I added that I wasn’t sure I was the right person. I know they were a bit leery of me with my background in education and city government, but they encouraged me to take my time and assured me everything would begin to fall into place.

I have served four three-year terms on the Board altogether: from 1982 to 1988, and from 1993 to the present. During those 12 years, I have seen many changes. In 1982, the Board’s offices were on the second floor of the North Carolina Medical Society Building. They were small and their square footage approximated the size of the current boardroom. At that time, the Board employed three investigators. Now, there are eight. We were represented on a part-time basis by a private law firm. Today, we have four attorneys on our full-time staff. There were only a few permanent staff members. Today, there are 35, not including the investigators.

Other changes during my tenure have been the inclusion of physician assistants and nurse practitioners within the Board’s jurisdiction, the addition of two more public members, and representation on the Board of a physician assistant or a nurse practitioner. The name of the Board was changed to the North Carolina Medical Board in 1995. In 1999, it was my privilege to serve under the leadership of the first public member to hold the office of board president. Mr Paul Saperstein did an outstanding job, and currently Mr Wayne VonSeggen, a physician assistant, is serving as president with equal dedication. Not too many years ago, no active effort was made to release information to the press about the Board’s actions against doctors. In recent years, however, that information has been released promptly to all of the media and published in the Board’s Forum. This may seem unnecessary to some. However, Board members view this disclosure as imperative because once action is taken against a doctor, he or she has the option of pursuing the case in the courts. Sometimes, this process can drag on for several years. This occurred in one of the first hearings in which I was involved. When the Board decided to take the doctor’s license, he elected to present his case in the courts. He was able to practice for two years in his community before our decision was upheld. Because our first duty is to protect the public, the Board does not wait for the courts to rule but, instead, informs the public of its adverse decisions.

From a broader perspective, the National Practitioner Data Bank, operated by the federal government, and the Board Action Data Bank, operated by the Federation of State Medical Boards, have gone far toward closing the window of opportunity questionable physicians once had to move from state to state undetected. Meanwhile, the United States Medical Licensing Examination, created by the National Board of Medical Examiners and the Federation of State Medical Boards, has enhanced the quality, rigor, and uniformity of medical licensing examination.

Working with the North Carolina Physicians Health Program and serving on their board has been one of my most rewarding experiences. This program has contributed invaluable services to the North Carolina Medical Board. Not only does it rehabilitate doctors, it also works closely with the Board and is the cooperating doctor’s advocate when his or her case is presented. The biggest problems facing doctors are first, alcohol, second, drugs, and third, crossing sexual boundaries.

“I did think it was possible for a public member to make a contribution.”

“The biggest problems facing doctors are first, alcohol, second, drugs, and third, crossing sexual boundaries.”

With a success rate of almost 90%, one can understand why the NCPhysicians is recognized nationwide as a model.

The workload of the Board increases every year, and the number of doctors coming to North Carolina continues to climb. In the last 15 years, we have seen sharp increases in the number of doctors and of physician assistants in the state. Each year they are better served by the Board. Those with problems represent only a small percent, but they are being conscientiously disciplined and, when appropriate, rehabilitated. We are always working toward improving the protection of the public. I have seen us improve steadily, though we are still not perfect. I believe public members have been a vital part of the Board’s improvement, as a significant element in the process of change.

Certainly, the presence of public members has made it easier for the medical professionals on the Board to understand the public viewpoint, just as the public members benefit from the expertise and experience of the medical professionals. As a result, I believe the Board, as a whole, has become more alert to public concerns and its decisions have been shaped by those concerns.

When I reflect on it, every medical professional with whom I have had the privilege of serving has been supportive of public members. They have included us in every aspect of the Board’s work and made us an integral part of the process. I am grateful for the many dedicated doctors, PAs, and NPs who work in our state, and I would encourage any member of the public who is asked to serve on the Board to accept the challenge. ♦
From the NC Board of Nursing

Mutual Recognition in Nursing:
Licensure for the New Millennium

Y2K took on a new meaning for nursing regulation when the 1999 North Carolina General Assembly enacted the Nurse Licensure Compact! This interstate compact is the basis for the mutual recognition model of nursing regulation among states whose legislatures have enacted the compact. These states are called party states. To date North Carolina, Maryland, Arkansas, Texas and Utah have enacted this interstate compact. Beginning in the Year 2000, each of these party states will “recognize” or honor the nursing licenses issued by other party states. In order for nurses to have a better understanding of this new model for nursing regulation, the following questions are addressed.

Q: How will the Nurse Licensure Compact affect nurses who live in North Carolina?
A: Effective July 1, 2000, nurses who live in North Carolina will no longer obtain (or renew) a license in any of the other states that have enacted the interstate compact. A nurse who resides in our state and holds an unencumbered North Carolina nursing license will have the ‘privilege to practice’ in any of the other party (compact) states. Only when a nurse moves to one of other party states will he/she be required to apply for and obtain a nursing license in that state.

Q: Where will nurses obtain/renew their license under this mutual recognition model of licensure?
A: Similar to the driver’s license model of licensure, nurses must meet the requirements to obtain and renew their license in their primary state of residence. For most nurses licensed in North Carolina, there will be no change at all in the way they renew their license. For nurses who hold a license in more than one of the 5 party states (TX, MD, UT, AR, NC), only the license in the nurse’s state of residence will be valid after July 1, 2000.

Q: Will the nurse who lives in a non-party state and practices in North Carolina still need to have a license to practice in North Carolina?
A: Yes. Nurses who practice nursing in North Carolina but live in a non-party state, such as South Carolina or Virginia, must continue to hold a license issued by the North Carolina Board of Nursing.

The Nurse Licensure compact will not change how they obtain/renew their North Carolina license. However, their North Carolina nursing license will not include the multistate licensure privilege to practice in other party states. This privilege is extended only to those nurses who reside in North Carolina.

Q: What does a multistate licensure privilege mean?
A: This privilege means that a nurse who resides in one party state will be legally permitted to practice in another party state without needing to obtain a license in the other party state. It is important to understand that the Nurse Licensure Compact requires the nurse to adhere to the practice laws and rules of the party state in which he/she practices. In the case of electronic practice (teledrnursing), the nurse must adhere to the practice standards of the state in which the client(s) receives care.

Q: How will primary residence for licensure purposes be determined?
A: Compact rules and regulations will require each nurse to declare in writing his/her primary state of residence upon initial application and renewal of the nursing license. Other sources of proof that boards of nursing may use to verify primary residence include one’s IRS tax return, voter registration or driver’s license.

Q: How will employers and other members of the public verify licensure status of nurses under this mutual recognition?
A: Employers may continue to verify licensure status of NC licensees via the Internet or through our automated telephone verification system. For licensure verification of those nurses who reside in other party states and are seeking employment in NC, the employers will be able to access the coordinated licensure information system, called NURSYS. Access to NURSYS will occur either through our Web site or directly through a Web site that will be announced closer to the July 1, 2000 implementation date. Basic licensure information as well as disciplinary history will be available to the public through this information system.

