Is Professionalism in Medicine on a Slippery Slope?

Let me answer the question posed in my title right away: I do think professionalism in medicine is on a slippery slope! What do you really think? I know some of our readers will disagree, perhaps even feel that the author is from a generation past that doesn’t fully comprehend what it is like to practice today in a corporate, competitive era; that cannot grasp the societal and economic forces that have warped the practice of medicine, in some cases, into something scarcely recognizable by our forebears. Responses to this piece from our readers, in the form of letters to the editor, would be particularly welcome as we assess whence we have come and where we are headed.

Now, some cases in point.

Advertising

The North Carolina Medical Board’s Position Statement on Advertising and Publicity allows for advertising that is not misleading and does not portray unrealistic outcomes. Have you seen ads that scoff at this admonition, eg, those that appear to offer unrealistic cosmetic perfection? Are there not medical advertisements that imply specialty training or board certification not possessed; that suggest that the physician’s training, skills, or experience are superior to their colleagues?

Communication

The vast majority of patient complaints to the North Carolina Medical Board relate to a perceived failure to communicate effectively: arrogance, aloofness, a seeming lack of interest or ability in explaining an illness or its treatment in lay terms (without being condescending). Most worrisome of all are allegations of loss of control. I believe we continued on page 2

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License Portability

I know it is a selfish thought, but every time I sit down in an airplane seat, I hope and pray that the person sitting next to me is continued on page 3
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would all agree that abusive, foul language directed at patients is unprofessional no matter how provoked. Patients will readily accept the physician's designee to communicate details and answer most questions. However, a few minutes spent listening with genuine empathy, truly connecting with the patient with eye, voice, and body language, personally conveying a commitment that the patient's concerns will be truly and competently addressed not only increases the likelihood of a satisfactory outcome; it makes the doctor's day more satisfying, encourages compliance, and mitigates against patient attitudes conducive to complaints to the Board and litigation.

Scope of Practice

A disturbing trend recently observed has been for some physicians to exceed their customary scope of practice. When the Board grants a full and unrestricted license to practice medicine and surgery, the ethical burden to practice within one's scope, based on adequate training received from professionally accepted sources, lies squarely with the practitioner. Did that weekend course by the manufacturer of the device really prepare the physician to undertake this new procedure, heretofore well outside the customary scope of his or her practice?

Collegiality

Item V of the American Medical Association's Principles of Medical Ethics states: "A physician shall continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated." As part of its recently implemented CME requirements, the Board has made consultation eligible for Category 2 credit. Would you be shocked to learn that more than a few consultative reports to referring physicians not only do not reflect a willingness to teach, but consciously withhold information so that a perceived or suspected competitor will not be able to use it in his or her practice? All too often, physicians are noted to be groundlessly accusing a colleague of unethical surgery, of stealing a technique, of being too eager to take risks. It is one thing to criticize or to report aberrant behavior when it is in the best interest of the patient. It is another entirely when it is a matter of defending one's turf.

New Challenges

The practice of physicians who offer both medical care and non-health related goods and services for sale from their office or from an adjacent facility has become a matter of concern to state medical boards due to the potential for patient exploitation. The Board's position statement on this subject (Sale of Goods from Physician Offices) attempts to provide guidance on such practices, recognizing the legitimate need to supply medically necessary goods when incidental to quality patient care, but frowning on such practices when blatantly pursued for financial benefit to the physician.

Another troubling contemporary issue is the use of the Internet to prescribe drugs and counsel patients. Your Board has now issued guidelines on this subject (Contact with Patients Before Prescribing), which should be carefully adhered to by North Carolina's physicians. (Legislation on this subject is also pending in the North Carolina General Assembly.)

Conclusion

The North Carolina Medical Board, the Federation of State Medical Boards, the American Medical Association, the American Osteopathic Association, and professional and specialty societies all strive to embrace and/or promulgate standards that will maintain a high level of medical professionalism. However, only our licensees themselves can realistically determine whether medicine will remain an honored profession or become a trade. Clearly, we need to be highly adept at leaving the many aggravations we now face in our practices out in the hallway before opening that door behind which our patient waits. As the future of medicine passes from my generation to that which follows, physicians have the opportunity and responsibility to determine the level of professionalism that will characterize that future. ♦

North Carolina Medical Board

1-800-253-9653
A Trip to Useless
continued from page 1

not talkative. I prefer to use this time to catch up on work or to read, usually the latter. In this particular instance, however, I was woefully behind in my e-mail (I had 80 unanswered messages in my notebook computer), and I had an overdue report I had promised to the Medical Board, so I was not in a particularly chatty mood. However, the person sitting next to me was. He was an engineer, and when he saw the nature of the work on my notebook, he wanted to talk about licensure. Engineers have licensing boards that in some states are under the same organizational umbrella as medical boards. He was a sole proprietor, providing consulting engineering services to clients all over the country. Thus, he found it necessary to have 30 different state licenses. It did not matter to me that he was licensed in a different field; his problems as a licensee were universal and applied to the professionals we license: physicians, physician assistants, and nurse practitioners. Imagine, if you will, the daunting task of keeping up with 30 different licenses. Thirty different agencies of state government are involved. That would include 30 different application processes, 30 different application fees, 30 different registration forms, and almost 30 different continuing education requirements, depending on whether or not all the boards required continuing education. This engineer had no employees. It occurred to me he needed an employee just to keep up with his licenses.

I found this contact particularly timely, inasmuch as the purpose of my meeting at the FSMB was to serve on an Executive Directors Advisory Council currently charged to explore mechanisms for enhancing license portability. Also attending the meeting was the assistant executive director of the North Carolina Medical Board, Diane Meelheim. She serves by virtue of her role as president of the Administrators in Medicine, the national organization of medical board executives. In addition, a Special Committee on License Portability was appointed by the then president of the FSMB, George Barrett, MD. Dr Barrett is a member of the North Carolina Medical Board. As you can see, we are heavily invested in licensing issues outside our borders. We feel this is vitally important because these issues directly impact the people we care most about, the citizens of North Carolina.

FSMB’s Role
The Committee on Portability is but a small part of the corporate effort of medical boards to reach across licensing borders and design a better mousetrap through the FSMB. Other activities include developing an international licensing community through more formal organization of licensing boards across international borders, developing improved communication between state boards to further reduce the opportunity for questionable doctors to move from state to state, developing minimum standards for office-based surgery, and the topic of the meeting I was attending, developing a more portable license. This is not an exhaustive list of topics of concern to our corporate licensing community. These are just some of the topics generating the most immediate work. Any one of these topics should be of eminent concern to both licensing boards and consumers.

For example, on the issue of office-based surgery, the pressure of cost containment is driving some medical procedures formerly reserved for hospitals and other licensed facilities into the less costly office environment. As we examine this process, we find patients exposed to increased risk as a result of getting anesthesia in an office. Put simply, there is moderate risk of anesthesia complications in any setting, but the risk is ratcheted up in an office that is not as well equipped as a hospital or outpatient clinic to deal with these complications. This is one of many important consumer issues of national, not just local, interest.

Need to Adapt
The topic for this latest trip, however, was license portability. The marketplace in medicine has changed, thus affecting the mobility of medical board licensees. As managed care develops, physicians are much more mobile and are much more likely than in years past to be working in several different states. The Department of Defense has downsized its medical resources, and is, therefore, looking for ways to train its medical staff and to provide medical care to military personnel and their dependents through non-military facilities. This provides another pressure point for portability. Our particular licensing system in North Carolina was one of the first, having been established in 1859. Back then, county borders were often designed so the county seat was no more than a one day ride by horseback for any citizen. Interstate medical practice only occurred in border towns. Now we have people who practice their profession in 30 or more different states. We see these professionals in medicine as well as engineering. Things have changed a lot since 1859 and, like everyone else, we need to adapt. We need to come together as a national licensing community and find better ways to do what we do. Consider that our U.S. nursing boards have developed interstate compacts that are spreading rapidly and that our friends in Australia have a successful mutual recognition system among their states. We need a workable portability plan for medicine in this country.

Thomas W. Mansfield, JD, New Director of NCMB’s Legal Department

In April 2001, Thomas W. Mansfield, JD, joined the staff of the North Carolina Medical Board as new director of the Board’s Legal Department. He comes to the Board after 12 years of private practice covering a variety of practice areas. From 1996 until joining the Board, he was a partner in the Cary, NC, firm of Mansfield, Kochanek & Zillioux. During that time, he represented individuals in tort litigation, business disputes, and claims against employers, and in licensing matters before various administrative agencies. He also represented health care providers in administrative matters, business disputes and transactions.

A native of Cary, NC, Mr Mansfield graduated from North Carolina State University in 1985 with a degree in English and took his JD from the University of North Carolina School of Law in 1989.

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Before starting his own firm in 1996, Mr Mansfield spent time acting as a consultant for a large legal and business publishing and technology company.

Conclusion
As you can see, Useless is not really useless. All in all, it is an important place, and this is why we invest our time and effort in its work. We encourage our readers to similarly invest through us.

This publication is called the Forum, and that is exactly what it is. If you feel like sounding off about national issues involving medical licensure, we encourage you to do so through your own Medical Board and the pages of this publication. This is a role, among our others, we feel is important to us. We invite your participation.

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Reexamining the Doctor-Patient Relationship

John T. Klimas, MD
President, Mecklenburg County Medical Society

Sadly, managed care and other factors have altered medical practice to such a degree that the very essence of good medical care, a close and caring relationship between a doctor and a patient, may be headed for the endangered species list.

Decline of an Ideal

Never before has the nature of the doctor-patient relationship been considered a postscript in the practice of medicine. The Hippocratic Oath and Credo, written 2,500 years ago, urged physicians, as their primary duty—actually, their sacred duty—to serve their patients. We, as physicians, are clearly in a servant role. While patients may choose to leave a physician, generally speaking, it is not the prerogative of a physician to abandon his or her patient unless under extreme circumstances.

In a lecture and subsequently published essay delivered in 1926 to a medical school class at Harvard, Dr Francis Peabody outlined principles of good patient care. In dealing with patients, a doctor should individualize care and get to know the patient as completely as possible.

“The practice of medicine in its broadest sense includes the whole relationship of the physician with his patient. It is an art, based on an increasing extent on the medical sciences, but comprising much that still remains outside the realm of a science.”

He adds, “The essence of the practice of medicine is that it is an intensely personal matter. . . . The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases, both diagnosis and treatment are directly dependent on it.”

Dr Peabody also warned against the dehumanization process involved with hospitalizing a patient. And in the final section of his essay, he notes that special care and explanation be given those patients for whom no organic disease can be detected, that emotional stress and strain may be causing problems.

As far back as 1859, Dr James Bigelow described the duties of an attending physician in the care of terminal patients. He wrote of the responsibilities of physicians to diagnose, treat, relieve symptoms, and, especially with very ill patients, provide “safe passage.” By safe passage, he meant a doctor’s support and ready availability to a dying patient.

While warm, humanistic doctor-patient relationships may have flourished for a time in the practice of American medicine, they as a rule, no longer exist. Doctors and patients will probably agree there has been a marked deterioration in this formerly sacred relationship in the past 10 to 15 years. In my view, this disruption has been abetted by a number of outside factors:

- managed care and corporate medicine;
- the development and widespread use of the Internet;
- direct-to-consumer advertising by pharmaceutical firms.

Managed Care

Considering the doctor-patient relationship as influenced by managed care, it is an undisputed fact that most patients can’t afford to pay out of pocket for health insurance; therefore, they are at the mercy of their employer’s choice for coverage. When health care costs rise, corporations shop around for the best buy and frequently change plans or carriers annually. A patient is offered the option of choosing a primary care physician from a list of plan physicians, as if it were a lottery pick. Obviously, it’s difficult to establish a relationship with a patient/doctor, and maybe even pointless if next year the names on the MD lottery list change because insurance affiliation changes. Revolving-door medicine does not enhance the patient-doctor relationship.

Beyond that, no longer does the dual relationship of doctor and patient exist; it has been replaced by what Dr Kevin Vigilante terms “a triadic relationship.” The physician is no longer employed by the patient, but by a corporation. As such, the doctor has two responsibilities: he or she must care for the patient, but must also practice in such a way as to meet financial objectives imposed by the organization, whether it be a managed care corporation or hospital-owned corporate entity.

