President's Message

Walter J. Pories, MD

Are You Having a Bad Day?

Charles Granville Rob, MD, one of our licensees, was a true hero, well worth remembering in these difficult times. After he completed his surgical residency in 1941 at the St Thomas Hospital during the London Blitz, he was assigned as a surgical specialist to the First Parachute Brigade. Only a few months later, he was dropped into the desert, 90 miles east of Tunis, behind the German lines. Fighting was fierce and casualties were heavy. Even though he sustained fractures of the tibia and patella during the drop, he rapidly converted a French garrison school into a 20-bed hospital and carried out 150 operations on the first day of the battle. He cared for all: the British soldiers first, then the civilians, and finally, with equal care, the German prisoners. When the blood bank was exhausted, he gave a unit of his own blood. Only when the work was done did he finally dress his own wounds. For these contributions under fire, he received the British Military Cross, the United Kingdom's second highest medal for valor.

He had a glorious career. He was one of the founders of vascular surgery, performed the first carotid endarterectomy, and offered the first descriptions of the thoracic outlet syndrome and meralgia paresthetica. He also taught legions of grateful surgeons as a chairman at St. Thomas and the University of Rochester, as an inspiring professor at East Carolina and, finally, at the Uniformed Services University for the Health Sciences (USUHS), our country's premier medical research university.

License Registration

In the last number of this publication, we offered a guest article by Dr Alison C. VanFrank in this space. In that article, she explained the travails of her most recent encounter with license registration. You see, she failed to register her license in 2000 as required by law and suffered some rather significant consequences. One consequence was that, at the request of the Board, she agreed to write an explanation of what had happened for the benefit of other licensees. The Board's intentions were good. It did not view this as some sort of humiliation; rather, it wanted to be helpful to its licensees by showing sequelae that can accrue from this process if one is not careful. Many of these problems are unanticipated, particularly if one views medical license registration as simply bureaucratic and ministerial. The burden to register annually is placed by law on the licensee. We are not isolated in this respect; in 49 other states, medical board licensees have an affirmative responsibility to keep their licenses current. This serves several purposes, not the least of which is the providing of information to the Board that is critical for the public trust conferred by medical licensure.

In my opinion, Dr VanFrank's article was thoughtful and very well written. It pointed out the problem she encountered and made the point the Board envisioned. However, it did generate several strong letters of concern in response (see the "Letters to the Editor" in this number of the Forum). Physicians, attempting to practice medicine as best they can, often feel that they are up to their necks in bureaucracy. The message conveyed in Dr VanFrank's article was received by some as reflecting an uncaring bureaucracy adding to their burdens.

In this number of the Forum, we continue our efforts to help our licensees keep pace with the regulatory and practice challenges of medicine today.
Are You Having a Bad Day?

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military medical school.

There are, of course, many “Rob Stories,” of which two are especially timely. I recall one about his uncle that he told us during a graduation address at ECU. Uncle Mitchell was a morbidly obese family physician who provided excellent care in northern England during the war under unusually harsh conditions. However, when he was summoned one day to deliver a baby in a rural trailer, it rapidly became apparent that he could not fit through the narrow door, even when he stripped down to his skivvies. It must have been quite a sight. Eventually, the problem was solved by erecting a makeshift tent outside the trailer where the baby was successfully delivered. During a visit to the village about 40 years later, Rob asked the family how they survived the war. “Oh, we made it,” they said, “we got along,” but instead of dwelling on the hardships, they spent most of the time still laughing about the time Uncle Mitchell couldn’t get into the trailer. By this point in his story, Rob had the students laughing too, and then he offered them the moral, which is good advice for all of us: “Be careful what you do as a physician, folks will remember it for a long time.”

My other favorite story occurred when I was his resident at the University of Rochester. Similar to many other centers, we had developed a culture of surgical divas, surgeons whose every operation was a tantrum with screamed obscenities and flung instruments. After all, that’s how surgeons were expected to behave. Rob felt differently. To him, caring for patients was the greatest privilege and surgery was not only easy, it was fun. If you didn’t enjoy doing it, you shouldn’t be in the O.R. After he heard several complaints from the staff, he told Connie, the OR supervisor, also from England, to give him a call at the next incident. He did not have to wait long. On the next day, one of our most notorious bullies was having the mother of all tantrums during a thyroidectomy, throwing clamps and insults in all directions. While there is never, in my opinion, a reason to lose your temper during surgery, such misbehavior is especially difficult to understand during a thyroidectomy, an operation that is a delight to perform. The procedure is rarely emergent, the anatomy is stunningly beautiful, and the techniques are not very challenging. But back to the story. Rob suddenly appeared in the O.R., fully scrubbed, and asked, “Are you having a bad day?” As he donned the gown, he quietly told the bewildered surgeon that he would finish the case for him; after all, if he was that upset, he must be in trouble and needed help. When the surgeon refused to leave, Rob told him that he must if he wanted to keep his privileges. When he did, the operation was finished quickly and quietly. It was the last time I ever observed a tantrum in the operating rooms at Rochester. I am not at all sure that Rob’s decision would stand today in our restrictive legal environment, but his principle is still sound. The physician who causes peptic ulcers in his staff as he treats such a lesion in his patient is not a great humanitarian.

Charles Rob died at age 84. We will miss him. However, his principles will long survive. They bear reemphasis in these difficult times.

- Patients come first.
- Folks have long memories.
- Serve with grace and be thoughtful of your colleagues.