Q: How will complaints about nurses be handled within this mutual recognition model?
A: The compact authorizes the nurse licensing board of any party state (home or remote) to investigate allegations of unsafe practice by any nurse practicing in that state. Based upon the outcome of the investigation, a remote party state licensing board may deny the nurse’s privilege to practice in that state. Only the nurse’s home state (state of residence) licensing board may take action against the nurse’s license. States will continue to apply the same administrative and due process procedures for imposing discipline as they have always done. However, party states will have more timely access to information, including current significant investigative information and the disciplinary history of nurses, through the coordinated licensure information system (NURSYS).

Q: Will nurse practitioners (NPs) and certified nurse midwives (CNMs) be affected by the Nurse Licensure Compact?
A: Yes and no. In North Carolina, the NP or CNM must hold a current license to practice as a registered nurse in order to be granted approval to practice as a NP or CNM. The Compact only affects where the RN license is obtained, i.e. in the NP or CNM’s state of residence. The Compact will not affect any other aspects of the initial or renewal process for approval to practice as a NP or CNM.

Q: How do I get more information about mutual recognition and the Nurse Licensure Compact?
A: The Board will be sponsoring informational forums in Spring 2000 - dates and places to be announced in the February 2000 Bulletin. You may check out our Web site (www.ncn.com) for a copy of the Nurse Licensure Compact, the proposed rules once they have been filed in mid-December, and other information related to mutual recognition. The National Council of State Boards of Nursing (NCSBN) also has a Web site (www.ncbsn.com) that offers further information on the mutual recognition model. This Web site may be accessed directly or through the NC Board of Nursing.

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Mutual Recognition

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Nursing’s Web site. If you have specific questions about this new model of nursing regulation, you may call the Board office at (919)782-3211 or e-mail us at ncbn.com.

The Board of Nursing is excited about taking this next step in nursing regulation. The Board wishes to thank the many nurses, employers of nurses and healthcare organizations in North Carolina who actively supported the passage of the Nurse Licensure Compact in the 1999 General Assembly. We will be writing a new chapter in our rich history as we move into the new millennium. It truly is an exciting time to be a nurse!

[As of February 2000, six states had enacted the Compact: Arkansas, Maryland, North Carolina, Texas, Utah, and Wisconsin. Six other states have begun the enactment process.]

Reprinted from the October issue of the Bulletin of the North Carolina Board of Nursing. ♦

George C. Barrett, MD, Member of NCMB, to Become President of Federation of State Medical Boards

On Saturday, April 15, 2000, in Dallas, Texas, at their Annual Meeting, the members of the Federation of State Medical Boards of the United States will install George C. Barrett, MD, of Charlotte, as the Federation's president. He will serve in that position until mid-April, 2001. Dr Barrett has been a member of the Federation’s Board of Directors and has served as that organization’s vice president and president elect.

Dr Barrett was a member of the North Carolina Medical Board from 1992 to 1998, chaired most of the Board’s committees at one time or another, and was president of the Board in 1996-97. After a year’s absence from the Board, Dr Barrett was reappointed by Governor James B. Hunt, Jr, in January 2000.

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

He is certified by the American Board of Radiology, with a medallion in nuclear medicine. In 1986 and 1989, he pursued advanced studies in bioethics at the Kennedy Institute of Georgetown University in Washington, DC. He is a fellow of the American College of Radiology and a member of the North Carolina Medical Society, the Mecklenburg County Medical Society, and numerous other professional organizations. In April 1999, he received the 1999 Distinguished Service Award of the University of North Carolina at Charlotte, which is the most prestigious non-academic tribute offered by that university.

The Federation of State Medical Boards of the United States, founded in 1912, is the national voluntary membership organization of state medical boards. It has 68 member boards representing every medical licensing jurisdiction in the United States, including Puerto Rico, Guam, and the Virgin Islands. (In some states, medical doctors--MDs--and doctors of osteopathy--DOs--are licensed by separate boards. All belong to the Federation, however.)

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

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

“I can think of no one better equipped or better suited than Dr Barrett to lead the Federation into the new century and the new millennium. He is a remarkable person, a man of vision and integrity,” Mr Watry said. “He brings pragmatic creativity and dynamism to all he does. The Federation will benefit significantly under his guidance.” ♦

LETTERS TO THE EDITOR

I Count My Blessings Every Day.
Thanks for Helping!

To the Editor: As a fairly recent graduate of one of North Carolina’s fine medical schools, I would like to offer a personal note of congratulations to Wayne W. VonSeggen, PA-C, on his recent election as president of the North Carolina Medical Board. I was reading through the Forum recently, saw his picture, and was reminded that I met him in his professional capacity several times while I was a medical student.

My other purpose in writing is to share with you that I am currently a member of the North Carolina Physicians Health Program. I have enjoyed a number of years of sobriety, one day at a time. I count my blessings every day that I was afforded the opportunity to remain in medical school after my drinking problem was discovered and to return to rotations after I participated in treatment. Through the help of several concerned physicians and others at the medical school, as well as my sponsor and friends in AA and Caduceus, I was able to continue my studies, graduate, and pursue residency training.

Now that the NCPHP staff is involved in the monitoring process, their support and genuine interest in my recovery program overwhelm me. Physicians and physician assistants in this state are incredibly fortunate to have such a program in place. The rewards such a program offers to those of us in the program, as well as to our patients and colleagues, is indeed far-reaching and immeasurable. My thanks go out to Mr VonSeggen, the other members of the North Carolina Medical Board, Dr Wilkerson, Paul Peterson, and the many others who have offered help and support to the impaired physicians here in North Carolina.

My best wishes to Mr VonSeggen in his new position. If I can serve the Board in any capacity in support of the NCPHP, I will do so. On behalf of my family, patients, colleagues, and members of my community, I thank everyone involved for helping physicians such as myself continue to do what we love to do. . .practice the art of medicine while staying sober one day at a time.

A North Carolina Physician

Response

Thank you for your supportive comments to the many individuals who have helped fund the North Carolina Physicians Health Program and have contributed time and expertise as monitors and counselors, to the current and previous members of the Medical Board, and to Dr

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Vanderberry and Dr. Wilkerson, who have guided the NCPHP, it is encouraging to see that the NCPHP can make such an impact early in a medical career, even during residency. The medical schools are able to provide appropriate empathetic direction to give medical students a way to keep a promising medical career on track.

I hope that your success story will remind us all that “one day at a time” choices help to bring a sense of true accomplishment in medical school, residency, and throughout our life mission.

Wayne W. VonSesseng, PA-C
President, NCMB

Lying to the Board

To the Editor: I graduated from medical school in North Carolina in 1985. In order to obtain our licenses at the time, we were asked several questions, including whether we ever received counseling of any type and if we had ever used a nonprescription illegal drug.

Regarding the first question, we were told by a faculty member that this was an inappropriate question with the implication that we need not feel bound to answer truthfully. I assume that some percent of us had obtained psychological counseling of some type and I would guess that most did not disclose this.