Also, restrictive managed care plan measures that are explicit or implicit include the pressure to see more patients in less time and perform somewhat restricted diagnostic testing.

The Internet

Who could have anticipated that the Internet would change how doctors and patients interact? As more patients surf the “Net” seeking information about disease or treatment, they digest information that may or may not be accurate. Not every patient can tell the difference! There is no doubt that because of the Internet and other media resources, people are becoming more sophisticated about medicine. Information empowers a patient to become a more equal partner in making health care decisions. This is not a bad thing, but it does affect the nature of interaction between physician and patient, and sometimes it sets up a contest of wills.

Another side effect of the Internet is that it has become a major advertising and information source for alternative medicine, not to mention a sales tool for marketing vitamins and herbal and so-called natural products that promise everything from weight loss to sexual potency. No wonder alternative medicine is a multi-billion dollar industry!

Reading the often unsubstantiated claims, patients buy the products. Physicians, who are trained in traditional methods and treatment, are largely ignorant of holistic or herbal therapy claims, yet they are increasingly dealing with patients who are self-medicating themselves.

Ironically, alternative medicine providers cultivate an image of the individual that is concerned about the wellness of the whole continued on page 5
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person, contrasting their caring approach with the impersonal, rushed, greedy physician.

Direct-to-Consumer Advertising
Direct-to-consumer advertising by pharmaceutical companies, while alerting people to certain medical products or diseases, has also interfered with the doctor-patient relationship by inverting the normal process by which a patient is seen and treated.

On greeting the doctor, a typical patient who has viewed a medical ad will often say, “Hi, Dr Smith. You know, I saw an ad last night on TV about product X. Do you think I should take it for my condition?”

Instead of the usual method of first taking a history, discussing symptoms, conducting a physical examination, and ordering appropriate laboratory testing to confirm a diagnosis, the patient peremptorily jumps to treatment options for a presumed medical condition. Does the physician then become the purveyor of the newest drugs? Does the physician prescribe a medication or does he or she allow the patient to dictate the course of treatment?

What’s a physician of the 21st century to do?

Adapt to a Changing World
Well, realizing that it is a permanently changed world, and assuming that managed care is here to stay, the modern day doctor must adapt. Since the idealistic Peabody approach to fully knowing a patient is unattainable, we must try in the limited time available to get to know our patients as best we can. This means not only taking a history and eliciting symptoms, but also delving into a person’s family life and employment, which can often be stressful and directly impact disease and treatment.

There is no room for Dr Arrogant Know-It-All or Dr God-Like Figure. We must now partner with our patients in medical decision making. Patients today are much more sophisticated and armed with knowledge. Our job, as experts in health care and medicine, is to present the relevant data and options so that the patient can decide on a course of treatment that is most acceptable to him or her. Often, the patient will still defer to us for advice, but we are still obligated to inform the patient completely.

We, as physicians, must learn more and keep abreast of alternative medical methods and treatments. Some research has been done in the past, but more needs to be done, especially in confirming or validating the clinical effectiveness of drugs, vitamins, etc. Little is known about the interactions of natural drugs/products and prescription drugs, and more studies are needed.

Continue to Serve Patients Well
And finally, in this age of managed care, with all its restrictions and hassles, we must become the patients’ advocates so they can get the best care or treatment available. It may mean extra time, extra telephone calls, or extra forms, but we owe it to our patients.

While Hippocrates could never have envisioned the modern day practice of medicine, it is still incumbent on us as physicians to serve our patients well—to practice the best medicine we can under the conditions of managed care and to serve our patients well in any way, shape, or form. The deterioration of the doctor-patient relationship must not continue.

Reprinted with permission from Mecklenburg Medicine, April 2001, a publication of the Mecklenburg County Medical Society.

Licensure by Examination: USMLE Step 3 Taken Under North Carolina Law
Tammy L. O’Hare  
NCMB Licensing Department

There are two ways to obtain a full and unrestricted medical license in the state of North Carolina: by examination and by endorsement. This is a brief description of the procedures for obtaining a license by examination (USMLE Step 3) in North Carolina. This is intended as an overview and does not contain detailed requirements. A list of requirements, along with the request form for the applications packet, can be found on the North Carolina Medical Board’s Web site at www.ncmedboard.org/usmleapp.pdf.

Applications Packet
We suggest an applications packet be requested at least four (4) months before you expect to take the examination. The packet contains application forms for both the North Carolina full medical license and the USMLE Step 3 examination. The examination, which is computerized, is given on a daily basis and can be taken within a three (3) month eligibility period assigned to you by the Federation of State Medical Boards (FSMB). You must complete and submit application forms for both the full license and the examination to the North Carolina Medical Board for its approval.

You will be notified when your applications are complete. Completion constitutes receipt by the Board of completed application forms, all required credentials, and any additional information requested by the Board. It is your responsibility to follow-up with the Board’s office regarding the status of your application materials.

Once the Board approves your application for examination, the USMLE Step 3 form is sent to the FSMB. The FSMB will take four (4) to six (6) weeks to process the application form before your Scheduling Permit is mailed to you with instructions for making an appointment at a testing center.

After you have taken the examination, the FSMB notifies both you and the Board of your scores. Applicants with passing scores are advised by a letter from the Board of the final documentation needed in order to process the application for a full medical license. Upon receipt of these materials and any additional information the Board may request, you will be advised in writing of when your license application will be presented to the Board. You will receive your license number 15 or more days following the Board’s final approval of your application for a license.

If you pass the examination and elect to wait to obtain your full license until a later date, you may have to update portions of your license application. Please send an e-mail to tammy.o hare@ncmedboard.org requesting an update packet. Include your current address in your e-mail.

Licensure by Endorsement
Those applicants who take USMLE Step 3 directly through the FSMB or under the auspices of another state, will need an application for licensure by endorsement. Please e-mail license@ncmedboard.org to request an application packet for licensure by endorsement.

DEA to Provide Speakers
The U.S. Drug Enforcement Administration has announced that it is offering to provide speakers for meetings and training sessions related to federal drug regulations, including the prescribing of opioids and other topics of interest to physicians. Resources available for this program are limited, however, and those societies, organizations, and groups interested in taking advantage of this opportunity should make inquiries as soon as possible.

Contact Robert C. Williamson, Diversion Program Manager, U.S. Drug Enforcement Administration, 75 Spring Street, SW Room 740, Atlanta, Georgia 30303. Telephone (404) 893-7136.
There have been over 400 recognized homicides of North Carolina children killed by caregivers since 1985. These fatalities do not include deaths from neglectful actions such as a drowning due to lack of supervision. This significant cause of child mortality and major public health problem gets little attention due, in part, to public and professional unwillingness and inability to believe parents and other caregivers kill their children. These murders occur in our state with a frequency of two to three each month. Therefore, it is important for physicians and other medical providers to understand the characteristics of child abuse homicides. In this report we describe our ten-year review, 1985 through 1994, of homicides of North Carolina children under the age of eleven.

**Methods**

The North Carolina Medical Examiner (ME) System investigates and certifies all homicides of North Carolina children killed (Herman-Giddens & Zolotor, 1997). Cases were characterized as “abuse” or “non-abuse” according to this definition, or “undetermined” if there was insufficient information to make a determination. The 17 cases given an undetermined status were not included in the analysis. Perpetrators were identified where possible using several data sources.

North Carolina population numbers were used as a reference. According to the United States Census, in 1990, 69% of North Carolinians under 11 years of age were white, 28% black, and 3% other minorities.

**Results**

During the 10-year period from 1985 through 1994, there were 16,800 deaths of North Carolina children ages 10 and under; thus, the 259 homicides comprised 1.5% of the total mortality. Child abuse accounted for 84.9% (220/259) of all child homicides (Herman-Giddens, et al, 1999). Twenty-two child homicides (8.5%) were not abuse related (Figure 1). (Eleven of these 22 children were killed by persons known to them, though not caregivers at the time.) The 10-year rate for child abuse homicide was 2.2 per 100,000 children. Annual rates increased during the 10-year period from 1.5 per 100,000 children to 2.8, a mean increase of 12.3 % (95% confidence interval, 3.0%-21.6%) per year (Figure 2). Homicides per 100,000 by age were 10.6 for infants (<1 year of age), 2.4 for children 1 through 4 years of age, and <1 for children ages 5 through 10.

**Perpetrators.** The accompanying Table shows the distribution of the assailants. Male caregivers were responsible for 65.5% (n=133) of the murders of the 203 child abuse cases where the perpetrator was known. Sixty-seven of the male perpetrators were the child's father, 37 were the mother's boyfriend, 8 were stepfathers, and the other 21 were male relatives, sitters, or acquaintances. Female perpetrators were responsible for 34.5% (n=70) of the cases. Sixty-one of the female perpetrators were mothers, 5 were baby-sitters, and 4 were female relatives or friends. The identity of the perpetrator was unknown in the remaining 17 cases. Overall, one or both biological parent(s) comprised 63% (n=128) of the known perpetrators in the study period. For the study population as a whole, only 3% (n=10/259) of the homicides were committed by strangers.

**Age and gender.** Children ages 3 and under comprised the majority of abuse homicides (Figure 3). Children under the age of one year were at highest risk for child abuse homicide, making up 47% (n=103) of the child abuse homicide population. Further breakdown under one year of age shows that within the first year of life very young infants are at particular risk, with peaks at one day, 2 months, and 3 months of age (Figure 4). It is important to note that after the first day of birth, the period at most risk for homicide is also that for SIDS.

Homicides of newborns were generally childbirth-related cases where the child was unwanted and the mother denied her pregnancy.

Male and female victims were nearly equally represented at 52% (n=113) and 48% (n=105) of the abuse cases, respectively. African-American children were overrepresented in the child abuse homicide group, making up 54% (n=118) of the abuse cases.

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**Figure 1. Type of homicide by abuse classification for children 0 through 10 years of age, NC residents, 259 cases, 1985-1994.**

**Figure 2. Child abuse homicide rates per 100,000, NC, 1985-1994.**

**Figure 3. Age of child abuse homicide victims in years, NC, 1985-1994.**

**Figure 4. Age and gender.** Children ages 3 and under comprised the majority of abuse homicides (Figure 3). Children under the age of one year were at highest risk for child abuse homicide, making up 47% (n=103) of the child abuse homicide population.
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but only 28% of the population under the age of 11 years in North Carolina.

Methods. Blunt force injury was the most common cause of death, occurring in 43% (n=94) of the child abuse homicide cases (Figure 5). Less common, but still significant, were shaking, 14% (n=30); asphyxia (including suffocation and strangulation), 12% (n=26); firearms, 9% (n=20); and drowning, 6% (n=12). Almost one-half of the firearm homicides were homicide-suicide incidents involving parents and were frequently related to domestic quarrels or custody disputes. Combination methods were used in 4% (n=8) of the cases. For example, in one case the child was strangled with an electrical cord and then stabbed.

Discussion

The findings of this study are based on the analysis of all 259 cases classified as homicides as to manner of death of North Carolina resident children less than 11 years of age over a 10-year period. The rise in rates of child abuse homicides in North Carolina over the study period reflects a national trend (US Advisory Board, 1995). This rise is particularly disturbing given the emphasis on prevention programs over the last two decades. There is no reason to believe that North Carolina has higher rates than other states, but actual comparisons cannot be made due to lack of data. The United States has higher rates of homicide, as well as child homicide, than any other studied industrialized country (Williams & Kotch, 1990). This may reflect, in part, a societal tolerance of filicide or of homicide in general and is in need of further study.

Whether killed by a caregiver or not, we found 97% of the children were killed by relatives or other persons known to them. That at least 85% of all homicides of young children can be categorized as involving abuse is critical information for the initial death investigation as well as for development of prevention strategies and the pursuit of justice. Biological parents accounted for the majority (63%) of the perpetrators of fatal child abuse, a finding that may be contrary to general professional or lay belief. Males were also found to be more likely to kill children in their care than females. The fact that infants and toddlers represent the most likely age groups in childhood at risk for murder has been well documented in other studies (Abel, 1986; Ewigman, Kivlahan & Land, 1993).