From
Dr. Elizabeth P. Kanof:
A Personal Thank You

Over the past year or so, I have had the great pleasure and honor of visiting over 30 medical societies, hospitals, and other groups across the state to discuss the role and work of the North Carolina Medical Board and to answer questions about the Board. During most of that time, I was also serving as president of the Board. Today, as immediate past president of the Board, I want to extend my deepest appreciation to those many people, physicians and non-physicians, who invited me to meet with them and who welcomed me so warmly. Though other Board members, Board staff, and I will continue to respond to requests for presentations from all interested organizations, professional and public, I want to take this opportunity to offer my thanks to those groups that have given me their time and attention over the past year.

Elizabeth P. Kanof, M.D.
Immediate Past President, NCMB
License Registration

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a physician’s bureaucratic headaches.

There are those who, perhaps without intending to do so, make a case that tends to devalue the significance and meaning of the medical license. Quite frankly, I think that the privilege of practicing medicine is one of the highest that can be conferred by any state, that the medical license is a positive reflection of the importance our society places on medical practice. In fact, our forefathers thought requiring a license to practice medicine was so essential to the public good that North Carolina was one of the first states to do so. Our medical licensing statute was created in 1859.

Today, there are very few places in the civilized world where one can practice medicine without a license. I was once visited by the health minister of a breakaway Soviet republic. As this country was joining the international community, one of its first tasks was to set up a medical licensing system to protect its citizens from unqualified practitioners. So in my mind, if one trivializes the medical license and the supporting registration process, one is trivializing the importance of the practice of medicine itself. I am not aware of a single court in this land that has found there is an inherent right to practice medicine. Many plaintiffs have unsuccessfully argued there is such a right.

We care about the process and we are dedicated to making the registration system easier for all licensees. We were one of the early states to adopt electronic registration and we have one of the highest participation rates in the country — over 70%. What used to take weeks now takes minutes, with next-day written confirmation via e-mail. This process required a substantial investment of time and money to make work. We send reminders about registration to the last address furnished to us by each licensee, and we publish reminders to each licensee quarterly via the Forum. All of this is intended to help avoid the significant consequences suffered by Dr VanFrank. We do care significantly about serving the public and all licensees.

One thing we have planned to help both licensees and their patients is to expand our range of disciplinary options. The benefits of an expanded range of disciplinary options to patients are perhaps obvious, the benefits to licensees not so obvious. As of today, the disciplinary options available to the Board by statute (see NC GS 90-14 at our Web site) are “... deny, annul, suspend, or revoke a license...”. This list needs to be updated to include probation, withholding disposition, levying a fine, requiring community service, issuing private or public reprimand, and other lesser sanctions. These would provide a range of appropriate actions available for marginal violations or special circumstances. So, in a peculiar way, increasing our range of disciplinary options helps both the public and those subject to Board action. We will likely work on this in the legislature.

As to consequences for failure to keep a license current, my point can be made by analogy. Let’s consider deer hunting in a neighboring state. If you drive a brand new truck into the woods, shoot a deer without a hunting license, and get caught, the brand new truck becomes the property of the state, along with your hunting rifle. That is the penalty before the court decides what to do with you. These items are confiscated because they were used in the commission of a crime. You can’t go into court with the defense that the state failed to notify you of the requirement to get a hunting license. In that instance, the state sends you no reminders. If you intend to go into the woods and hunt, it is your responsibility to find out what the law is, where to get a hunting license, and how to obtain one. It is further your sole responsibility to keep that license current. If you don’t keep it current, you will suffer the consequences.

In my estimation, the medical license is many times more important than that hunting license. It has to do with people rendering medical care to the most precious of a state’s assets: its citizens.

That gets to the core of why the Board asked Dr VanFrank to write her article: to be helpful to her colleagues. There are sequela to non-registration that are quite significant. Medical malpractice carriers may drop coverage. Third-party insurers, who check our system, sometimes daily, to see who is currently registered, may also drop someone from coverage. In some instances, they may only check at intervals of six months. If they happen to check at the wrong interval, the licensee may get a recoupment notice for the still equally as important of a state’s assets: its citizens.

The critics we have received for the VanFrank article have been taken seriously. We respect the concerns expressed. However, with 31,000 licensees, I don’t think the average licensee would want or expect us to use his or her registration money to pay for the extra staff necessary to track down or search out people who fail to take care of their registration burden. There would be significant overhead in that. It is better to publish regular reminders in the Forum, to provide a mechanism to make the process much easier, like electronic registration. Licensees uniformly advise us that our electronic registration process is superior to any other they have used.

We are, therefore, grateful to Dr VanFrank for her commentary. We are also grateful for the letters we have received that were generated by her article. It all draws attention to the importance of the licensee keeping up with the registration process. So although we have generated some criticism, at the end of the day we hope some good has come of it. One of our critics writes: “By appearances, a Brodchingnagian punishment was meted out for a Lilliputian offense.” I disagree. The medical license and the respect in which it should be held by every licensee is anything but Lilliputian, and much of what he sees as punishment is really sequelae. I hope this helps, and as always we genuinely appreciate your comments about these and other issues.

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NOTICE:
Annual Registration Fee to Rise Beginning with March 2002 Birthdays

During its 2001 session, the North Carolina General Assembly approved legislation raising the annual registration fee for the medical license from its current level of $100 to $125. The new fee is still below the average of medical license registration fees nationwide.

The $125 annual fee becomes effective beginning with the registration of licensees with birthdays in March 2002, and will be reflected in registration notices.