As to the drug question: a study in JAMA, Vol 267, No 17 (May 1992), reports that “physicians were as likely to have experimented with illicit substances in their lifetime as their age and gender peers in society...” For that peer group of 20-year-olds and 30-year-olds in 1985, close to 50% had used drugs at one time or another.

My question is, did the medical board receive substantial numbers of admissions on either of these points? I dabbled with marijuana in my youth and I obtained marital counseling while in medical school. I lied about these things and have always felt bad about it. Normally, I am an honest person. To have told the truth would have entailed a protracted hassle, and that no such disclosure led to the denial of the application. Too often, it seems, applicants assume the Board is composed of unthinking, uncaring bureaucrats who cannot be trusted to judge applicants’ pasts fairly. My experience is that, for the most part, Board members’ attitudes reflect both the profession’s and society’s.

The application questions have undergone changes over the years and are now much narrower. Applicants are asked about impairments and recent illegal drug use, not about an occasional youthful indiscretion or the seeking of needed help.

What a sad thing it is for all involved for you to have embarked on the practice of so noble a profession in a way that continues to haunt.

James A. Wilson, JD
Director, NCMB Legal Department

Electronic Distribution Used for Some Forums, Bimonthly Board Action Reports, Immediate Action Notices

Forum

Beginning this year, the Forum is available to commercial organizations and a number of other groups and individuals only via the Internet. The North Carolina Medical Board’s Web site (www.docboard.org/nc) has been presenting the Forum, exactly as it appears in its printed form, since late 1998. To access it only requires the Adobe Acrobat Reader, which can be downloaded free at www.adobe.com, and the Board’s Web site provides a quick link to the Adobe site. Using the Adobe Acrobat Reader, the Forum can be easily read on screen and readily printed out. This has been the general public’s major access to the Forum for the past year or so. (Should you have trouble with this process, please contact Shannon Kingston of the Board’s Public Affairs Department. She can be reached by telephone at 1-919-326-1100, ext 271, or by e-mail at public.affairs@ncmedboard.org.)

This approach is the only effective way of dealing with the constantly growing demand for the Forum on the part of a very wide spectrum of readers. From a practical point of view, only so many copies of the Forum can be published and mailed each quarter. However, the electronic system allows those who have an interest in the Forum, the diverse articles and the data it presents, to receive it if they have access to the Internet in home, office, or library.

Bimonthly Board Action Reports and Immediate Action Notices

For over five years, the North Carolina Medical Board has been sending a Bimonthly Board Action Report, listing all its public actions relating to physicians, physician assistants, and nurse practitioners, to hospitals, medical groups, and the news media. It has also issued Immediate Action Notices for actions involving annullments, revocations, suspensions, summary suspensions, and license surrenders. These notices go out as soon as possible after the actions occur, not delaying until the next bimonthly release. Due to cost constraints, the Board has focused over these years on sending these materials only into those counties in which the involved physicians, PAs, or NPs actually practiced and to relevant state agencies. As with the Forum, which reprints the reports for statewide circulation, the Bimonthly Board Action Reports and the Immediate Action Notices have been appearing on the Board’s Web site (www.docboard.org/nc) since 1998. In fact, we are now posting a full year’s worth of the bimonthly reports, allowing the Web user to go back over the year’s activity. Anyone with access to the Internet can easily review these reports and notices: the public, hospitals, medical groups, the media, other state agencies, other states, etc.

Through the Forum, we have informed all the state’s hospitals, medical groups, news media, and relevant organizations that we would like to notify them by e-mail each time a new report or notice has been posted. This notification system would ensure quick statewide distribution of the material, not limited simply to the counties in which the involved practitioners may practice. Any hospital, medical group, newspaper or journal, television or radio station, or interested organization that makes its e-mail address available to us in writing or by e-mail will be made a part of this notification system. That will make it unnecessary for us to mail a printed copy of the particular Bimonthly Board Action Report or Immediate Action Notice to that institution, organization, or person, saving time and costs on both sides. Any eligible group wishing to participate in this system, should send the appropriate e-mail address, along with the name of the responsible person, and the name and address of the institution, organization, or other affiliation, to: Shannon Kingston, Public Affairs Department, North Carolina Medical Board, PO Box 20007, Raleigh, NC 27619; or e-mail the same information to Ms. Kingston at public.affairs@ncmedboard.org.
Part 1 of a Series

Medicine in Moldova: A Time of Transition
Morton Meltzer, MD

The medical mission of the North Carolina National Guard in Moldova is part of the North Atlantic Treaty Organization’s Partnership for Peace Program (PFP), which was launched by the January 1994 NATO summit meeting. The PFP is designed to establish strong links between NATO and its new democratic partners in the former Soviet bloc, links intended to provide a foundation for joint multilateral activities, such as humanitarian assistance, peacekeeping, and crisis management.

Twenty-seven nations, including Moldova, have joined the PFP. North Carolina is a partner of Moldova in the program and the North Carolina National Guard is the agency designated to implement that partnership. The National Guard’s medical efforts in Moldova, which will be expanded on in Part 2 of this series, reflect the value of the humanitarian aspects of the PFP. Better known, of course, is the NATO peacekeeping operation in Bosnia in which 13 PFP members worked side-by-side with the NATO allies.

My friend and colleague, Colonel Hector H. Henry, II, MD, a member of the North Carolina Medical Board and the North Carolina National Guard, made his first trip to Moldova in 1996, the second in 1997, and returned from his third trip on September 17, 1999. My first and second visits were in 1998. I made three more trips in 1999, the last with Dr Henry in September of that year. Moldova is one of the former Soviet Republics incorporated into the Soviet Union after WWII. Since gaining independence in 1991, the country has been struggling to survive and prosper. Medicine is practiced according to the Soviet model. During the span of our visits, Dr Henry and I have noticed changes that have enhanced the practice of medicine.

**Things as They Are**

Students enter medical school directly from high school and receive specialty training after graduation. During medical school, all students are instructed on military medicine. By ensuring that all physicians are familiar with military medicine, the state has a ready crisis management force.

In Soviet medical practices, patients are treated as inpatients with long hospital stays rather than as outpatients. However, outpatient care has recently become a topic of discussion for many Moldovan physicians. There is a move toward family medicine and multi-specialty clinics, as well as short-stay surgical centers. These new practices are privately owned or philanthropic enterprises. The Moldovan Academy of Sciences Preventive Medicine Center, GYNE Source of Reproductive Medicine, and the Central Military Hospital are a few of the facilities I had the opportunity to visit while in Chisinau, the capital city.

It is general knowledge that there are too many physicians in the country and all are employed by the hospitals. The World Health Organization made this point in a recent report. The problem is being addressed by the non-profit organization known as the National Centre of Public Health and Health Management. Dr Valeriu Sava heads this organization and is deeply interested in learning our system of managed health care and our fee-for-service system.

The Moldovan system is publicly run but there is a great need to expand into private enterprises. Dr Sava would like to develop outpatient programs to encourage physicians to move out of hospital practices and into the community. This move would require vast amounts of retraining for the physicians. Per capita, the number of physicians in Moldova is five times that of North Carolina. American expertise in outpatient care delivery would be most beneficial to the survival of Moldovan physicians.