Strangers were responsible for only 3% of all child homicides in this 10-year period. Thus, professions responding to child homicides and the public need to be aware that the primary suspect in such cases is likely to be a parent or male known to the child and that homicides by strangers, though they tend to be highly publicized, are quite uncommon.

African-American children were three times more likely than white children to die at the hands of their caregivers. This apparent racial disparity is probably a reflection of socioeconomic status and bears further exploration. Nelson, in a North Carolina study of all deaths among poor children as compared to non-poor, found that poor whites actually had higher mortality rates than poor blacks (Nelson, 1992). Poor children died at three times the rate of the non-poor for all causes of death.

Information on the victim’s child protective service history, socioeconomic status, and medical history was not available. In addition, we made no attempt to identify missed homicides, but only included those classified as homicides by manner of death.

Conclusions

Rising rates of child abuse fatalities denote a serious problem in our culture and one that disproportionately affects African-American children. It is likely that socially and economically disadvantaged children are at increased risk of fatal maltreatment regardless of racial or ethnic background.

The findings from this study indicate that males and caregivers of children under one year of age are more likely to fatality abuse children and, therefore, need to be targeted in prevention efforts. Medical professionals, the public, and law enforcement officers need a heightened sensitivity to the reality that most victims of child homicide are killed by parents or parent-figures. Medical professionals involved with sudden, unexpected deaths of young children also need to be aware that young children killed by shaking, beating, or asphyxiating will often have no external signs of injury. This knowledge could and should lead to increased involvement of medical examiners, ordering of autopsies, and increased reporting of possible maltreatment to law enforcement and child protective agencies. Reporting in a timely fashion is also essential.

The need to devise primary strategies for the prevention of child homicides and child abuse atemement is urgent. A Nation’s Shame: Fatal Child Abuse and Neglect in the United States (1995) discusses some of the reasons for and results of our continued blindness to the tragic reality that very young children in this country are more likely to die from being murdered or from fatal neglect by their caregivers and others known to them than from falls, automobile crashes, hazardous toys and products, fires, suffocation, drowning, or choking—all of which continued on page 8

Table. Relationship of probable perpetrator, when known, by gender, to child abuse homicide victim.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological parent (mother or father)</td>
<td>67 (33.0)</td>
<td>61 (30.0)</td>
</tr>
<tr>
<td>Sitter</td>
<td>1 (0.5)</td>
<td>5 (2.5)</td>
</tr>
<tr>
<td>Other relative or friend</td>
<td>20 (9.9)</td>
<td>4 (2.0)</td>
</tr>
<tr>
<td>Stepfather</td>
<td>8 (3.9)</td>
<td>0</td>
</tr>
<tr>
<td>Mother’s boyfriend</td>
<td>37 (18.2)</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>133 (65.5)</td>
<td>70 (34.5)</td>
</tr>
</tbody>
</table>

Figure 4. Age of child abuse homicide victims less than one year of age, NC, 1985-1994.

Figure 5. Method of homicide in child abuse to children ages 0 through 10, NC residents, 1985-1994.

* Poison (2), Starvation (2), Sharp Instruments (7), Unknown (19)
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continued from page 7

receive more public attention and prevention efforts than fatal child abuse and neglect.

Acknowledgements: I am grateful for the support of the Governor’s Crime Commission and the Injury Prevention Research Center: 1) “Supported by Federal Formula Grant 180-194-D1-H015, awarded by the Bureau of Justice Assistance, US Department of Justice through the North Carolina Department of Crime Control & Public Safety/ Governor’s Crime Commission. Points of view or opinions contained within this document are those of the authors and do not necessarily represent the official position of policies of the US Department of Justice.” 2) This research was supported in part by grant number R49-CCR402444 from the Centers for Disease Control and Prevention, Atlanta, GA., to the Injury Prevention Research Center, University of North Carolina.

I am also grateful for the support of the NC Child Advocacy Institute that allowed further development of the Child Homicide Project. In addition, I thank the other authors of the Child Homicide Study and original paper from the study (JAMA, 1999): Gail Brown, MD, MPH, Sarah Verbiest, MSW, MPH, Pamela J. Carlson, RN, MPH, Elizabeth G. Hooten, MSPH, Eleanor Howell, MS, and John D. Burts, MD.

References


For more information or questions or comments, contact: North Carolina Child Advocacy Institute, 311 East Edenton Street, Raleigh, North Carolina 27601; (919)834-6623, ext 232; www.ncchild.org.

Preventing Foodborne Illness Through Irradiation

J. Newton MacCormack, MD, MPH
Head, General Communicable Disease Control Branch,
Epidemiology, Division of Public Health, NCDHHS

While somewhat controversial, irradiation of certain foods as a safeguard to prevent foodborne disease is now a reality. The process involves exposing raw food to radiation to kill bacteria and parasites. This treatment leaves no residue, and long-term studies have proven that it is a safe and effective means of preventing foodborne illness. Irradiation has been used successfully on poultry, fruits, and spices, and, this past December, the U.S. Department of Agriculture joined the U.S. Food and Drug Administration in approving the sale of irradiated ground beef.

Food safety relies on establishing multiple barriers against disease transmission. Thus, irradiation does not replace requirements for sanitary food processing plants or the need for proper food storage and handling. However, it does reduce the risk of disease should one or more of those other safeguards fail. The outbreak of Escherichia coli 0157:H7 disease traced to a fast-food restaurant in the Pacific Northwest a few years ago left four children dead after eating hamburgers. Sanitation and monitoring procedures should not have allowed the ground beef to become contaminated, and proper cooking of the hamburger patties at the restaurant would have killed the E. coli bacteria. Both of those barriers failed. Irradiation of the ground beef kills such pathogens and provides another barrier against disease transmission. Widely used, irradiation will safely and reliably prevent a great deal of foodborne illness at very low cost.

Not all foodborne pathogens are susceptible to control by irradiation. While this technology works well for such organisms as campylobacter, cryptosporidium, E. coli, listeria, salmonella, and toxoplasma, it does not kill bacterial spores nor does it work well against viruses like the hepatitis A virus and Norwalk-like viruses. Another problem is that the irradiation process causes wilting of leafy vegetables and sprouts. These disadvantages, however, should not deter its use where appropriate.

There are interesting parallels between irradiation and the advent of pasteurization some 100 years ago. There was a prolonged period when the public was uninformed about the benefits of pasteurization and was suspicious that it might harm their health or reduce the nutritional value of the milk. The vast majority of the public now recognizes raw milk as a potential health threat, and regulations prohibit the retail sale of non-pasteurized milk. Notwithstanding, the use of pasteurization has not diminished the need for sanitation in dairies or proper storage of milk. The public was slow to accept pasteurization at least partially because public health authorities did not advocate its use. That is not the case with irradiation. The American Medical Association, the World Health Organization, the American Dietetic Association, the Centers for Disease Control and Prevention, and a variety of other organizations endorse irradiation as a means of preventing foodborne illness.

From EpinoNotes, Vol. 44, No. 3, the NC Department of Health and Human Services Division of Public Health. ♦

New FDA Publication on Foodborne Illness Available

A major part of the National Food Safety Initiative is the education of physicians in the diagnosis and treatment of foodborne illness. The Food and Drug Administration, with the American Medical Association, the Centers for Disease Control and Prevention, and the U.S. Department of Agriculture, has developed an educational tool on foodborne illness for physicians. Called Diagnosis and Management of Foodborne Illness: A Primer for Physicians, this publication is intended to provide physicians with current guidelines for the diagnosis, treatment, reporting, and prevention of foodborne illness. It also provides physicians with information for patients on prevention of foodborne illness.

The Primer includes presentations of patient scenarios and clinical vignettes. It also offers information on clinical considerations: tables on foodborne illness with summaries of clinical and diagnostic considerations; laboratory tests and treatment of bacterial, viral, parasitic, and noninfectious causes of foodborne illness; current suggested food safety resources and reading lists; and patient education information on prevention of foodborne illness. There are 3 hours of CME credit offered after submission of the related examination to the CDC/MMWR.

A free copy of the Primer can be obtained from the FDA’s Center for Food Safety and Applied Nutrition. Requests can be faxed to 1-877-866-3222. An electronic version is available on the CDC’s Web site at www.cdc.gov/mmwr/cme/conted.html. ♦
Reporting Domestic Violence When the Victim Is Your Patient

James A. Wilson, JD

The Forum has published several pieces lately on domestic violence. These implore physicians to take a more active role in helping patients who are victims. There is quite a bit physicians can do, and the Forum articles offer many suggestions and resources. One thing, though, physicians generally should not do when treating patients who are victims of domestic violence is take it upon themselves to call the police. Surprised?

The General Rule

The general rule for medical practice is that the things a patient tells a physician when seeking medical care and the things the physician observes about the patient, are confidential. Physicians generally may not voluntarily disclose these things without the patient’s consent. The American Medical Association’s Code of Medical Ethics, Current Opinion 5.05, says:

The information disclosed to a physician during the course of the relationship between physician and patient is confidential. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.

The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities. Also, communicable diseases, gunshot wounds andknife wounds should be reported as required by applicable statutes or ordinances. A physician who does otherwise could be in trouble with the Board and could be liable to the patient.

Exceptions

So what are some of North Carolina’s laws requiring or permitting physicians to report things that would otherwise constitute confidential patient information?

Physicians generally must disclose patient information if ordered to do so by a court or certain governmental agencies, including the Medical Board. Physicians generally must permit the execution of search warrants. Physicians generally may not disclose patient information in response to an attorney-issued subpoena without patient consent or a court order.

Physicians are required to take steps when they reasonably believe that their patients are likely to hurt themselves or others. Physicians are required to report child abuse and disabled abuse. Physicians are required to report to law enforcement every case of a bullet wound, gunshot wound, powder burn or any other injury arising from or caused by, or appearing to arise from or be caused by, the discharge of a gun or firearm, every case of illness apparently caused by poisoning, every case of a wound or injury caused, or apparently caused, by a knife or sharp or pointed instrument if it appears to the physician or surgeon treating the case that a criminal act was involved, and every case of a wound, injury or illness in which there is grave bodily harm or grave illness if it appears to the physician or surgeon treating the case that the wound, injury or illness resulted from a criminal act of violence.

Even over patient objection, physicians must report certain communicable conditions, deaths resulting from violence, poisoning, accident, suicide, or unexpected or unusual causes, deaths of migrant workers, fetal deaths, and cancer. Physicians are permitted, but not explicitly required, to report their patients who should not be driving.

Things a physician learns apart from a physician/patient relationship generally are not covered by physician/patient confidentiality, and the physician has the same duty to report things as any other member of the public. When a physician learns something troubling about a colleague, at least one who is not the physician’s patient, the physician may have a duty to act, including, if necessary, reporting the matter to an appropriate authority.

The Board’s Position Statement Professional Obligation to Report Incompetence, Impairment, and Unethical Conduct in this circumstance.

Conclusion

A physician is allowed to report an incident of domestic violence without the patient’s consent only in limited circumstances. Confused? This article has touched on only the highlights. Confidentiality of patient information is a complicated area of law and a sensitive subject. New federal rules may be in effect soon. Well intended as these are, expect a considerable burden complying with them. To learn more, contact your attorney or your malpractice insurance company.

Notes

i. N.C. GEN. STAT § 8-53.
ii. Id. § 90-8.

v. N.C. GEN. STAT. § 122C-261 (involuntary commitment); In re Farron, 41 N.C. App. 680, 255 S.E.2d 777 (1979) (patient confidentiality does not apply to involuntary commitment proceedings); Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (physicians have a duty to warn intended victims when patients make credible threats of harm).


vii. N.C. GEN. STAT. § 108A-102. Subsection (c) provides immunity for persons reporting in good faith and without a malicious purpose.

viii. Id. § 90-21.20. Subsection (d) provides immunity for persons reporting in good faith.

ix. Id. §§ 130A-135, 130A-143, 130A-395(a); N.C. Admin. Code tit. 15A rr. 130A-383.

x. N.C. GEN. STAT. § 130A-383.

xi. Id. § 130A-418(a).

xii. Id. § 130A-114.

xiii. Id. § 130A-209.

xiv. Id. § 20-9.1.