Most licensees now register on line by way of the “Electronic Registration” section of the Board’s Web site (www.ncmedboard.org), and the new $125 fee will be clearly noted on the site for birthdays in March 2002 and following.
The Reality of Child Abuse Homicides

Marcia E. Herman-Giddens, PA, DrPH
Senior Fellow, North Carolina Child Advocacy Institute
Former Medical Director, North Carolina Child Fatality Prevention Team


A child is killed every two to three weeks in North Carolina by a caregiver, usually a biological parent, sometimes a stepparent, sometimes a boyfriend or girlfriend of the parent, occasionally other relatives or babysitters. These children's deaths are not easy deaths. Too often they have been abused before the lethal event, and, in some cases, tortured for months or years. Sometimes the killings are silent and without outward sign of force, usually they are far more violent than anyone would want to believe. Autopsy photographs in these cases are all too often full of bruises, cuts, and blood.

Our society's violence towards children belies the impression we give of caring about children, our concern for children's safety, our desire for good schools, and the advertisements of smiling babies and doting parents. Statistics tell of another reality. Homicide is now the third leading cause of death for children ages one to five in the United States. Almost all of these homicides are due to abuse. Behind this number are the tragic, awful stories of the murdered children.

These stories are described to offer a depth and perspective to the reality of child abuse. Each case history represents a brief summary of extensive work done by not only the medical examiner, but often many other professionals. Names have been changed to protect the fact that in some cases some of the information is from confidential files. All are North Carolina cases from the last 15 years. Legal outcome data in some cases were impossible to get because information is not kept in central files by the name of the victim. Disparities in legal outcome are clear from these cases. Always, there is a lot of missing information. And always, there is a tragedy that should never have happened.

Two-year-old Susan
Susan was placed on an adult toilet by her mother's live-in boyfriend. He then allegedly struck the child in the chest causing injuries from which she later died. Susan's siblings had been removed from the home before her birth. Susan had been seen at age one for vaginal bleeding. Her mother had changed her story about the bleeding twice. There had been three reports of child neglect (one substantiated) and one for sexual abuse (unsubstantiated) on Susan. Her mother had brought an assault charge against her boyfriend, but it had been dismissed. The boyfriend was a convicted sex offender with a history of substance abuse. Legal outcome: Susan's mother's boyfriend was charged with murder but found not guilty in a jury trial.

Eight-year-old Sara
Sara's father took her into a wooded area and shot her in the neck. It took several days to locate the child's body. Prior to the incident, he had sent Sara's mother a murder/suicide note. Sara's parents had recently separated and the child was living with her father. The mother had wanted to have Sara on weekends when she received the note. There had been some concerns about sexual abuse on the part of the father. No evidence was found by the autopsy to confirm or deny sexual abuse. Legal outcome: Sara's father pled guilty to a murder charge, and was sentenced to life in prison.

Nineteen-month-old Lily
Lily had been forcibly immersed in a tub of scalding water one morning by her mother's boyfriend. The child's injuries were noted by a policeman who saw her with her mother and her boyfriend at a parking lot at a 'remote' restaurant later that day. Lily was wearing a diaper and the burns were evident. The couple said they were on the way to get help. Lily was taken to the hospital for treatment of burns over 47 percent of her body. Other injuries noted included a cigarette burn on her mid upper back, and bruises on her arm, face and cheeks, and labia. Her burns were consistent with intentionally holding the child in hot water. Lily died due to complications from the burns. Legal outcome: Lily's mother's boyfriend was charged with murder and pled not guilty. The jury determined he was not guilty.

Ten-month-old Daria
Daria was sleeping in the same bed as her father. The father later gave the story that he saw Daria falling off of the bed and pulled her back on the bed by her arm. At that time, he noted that she was limp and unresponsive. He called Emergency Medical Services but when they arrived they found the baby dead. At first it was considered to be a SIDS death, but the ER doctor felt there was some question. The autopsy found that Daria died from abdominal trauma. Her father reportedly said it was his fault because he was too rough with her. Legal outcome: The case against Daria's father was closed due to insufficient evidence. The investigators concluded, "No evidence of prior abuse or trauma. Injuries innocentely obtained."

Newborn Dahlia
Dahlia's mother had concealed her pregnancy by saying she had a tumor. Her estranged husband and his mother were visiting when she excused herself to go to the bathroom for her "tumor" problem. She came out about 1 1/2 hours later. A full-term fetus was later found in the trash can behind the house. The mother admitted herself to Dorothea Dix a few days later. Legal outcome: Dahlia's mother was charged with concealing a birth and first-degree murder. She pled guilty to concealing the birth and received a six-year suspended sentence with supervised probation and mental health involvement.

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Child Abuse Homicides  
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Three-year-old Jimmy
Jimmy’s mother’s boyfriend was babysitting for Jimmy. The boyfriend ‘disciplined’ the child by administering blows on the head with a hairbrush, which subsequently killed the child. The medical examiner’s file had clear pictures of the patterned injuries that matched the hairbrush.

Legal outcome: Jimmy’s mother’s boyfriend was charged with second-degree murder. The jury convicted him of a misdemeanor and gave him a two-year jail sentence.

Two-year-old Bruce
Bruce was found dead in the early morning in his home. He had been ill for a week following a visit to his biological father’s house. Bruce’s mother said that he was having trouble walking and was vomiting intermittently. She had taken him to the emergency room the day before his death, but no specific therapy was given. An appointment with a doctor was made for a later time, but he died before this could occur. The autopsy found that he died from blunt trauma to the head and had evidence (rectal bleeding and enlargement) of child sexual abuse.