Midwives play a prominent role in the health care system, however, physician assistants and nurse practitioners have not yet been utilized. At this time, adding another layer of health care professionals would only further burden an already saturated system.

At present, I have only seen one clinic that performed outpatient, same-day surgery. In the military and civilian arena, the norm for inpatient hernia repair is three to four days. The GYNE Clinic, which I mentioned previously, specializes in elective surgery in a Western-style setting and requires a four to five day stay for uncomplicated procedures such as hernia.

**Support for Change**

Many groups are attempting to assist the Moldovan medical community, the Baptists through the establishment of the Christian Clinic. Jewish Health International, under the guidance of Drs Stephen Kutner and Stephen Mackler, has placed two ophthalmologic lasers in one of the pediatric hospitals and the Republican Hospital. It has also put dental chairs in the Christian Clinic and

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**Medicine in Moldova**  
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the Central Military Hospital. It has helped arrange a fellowship for a pediatric neurologist at Bowman Gray, and he will be visiting shortly with a member of Bowman Gray’s medical staff who specializes in pediatric neurology. One of the largest donors of medical supplies has been Wake Medical Center in Raleigh. Its efforts and generous contributions were well received and greatly appreciated by the Moldovans.

One of the main difficulties facing Moldova is the difficult economic times that are the result of going from a controlled to a free market economy in a previously Communist country. This has left the country and the vast majority of its people without the finances to afford medications or medical care. Often the medical facilities cannot afford to stock even common drugs, therefore patients have to purchase them themselves. If they cannot afford the drugs, they do not get them. This also applies to medical equipment. Though the Republican Hospital was given an MRI machine, the hospital is so financially handicapped it cannot afford to purchase a disc to transmit an image to a Western consultant. Many procedures that are delegated to non-physician providers in the West are performed by physicians in Moldova. Despite all these hardships, there have been significant accomplishments.

**Accomplishments**

The Central Military Hospital used the barter system to transform five cinder block operating rooms into modern, tiled rooms. In exchange for the tiles, the hospital treated the employees of the donating company free of charge. Also, with the help of an auto body shop, the hospital refurbished operating room lamps into like new condition.

The Moldova Academy of Sciences Clinic has grown from four employees to 24 in just over seven years, and they accomplished this without government assistance. The Christian Clinic is moving into rehabilitation medicine and hospice, and is planning on opening two new facilities. The private school of dentistry in Chisinau is looking to develop a program of instruction for dental hygienists, which does not currently exist. The Medical University hopes to have assistance in preparing a training program for nursing. Many of the projects will be assisted by a grant administered by Dr. William Crowder, bringing together the University of North Carolina System with its counterparts in this nation. This will allow for an exchange of information and personnel to strengthen the alliance between us.

Future visits to the country will involve meeting with medical leaders in military, public, and private sectors. I wish to continue to work closely with the military physicians because their role covers both military and civilian disaster medicine. It is also very important to coordinate all our efforts with the minister of health and others in the Duma, since changes in legislation will be required.

In conclusion, as we move toward the close of the twentieth century and enter into the third millennium, so does Moldova. Much of this is the result of changes that occurred and are occurring in our health care delivery system. All institutions have to make decisions about where to send an elderly patient who cannot care for himself but refuses a nursing home. Determining competence to make decisions confronts both physicians and families. The

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**An Ethics Casebook for Hospitals**

George C. Barrett, MD  
Member, North Carolina Medical Board  
President, Federation of State Medical Boards

Ethics committees in hospitals have some of their roots in a decision by the New Jersey Supreme Court. In 1976, the court said Karen Quinlan could be disconnected from a respirator. In reaching that decision, the court found that when faced with terminally ill patients, many doctors chose not to prolong the process of dying but could not practice this humane approach openly. Fear of being sued or prosecuted caused them to make the decision “furtively, self-protectively, and, to that extent, nonobjectively.”

The court proposed that decision making should be divided beyond patient, family, and physician. Ethics committees composed of physicians, attorneys, social workers, and theologians should be established by hospitals. The New Jersey court said this would protect the physician by “diffusing responsibility.”

Teaching hospitals and large community hospitals did establish committees, and now the Joint Commission on the Accreditation of Healthcare Organizations requires them. Bioethics was the topic of the day from the mid-seventies to mid-eights. A flood of articles resulted on ethical principles that should be considered and met: autonomy, beneficence, nonmaleficence, and, at times, justice. Truth telling, informed consent, decision-making capacity, and end-of-life issues were enfolded as equally basic to academic centers and community hospitals. Much of this is the result of changes that have occurred and are occurring in our health care delivery system. All institutions have to make decisions about where to send an elderly patient who cannot care for herself or himself but refuses a nursing home. Determining competence to make decisions
Ethics Casebook

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authors of An Ethics Casebook for Hospitals: Practical Approaches to Everyday Cases, Mark G. Kuczewski and Rosa Lynn B. Pinkus, maintain that these problems are “the ‘stuff’ of clinical ethics across most of the country, but only rarely does it provide the focus for ethics casebooks.” This reviewer agrees.

An Ethics Casebook for Hospitals: Practical Approaches to Everyday Cases
Mark G. Kuczewski and Rose Lynn B. Pinkus
Georgetown University Press, Washington, DC, 1999
240 pages (appendix, bibliography, index) $23.95 paper
(ISBN 0-87840-723-5)

The book is organized in such a manner that it can be an easy reference source or a resource for teaching new ethics committee members, medical students, and residents. Its narrative format is an excellent example for students learning to prepare cases for presentation and includes materials that can assist in teaching case presentations. The authors encourage ethics committee members and students to use this book. However, the format requires some discussion to focus and clarify issues raised by each case, making the book less useful to individual physicians.

All the cases are from nonacademic hospitals. They are grouped into eight sections.
- Consent and Competence
- Advance Directives and Surrogate Decision Making
- Discharge Dilemmas
- The Family in Medical Decision Making
- Organizational and Institutional Ethics
- Rehabilitation Ethics
- Professional Responsibility: Employers, Colleagues, and Others
- AIDS: Problems of Confidentiality

It will be evident that there had to be some arbitrary assignment of some of these cases, for there is considerable overlap in these real situations as there is when one is confronting a problem on the ward.

The first case, “He Doesn’t Know what He’s Saying,” illustrates the format used for each case presentation. Key terms are: Competence to Give Informed Consent, Decision-Making Capacity, Advance Directives, Emergency Department Ethics.

The case is that of a 65-year-old married man who presented in the ER in acute respiratory distress. He had many previous admissions requiring ventilator support and his family said he had expressed strong feelings about being placed on a ventilator again. He was taken into the treatment room without the family.

The ER physician explained to the patient the need for the respirator and in the presence of nurses and respiratory therapists the patient nodded “yes.” Once informed of the intubation, the family became very upset.