James A. Wilson is a lawyer in private practice in Durham. Formerly director of the Legal Department of the North Carolina Medical Board, he now represents physicians and others in occupational licensing and related matters. This article is provided as general information and should not be construed as legal advice on specific factual scenarios.
The Pain & Policy Studies Group: Past, Present, and Future

David E. Joranson, MSSW, Senior Scientist and Director; Pain & Policy Studies Group
Jessica A. Nischik, Policy Specialist, Communications Coordinator; PPSG

Establishment of the PPSG

Formerly, the PPSG was the Division of Policy Studies at the University of Wisconsin Pain Research Group. When that group relocated in 1996 to the University of Texas M.D. Anderson Cancer Center in Houston, Joranson and staff decided to start a new organization, the PPSG, at the University of Wisconsin Medical School to continue their work, including the evaluation of state policies regarding pain management and the expansion of educational and policy activities with state medical boards. With support from the Project on Death in America, Advocates for Children’s Pain Relief, the Robert Wood Johnson Foundation, and unrestricted educational grants from industry, the PPSG soon established itself as a pain and policy research organization.

Building on and expanding the past work of its staff, the group developed several projects that addressed policy issues in the United States. With the Federation of State Medical Boards, the PPSG sponsored a re-survey of state medical board members’ knowledge and attitudes toward the use of opioid analgesics for chronic pain treatment and conducted more workshops on pain management for medical board members. Other work included a similar survey of Wisconsin pharmacists, a Resource Guide providing basic information about pain policy (controlled substances and professional practice policies affecting pain management), and a project with state and national drug regulatory authorities and members of the pain community to improve communication about prescription monitoring programs.

The communications component of the PPSG program was also developing. Soon after its founding, the group launched its own Web site, which included a database of state pain policies in the U.S. and an extensive bibliography containing the full text of many PPSG publications. The Web site has been steadily expanded and is found at www.medsch.wisc.edu/painpolicy.

In 1996, the PPSG was also designated a World Health Organization Collaborating Center, which included the continuing publication of its WHO newsletter, Cancer Pain Release, with Sophie M. Colleau, PhD, remaining as editor. In addition, the PPSG continued its efforts to provide assistance to governments in Asia, Europe, and Latin America, and established a WHO Demonstration Project in Calicut, India. The project undertaken by the group that had the broadest international reach was the drafting of new WHO Guidelines for national governments to use to evaluate their narcotic control policies to determine the presence of impediments to opioid availability. In 1999, the PPSG hosted an international working group in Madison to review the draft guidelines. The participants came from India, Italy, China, Nigeria, Saudi Arabia, the WHO, the Pan American Health Organization, and the International Narcotics Control Board. The group endorsed the Guidelines and the WHO issued them in 2000.*

The PPSG Today

The PPSG has reached an important point in its development as a viable research and communications organization. In the last year, it has published three articles in peer-reviewed journals and developed several tools to be used to improve national and state policies affecting pain management, which can all be found on its Web site.

In August 2000, a milestone in state evaluation of pain policy was published. Achieving Balance in Federal and State Pain Policy: A Guide to Evaluation uses criteria based on the internationally recognized principle of “balance” to evaluate for the first time U.S. federal and state laws, regulations, and other official policies affecting pain management. “Balance” refers to government’s obligation to prevent misuse and diversion of controlled substances while at the same time ensuring their availability for medical use.

The PPSG published Trends in Medical Use and Abuse of Opioid Analgesics in the

*continued on page 11
April 5, 2000, issue of the *Journal of the American Medical Association*. The study found that in 1996 the class of opioid analgesics accounted for just 3.8% of all national drug abuse. For the period 1990-1996, there was a substantial increase in the medical use of fentanyl (1168%), hydromorphone (19%), morphine (59%), and oxycodone (23%). At the same time, their abuse remained low and stable (each drug was determined to be less than 1% of national drug abuse for each year of the study period).

The PPSG survey of Wisconsin pharmacists’ knowledge and attitudes toward the use of opioid analgesics for chronic pain was published in the March/April 2001 issue of the *Journal of the American Pharmaceutical Association*. The study found that in the context of federal and state controlled substances policies, most pharmacists would dispense correctly, but there is a significant number who might fail to dispense a valid opioid prescription to patients with pain due to problems in knowledge and attitudes. The results have been shared with pharmacy groups in the state, and efforts are underway to improve Wisconsin pharmacists’ understanding of pain management and requirements for prescribing, dispensing, and managing controlled substances.

The PPSG analysis of changes in medical board members’ knowledge and attitudes toward the use of opioid analgesics for chronic pain treatment was published in the March 2001 issue of the *Journal of Pain and Symptom Management*. The article reports on two studies. The first compared the results of a 1997 survey of state medical board members’ knowledge and perceptions about opioid analgesics with a similar survey conducted in 1991. The other study reported on changes in knowledge and attitudes of those state medical regulators who participated in PPSG educational workshops conducted in 1998, which were much like the workshop conducted with the North Carolina Medical Board in 1996. Both studies found significant and lasting improvements in the knowledge, attitudes, and beliefs of state medical board members.

A key component of the group’s work in the U.S. is the on-line database of regularly updated state pain policies. The database includes state statutes, regulations, and other official policies affecting pain management. It is organized in a user-friendly manner by state and type of policy and can be found at or through the PPSG home page.

Internationally, the PPSG has represented the WHO to improve pain relief and opioid availability in a number of countries in the world. The PPSG and the Pan American Health Organization organized the first international workshop to implement the new WHO Guidelines. The workshop was held in December 2000 in Quito, Ecuador; participants represented six countries from the Andean region of Latin America. Narcotic regulators met with pain and palliative care experts from their own countries to develop action plans to improve the availability of opioids for cancer pain relief and palliative care.

The PPSG is also publishing the results of its work with the Government of India and a WHO Demonstration Project in Calicut, India, to improve the availability of and access to opioid analgesics. The PPSG has been working for the last five years in India to develop a model state rule to simplify India’s narcotic regulations. The PPSG and Indian colleagues organized a series of eight state workshops to encourage adoption of the simplified regulations. The workshops brought together representatives from government, cancer control, palliative care, and education to simplify opioid licensing requirements and to foster cooperation between government and health care professionals. The PPSG has developed relationships with key national and state government officials, including the Narcotics Commissioner of India and members of the Department of Revenue and the Ministry of Health, as well as many dedicated health care practitioners, including those in the Indian Association for Palliative Care and regional cancer centers. The PPSG believes that these efforts will help to establish a national infrastructure for ensuring opioid availability and enhancing the health priority of pain management and palliative care in India.

The PPSG report *Improving Cancer Pain Relief in the World: 1997-1999* gives details of its international work; it is available on the PPSG Web site.

The PPSG in the Future

At the top of the group’s list of priorities is to update its *JAMA* article on use and abuse of opioid analgesics. Recognizing that medical use and abuse of some medications has increased since 1996, the PPSG plans to update this study when the 2000 data become available. This information takes on particular significance in light of recent concern about the diversion and abuse of pain medications.

PPSG also plans to develop a “report card” which will rank states according to the quality of their pain policies.

In addition, the group would like to continue its work with state licensing boards to improve and then communicate policies that encourage pain management, addressing regulatory barriers to pain relief while discouraging misuse and diversion.

Internationally, the PPSG plans to continue organizing national and regional workshops in other parts of the world to put the new WHO Guidelines into action. The PPSG will continue its efforts to assist the government of India with the hope of establishing a lasting infrastructure to ensure the availability of opioids for pain relief and palliative care.

The PPSG plans to continue working toward achieving its mission to promote “balance” in international, national, and state policies to ensure adequate availability of opioid analgesics for patient care while addressing diversion and abuse; and to support a global communications program to improve access to information about pain relief, palliative care, and related policy.
Sex with Patients? Physicians Should Know Better
Edward E. Hollowell, JD, and William E. Parker, III, JD

The physician-patient relationship is the “linchpin” between physicians and their patients and patients and their physicians. Because both physician and patient are involved in the physician-patient relationship, violating patient boundaries can jeopardize patient care and the physician’s ability to practice medicine. Although certain boundaries in the physician-patient relationship are defined by custom, laws, and regulations, some boundaries may be defined by common sense. The challenge facing every physician is to know the appropriate boundaries for each aspect of the physician-patient relationship. Thus, the burden for knowing about and complying with boundaries is borne solely by the individual physician.

Mutual trust forms the cornerstone of the physician-patient relationship. Patients must know that their needs are paramount. Physicians and their patients act on the trust and confidence they have in each other, which is founded on the physician-patient relationship.

Through its Position Statements, the North Carolina Medical Board has provided both general and specific guidelines that, if strictly observed, should protect physicians from overstepping the boundaries and the relative “safety” that the boundaries provide.

In May 2000, the Board published an expanded version of its Position Statement on the Physician-Patient Relationship, first adopted in 1995, saying that the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on mutual trust, is considered sacred. The Board further elaborated that the crucial elements of the physician-patient relationship, and the inherent underlying trust, include communication, patient privacy, confidentiality, competence, patient autonomy, compassion, selflessness, and appropriate care, all of which should always be foremost in the hearts, minds, and actions of physicians.

Because of the unique relationship between physicians and their patients, one aspect of the human experience that frequently invites violation of established boundaries is that of inappropriate sexual contact and intimacy. It is more than obvious that sexual interactions between physicians and their patients detract from the goals of the physician-patient relationship. Bringing sexual conduct into the physician-patient relationship may:

- exploit the patient’s vulnerability;
- obscure the physician’s objective judgment concerning the patient’s health care; and
- be detrimental to the patient’s well-being.

The Board’s Position Statement on Sexual Exploitation of Patients is clear and unequivocal: the Board will not tolerate a physician entering into a sexual relationship with a patient, consensual or otherwise. Such behavior and conduct is extremely unprofessional and provides a basis for suspension or revocation of a physician’s license. The Board extends this position to apply to midlevel health care providers, including physician assistants, nurse practitioners, and EMTs. Disciplinary actions taken by the Board, which are part of the public record, are posted on the Board’s Web site, published in the Board’s Forum, and released to the media, to state and federal governments, and to medical and professional organizations.

Besides being violative of the Board’s Position Statements, inappropriate sexual conduct is prohibited by the American Medical Association’s ethical guidelines. Such conduct by physicians may open a physician to civil suits or possible criminal liability if minors are involved.

Guidelines that prohibit sexual contact between health care providers and patients often rely on the argument that such relationships violate ethical principles of respect for both autonomy and beneficence. Although some may argue that a patient’s valid consent for a sexual relationship with a physician overrules such principles, mutual consensual participation will never excuse a physician’s duty to adhere to professional ethical standards of conduct. Professional virtues such as self-effacement and self-sacrifice always obligate the physician to set aside any personal feelings and forego acting on feelings of sexual attraction toward patients.

Since erotic feelings sometimes arise in physician-patient relationships, despite prohibitions against sexual involvement between physicians and patients, what can the prudent physician do to protect the physician-patient relationship? Consider the following:

- consciously establish behavioral limits for your professional relationships;
- examine your own sexual feelings rationally, and respond to a patient’s sexual overtures in a firm but nonjudgmental manner.

If such steps do not work, the provider should seek appropriate consultation and terminate the professional relationship, especially if sexual feelings create an imminent compromise of a patient’s care.

One of the most basic precautions that a physician can take to avoid baseless allegations of improper sexual contact is to always have another person in the examination room when examining a person of the opposite sex. By adhering to this practice without deviation or compromise, physicians will eliminate virtually all of the opportunities to become inappropriately involved with a patient. (For further insight on this issue, see the Board’s Position Statement on Guidelines for Avoiding Misunderstandings During Physical Examinations, first adopted in 1991 and revised in early 2001.)

Although much of this discussion has focused on, presumably, violations of sexual boundaries in the physician-patient relationship between adults, it is important to consider other types of relationships. The relational boundaries between the physician and the patient have been expanded to include other patient family members as well. The Committee on Bioethics for the American Academy of Pediatrics has stated that pediatricians must also strive to maintain appropriate professional boundaries in their relationships with patients’ family members. The Academy insists that pediatricians should avoid any type of behavior that patients and parents might misunderstand as having sexual or inappropriate social meaning.