Legal outcome: Bruce’s father was charged with first-degree murder and first-degree sexual offense. The outcome of the trial was not available.

Four-month-old Lynn
The mother of Lynn was having problems with Lynn’s father. She went to the police department to get an officer to remove the father, age 19, from the residence. When she returned, the father met her at the door and stated that Lynn had just quit breathing. The mother took Lynn to the police department, but by the time an emergency medical worker saw the baby she was unresponsive. The father’s account was that he was drunk and went to bed, leaving the baby strapped in her chair. The next door neighbor had come over and put the baby in bed with him. The father stated that the baby started crying and he reached over and put a pacifier in her mouth and, then, a few minutes later she started ‘losing her breath.’ The autopsy found that the child died as a result of multiple traumatic insults, including 24 new and healing rib fractures, bruises to the back of the head, eye, lips, chest, and a left skull fracture.

Legal outcome: The child’s father was charged with first-degree murder. The first trial was a mistrial. In the second, he was convicted of second-degree murder, and given a life sentence.

Eight-month-old Billy
Billy lived with his mother and maternal grandparents. The sequence of events regarding his death was not clear and varied with the interviewer. Neither of the grandparents was at home at the time of the lethal incident. Billy’s mother called EMS four hours after the child’s death. Billy was found in his crib, naked, with his head lying between cushions. His death was considered to be due to SIDS until the mother confessed to the SIDS counselor that she smothered Billy. Billy’s parents were not married and his father only saw him occasionally. There was some evidence that the mother may have been intoxicated at the time of the incident. Billy did not have evidence of abuse on his body.

Legal outcome: Billy’s mother was charged with first-degree murder. She pled guilty of second-degree murder and received a 40 year prison sentence.

Save Time, Register On Line
Nick Hunt, NCMB Licensing Staff

It is no secret that members of the medical community are extremely busy. Doctors, especially those new to the profession, can regularly work 80 hours per week. Throw in the additional demands placed by family, friends, and everyday life, and the result can be a community of tired practitioners. The mere fact that you are reading this publication is a credit to your time management skills.

The North Carolina Medical Board wants to make your annual license registration as quick and painless as possible. In an effort to save you time and increase the accuracy of your medical license information, we have established on-line license renewal.

With a few simple clicks of the mouse, we will eliminate the hassle of pens, paper cuts, and the U.S. Postal Service. On-line registration is simple. All you need are a:
• computer with Internet access,
• certificate ID number (found on last year’s certificate and renewal notices sent by the Board),
• Social Security number, and
• birth date.

Secure on-line payment can be made using a Visa® or MasterCard®. It’s that simple! Renew your registration up to two months prior to expiration by going to our Web site (www.ncmedboard.org) and clicking on the link for electronic registration. Just a few quick keystrokes, pushes of the “enter” button, and mouse clicks, and you are done.

Need another reason to forgo paper and peck at the PC? The chances of your information being correct increase ten-fold when your registration is completed on line. When you register using the paper method, numerous things can happen that can delay or corrupt the processing of your application, including slow mail service and our staff or computer misinterpreting illegible handwriting.

On-line registration also saves the time you would have spent filling out the paper forms, and that is just the beginning. It takes one or two days to process on-line registration. Compare that to the three weeks (from the time you mail it to us) that it takes to process the paper registration. Won’t it be nice when the DEA calls for proof of your license and you can provide it instantly?

Some of you may not consider yourselves computer savvy. We understand that and are trying to help make your on-line registration as painless as possible. If you have trouble, e-mail us at registration@ncmedboard.org. We will send you a response within two business days.

Save time, increase the odds that your registration information will be correct, and maybe learn a little about the Internet by registering on line.

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North Carolina Medical Board

Web Site: www.ncmedboard.org

E-Mail: info@ncmedboard.org
Training Staff and Seeing Patients: 
Stories from the Moldova Hospice Project

Laurie Saxton, Director of Communications
Carolinas Center for Hospice and End of Life Care

Last spring, Pat Ashworth was drawn back to Moldova. Ashworth, a certified hospice palliative nurse at Hospice and Palliative Care of Greensboro, is a consultant to the project to open the first hospice in this Eastern European country. She had first joined Judi Lund Person, president and CEO of The Carolinas Center for Hospice and End of Life Care, on a trip to Moldova in the fall of 2000. On her return visit, sponsored by The Carolinas Center, she joined the staff of the planned hospice for two weeks of training in Romania. Home visits in Moldova followed, to put the team’s new knowledge into practice. This is the story of her journey.

Ashworth shared her experiences in a workshop she presented with Person at The Carolinas Center’s annual conference in October. The workshop offered the opportunity to discuss the hospice movement in Eastern Europe, the Moldova experience, and cultural similarities and differences regarding death and dying.

**Moldova: the Country and the Challenge**

About 4.5 million people live in this hilly agricultural country with rich traditions of family ties, culture, art and music. The literacy rate is near 100 percent. About the size of Connecticut, Moldova lies between Romania and Ukraine. After a long history of foreign domination, Moldova achieved independence from the Soviet Union in 1991. Since then, Moldovans have struggled to rebuild and replace their system of social and medical care. (Life expectancy has actually declined during the last 10 years.)

NATO’s Partnership for Peace paired each former Soviet state with a partner in the United States. Moldova is North Carolina’s partner. Many private and public organizations are working to support the partnership, foster democracy in Moldova, and provide assistance to the government and private economy.