The case report then defines the language and issues of the case, gives perspectives of the ER physician and the family, suggests possible alternative endings, and presents a commentary, some of which is from the useful bibliography presented.

Case four illustrates the importance of physicians being familiar with withdrawing and/or foregoing treatment. This case has many complex ethical questions: competence, possible physician assisted suicide, and “futility,” to name a few discussed. However, the physician was inexperienced in withdrawing treatment, uncomfortable with the concept. Asking for ethics consultation was important to him but viewed as an intrusion by the family. So bedside education (or a crash course in foregoing treatment, as described by the authors) was needed. This caused the family additional pain.

The multiplicity of complex issues surrounding advance directives and surrogate decision making is clearly presented, particularly in case seven. An 83-year-old woman is admitted after a stroke. She has advanced directives, however their clarity is in question, her competence is in question, and her daughter’s wishes are in question; and the health care team is conflicted with regard to appropriate management. The general principles guiding decision making in this type of case are defined, providing guidance for such cases in the future.

I found section seven, focused on professional responsibility, to be the least valuable for me. Conflicts among physicians are too circumscribed for the dynamics of professional conflicts.

Case twenty-two, “Who Pays? Hospital Coping Strategies in a Managed Care Environment,” is an excellent example of problem solving when physicians and institutional administrators appreciate the importance of communication. Today, institutions increasingly encounter financial problems that require sharing responsibility if a solution is to be found. The solution almost always requires shared concern by physicians and administrators for the institution’s survival and ability to continue its mission.

Case twenty-three, “Who’s in Charge? Managed Care and the Ethics Consultant,” addresses organizational ethics only casually. The focus of this case is centered around who informs the patient and/or the patient’s family when insurance coverage is no longer available. The setting is managed care. It seems improbable that the physician is unaware of this problem. It seems improbable that no one feels free to talk to the family; however that is this case and its dilemma.

Problems of confidentiality, particularly in case thirty, I found to be very helpful and rather poignant. It provides some guidelines for times when a breach of confidentiality may be an act of kindness and grace.

An Ethics Casebook for Hospitals: Practical Approaches to Everyday Cases is true to its title. It presents common cases with adequate history, focuses on the perspective of key persons involved, provides common sense solutions to the dilemmas posed. Throughout, a common thread is evident: communicating with patient, family, nurses, and other care givers by the physician is mandatory. Good communication obviates many problems and we are not consistently disposed to communicate with our patients or with those who provide care with us.

Since 1976, court decisions have emphasized the right of competent patients or their surrogates to determine their destiny. We can have respirators disconnected, feeding tubes removed, and expect adequate pain control from our physicians (who need not fear if unintended consequences occur). However, patients and all health care givers are still learning how to balance this autonomy and technology. We are also having to learn that death is not necessarily an enemy of our patients. Rather, death is the destiny each of us faces from the moment we are born. Autonomy can be a two-edged sword.

This casebook provides useful tips on dealing with autonomy and giving guidance to those who want to be in control. Physicians and other care givers need to be sensitive to subtle requests for help. In so doing, we become more than a case manager.

NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
November-December 1999/January 2000

DEFINITIONS

Annullment:
Retrospective and prospective cancellation of the authorization to practice.

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

Consent Order:
An order of 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. Information not available.

NCBP:
North Carolina Board of Psychology

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.)

ANNULMENTS
NONE

REVOCATIONS

BELTZ, Charles Robert, III, MD
Location: Athens, GA
DOB: 1/10/1964
License #: 0096-01224
Specialty: P/FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1994)
Cause: On the Notice of Charges and Allegations against Dr Beltz dated April 16, 1997. Dr Beltz pled guilty to and was convicted in Superior Court, Cumberland County, of soliciting to sell and deliver marijuana; in August 1983, he was convicted in Cumberland County of driving under the influence of alcohol; in September 1985, he pled guilty to and was convicted in District Court, Cumberland County, of carrying a concealed weapon; in April 1986, he was convicted in Cumberland County of lacking required vehicle liability insurance; in October 1987, January 1988, February 1988, and twice in October 1988, he was convicted in Cumberland County of operating a motorcycle without the required motorcycle endorsement; in October 1988, he was convicted in Cumberland County of driving with a revoked license; in March 1991, he was convicted in Lee County of failing to appear to answer charges. On his application for a resident's training license in 1994 and for a full medical license in 1996, he answered "no" to questions asking if he had ever been convicted of or pled guilty to a violation of a federal, state, or local law other than minor traffic violations. These answers were false.
Action: 12/16/1999. Findings of Fact, Conclusions of Law, and Order issued following a hearing in November 1999: Dr Beltz' license is revoked.

SUSPENSIONS
See Consent Orders:

BOSLEY, Larry Lee, MD
CARMICHAEL, Fletcher Eugene, Emergency Medical Technician-Intermediate

SUMMARY SUSPENSIONS
NONE

CONSENT ORDERS

BOSLEY, Larry Lee, MD
Location: Beverly Hills, CA
DOB: 9/19/1931
License #: 0096-01698
Specialty: D (as reported by physician)
Medical Ed: University of Nebraska (1956)
Cause: The Board finds and Dr Bosley admits that during the times relevant herein he was the majority shareholder and CEO of the Bosley Medical Group, that the Group owned and operated numerous clinics throughout the country specializing in hair restoration and scalp reduction procedures; that the California Board of Medical Doctors suspended his license for one year effective June 4, 1999; and the Board discovered that in numerous terms and conditions; that the discipline by California was based on allegations that Dr Bosley and others at his direction engaged in various deceptive and misleading practices in connection with the operation of the Group.
Action: 1/13/2000. Consent Order executed: Dr Bosley's North Carolina license is suspended for one year, effective June 4, 1999, said suspension being stayed for five years upon the Board's finding that the public health, safety, or welfare requires emergency action. Dr Bosley shall comply in all respects with the California Consent Order; he shall obtain and document to the Board 50 hours of Category I CME relevant to his practice each year; must comply with other conditions.

CARMICHAEL, Fletcher Eugene, Emergency Medical Technician-Intermediate
Location: Goldsboro, NC (Wayne Co)
DOB: 9/19/1966
Cause: Mr Carmichael knowingly submitted false information to the Office of Emergency Medical Services in conjunction with his application for certification as an EMT; he falsely certified he had not been convicted of any crimes, though he was convicted of felony embezzlement in 1998 and of felony financial card fraud in 1996. In both convictions, he was sentenced to 36 months supervised probation. He was suspended as an EMT Intermediate in the Wayne County ALS for 12 months effective October 31, 1998, but has been permitted to serve as an EMT Basic with the Wayne County EMS.