Compliance with boundaries in physician-patient relationships begins with a knowledge of what the boundaries are. If you are “fuzzy” on what constitutes appropriate behavior, a review is in order. A firm personal commitment to refraining from exceeding established boundaries is the key factor in maintaining appropriate relationships. Finally, avoiding situations that may create opportunities for inappropriate sexual contact is crucial. In the event an unexpected or unforeseeable situation presents itself, physicians in such a situation should, having recognized the dangers, “flee,” because any improper involvement or behavior resulting in a sexual boundary violation can cause irreparable devastation to physicians personally, their families, and, ultimately, their professional careers.

Revised from an article by the same authors in the Medical Law Alert, a newsletter published by Hollowell, Peacock & Meyer, PA, Attorneys and Counselors at Law, Raleigh, NC.
Killing a Panda

Walter J. Pories, MD
Vice President, NCMB

Now don’t get me wrong. I was delighted to learn that the Washington Zoo got those new pandas. Who wouldn’t be charmed by those cuddly black and white creatures?

It was a cool move. Suddenly attendance at the zoo was up; kids got their pictures in the paper; and the sales of souvenirs exploded. A celebration of life, of respect for endangered species. A noble performance.

Or was it really all that noble? I’ll let you judge for yourself. You might recall that these were not our first pandas. No, there was another pair, given to commemorate President Nixon’s historic trip to China. One of those bears, Ling-Ling, lived on, but recently, as he developed kidney failure in 1992. Hsing-Hsing, the other, became too busy to be burdened by the sick, the confused, and those old folks with the sores, the bad smells, and the incontinence?

We have taken the highest oath that anyone is ever privileged to take. We have promised our patients that we would be there to protect them, to do our best for them, to be their succor of last resort.

We must fight this passing fad of “humane euthanasia.” We cannot fall for this lie that somehow, with tortured logic, tells you that killing a patient is for his own good.

When our patients hurt, let’s give them drugs to relieve the pain. When they are dry, give them fluids. When their guts are in knots, relieve the obstruction. Most important, when they are frightened, listen, listen, and listen some more.

In that relief, in that support of families, and in that return to God, we too will be saved and refreshed. We will be reminded, again and again, why being a doctor is such a gift.

(Adapted from a “Pearls” presentation given to the graduating class at East Carolina University School of Medicine, April 2001.)

USMLE Step 3 Passing Score Is Raised

At its March 2001 meeting, the United States Medical Licensing Examination Step 3 Committee increased the minimum three-digit scaled score required to pass Step 3 from 177 to 182. This marks the first increase in the Step 3 minimum since 1997. The new minimum passing score of 75/182 will be applied to all Step 3 examinees who test on or after April 1, 2001.

In reaching its decision, the Committee considered information from multiple sources, including survey results from various groups concerning the appropriateness of the current pass/fail standards for Step examinations; trends in examinee performance; score precision and its effect on the pass/fail decision; and recommendations from physicians who participated in content-based, standard-setting activities early in 2001.

All state medical boards were contacted and representatives from 14 boards participated in the standard-setting process.

The USMLE program periodically reviews the minimum passing score for each of the three steps in the USMLE examination. Prior notice and adjustments are posted on the USMLE Web site: www.usmle.org. For more information, contact David Johnson at the Federation of State Medical Boards: telephone (817) 868-4081; e-mail djohnson@fsmb.org.

CD on Ethics Now Available

The Board has recently released a 25-minute compact disk titled “Why Do We Speak of Responsibility?” It features Edmund D. Pellegrino, MD, one of the nation’s most distinguished medical ethicists, discussing the duties of medical board members, the ethics of medical practice, and the role of medical educators. Dr. Pellegrino is director of the Center for Clinical Bioethics at Georgetown University Medical Center and the author of numerous books and articles on the subject of medical ethics. Previously available only on video tape, this presentation is now offered in this more convenient audio format for only $4.00, which includes mailing charge. Orders should be sent to the NCMB’s Public Affairs Department, PO Box 20007, Raleigh, NC 27619. Payment should be enclosed with your order. (Please inquire in advance for costs if requesting shipping outside the U.S.)
West Nile Virus Update
Nolan Newton, PhD, Chief; Public Health Pest Management Section
Kimberly Hattaway, Public Information Officer
Division of Environmental Health
NC Department of Environment and Natural Resources

The discovery of an infected crow in Chatham County on October 20, 2000, marked the arrival of the West Nile virus (WNV) in North Carolina. Transmitted through the bites of mosquitoes, the WNV is passed from wild birds to humans, horses, and many wild animals. It can cause severe illness in the elderly and infirm, and is fatal in about 10 percent of hospitalized cases. This virus was introduced into the northeastern states in 1999 and has spread as far south as North Carolina. We anticipate that it may become established in North Carolina during the summer of 2001.

The Public Health Pest Management Section, North Carolina Department of Environment and Natural Resources (DENR), has taken a proactive stance with regard to the threat of the WNV. Its efforts have included monitoring for viral activity, promoting education about the WNV, and preparing a statewide emergency response plan. In these efforts, the Section has collaborated with state agencies including other sections of the DENR, the Department of Health and Human Services, and the Department of Agriculture and Consumer Services; the Centers for Disease Control (CDC) and other federal agencies; and local health departments and mosquito control programs.

The Public Health Pest Management Section has monitored WNV activity within the state through mosquito testing, dead bird testing, and testing of blood samples drawn from sentinel chicken flocks previously established throughout the state for tracking the Eastern Equine Encephalitis virus. The Section maintains a toll-free phone number, dedicated e-mail address, and online computer form for reporting dead birds. Activity outside North Carolina is monitored via daily electronic communication with the CDC and other states, news articles, and weekly conference calls with the CDC and other states.

Educational efforts include training workshops for public health and mosquito control officials; providing public health officials with frequent updates about the WNV; preparing brochures and other educational materials; developing Web pages; and responding to media opportunities.

As part of its educational outreach efforts, the Section recognizes the importance of increasing the awareness of health care professionals about the WNV and its symptoms and soliciting their help in reporting potential human cases.

In humans, the WNV usually causes mild disease or no symptoms at all. The clinical description of West Nile Fever includes fever, swollen lymph glands, headache, abdominal pain, vomiting, rash, and conjunctivitis. The incubation period is usually five to 15 days. In a few cases the disease may be severe, with central nervous system involvement. Serologic studies suggest that about one in 150 human infections results in an illness severe enough to require hospitalization.

Laboratory testing for the WNV and other arboviral infections (Eastern Equine Encephalitis, Western Encephalitis, Saint Louis Encephalitis, and LaCrosse virus Encephalitis) is available at the State Laboratory of Public Health. If you draw a serum specimen because of suspected arboviral infection, send it immediately; but a convalescent serum should also be submitted two to three weeks later. Call the State Laboratory of Public Health at (919) 733-7544 and ask for the Virology/Serology Unit prior to submitting any specimens.

If the WNV spreads in North Carolina, local health departments and mosquito control programs will be challenged to educate residents in personal protection against mosquito bites; promote environmental sanitation for better mosquito control; increase the frequency and extent of spraying for mosquito control where the WNV is a human disease concern; work with the medical community to improve cooperation in WNV management activities; and monitor the spread and severity of the virus.

Although about 100 cities, towns, and counties in North Carolina currently have established mosquito control programs, the WNV will spur others to start new programs as their citizens demand protection from this virus. State and local spending on mosquito and mosquito-transmitted disease control will need to be increased significantly to adequately manage the public health threat of the WNV. Spending in other states where the WNV has spread has increased from 20 to 100 percent in one year alone. Currently, about $6 million is spent by local programs each year on mosquito and mosquito-transmitted disease control. Additional funding for these local mosquito control programs will be required to meet the additional challenge of managing the WNV.

For more information see: http://www.deh.enr.state.nc.us/phpm/pages/index.html. Also, see the Centers for Disease Control site: www.cdc.gov/ncidod/dvbid/westnile/.
Walter J. Pories, MD, Vice President of NCMB, Honored for Work on Obesity-Linked Diabetes

Anne Blythe, Staff Writer, Raleigh News and Observer

Walter J. Pories, MD

[Walter J. Pories, MD, has been a member of the North Carolina Medical Board since 1997. In 1999-2000, he served as the Board’s secretary-treasurer. He is currently vice president of the Board.]

Walter Pories pulls a pen from his shirt pocket and makes two quick sketches of a stomach on a yellow legal pad.

In a soothing timbre, the surgeon explains how gastric bypass surgery works, and how, really by fluke, he and others at the East Carolina University School of Medicine came to the remarkable conclusion that the procedure could cure adult-onset diabetes.

“It’s fascinating,” Pories said, using his drawings to simplify the topic. Whether it’s his theory on diabetes or other medical ailments, or the lesson in his saga about the cow with zits or his own incredible rags-to-riches story, the gentle physician has a knack for painting a picture with words.

“I call him the Leonardo da Vinci of North Carolina,” said Jose Caro, vice president of Eli Lilly and Co., an Indianapolis-based pharmaceutical company, and a former chairman of endocrinology at ECU. “He’s an artist, he’s a surgeon, he’s a mentor.”

This month, the University of North Carolina Board of Governors gave Pories the O. Max Gardner Award, its highest faculty honor. The overseers of the 16-campus system recognized the ECU professor of surgery and biochemistry for his research and findings on the nutritional needs of children and the elderly, as well as his discoveries concerning morbid obesity and its relevance to adult-onset diabetes.

“If anybody is worthy of that award, it is Walter,” said Hisham Barakat, an ECU professor of biochemistry who has worked with Pories for 16 years. “You think of surgeons as being technical and very precise, yet he does it with the fluidity and grace of a ballet dancer. He has imagination, thoughtfulness, is very curious, always questioning. In my mind, he is a scholar and a humanitarian.”

Nazi Germany Leads to U.S.

The humanitarianism was instilled early. Pories’ father insisted that his children leave the world a better place and often quizzed them about what they were doing to make that happen. But it was his uncle, Josef Seidl, who piqued his interest in medicine. Pories was just 9 years old; his family still lived in Germany, where he was born. His uncle, a physician to a large monastery in the Bavarian countryside, used to pack the curious youngster and four of his cousins into the back of a Volkswagen and take them on rounds through the religious community.

Toward the end of each visit, his uncle would pull over at a little butcher shop, and the children would pile out of the back seat to feast on warmed, crispy rolls and leberkaese, a hot, chunk bologna. “That was so good, I knew then that I had to be a doctor,” Pories said, flashing an impish smile. But there would be many twists and turns in his life first. After all, this was Hitler’s Germany, and his mother’s side of the family was Jewish. “We were one of those half-and-half families,” Pories said.

In the middle of one May night in 1939, German soldiers arrested Pories, his mother, sister and an uncle from the Jewish side of the family, put them in a paddy wagon, took them to a holding station in Munich, then to a concentration camp in Dachau, where, they later learned, Polish guards refused to kill them.

His father, a Catholic, was away when his family was wrenched from their home. But after learning what happened, he immediately set out to get help. A successful businessman and a decorated World War I veteran, the elder Pories found a sympathetic friend when he walked into a Nazi station. The man remembered a skirmish in the streets of Munich in 1933, when Ted Pories, Walter’s father, had helped him, so he gave him a visa that would allow the family to leave the country.

Reunited after five days apart, the family made its way to several churches, then to Lisbon, Portugal, and Rio de Janeiro, Brazil, where they sought another visa, one for the United States. But for a family to get into this country then, a sponsor was needed.

“A man in Milwaukee, a man we never met, stepped forward and signed a document assuring the government that he would be fully responsible for our financial support should we need him,” Pories said.

“He didn’t know our family at all. That was incredible to me. Because of his service to humanity, I was allowed to grow up in this country.”

That was not the last nameless stranger he would encounter.

When he was a senior in high school, someone, unbeknownst to the teenager, wanted to help finance his college studies. He was summoned to the principal’s office on the last day of class.