The Moldova Hospice Project is a collaboration of The Carolinas Center, other medical and hospice professionals, the North Carolina National Guard, and North Carolina Rotary Clubs in an endeavor to make a real difference in the lives of dying Moldovan patients and their families. These people and organizations are working to achieve the dream of developing the country’s first hospice in the village of Zubresti.

The service area of the new hospice includes 51,000 people who live in 11 towns ranging in size from 1,400 to 22,000 inhabitants. Approximately 100 people within the service area die each month. The leading causes of death include cardiovascular disease, liver disease including cirrhosis and cancer, and other cancers.

Efforts to improve the area’s health must overcome several challenges. The local water supply is contaminated with pesticides and human waste. Leukemia in children has been linked to the impure water. Pain medication is scarce, affecting both hospice care and more general medical care. Morphine is available only in very small doses; the amount of a four-hour dose in the U.S. must last all day in Moldova.

Four key elements were identified early in the hospice development plan and are now being addressed: training for hospice staff; governmental and regulatory issues (import laws, medication, standards of care); the proposed hospice facility itself; and the funding required to tackle the first three elements.

**Training the Hospice Medical Staff**

Fourteen physicians and nurses from Moldova participated in a very intensive two-week training program, covering all the standards of hospice care, operations, and protocols applicable to Eastern Europe. Ashworth praised her colleagues’ dedication and enthusiasm under difficult circumstances. “The Brasov Study Center [in Romania] had never conducted training in back-to-back weeks. They agreed to try it to make it easier for the Moldova staff to attend — and it was intense!”

Hospice care is a completely new field in Moldova. Education in pain management and palliative care, so fundamental to hospice, was essential for the medical team. They absorbed it eagerly, mastering the pain management ladder, knowledge of round-the-clock dosing, and other aspects of hospice care.

After the training, Ashworth and the hospice team returned to Moldova for home visits in the service area of the new hospice. The two-way education continued with discussions of the care appropriate for the kinds of illnesses and patients seen in the area. “We can learn from them, too,” Ashworth said. “Moldovans have a very family-centered idea of care for the dying.” But there is a severe shortage of caregivers in a country where over 600,000 people leave every year in search of work.

I imagine delivering home care — on foot — for an entire day. Within the villages, this is a way of life for physicians and nurses. In and around Straseni, the largest town in the area, visits were made in the “company car” — a WWII-era jeep. After a day of navigating the terrain by jeep, Ashworth was glad to travel on foot again. The most memorable features of this remarkable environment were the patients and their families. Here are just three of their stories.

As his mother was dying, this boy was given to the neighbors.

**Given to the Neighbors**

In Straseni, the team paid a visit to the home of a 37-year-old woman with advanced breast cancer. The patient was not there; instead, a small boy came out to meet them. Where was his mother?

The boy’s aunt had come and taken his mother to the aunt’s home to die. His father had left home years before, an older sibling was away working — and this eight-year-old had been given to the neighbors.

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A Physician Needs Healing

Drs Andre and Maria Grozav run the clinic in the village of Recea. Maria accompanied Ashworth and Dr Eleonora Suruceanu on their travels. One day as they stopped for lunch at Andre and Maria’s home, Maria confided in broken English, “My husband is not well.”

Dr Andre Grozav was undergoing chemotherapy for pancreatic cancer. The Grozavs are the only physicians in their village. So, though pale and thin, he was still making his rounds. Maria too continued to provide care, to her patients and to Andre, working through her fear that she may soon be the only doctor in Recea.

Confined to One Room for Five Years

On her home visits, Ashworth saw more than one case of untreated fractures resulting in disability. One patient had been confined to bed for eight years, and to only one room for five. Untreated fractures, including her right hip, left her unable to walk. The woman’s situation, so rare to American eyes, was not unusual.

Untreated fractures left her confined to one room for five years.

The woman’s daughter cares for her at night when she returns from work. During the day, a neighbor looks in on her. Family members often must go to another village to find work. When this happens, it is not uncommon for neighbors to provide care.

Patients even administer their own medications — including IV — because there is no one else to do it. Ashworth was humbled by the experience. “We have so much in the U.S. So many of us for granted that our fractures and our heart disease will be treated.”

Prospare Zubresti — the New Hospice Facility

The Moldovan government has donated a former hospital building to be used as the hospice inpatient facility. Major renovations are needed to get the building into working condition and to provide even the basics of comfort and care: running water, indoor plumbing, electricity, heat.

Changes will have to take place as well in the practices of the patients and their families. In Moldova, patients generally take their own linens, food, and even medicines with them when they enter a hospital. How will they respond to a hospice facility where all these things are provided for them?

And there might be some adjustments in the American expectations of a hospice inpatient facility. In Moldova, 98% of patients die at home. How should a hospice be sensitive to the customs and wishes of the patients? The inpatient facility might address short-term pain management and symptom control needs, then release patients to return to their homes.

Support and Funding for the New Hospice

After 25 years of providing hospice care in North Carolina, it is time for us to share our knowledge with people in other countries, as we ourselves learned in the 1970s from Dame Cicely Saunders and her hospice experience in Great Britain. The commitment to hospice care in Moldova is not a short-term association, but a lasting relationship between our countries and our hospice care providers that is based on mutual understanding.

The training of the Moldova hospice staff last spring marked one step in this relationship. The contributions of many individuals in the Carolinas made this training possible, paying for the travel by van to Romania and for the two-week intensive course. The Carolinas Center for Hospice and End of Life Care is seeking funding through grants and individual contributions to realize the goal of opening the inpatient facility next year and continuing to serve patients like the ones Ashworth saw.