CROLAND, David Alan, DO
Location: Little River, SC
DOB: 11/27/1962
License #: 0097-01729
Specialty: FP (as reported by physician)
Medical Ed: Southeastern College of Osteopathic Medicine (1989)
Cause: To amend the Consent Order of 12/18/1997, which addressed the Consent Order between the South Carolina Board and Dr Croland dated 10/17/1996 in which he admitted (1) he furnished fraudulent information in orders and documents purporting to be prescriptions that were issued outside the reasonable bounds of a practitioner-patient relationship and for other than legitimate medical purposes, (2) he issued fraudulent documents for the purpose of obtaining fentanyl and other controlled substances for administration to himself, and (3) he furnished false and fraudulent material information to his medical records that indicated he administered fentanyl and other controlled substances to patients when he was actually using those substances himself. In May 1999, the Board amended his Consent Order to allow him to prescribe Schedule IIIN substances. He has asked the Board to allow him to dispense, administer, and prescribe controlled substances. It appears Dr Croland has complied with
the terms of his Consent Order and is doing well with his recovery and that this restriction is no longer needed.

Action:

1/04/2000. Consent Order executed: Dr Croland shall maintain and abide by a contract with the NCPHP, unless lawfully prescribed by Dr Pooles medical practice; that Dr Croland shall not consume alcohol, controlled substances, or any other abusable substances; and that Dr Croland shall determine if the Board's request, he shall supply bodily tissues or fluids for screening to determine if he has consumed alcohol, controlled substances, or other abusable substances; except as prescribed by his staff who have read this Cons commits to these terms for the purpose of his Consent Order to complete a “Staff Surveillance Form,” and these forms shall be forwarded to Dr Norris or his successor so they can be incorporated into his quarterly reports to the Board; during one week each quarter, Dr Poole or his staff will ask all mothers of pediatric patients seen by Dr Poole that week to complete a “Patient/Patient's Family Survey Form,” and these shall be forwarded to Dr Norris or his successor so they can be incorporated into his quarterly reports to the Board; Dr Poole shall undergo a polygraph examination to determine if he has been involved in sexual misconduct with patients of his pediatric patients or female staff member; and the results of these examinations shall be forwarded to Dr Norris or his successor so they can be incorporated into his quarterly reports to the Board; Dr Poole shall continue his therapy with Dr Norris or such other therapist as may be approved in writing by the Board on appeal.

MARTIN, Carol Ann, MD
Location: Raleigh, NC (Wake Co)
DOB: 10/14/1952
License #: 0094-00988
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1978)
Cause: Regarding the Notice of Charges against Dr Shah dated June 11, 1997, the Board finds and concludes that the Board has information that while seeing patients at his office, on at least five occasions, Dr Poole embarked, kissed, and otherwise touched mothers of his pediatric patients in a manner he should have known violated the boundaries of such mothers; that the Board has information that while at his office seeing patients, Dr Poole, on at least two occasions, sexually harassed certain staff members; that for the purposes hereof and without a hearing, the foregoing are deemed boundary violations with mothers of pediatric patients and sexual harassment of staff members. Dr Poole has obtained an assessment at the Behavioral Medicine Institute of Atlanta; following assessment, he attended and successfully completed eight weeks of cognitive-behavioral treatment at BMI with a strong relapse prevention component; he reports he plans to continue this treatment on an outpatient basis with Dr Norris.

Action:

1/04/2000. Consent Order executed: Dr Poole is reprimanded; he shall ensure a female chaperone, who has read this Consent Order, is present any time he examines a pediatric patient accompanied by the mother or other female person responsible for that patient; the chaperone shall co-sign and date each entry in the patient chart confirming she was present during the examination and no boundary violations or other misconduct occurred; Dr Poole shall post a copy of the “Principles of Medical Practice” on his office wall, on examination room walls, on the reception area wall, and any other places where it can be easily read by mothers of his pediatric patients or other adult persons responsible for the care of those patients; each month, he shall ask three members of his staff who have read this Consent Order to complete a “Staff Surveillance Form,” and these forms shall be forwarded to Dr Norris or his successor so they can be incorporated into his quarterly reports to the Board; during one week each quarter, Dr Poole or his staff will ask all mothers of pediatric patients seen by Dr Poole that week to complete a “Patient/Patient's Family Survey Form,” and these shall be forwarded to Dr Norris or his successor so they can be incorporated into his quarterly reports to the Board; Dr Poole shall undergo a polygraph examination to determine if he has been involved in sexual misconduct with mothers of his pediatric patients or staff members, and the results of these examinations shall be forwarded to Dr Norris or his successor so they can be incorporated into his quarterly reports to the Board; Dr Poole shall continue his therapy with Dr Norris or such other therapist as may be approved in writing by the Board on appeal.

REES, Perry, III, MD
Location: Cary, NC (Wake Co)
DOB: 8/17/1958
License #: 0094-00988
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1978)
Cause: Regarding application for reinstatement of his license placed on inactive status due to Dr Reese's failure to return his registration form and fee to the Board in a timely manner. Dr Reese has had two previous Consent Orders with the Board (6/04/1996 and 3/19/1998); he failed to register his license while practicing pursuant to the 3/19/1998 Consent Order.

Action:

11/01/1999. Consent Order executed: Dr Reese is issued a temporary license to expire on the date shown on the license (6/03/2000); he shall ensure that a female chaperone is present when he examines a female patient and that the chaperone co-sings and dates each entry in the patient chart; he shall present a copy of this Consent Order to all current employers and to any future employers prior to beginning work; he shall maintain 60 hours of relevant CME each year, at least 30 of which shall be Category I; must comply with other conditions.

SHAH, Nandlal Chimanlal, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 7/03/1933
License #: 0000-23759
Specialty: PMR (as reported by physician)
Medical Ed: Medical University of South Carolina (1976)
Cause: Regarding the Notice of Charges against Dr Shah dated June 11, 1997. The Board finds and Dr Shah admits, that Dr Shah was convicted in February 1997 of 11 misdemeanor counts of unlawful possession of controlled substances and was sentenced to five years probation, a fine, and community service; in August 1999, Dr Shah's probation officer petitioned the U.S. District Court for summonses, believing Dr Shah had violated his probation by distributing controlled substances; after discussions with the assistant U.S. attorney about the alleged probation violation, the Board and Dr Shah agreed to resolve the Notice of Charges of 1997 by Dr Shah surrendering his North Carolina medical license and any other medical licenses he may have in the U.S. and by his agreeing never to reapply in any U.S. jurisdiction for any sort of medical or health care license.

Action:

11/24/1999. Consent Order executed: Dr Shah surrenders his medical license effective December 31, 1999; he shall also surrender by the same date any medical or other health occupation license he may have in any other U.S. jurisdiction; he shall immediately begin an orderly wind down of his practice without adversely affecting the continuity of care of his patients; he shall not apply to the Board or any other similar agency in any jurisdiction in the U.S. for any medical or other health occupation license; must comply with other conditions.