“There, a gray man in a gray suit carrying a gray umbrella told me that I had been awarded a four-year scholarship to Wesleyan University in Connecticut,” he said. “My family had only modest means at that point, so a school the caliber of Wesleyan was out of the question. Plus my mother didn’t want me to go so far away from home. I had never heard of the school. But I was so contrary a kid that when she told me that, I said, ‘Well, that’s where I want to go.’ Had she wanted me to go there, I’d probably have gone to the University of Wisconsin.”

Research Yields Results

His path was set — sort of. As an undergraduate, he was convinced he would be a great artist or one heck of a trombone player. But his limited musical talent got in the way of his success, he said, and he decided that jazz, painting and drawing would be his avocations, and medicine would be his vocation.

“What really excites me is research,” he said. “You sort of fall into it by absolute accident.”

He made a mark early on that way. He was studying rats as a second-year medical student with William Strain, an organic chemistry professor. They realized that zinc, a contaminant in their experiment, was actually helping the animals heal. They wrote up their findings, but their theory went untested for a couple of years. But another researcher picked up on the study and gave more credibility to their idea, and now zinc is included in prenatal vitamins, mineral and vitamin preparations, infant formulas and liquid nutritional supplements for the elderly.

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Pories Honored

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‘Mistake’ a Breakthrough

While at the ECU Brody School of Medicine, Pories and a team of researchers broke new ground in diabetes research, again by delving into data that didn’t make sense immediately. The surgeon had done numerous gastric bypasses on obese people, sealing off most of their stomachs to decrease the amount of food they could eat and rearranging their intestines to reduce the calories their bodies absorbed. But the program had not taken diabetic patients because they were more prone to infection and other complications from surgery.

Finally, they took a diabetic. But during post-operation blood and fluid checks, the physician could find no signs of the diabetes. His first thought was, “Oh no, the lab made a mistake: The patient was not really diabetic.”

“I was livid,” Pories said. “Usually, I’m pretty loose. I don’t think anyone’s ever seen me lose my temper in an operating room. But I am very compulsive about records. I don’t demand much of others, but I do demand that we be rigorously honest with our patient records. How do you give an honest assessment of a patient if you don’t have accurate records?”

But when the same thing happened with three other diabetic patients, Pories decided to take a closer look, not at the lab, but at why the disease disappeared. They continue to explore why this happens.

“Walter’s the kind of guy who thinks in a totally different dimension,” said Randolph Chitwood, chairman of the ECU department of surgery. “He uses both his right and left brain.”

Family Lore: A Cow with Zits

When he’s not at the hospital, he’s often on the farm that he and his wife, Mary Ann Rose, special assistant to the ECU chancellor, created. She nudged him in bed one morning and asked why they lived in the Greenville suburbs when they could be surrounded by rows of cotton, soybeans, goats, a llama and cows.

As the family story goes, Rose rescued a calf in the swirling waters of Hurricane Floyd floods. The creature subsequently developed soft, shiny lesions on its face. A local veterinarian and agriculture extension agent suggested a quick trip to the stockyard so the disease would not spread through the herd. But the story has a medical moral: Seek a second opinion, as Pories did. The adolescent calf had nothing more than bovine zits, which, with patience, would disappear in three months. [Dr Pories essay on the Cow with Zits, better known as Papilloma Picasso, was published in Forum #4, 2000.]

In his spare time, Pories draws satirical cartoons. His goal is to be published in The New Yorker.

“He’s got so many interests, I almost classify him as a polymath,” said Paul Friedmann, senior vice president for academic affairs at Bay State Medical Center in Springfield, Mass. “If every surgeon were more like Walter Pories, it would be so much better for the profession.”

Reprinted with permission from the Raleigh News and Observer’s “Tarheel of the Week” feature.

Wayne W. VonSeggen, PA-C, Named Outstanding PA of 2001 by AAPA

The American Academy of Physician Assistants (AAPA) has named Wayne W. VonSeggen, PA-C, of Winston-Salem, the recipient of its 2001 Outstanding Physician Assistant of the Year award. The award was presented on May 30 at the AAPA’s 29th Annual Physician Assistants Conference in Anaheim, California. Mr VonSeggen served as president of the North Carolina Medical Board from November 1999 through October 2000.

Since 1996, Mr VonSeggen has worked as a PA at the North Carolina Baptist Hospital Employee Health Center, providing adult occupational health care for medical center employees. He has more than 23 years of clinical experience practicing as a PA in North Carolina in outpatient primary care settings in family, occupational, and internal medicine.

Appointed to the Medical Board by Governor James Hunt, he was the first PA to serve on the Board, the first to be elected president of the Board, and the first to serve two years in a row as a delegate to the Federation of State Medical Boards. While on the NCMB, with the cooperation of the North Carolina Academy of Physician Assistants (NCAPA) leadership, “we were able to overhaul the PA statute and PA regulations,” he says. “The results greatly improved the standing of the PA profession through direct interaction with regulators, the legislature, and the PA profession in North Carolina.”

In recommending Mr VonSeggen for the award, Elizabeth P. Kanof, MD, currently president of the Medical Board, said, “during his tenure, Mr VonSeggen launched a PA Advisory Council, an entity that will enhance even more the productive professional relationship between physicians and PAs in the state.” She added: “He is an exemplary model to emulate.”

“Mr VonSeggen’s professionalism to his patients, physicians, and PAs has greatly advanced the PA profession,” said Wade H. Marion, PA-C, president of the NCAPA. The NCAPA granted Mr VonSeggen an honorary membership for his dedication as a leader in the North Carolina medical community.

Since 1979, Mr VonSeggen has served in various capacities in the NCAPA, including president and chair of the Publications and Public Education Committees. He is a member of the AAPA, a founding member of the Fellowship for Christian PAs and the Piedmont Association of PAs, a member of the Christian Medical and Dental Association, and an affiliate member of the North Carolina Medical Society.

The Outstanding Physician Assistant of the Year award, supported by Pfizer, Inc, honors a PA who has demonstrated exemplary service to the PA profession and the community and has furthered the image of PAs. Mr VonSeggen was presented a crystal Paragon Award and a check for $2,500. A matching contribution was given in his name to the Physician Assistant Foundation.

The AAPA is the only national organization to represent physician assistants in all medical and surgical specialties and work settings in the United States and federal services. Founded in 1968, the AAPA works to promote quality, cost-effective health care, and the professional and personal growth of PAs.
Vital Information Required by the NCMB

When a physician or physician extender dies or legally changes name by marriage, divorce, or other means, that information is vital to the North Carolina Medical Board to ensure the accuracy of its records and to serve the interests of its licensees and the public. Copies of the legal documents relating to those events are also needed for the appropriate files.

When a licensee dies, a copy of the death certificate should be sent to the Board as soon as possible. When a licensee marries and thereby changes name, a copy of the marriage certificate, showing the name change, should be forwarded to the Board. In the case of divorce, if the decree contains the resumption of a maiden or previous name, a copy of the decree should also be sent to the Board. When a licensee’s name is changed by any other legal means, the relevant document(s) should be sent to the Board.

It is important to note that without the legal documentation the necessary changes cannot be made to the Board’s records, and that will result in incorrect names on registration forms, incorrect verifications of license, and misinformation should a licensee be deceased.

This vital information, and the supporting copies of relevant documents, should be sent to the following address: North Carolina Medical Board, Attention—Ms Ann Norris, PO Box 20007, Raleigh, NC 27619.

Bryant D. Paris, Jr, Emeritus Executive Director of NCMB, Given Special Recognition

Bryant D. Paris, Jr, former executive director of the North Carolina Medical Board and currently emeritus executive director of the Board, was named recipient of the Federation of State Medical Board’s prestigious Special Recognition Award for 2001 during a ceremony at the Federation’s Annual Meeting in Atlanta on April 21. The award is given from time to time to individuals who have made exceptional contributions to the field of medical licensure and discipline and to state medical boards.

Mr Paris served on the Federation’s Board of Directors in 1987-1988, worked on a number of Federation committees, including the Ad Hoc Committee on Licensure by Endorsement, the Federation Licensing Examination Transition Task Force, the Long Range Planning Committee, the Program Committee, and the Rules Committee, and participated in many special working groups.

For over 25 years, he has made exceptional contributions to the North Carolina Medical Board, serving first as its executive secretary and then as its executive director. He has been a member of the North Carolina Society of Association Executives and the North Carolina Board of Legal Specialization. In 1997, the Administrators in Medicine honored him with its Lifetime Achievement Award. He has also been a member of the North Carolina Advisory Committee on Contract Programs in Dentistry, Medicine, and Optometry for the last seven years.

As emeritus executive director of the North Carolina Medical Board, he acts as a consultant to the Board and interviews a large percentage of applicants for the medical license.

A native of Alamance County, Mr Paris received his bachelor’s degree in psychology from East Carolina University. He did postgraduate study in association management at Michigan State University. His successor as executive director of the Board, Andrew W. Watry, has said, “I can think of no one more deserving of this Federation honor than Bryant Paris. He served the North Carolina Medical Board with distinction and grace for over 25 years and remains a significant part of the Board’s family. All of us at the Board offer him our congratulations and our thanks.”

Retirement “in the Trenches”

To the Editor: I read with interest [Dr Kanof’s] article, Doctor, Is It Time?, in the most recent issue of the Forum regarding [her] personal experience with the uncertainties of retirement. [She] stated that the most disconcerting uncertainty is “to be out of the trenches of the profession.” I would like to take this opportunity to propose an option that retired physicians [whose licenses are not inactive] and physicians who are contemplating retirement may want to explore.

I encourage pediatricians, internists, obstetricians/gynecologists, and general practitioners who are retired or are facing retirement to contact the director of the local public health department in their areas. It is very likely that the health director is interested in contracting with a physician who can provide professional services on a part-time basis. A contractual arrangement with a local health department allows the retired physician to return to the trenches on friendlier terms. The pace in a health department is not as hectic as compared to that in a traditional medical practice setting. The retired physician can satisfy his or her desire to have a set purpose each day, ie, still seeing patients, but without sacrificing the freedom that retirement provides from imposing office schedules and obligations. Another benefit of a contractual arrangement with a local health department is that the physician is not locked into a long-term commitment. The terms of the contract can be renegotiated or even terminated with reasonable notice.

The retired physician who may have a lowered threshold of fatigue due to the cumulative effects of years of long, arduous hours at the office may find the slower pace, fewer work hours, and fewer demands of part-time contractual work at a local health department to be accommodating to his or her present energy level.

Again, I want to encourage retired physicians [with active licenses] to contact the director of a local health department and consider the feasibility of a contractual arrangement. I am sure the local health director will be glad to hear from a physician who may be interested in working with the health department.

Joey Huff, Director
Lenoir County Health Department
Kinston, NC
NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
February/March/April 2001

DEFINITIONS

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

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

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

Denial:
Final decision denying an application for practice authorization or a motion/request for reconsideration/modification of a previous Board action. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)

Suspension:
Temporary withdrawal of the authorization to practice.

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

Voluntary Dismissal:
Board action dismissing a contested case.

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

ANNULMENTS

NONE

REVOCA TIONS

JONES, Tobin Jack, MD
Location: Oakwood, VA
DOB: 10/22/1959
License #: 0000-39831
Specialty: END/PD
(Medical Ed: Duke University School of Medicine (1979)
Cause: Dr. Girgis may be unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or other materials. He has had his license suspended by South Carolina.

GIRGIS, Sobhi Anis, MD
Location: Cordova, SC
DOB: 7/24/1938
License #: 0000-25913
Specialty: GER
(Medical Ed: Alexandria University (1964)
Cause: Dr. Girgis may be unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or other materials. He has had his license suspended by South Carolina.

SUSPENSIONS

See Consent Orders:

GRANT, John Leland, MD
Location: Chesapeake, VA
DOB: 8/06/1946
License #: 0000-29113
Specialty: NS
(Medical Ed: Ohio State University (1975)
Cause: Dr. Grant may have committed acts of unprofessional conduct, he has been convicted of a felony, and he has had his license to practice medicine suspended by the Virginia Board of Medicine.
CONSENT ORDERS

DECLERCK, Paul A., MD
Location: Kinston, NC (Lenoir Co)
DOB: 10/07/1947
License #: 0000-24240
Specialty: FP (as reported by physician)
Medical Ed: University of Brussels, Belgium (1975)
Cause: To amend his Consent Order of 1/09/2001. Dr Declerck has had problems with depression and substance abuse as noted in his Consent Order, which states, in part, that he shall not purchase, administer, prescribe, dispense, or order any controlled substances. He is also not to permit controlled substances to be at his place of employment for any purpose. He has asked that the restrictions on controlled substances be deleted so he may prescribe, etc., if permitted by the DEA. It appears he is complying with his Consent Order, including maintaining and abiding by his NCPHP contract. The NCPHP believes the requested change will not interfere with Dr Declerck's recovery and will not impair his ability to practice safely.