The Carolinas Center is awaiting word on a grant that will allow renovation of the 20-bed former hospital to create the hospice inpatient facility. The needed renovations could begin as early as next spring, and not a day too soon for those who await the support and care the hospice will provide. More than dollars are needed. Volunteers are vital as well, to travel to Moldova to assist the fledgling hospice.
Last quarter, the North Carolina Medicaid Drug Utilization Review (DUR) Board, consisting of practicing physicians and clinical pharmacists, conducted a review of prescription claims for patients who had been diagnosed with diabetes and were not receiving a “statin” drug. Surprisingly, over 24,000 patients met this criterion; 1,000 of these were further reviewed. We do not mean to imply that all patients with diabetes automatically require statin therapy. However, analyzing the aggregate data has at least raised the possibility that we are not treating dyslipidemia as aggressively as we should.

Persons with diabetes who have had a myocardial infarction have an unusually high death rate. The American Diabetes Association recommends annual lipid profiles for adult patients with diabetes. However, according to data compiled by Medical Review of North Carolina, only about 60% of Medicare patients with diabetes received this test within two years in the Carolinas. A complete discussion of the new National Cholesterol Education Program (NCEP) ATP III high cholesterol guidelines is beyond the scope of this article, but can be found in JAMA and other medical literature. The Executive Summary of these new guidelines may be downloaded from the following National Institutes of Health (NIH) Web site: http://www.nhlbi.nih.gov/guidelines/cholesterol/atp_iii.htm.

Therapeutic lifestyle changes (TLC) such as diet, weight reduction, and increased physical activity remain an integral part of cholesterol treatment. Key changes include more aggressive LDL lowering to less than 100 mg/dL in all patients with diabetes, a higher level (40 mg/dL) at which HDL becomes a risk factor, a new set of TLC, targeting the “metabolic syndrome,” and increased attention to high triglycerides. Please refer to peer-reviewed, evidence-based medicine (EBM) guidelines for detailed recommendations on managing your patients who suffer from diabetes or dyslipidemia. The American College of Endocrinology (ACE) and American Association of Clinical Endocrinologists (AACE) practice guidelines for the diagnosis and treatment of dyslipidemia and prevention of atherogenesis may be found at http://www.aace.com/clin/guidelines. In addition, diabetes management guidelines from the ACE Consensus Conference on Guidelines for Glycemic Control may be text continued on page 11.

### Effectiveness Tables

#### Table 1: Statin Effects On Lipids After 8 Weeks of Treatment With LDL from 192 to 244 mg/dL

<table>
<thead>
<tr>
<th>Drug</th>
<th>Statin</th>
<th>Lipid Class</th>
<th>TC (%)</th>
<th>LDL (%)</th>
<th>HDL (%)</th>
<th>TG (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atenolol</td>
<td>0-10</td>
<td>10-44</td>
<td>8-14</td>
<td>4-14</td>
<td>4-14</td>
<td>4-14</td>
</tr>
<tr>
<td>Lescol</td>
<td>0-10</td>
<td>10-44</td>
<td>8-14</td>
<td>4-14</td>
<td>4-14</td>
<td>4-14</td>
</tr>
<tr>
<td>Lescol</td>
<td>0-10</td>
<td>10-44</td>
<td>8-14</td>
<td>4-14</td>
<td>4-14</td>
<td>4-14</td>
</tr>
<tr>
<td>Pravasad</td>
<td>0-10</td>
<td>10-44</td>
<td>8-14</td>
<td>4-14</td>
<td>4-14</td>
<td>4-14</td>
</tr>
<tr>
<td>Zocor</td>
<td>0-10</td>
<td>10-44</td>
<td>8-14</td>
<td>4-14</td>
<td>4-14</td>
<td>4-14</td>
</tr>
</tbody>
</table>

Key: TC: total cholesterol; LDL: low-density lipoprotein; HDL: high-density lipoprotein; TG: triglycerides

#### Table 3: Antihyperlipidemic Drugs and Their Effects

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Statin</th>
<th>Lipid Effects</th>
<th>Side Effects</th>
</tr>
</thead>
</table>
| Primary Prevention: AFCAPS/TexCAPS = Air Force/Texas Coronary Atherosclerosis Prevention Study; WOSCOPS = West of Scotland Coronary Prevention Study Secondary prevention: 4S = Scandinavian Simvastatin Survival Study; CARE = Cholesterol and Recurrent Events Trial; LIPID = Long-Term Intervention With Pravastatin in Ischemic Disease

### Table 4: EBM Outcome Data and Dose of the Statins

<table>
<thead>
<tr>
<th>Statin</th>
<th>Morbidity/Mortality</th>
<th>Daily Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atenolol</td>
<td>None (studies ongoing)</td>
<td>Initiate: 10 mg, Range: 10-40 mg</td>
</tr>
<tr>
<td>Lescol</td>
<td>None</td>
<td>Initiate: 20-40 mg, Range: 20-80 mg</td>
</tr>
<tr>
<td>Zocor</td>
<td>Primary Prevention: AFCAPS/TexCAPS</td>
<td>Initiate: 20 mg, Range: 10-40 mg</td>
</tr>
<tr>
<td>Pravasad</td>
<td>Primary Prevention: WOSCOPS Secondary prevention: CARE LIPID</td>
<td>Initiate: 10-40 mg, Range: 10-40 mg</td>
</tr>
<tr>
<td>Simcor</td>
<td>Secondary prevention: 4S</td>
<td>Initiate: 20-40 mg, Range: 5-80 mg</td>
</tr>
</tbody>
</table>