YOUNG, Jeffrey Dale, Emergency Medical Technician-Paramedic
Location: Dunn, NC (Harnett Co)
DOB: 6/03/2000
License #: 0094-00988
Specialty: EMT-P (as reported by physician)
Medical Ed: Emergency Medical Institute of Alabama (1998)
Cause: Regarding application for certification as an EMT-P. Mr Young is an Advanced Life Support Professional previously certified as an EMT-P in Cumberland County, in 1994, while working as an EMT-P in Cumberland County, he responded to a call concerning a patient in respiratory distress and was directed by a physician to give the patient a certain dosage of Lasix; despite the direction, Mr Young gave the patient twice the dosage ordered; he then recorded in the Ambulance Call Report only the dosage originally ordered; his misadministration of the drug and his falsification of the report constitute unprofessional conduct; as a
result, Mr Young was discharged from participation in the Cumberland County Advanced Life Support Program in 1999. He did not function in any Life Support Program for at least a year, he has been permitted to function as an EMT-Basic volunteer with the Harnett County EMS Program since 1996; he has told the Harnett County ALS Program of his unprofessional conduct; he has been offered a position as an EMT-P with the Harnett County ALS Program subject to completion of a remediation program and monitoring of his performance.

**Action:** 11/18/1999. Consent Order executed: Mr Young is certified an EMT-P effective 12/01/1999 on the following terms—he shall work as an EMT-P only in Harnett County or other settings approved in writing by the NC Office of EMS; he shall have an EMT-P preceptor and shall ride with another EMT-P until 6/01/2000 or until he has completed 50 calls; he shall assure that for each call a copy of the Ambulance Call Report is provided to the Medical Director; if he should make an error in administration of care or in medication, he shall bring it to the immediate attention of his supervisor, with written documentation; by 6/15/2000 and 12/15/2000, he shall cause the Medical Director who monitored his performance to submit a summary of his calls and performance to the NC Office of EMS; must comply with other conditions.

**DENIALS OF LICENSE/APPROVAL**

**FINKEL, Richard Frederick, MD**
Location: Boca Raton, FL  
DOB: 10/26/1939  
License #: None  
Specialty: D (as reported by physician)  
Medical Ed: State University of New York, Buffalo (1966)  
Cause: Dr Finkel failed to satisfy the Board he is qualified for a license; the Board was not satisfied that he is of good moral character; he engaged in immoral or dishonorable conduct within the meaning of NC law; he engaged in unprofessional conduct within the meaning of NC law; he was convicted of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a felony; he obtained or attempted to obtain practice, money, or anything of value by false representation; and he had a medical license acted against by another jurisdiction.

**Action:** 11/29/1999. Dr Finkel’s application for a medical license is denied.

**NORRIS, Dolly Frances, MD**
Location: Winterville, NC (Pitt Co)  
DOB: 10/03/1966  
License #: 0096-01782  
Specialty: GP (as reported by physician)  
Medical Ed: Uniformed Services University of the Health Sciences (1992)  
Cause: On Dr Norris’ application for reissuance of her license. She was previously licensed in November 1996, but that license was annulled by the Board in July 1998. She first applied for reissuance of her license in October 1998. That application was denied in July 1999. She then applied in July 1999, and the Board denied that application in August 1999. She requested a hearing on the matter in August 1999. In connection with her first application to the board, she filed forged letters of recommendation; she also gave false answers to questions regarding actions taken against her in a residency program; she was denied a license in the state of Utah in 1996, a decision that was reaffirmed in 1997. At her hearing before the Board in November 1999, she presented no evidence of any reformation of her character since the incidents mentioned above. She has apologized, but shows no remorse and remains unrepentant, blaming others for her conduct. She is more recalcitrant than before and is not of good moral character.

**Action:** 12/16/1999. Findings of Fact, Conclusions of Law, and Order issued following a hearing in November 1999: Dr Norris’ application for a medical license is denied.

**WILLIAMS, David Randall, MD**
Location: Hendersonville, NC (Henderson Co)  
DOB: 1/10/1950  
License #: 0000-51218  
Specialty: U (as reported by physician)  
Medical Ed: University of South Alabama (1982)  
Cause: Dr Williams failed to satisfy the Board of his qualifications in that he has engaged in unprofessional conduct as set forth in the Consent Order of 5/04/1999.

**Action:** 10/29/1999. Dr Williams’ application for a medical license is denied.

**DENIALS OF RECONSIDERATION/MODIFICATION**

NONE

**SURRENDERS**

**FELDMAN, Armin Ira, MD**
Location: Littleton, CO  
DOB: 8/06/1949  
License #: 0000-33819  
Specialty: P (as reported by physician)  
Medical Ed: University of Wisconsin (1975)  

**GRAFF, Arthur Leonard, MD**
Location: Belhaven, NC (Beaufort Co)  
DOB: 9/21/1944  
License #: 0093-00707  
Specialty: PS (as reported by physician)  
Medical Ed: State University of New York Health Sciences Center (1969)  

**INJEIKIAN, Jirair Alexan, MD**
Location: Shelby, NC (Cleveland Co)  
DOB: 8/20/1936  
License #: 0000-16390  
Specialty: ABS/TS (as reported by physician)  
Medical Ed: American University of Beirut, Lebanon (1962)  

**KILGORE, Larry Charles, MD**
Location: Fayetteville, NC (Cumberland Co)  
DOB: 12/29/1950  
License #: 0000-26580  
Specialty: FP (as reported by physician)  
Medical Ed: University of Arkansas (1981)  

**RIDDLE, William Mark, MD**
Location: Greenville, NC (Pitt Co)  
DOB: 3/20/1956  
License #: 0000-39871  
Specialty: FP/EM (as reported by physician)  
Medical Ed: East Carolina University School of Medicine (1985)  

**SHERMAN, Randall Lester, MD**
Location: Elizabeth City, NC (Pasquotank Co)  
DOB: 6/15/1949  
License #: 0000-33891  
Specialty: NS (as reported by physician)  
Medical Ed: University of Oklahoma (1978)  

**WHITE, Ricky Allen, Physician Assistant**
Location: Clinton, NC (Sampson Co)  
DOB: 3/15/1970  
License #: 1-02358  
PA Education: University of Texas (1997)  

See Consent Orders:  
**SHAH, Nandital Chimanlal, MD**

**CONSENT ORDERS LIFTED**

**ADAMS, Beverly Jean Shakelford, MD**
Location: Cary, NC (Wake Co)  
DOB: 11/11/1945  
License #: 0000-25974  
Specialty: FPS/OTO (as reported by physician)  
Medical Ed: Duke University School of Medicine (1976)  

**BROWN, David Houston, MD**
Location: Raleigh, NC (Wake Co)  
DOB: 12/11/1945  
License #: 0000-28623  
Specialty: ADM/EM (as reported by physician)  
Medical Ed: Universidad Autonoma Guadalajara (1976)  

**GORDON, Gene Stephen, MD**
Location: Farmington, CT
DOB: 1/15/1947  
License #: 0000-20546  
Specialty: FP/PM (as reported by physician)  
Medical Ed: Duke University School of Medicine (1972)  

MASSEY, Howard Todd, MD  
Location: Durham, NC (Durham Co)  
DOB: 1/12/1963  
License #: 0098-01708  
Specialty: TS/GS (as reported by physician)  
Medical Ed: Medical College of Georgia (1990)  

POWELL, Thomas Edward, MD  
Location: Durham, NC (Durham Co)  
DOB: 7/11/1964  
License #: 0098-00439  
Specialty: GP (as reported by physician)  
Medical Ed: University of Texas, San Antonio (1995)  