Action: 4/16/2001. Consent Order executed: Dr Declerck is issued a license to expire on the date shown on the license; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription. The Board requested Dr Declerck to supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall attend AA, NA, and/or Caduceus meetings as recommended by the NCPHP; he shall continue to observe psychotherapy and cause his therapist to send quarterly reports on his progress to the Board; and must comply with other conditions.

JOHNSON, Joy Mooring, MD
Location: Butner, NC (Granville Co)
DOB: 4/06/1954
License #: 0000-29299
Specialty: IM (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1982)
Cause: On the request of Dr Johnson for retroactive reinstatement of her license. Dr Johnson failed to register within 30 days of certified notice and her license was placed on inactive status as of 9/27/1999. She continued to practice until 3/05/2001, when she learned her license was inactive. She did not resume practicing until the Board approved her reinstatement effective 3/09/2001. She asked the Board to retroactively reinstate her license to 9/27/1999 so there would be no lapse in her authority to practice. Her failure to comply with the registration requirement resulted in large part from her failure to keep the Board updated regarding her current practice address. She now appreciates the importance of maintaining a current address with the Board and of timely registration.

Action: 4/06/2001. Consent Order executed: Dr Johnson's license is reinstated effective 9/27/1999; she is reprimanded for her failure to timely register with the Board; must comply with other conditions.

KIRKS, Donald Ray, MD
Location: Durham, NC (Durham Co)
DOB: 10/06/1942
License #: 0000-16365
DOB: 4/05/1944
Specialty: DR (as reported by physician)
Medical Ed: Washington University (1968)
Cause: Regarding the Notice of Charges and Allegations against Dr Kirks dated 6/30/2000. Dr Kirks admits and the Board finds that on or about 6/07/1999, Dr Kirks pled guilty and was convicted in U.S. District Court in Massachusetts of one count of embezzlement from a medical practice that involved more than $70,000. He was sentenced to two years of probation and a fine of $10,000. Based on this felony conviction, his right to renew his medical license in Massachusetts was indefinitely suspended in November 1999. He voluntarily disclosed his wrongful action and made full restitution before any criminal investigation or prosecution; his employer did not seek prosecution of the offense; he has an otherwise exemplary record of service to children’s health; and he is practicing in Texas and does not intend to return to North Carolina.


GERVIN, Alfred Spencer, MD
Location: Richmond, VA
DOB: 4/05/1944
License #: 0000-16365
Specialty: GS/EM (as reported by physician)
Medical Ed: Duke University School of Medicine (1969)
Cause: Dr Gervin admits and the Board finds and concludes that an informal conference of the Virginia Board reprimanded Dr Gervin in an order dated 8/25/1999, based on evidence that Dr Gervin created a potential for lapse of trauma care by refusing to take call, exposed a hospital employee to infectious diseases, and falsely testified to the Informal Conference Committee. On 3/18/2000, Dr Gervin answered “no” to a question on the North Carolina registration form asking if he had had disciplinary or probationary action taken by any licensing board since 11/21/2000; he recognizes grounds exist for the Board to deny any application he might make for a license in the future; should he ever be licensed in the future, specific terms and conditions may be placed on his license.

Action: 2/22/2001. Consent Order executed: Dr Gervin is reprimanded for the discipline imposed by the Virginia Order; and for the false answers on the North Carolina registration form.

HAMILTON, James Greene, MD
Location: Durham, NC (Durham Co)
DOB: 4/13/1951
License #: 0000-29583
Specialty: FP (as reported by physician)
Medical Ed: Medical University of South Carolina (1982)
Cause: In October 2000, Dr Hamilton was stopped in Durham County by law enforcement authorities who found drug paraphernalia in his car, controlled substances for which he did not hold a legitimate prescription or order, and marijuana. In 1999 and 2000, he prescribed and dispensed large quantities of medications for several patients with questionable justification. In 1998, 1999, and 2000, he prescribed or dispensed medication, including a controlled substance, for at least one child of adult patients without ever examining the child. He currently faces stress brought on by these issues when he agreed to renewed suspension, has attended seminars on the use of pain medications, has reviewed his prescribing practices, and has recognized he was deficient regarding prescribing medications containing acetaminophen without properly monitoring patients. Dr Hamilton voluntarily surrenders his license; the Board dismisses without prejudice the case against him and terminates the summary suspension of 11/21/2000; he recognizes grounds exist for the Board to deny any application he might make for a license in the future and detailed requirements are placed on any application he might make for a license in the future; should he ever be licensed in the future, specific terms and conditions may be placed on his license.

Action: 4/26/2001. Consent Order executed: Mr Lovato's PA license is suspended for six months; the suspension is stayed on the following conditions: he shall not prescribe Schedule II controlled substances; he shall improve his keeping of medical records as required by the Board's position statements; he shall maintain a detailed log of all controlled substances he prescribes, orders, or administers and submit a copy of the log to the Board when requested by the Board; he shall obtain written approval from the Board's prior prior to engaging in practice with any additional primary supervising physician; he shall provide a copy of this Consent Order to all his current and prospective supervising physicians; he shall meet with the Board as requested, he shall have his supervising physician review his practice and prescribe a license in the future; and shall comply with all Board requirements.

LOVATO, Frank James, Physician Assistant
Location: Fayetteville, NC (Cumberland Co)
DOB: 12/02/1950
License #: 0001-02071
PA Education: Ft Sam Houston, TX (1983)
Cause: Dr Lovato privileges to practice as a PA at Womack Army Medical Center were revoked in December 1999 due to improper prescribing practices. Between July 1997 and November 1999, he prescribed excessive quantities of narcotics, including not less than 11,000 dosage units of oxycodone and acetaminophen, for a patient. In June 1999, he was confronted by his supervising physician and told to cease issuing prescriptions for this patient, but he continued to do so. He failed to examine the patient or make any entry in the patient's record about the prescriptions after December 1998. He also prescribed excessive amounts of narcotics for a second patient. With the termination of his privileges, he lost his position as a PA at Womack Army Medical Center.

Action: 4/26/2001. Consent Order executed: Mr Lovato's PA license is suspended for six months; the suspension is stayed on the following conditions: he shall not prescribe Schedule II controlled substances; he shall improve his keeping of medical records as required by the Board's position statements; he shall maintain a detailed log of all controlled substances he prescribes, orders, or administers and submit a copy of the log to the Board when requested by the Board; he shall obtain written approval from the Board's prior prior to engaging in practice with any additional primary supervising physician; he shall provide a copy of this Consent Order to all his current and prospective supervising physicians; he shall meet with the Board as requested, he shall have his supervising physician review his practice and prescribe a license in the future; and shall comply with all Board requirements.
physicians send reports on his practice to the Board; must comply with other conditions.

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)
Cause: On Dr Riddle's request to amend his Consent Order of 6/14/2000 that limits his practice to 30 hours per week. Dr Riddle has had problems with substance abuse and has had disciplinary action taken against him. He now appears to be complying with the terms of his Consent Order and the Board believes he can safely be allowed to work up to 40 hours per week.

Action: 4/16/2001. Consent Order issued: Dr Riddle is issued a license to expire on the date shown on the license; he shall practice only in a setting approved by the Board's president; he may not work more than 40 hours per week as a physician; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall not obtain registration to prescribe controlled substances without written endorsement by the Board; he shall not purchase, administer, prescribe, dispense, or order any controlled substances; he may not supervise PAs or NPs; he shall obtain and document 80 hours of Category I CME relevant to his practice each year; he shall provide this information until several months later. Dr Riddle met with the Board to discuss the above, and appears to fully appreciate the importance of appropriate and timely response to inquiries from the Board.

10/28/1999. Under Consent Order of 10/28/1999. Underaction taken by another medical board and prior criminal conviction. He reports he has not consumed alcohol or any other controlled substances since 2/03/1999; the NCPHP reports he has signed and is complying with the terms of his Consent Order and the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall not obtain registration to prescribe controlled substances without written endorsement by the Board; he shall not purchase, administer, prescribe, dispense, or order any controlled substances; he may not supervise PAs or NPs; he shall obtain and document 80 hours of Category I CME relevant to his practice each year; he shall provide this information until several months later. Dr Riddle met with the Board to discuss the above, and appears to fully appreciate the importance of appropriate and timely response to inquiries from the Board.

WORIAX, Frank, MD
Location: Pembroke, NC (Robeson Co)
DOB: 1/5/1962
License #: 0000-21384
Specialty: FP (as reported by physician)
Medical Ed: Duke University School of Medicine (1976)
Cause: Regarding Dr Woriax’s application for reinstatement of his license. Pursuant to a consent order of 4/20/1998, he surrendered his PA license and admitted he failed to disclose his sobriety since 4/12/1999, and he is involved in an active recovery program with AA and Caduceus. The NCPHP reports he has maintained sobriety since 4/12/1999, and he is involved in an active recovery program with AA and Caduceus. He reports he has not consumed alcohol or drugs since 2/03/1999; the NCPHP reports he has signed and is compliant with a NCPHP contract; he has regularly attended AA meetings and is working on a strong recovery program.

Action: 4/16/2001. Consent Order executed: Dr Woriax is reprimanded; he is issued a license to practice medicine to expire on the date shown thereon [8/31/2001]; within six months of the date hereof, he shall obtain and document to the Board a passing score on the SPEX exam or a comparable examination; each year he shall obtain and document 50 hours of Category I CME relevant to his practice; must comply with other conditions.

NABORS, Dennis Ray, Physician Assistant
Location: Greensboro, NC (Guilford Co)
DOB: 7/26/1950
License #: 0001-02153
PA Education: University of Washington (1976)
Cause: On Mr Nabors application for reinstatement of his PA license. Pursuant to a consent order of 4/20/1998, he surrendered his PA license and admitted he failed to disclose his sobriety since 4/12/1999, and he is involved in an active recovery program with AA and Caduceus. He reports he has not consumed alcohol or drugs since 2/03/1999; the NCPHP reports he has signed and is compliant with a NCPHP contract; he has regularly attended AA meetings and is working on a strong recovery program.

Action: 4/22/2001. Consent Order executed: Dr Love is reprimanded; he is issued a license to practice medicine to expire on the date shown thereon [8/31/2001]; within six months of the date hereof, he shall obtain and document to the Board a passing score on the SPEX exam or a comparable examination; each year he shall obtain and document 50 hours of Category I CME relevant to his practice; must comply with other conditions.

SAPPINGTON, John Shannon, MD
Location: New Bern, NC (Craven Co)
DOB: 1/30/1962
License #: 0094-06062
Specialty: P (as reported by physician)
Medical Ed: University of Texas (1989)
Cause: Regarding Dr Sappington's application for reinstatement of his license. Dr Sappington has a problem with alcohol abuse, which resulted in the surrender of his license on or about 1/5/1999. Dr Sappington sought and obtained continuing treatment for alcohol and substance abuse and is a participant in the NCPHP. It appears that Dr Sappington has maintained his sobriety since 4/12/1999, and he is involved in an active recovery program with AA and Caduceus. He reports he has not consumed alcohol or drugs since 2/03/1999; the NCPHP reports he has signed and is compliant with a NCPHP contract; he has regularly attended AA meetings and is working on a strong recovery program.

Action: 2/21/2001. Consent Order executed: Dr Sappington is issued a license to practice medicine to expire on the date shown thereon [5/31/2001]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board in writing within 10 days of his use of such medication, alcohol, and other controlled substances, and he shall maintain and abide by a contract with the NCPHP; he shall supply bodily fluids or tissue as requested by the Board for drug and alcohol screening; he shall maintain and abide by a contract with NCPHP; must comply with other conditions.