Primary prevention: AFCAPS/TexCAPS = Air Force/Texas Coronary Atherosclerosis Prevention Study; WOSCOPS = West of Scotland Coronary Prevention Study Secondary prevention: 4S = Scandinavian Simvastatin Survival Study; CARE = Cholesterol and Recurrent Events Trial; LIPID = Long-Term Intervention With Pravastatin in Ischemic Disease
NCMB Elects Officers: Walter J. Pories, MD, President; John T. Dees, MD, Vice President; Paul Saperstein, Secretary-Treasurer

In October, Andrew W. Watry, executive director of the North Carolina Medical Board, announced the Board's election of its officers for the coming year: Walter J. Pories, MD, of Greenville, as president; John T. Dees, MD, of Bald Head Island, as vice president; and Paul Saperstein, of Greensboro, as secretary-treasurer. They took office on November 1, 2001 and will serve until October 31, 2002.

Walter J. Pories, MD, President
Walter J. Pories, MD, of Greenville, took office as the Board's new president on November 1, replacing Dr. Elizabeth P. Kanof, of Raleigh, in that post. A native of Germany, Dr. Pories is professor of surgery and biochemistry at the East Carolina University School of Medicine. He is also a clinical professor of surgery at the Uniformed Services University of Health Sciences. He received his BA at Wesleyan University, Middletown, Connecticut, and his MD with honors from the University of Rochester School of Medicine and Dentistry. His postgraduate study included an internship at Strong Memorial Hospital of the University of Rochester; a part-time fellowship at the Centre du Cancer of the Universite de Nancy, France; a graduate research fellowship in biochemistry at the University of Rochester; and a residency in general and thoracic surgery at Strong Memorial Hospital. He is certified by the American Board of Surgery and the American Board of Thoracic Surgery. He was first appointed to the North Carolina Medical Board by Governor James B. Hunt, Jr. in 1997, and has served as the Board's secretary-treasurer and vice president.

Frequently honored for his work as a surgeon and teacher, Dr. Pories is a past governor of the American College of Surgeons and has served as president of the North Carolina Chapter of the American College of Surgeons, the North Carolina Surgical Association, the Eastern Carolina Health Organization, Hospice of Greenville, and the Association of Program Directors in Surgery. Active on a large number of professional boards and committees, he is also the author/coauthor of 47 book chapters, 7 books, and over 250 medical articles dealing primarily with the metabolism of trace elements, diabetes, and surgical education. He has also been involved in the making of four educational films. In 2001, he was awarded the O. Max Gardner Award by the University of North Carolina Board of Governors, the highest faculty honor they can bestow.

Dr. Pories is a retired colonel of the U.S. Army Reserves. He has published over 50 cartoons and is a talented artist.

John T. Dees, MD, Vice President
John T. Dees, MD, of Bald Head Island (formerly of Cary), became the Board’s vice president on November 1, replacing Dr. Walter Pories in that position. A family physician, he practiced for many years in his native Burgaw, a rural area of the state. He received his undergraduate education at the University of North Carolina, Chapel Hill, and his MD from Duke University School of Medicine. He did his internship at Durham’s Watts Hospital and his residency at Duke Hospital. He is a charter diplomate of the American Board of Family Physicians.

Besides his private practice, Dr. Dees has served, among other things, as Pender County Health Director, chief of staff of Pender Memorial Hospital, and medical director of the Huntington Health Care Center. He has also been involved in a wide variety of professional organizations, including the North Carolina Academy of Family Physicians, the North Carolina Medical Society, the American Academy of Family Physicians, the Southern Medical Association, the Wake and New Hanover-Pender County Medical Societies, and the American Medical Association. He has served as president of the North Carolina Medical Society in 1991-92 and was a member of the Society's Executive Council and an alternate delegate to the American Medical Association's House of Delegates. He has also been an active participant in civic affairs in Burgaw and Pender County and at the state level.

Dr. Dees was first named to the Board by Governor James B. Hunt, Jr. in 1997. While on the Board, Dr. Dees has served, among other committees, on the Complaints Committee, the Physicians Health Program Committee, the Investigative Committee, the Clinical Pharmacist Practitioner Joint Subcommittee, and the Executive Committee. In 2000, he was elected secretary-treasurer of the Board.

Dr. Dees says his philosophy is that “service to humanity is the best work of life.”

Paul Saperstein, Secretary-Treasurer
On November 1, Mr. Paul Saperstein, of Greensboro, took office as secretary-treasurer of the North Carolina Medical Board, succeeding Dr. Dees.

First appointed to the Board by Governor James B. Hunt, Jr. in 1993, he was elected secretary-treasurer of the Board in 1995 and 1996 and vice president in 1997. In 1998, he became the first public member of the Board to be elected president. He has been a member of a number of Board committees, including the Investigative, Complaints, Physician Assistant, and Telemedicine Committees, and has chaired the Operations and Executive Committees.

A graduate of North Carolina State University, he is president and chief executive officer of Concept Plastics, Inc, including its Craft-Tex and Ladybug divisions, in High Point. He founded Concept Plastics, Inc, which is one of the nation's largest manufacturers of custom-molded polyester, in 1970. In the 1980s, he was also president and chief executive officer of Case Casard Furniture Manufacturing Corporation. Over the years, he has been active in a wide variety of community organizations and groups. ♦
Death Be Not Proud: The Meaning of Wit
Jeffrey A. Peake, NCMB Licensing Staff

Vivian Bearing has advanced metastatic ovarian cancer. She has just endured eight grueling treatment cycles, one cycle a month, each combining chemotherapy and experimental drug administrations. It has taken enormous courage and toughness to get through each treatment, and in fact no one else has ever made it through all eight at full dosage. Always attracted to difficult challenges, Vivian recognizes that her latest accomplishment makes her a celebrity around the hospital, one who will soon be written about in a medical journal article. But there is nothing comforting in this fact, and, ever closer to death, she is not inclined to illusions. "The article will not be about me," she says, "It will be about my ovaries. It will be about my peritoneal cavity, which despite their best intentions, is crawling with cancer. What we have come to think of as me is, in fact, just the specimen jar, just the dust jacket, just the white piece of paper that bears the little black marks."