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

ADAMS, Beverly Jean S., MD  
Location: Cary, NC (Wake Co)  
DOB: 11/11/1945  
License #: 0000-25974  
Specialty: FPS/OTO (as reported by physician)  
Medical Ed: Duke University School of Medicine (1976)  

BEDINGTON, William David, Physician Assistant  
Location: Conover, NC (Catawba Co)  
DOB: 11/14/1959  
License #: 0001-02534  
PA Education: Butler University (1998)  

BREWER, Thomas Edmund, MD  
Location: High Point, NC (Guilford Co)  
DOB: 11/04/1956  
License #: 0000-28141  
Specialty: GP (as reported by physician)  
Medical Ed: Bowman Gray School of Medicine (1983)  

BROWN, David Houston, MD  
Location: Raleigh, NC (Wake Co)  
DOB: 12/11/1945  
License #: 0000-28623  
Specialty: ADM (as reported by physician)  
Medical Ed: Universidad Autonoma Guadalajara (1976)  

CHEEK, John Christopher, MD  
Location: New Bern, NC (Craven Co)  
DOB: 3/03/1957  
License #: 0097-01906  
Specialty: N/CN (as reported by physician)  
Medical Ed: University of North Carolina School of Medicine (1984)  

FREIBERGER, John Jacob, MD  
Location: Chapel Hill, NC (Orange Co)  
DOB: 1/04/1952  
License #: 0000-27912  
Specialty: P (as reported by physician)  
Medical Ed: University of Texas, Southwest (1979)  

GALEA, Lawrence Joseph, MD  
Location: Charlotte, NC (Mecklenburg Co)  
DOB: 10/19/1948  
License #: 0000-20746  
Specialty: FP/GP (as reported by physician)  
Medical Ed: University of Cincinnati (1980)  

GREGORY, Ginger Dobins, Physician Assistant  
Location: Fuqua-Varina, NC (Wake Co)  
DOB: 8/30/1963  
License #: 0001-01410  
PA Education: Bowman Gray School of Medicine (1991)  

HALL, Jesse McRae, Physician Assistant  
Location: Olivia, NC (Harnett Co)  
DOB: 6/23/1956  
License #: 0001-01830  
PA Education: Fort Sam Houston (1991)  

HARRIS, Donald Philip, MD  
Location: Greensboro, NC (Guilford Co)  
DOB: 11/20/1954  
License #: 0000-13127  
Specialty: ORS (as reported by physician)  
Medical Ed: University of North Carolina School of Medicine (1961)  

HOLTKAMP, John Harry, MD  
Location: Raleigh, NC (Wake Co)  
DOB: 6/11/1941  
License #: 0000-16400  
Specialty: HS/GS (as reported by physician)  
Medical Ed: University of Florida (1964)  

KEEVER, Richard Alan, MD  
Location: High Point, NC (Guilford Co)  
DOB: 11/14/1959  
License #: 0000-21048  
Specialty: AN (as reported by physician)  
Medical Ed: Bowman Gray School of Medicine (1969)  

LOVE, David William, MD  
Location: Clyde, NC (Haywood Co)  
DOB: 8/31/1960  
License #: 0000-31326  
Specialty: FP (as reported by physician)  
Medical Ed: University of Florida (1984)  

LOWE, James Edward, Jr, MD  
Location: Asheboro, NC (Sampson Co)  
DOB: 12/05/1950  
License #: 0000-37887  
Specialty: HS/GS (as reported by physician)  
Medical Ed: Meharry Medical College (1975)  

LOWE, James Edward, Jr, MD  
Location: Roseboro, NC (Sampson Co)  
DOB: 12/05/1950  
License #: 0000-37887  
Specialty: HS/GS (as reported by physician)  
Medical Ed: Meharry Medical College (1975)  

MEAD, Robert J., MD  
Location: Asheboro, NC (Randolph Co)  
DOB: 12/13/1945  
License #: 0000-32790  
Specialty: PD/PDA (as reported by physician)  
Medical Ed: Jefferson Medical College (1978)
North Carolina Medical Board
Meeting Calendar, Application Deadlines, Examinations
May 2000 -- March 2001

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

No. 1  2000

North Carolina Medical Board
May Meeting Deadlines:
Nurse Practitioner Approval Applications April 10, 2000
Physician Assistant Applications May 9, 2000
Physician Licensure Applications May 9, 2000

North Carolina Medical Board
July Meeting Deadlines:
Nurse Practitioner Approval Applications June 5, 2000
Physician Assistant Applications July 5, 2000
Physician Licensure Applications July 5, 2000

North Carolina Medical Board
September Meeting Deadlines:
Nurse Practitioner Approval Applications August 7, 2000
Physician Assistant Applications September 5, 2000
Physician Licensure Applications September 5, 2000

North Carolina Medical Board
November Meeting Deadlines:
Nurse Practitioner Approval Applications October 2, 2000
Physician Assistant Applications October 31, 2000
Physician Licensure Applications October 31, 2000

North Carolina Medical Board
January Meeting Deadlines:
Nurse Practitioner Approval Applications December 11, 2000
Physician Assistant Applications January 9, 2001
Physician Licensure Applications January 9, 2001

North Carolina Medical Board
March 21-24, 2001
March Meeting Deadlines:
Nurse Practitioner Approval Applications February 5, 2001
Physician Assistant Applications March 6, 2001
Physician Licensure Applications March 6, 2001

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.
The North Carolina Medical Board recommends at least 150 hours of continuing medical education every three years. Meanwhile, you should know that the Board's proposed CME rules have not been implemented as yet. Check the next number of the Forum for details on the final CME rules and the Board's program for their implementation.

Questions about license registration? Ask by e-mail and receive a prompt answer! Sonya.Darnell@ncmedicalboard.org

Coming soon! On-line registration! Information about this new system will be mailed to all licensees as soon as the system is operational.

Want to know when to expect your certificate after you mail in your registration? Most certificates are mailed two to three weeks after receipt of the form and fee. Want to know when the Board received your registration material? Go to the Board's Web home page and click on Registration in the site menu. After you receive your registration material, go to the Board's Web home page, where you will be able to check the date of receipt of your registration material. Meanwhile, you should know that the Board's proposed CME education will be mailed to all licensees as soon as the system is operational.

Important Information

Licensee Registration:

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

Full Legal Name of Licensee:__________________________________________
Social Security #:_______________________License/Approval #:______________________

Business:____________________________________________________________________
Business:____________________________________________________________________
Business:____________________________________________________________________
Phone:(______)_________________________Fax:(_______)____________________________

Home: ______________________________________________________________________
Business: __________________________________________________________________
Phone:(______)_________________________Fax:(_______)____________________________

Phone:(______)_________________________Fax:(_______)____________________________

Check preferred mailing address:
Business
Home

License/Approval #:__________________________________________________________
Social Security #:_____________________________________________________________
Name of Licensee:______________________________________________________________
Date:______________________________

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