RIDDLE, William Mark, MD
Location: Goldsboro, NC (Wayne Co)
DOB: 3/20/1956
License #: 0000-39871
Specialty: FP/EM (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1985)
Cause: On Dr Riddle's request to amend his Consent Order of 6/14/2000 that limits his practice to 30 hours per week. Dr Riddle has had problems with substance abuse and has had disciplinary action taken against him. He now appears to be complying with the terms of his Consent Order and the Board believes he can safely be allowed to work up to 40 hours per week.

Action: 3/29/2001. Consent Order issued: Dr Riddle is issued a license to expire on the date shown on the license; he shall practice only in a setting approved by the Board's president; he may not work more than 40 hours per week as a physician; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall not obtain registration to prescribe controlled substances without written endorsement by the Board; he shall not purchase, administer, prescribe, dispense, or order any controlled substances; he may not supervise PAs or NPs; he shall obtain and document 80 hours of Category I CME relevant to his practice each year; he shall provide this information until several months later. Dr Riddle met with the Board to discuss the above, and appears to fully appreciate the importance of appropriate and timely response to inquiries from the Board.
he examines a female patient; the chaperone shall co-sign and date each entry in the patient chart confirming she was present and that no sexual harassment or other misconduct occurred; he shall post the Principles of Medical Practice on his office wall, examination room walls, reception area walls, and other places where it can be easily read by patients; he shall ask three members of his staff, who are familiar with his disciplinary history, to complete a Staff Surveillance form to be sent to Dr. Gullick for her quarterly reports to the Board; during one week each quarter, Dr. Worai or his staff will ask all patients seen by him to complete a Patient/Patient’s Family Satisfaction Survey, which shall be sent to Dr. Gullick for her quarterly reports to the Board; every 12 months, he shall undergo a polygraph examination to determine if he has engaged in inappropriate sexual misconduct with patients or staff, results to be sent to Dr. Gullick for her quarterly reports to the Board; he shall continue his therapy with Dr. Gullick, or any successor approved by the president of the Board, and comply with all recommendations made by her; he shall direct Dr. Gullick to provide quarterly reports on his progress to the Board; he shall maintain and abide by a contract with the NCPHP; he shall obtain 50 hours of CME relevant to his practice each year, 30 hours of which must be Category I; must comply with other conditions.

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

DENIALS OF LICENSE/APPROVAL

OKUN, James Douglas, MD
Location: Durham, NC. (Durham Co)
DOB: 5/19/1956
Specialty: EM (as reported by physician)
Medical Ed: Albert Einstein College of Medicine (1983)
Cause: Application for license. Dr. Okun was unable to provide passing examination scores.

COURT APPEALS
NONE

CONSENT ORDERS LIFTED

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

GORSKI, Karen, Physician Assistant
Location: Charlotte, NC (Mecklenburg Co)
DOB: 1/08/1957
License #: 0001-02145
PA Education: State University of New York, Stonybrook (1982)

HALL, Jesse McRae, Physician Assistant
Location: Ft Bragg, NC (Cumberland Co)
DOB: 6/22/1956
License #: 0001-01830
PA Education: Ft Sam Houston, TX (1991)

HOROWITZ, Jack Charles, MD
Location: Wilmington, DE
DOB: 11/09/1962
License #: 2000-00840
Specialty: EM/PD (as reported by physician)
Medical Ed: University of Connecticut (1991)

JUBERG, Breton Chester, MD
Location: Randleman, NC (Randolph Co)
DOB: 4/03/1963
License #: 0000-34367
Specialty: OB/GYN (as reported by physician)
Medical Ed: Wright State University (1989)

LUTZ, Robert Paul, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 5/05/1948
License #: 0000-27387
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1982)

McCALL, Michael Alvin, MD
Location: Atlanta, GA
DOB: 11/04/1961
License #: 0000-36569
Specialty: OB/GYN (as reported by physician)
Medical Ed: University of Florida College of Medicine (1989)

O’DONNELL, Robert William, MD
Location: Shallotte, NC (Brunswick Co)
DOB: 1/30/1947
License #: 0000-29636
Specialty: FP/OM (as reported by physician)

PAINE, Karen Nicholson, MD
Location: Fuquay-Varina, NC (Wake Co)
DOB: 7/07/1946
License #: 0000-20834
Specialty: FP/OM (as reported by physician)
Medical Ed: University of Virginia (1977)

SCONTSAS, George John, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 12/17/1948
License #: 0000-52852
Specialty: ADDM/N (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1977)

TOLLESON, Thaddeus Rex, MD
Location: Durham, NC (Durham Co)
DOB: 11/10/1966
License #: 0007-01175
Specialty: IM/C (as reported by physician)
Medical Ed: University of Texas, Houston (1993)

WANGELIN, Robert Lester, MD
Location: Greensboro, NC (Guilford Co)
DOB: 5/21/1945
License #: 0000-28370
Specialty: P (as reported by physician)
Medical Ed: West Virginia University (1972)

WARD, David Townsend, MD
Location: Winston-Salem, NC (Forsyth Co)
DOB: 4/07/1960
License #: 0095-00473

WESSEL, Richard Fredrick, MD
Location: Elizabeth City, NC (Pasquotank Co)
DOB: 1/24/1959
License #: 0096-00772
Specialty: C/JM (as reported by physician)
Medical Ed: Eastern Virginia Medical School (1990)

ANDRINGA, Richard Cornell, MD
Location: Greensboro, NC (Guilford Co)
DOB: 12/23/1946
License #: 000-20463
Specialty: AN/PD (as reported by physician)
Medical Ed: University of Wisconsin (1974)

BJORK, Paul Edward, Jr, MD
Location: Laurinburg, NC (Scotland Co)
DOB: 3/06/1954
License #: 0000-36146
Specialty: OB/G (as reported by physician)
Medical Ed: University of South Carolina (1983)

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

CHEEK, John Christopher, MD
Location: Smithfield, NC (Johnston Co)
DOB: 3/02/1957
License #: 0097-01906
Specialty: GP/CN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1984)

CROMER, William Browning, MD
Location: Kinston, NC (Lenoir Co)
DOB: 11/16/1931
License #: 0000-10448
Specialty: GP/OE (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1956)

DECLERCK, Paul A., MD
Location: Kinston, NC (Lenoir Co)
DOB: 10/07/1947
License #: 0000-24240
Specialty: FP (as reported by physician)
Medical Ed: University of Brussels, Belgium (1975)

DENTON, Beecher Tate, III, Physician Assistant
Location: Greensboro, NC (Guilford Co)
DOB: 1/02/1955
License #: 0001-00993
PA Education: Bowman Gray (1987)

DIAMOND, Patrick Francis, MD
Location: Evergreen, NC (Columbus Co)
DOB: 5/15/1946
License #: 0098-00042
Specialty: FP (as reported by physician)
Medical Ed: Autonomous University of Tamaulipas, Mexico (1987)

FORD, Stephen Mitchell, MD
Location: Durham, NC (Durham Co)
DOB: 12/05/1952
License #: 0000-29570
Specialty: FP (as reported by physician)
Medical Ed: East Tennessee State University (1984)
Action: 2/22/2001. Full and unrestricted license was reinstated.

GORSKI, Karen, Physician Assistant
Location: Charlotte, NC (Mecklenburg Co)
DOB: 1/08/1957
License #: 0001-02145
PA Education: State University of New York, Stonybrook (1982)
Action: 3/18/2001. Full and unrestricted license was issued.

HOROWITZ, Jack Charles, MD
Location: Wilmington, DE
DOB: 11/09/1962
License #: 2000-00340
Specialty: EM/PD (as reported by physician)
Medical Ed: University of Connecticut (1991)
Action: 3/15/2001. Full and unrestricted license was reinstated.

LUTZ, Robert Paul, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 5/05/1948
License #: 0000-27387
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1982)
Action: 2/21/2001. Full and unrestricted license was reinstated.

McCALL, Michael Alvin, MD
Location: Atlanta, GA
DOB: 11/04/1961
License #: 0000-36569
Specialty: OB/G (as reported by physician)
Medical Ed: University of Florida (1989)
Action: 3/15/2001. Full and unrestricted license was reinstated.

MORRIS, Robert Harry, Physician Assistant
Location: Fayetteville, NC (Cumberland Co)
DOB: 11/18/1950
License #: 0001-00110
PA Education: Howard University (1975)

PAIN, Karen Nicholson, MD
Location: Fuquay-Varina, NC (Wake Co)
DOB: 7/07/1946
License #: 0000-20834
Specialty: FP/OE (as reported by physician)
Medical Ed: New York University (1971)
Action: 2/21/2001. Full and unrestricted license was reinstated.

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

SCONTSAS, George John, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 12/17/1948
License #: 0000-32852
Specialty: ADDM/N (as reported by physician)
Medical Ed: University of Virginia (1977)
Action: 2/22/2001. Full and unrestricted license was reinstated.
<table>
<thead>
<tr>
<th>Name</th>
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<th>DOB</th>
<th>License #</th>
<th>Specialty</th>
<th>Medical Ed</th>
<th>Action</th>
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<tbody>
<tr>
<td>WORIAX, Frank, MD</td>
<td>Pembroke, NC (Robeson Co)</td>
<td>1/06/1939</td>
<td>0000-21384</td>
<td>FP (as reported by physician)</td>
<td>Duke University School of Medicine (1976)</td>
<td>3/15/2001. Full license reinstated.</td>
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<tr>
<td>YOUNG, Richard Lane, MD</td>
<td>Sunset Beach, NC (Brunswick Co)</td>
<td>8/12/1951</td>
<td>0000-31090</td>
<td>ORS (as reported by physician)</td>
<td>Medical University of South Carolina (1979)</td>
<td>3/15/2001. Temporary/dated license extended to expire 11/30/2001.</td>
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</table>

**Dismissals**
- LOVE, David William, MD
- NABORS, Dennis Ray, Physician Assistant
- SAPPINGTON, John Shannon, MD

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**North Carolina Medical Board**

**Meeting Calendar, Application Deadlines, Examinations**

**July 2001 -- December 2001**

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

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<td>Physician Assistant Applications</td>
<td>July 3, 2001</td>
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<td>Physician Assistant Applications</td>
<td>July 31, 2001</td>
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<td>Physician Licensure Applications</td>
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<td>Physician Assistant Applications</td>
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<td>Nurse Practitioner Approval Applications</td>
<td>September 3, 2001</td>
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<td>Physician Assistant Applications</td>
<td>October 2, 2001</td>
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<td>Physician Licensure Applications</td>
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<th>North Carolina Medical Board</th>
<th>November 14-16, 2001</th>
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<td>November Meeting Deadlines:</td>
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<td>Nurse Practitioner Approval Applications</td>
<td>October 1, 2001</td>
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<td>Physician Assistant Applications</td>
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<th>North Carolina Medical Board</th>
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<td>December Meeting Deadlines:</td>
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<td>Nurse Practitioner Approval Applications</td>
<td>November 5, 2001</td>
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<td>Physician Assistant Applications</td>
<td>December 4, 2001</td>
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<td>Physician Licensure Applications</td>
<td>December 4, 2001</td>
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**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.
If you hold an active license (physician or physician assistant) or approval (nurse practitioner) from the North Carolina Medical Board, the Board urges you to let it know about any change in your home or work address within 60 days of the effective date of the change. Most practitioners do this. Unfortunately, some do not. The Board receives returned mail every day from practitioners who have not updated their addresses. Obviously, the Board can send registration notices only to your last known address of record. Failure to keep your address current with the Board could delay your registration, and that, in turn, could result in insurance lapses, loss of staff privileges, and license inactivation. Providing timely address changes to the Board will reduce the stress and frustration of late registration. Every Forum has a change of address form on its back cover (see above), the Post Office provides change of address forms, and the Board’s registration system itself, whether by mail or via the Internet, provides an opportunity to verify and update addresses. (The Board also accepts address changes by mail or fax, but not by telephone.) Address changes should include your full name, license number, the date, the new address(es), and any change in telephone and fax number(s).

The Board maintains two addresses for each practitioner: a practice address and a home address. You may designate either as your primary mailing address. You may also indicate which address you prefer to have in the public record.

Taking Care of Things

"If we take care of the little things, the big things tend to take care of themselves."