There is a central tension in modern life we all periodically encounter, perhaps never more so than when we are in a hospital setting. It is the struggle to maintain human dignity amidst the forces of technology, specialization, and bureaucracy. This tension drives Margaret Edson's wonderful, though devastating, play Wit, a dramatization of a woman's battle against cancer, which won the Pulitzer Prize in 1999. Edson's play has been lovingly adapted into an Emmy-winning HBO movie (now available on VHS and DVD), directed by Mike Nichols and starring the unrivaled Emma Thompson, whose performance is a tour de force. Directed by Mike Nichols; HBO Films, HBO Home Video, DVD, 2000 99 minutes, $19.95

The entire drama unfolds at the fictional University Hospital Comprehensive Cancer Center, though there are flashback scenes throughout. Edson, an elementary school teacher now living in Georgia, previously worked in the cancer and AIDS unit of a research hospital, and that experience was the impetus for writing the play. We can surmise from Wit that her impressions of the hospital were largely unflattering, even ghastly at times. In a recent television interview, she said she wanted to write a story about grace, and could best do so through use of a graceless setting.

The narrator and lead character of both the play and film is Vivian Bearing, an English professor with expertise in the poetry of John Donne, the seventeenth-century Englishman best known for his highly complex works that have been dubbed "metaphysical" poetry. In particular, she is a scholar of Donne's Holy Sonnets, 19 intense religious meditations. The play's title derives from Vivian's connection with Donne, for in the seventeenth century the term wit did not merely suggest arousing amusement, but referred to a high level of mental activity, characterized in Donne's poetry through finding similarities in seemingly dissimilar images or elements, and in exploring paradoxes, contradictions, and irony. The point of this wit, as Vivian's mentor, Professor Ashford, reminds her in a flashback scene, is to illuminate truth. Edson's play follows suit, using wit to great dramatic purpose. For example, connections are made in Wit between poems and tumors, English professors and research fellows, the rich language of poetry and the clinical language of science. The result is a complex and layered work, one that contemplates the lessons of mortality and the sad consequences of forgetting our primary responsibilities for each other.

Vivian is an extremely intelligent woman, at the top of her field, proud of her work and quite willing to show off her verbal dexterity. She is impressive, or in her own words, she is "a force." Early in the play, she greets us with an engaging sarcasm, remaining as objective about and as distant from her dire situation as she can, though as the play progresses she becomes more insular and perhaps more her true self. In the midst of telling her story, Vivian is constantly being wheeled from room to room, poked and prodded by staff members who don't know her name, and put at the mercy of tubes and machines. Her physicians, Dr Kellekian and his chief clinical fellow, Dr Posner, have woe-ful bedside manners, which generally consist of empty exhortations, such as "keep pushing the fluids." Once she is even thoughtlessly left alone in a room, lying prone and exposed on an exam table. The indignities seem to increase as Vivian's condition worsens. Competitive research fellows speak over her during grand rounds, discussing her symptoms and side effects as if she were not even present. While on individual rounds, a masked Dr Posner enters her isolation unit, such a harrowing and lonely place, and murmurs "I really have not got time for this. . . ."

... my physicians by their love are grown Cosmographers, and I their map, who lie Flat on this bed.

I observe the physician with the same diligence as he the disease.

John Donne, Devotions VI

The play, though, is not simply a philippic against cold and faceless hospitals. As Vivian reviews her life, we see that she, too, is guilty of living ungraciously. Flashback scenes reveal she has had little to no affection for her students, often "refused them the touch of human kindness," and was mainly interested in impressing them. Apparently her colleagues do not like her, and she imagines many "would be relieved" at her death. Though her entire history is not revealed, we learn that she has lived largely in isolation and has no husband or children, no close family members, no close friends. The impression is that she has almost invited such a life.

Perhaps most importantly, we see Vivian's sterile attitude towards her life's work for the past 20 years. Of all the formal arts, poetry is best able to capture the totality of experience. In our greatest poems, the proper wedding of words and images creates what has been called a "miracle of harmony," through which we glimpse truths that cannot be represented any other way. Donne's poetry achieves this harmony through complex images and arguments. In his Holy Sonnets, these complexities lead to a moving exploration of sin, suffering, death, and, ultimately, divine reconciliation. Vivian, however, is drawn to Donne only because he is complex, saying that his "wit provides an invaluable exercise for sharpening the mental
faculties." Thus, the best reason she can give for her studies is that they bring an intellectual challenge, "a way to see how good you really are." Such reasoning ignores, of course, the most important dimension of poetry, the human dimension. In the same way, Vivian's physicians seem to have forgotten that their research isn't done for the sake of research, but for the sake of people. We remember those haunting words, "just the specimen jar, just the dust jacket, just the white piece of paper that bears the little black marks."

Yet, out of the darkness comes light. In her most desperate moments, when the pain of cancer and loneliness grow unbearable, Vivian becomes most fully human. In two scenes of great emotional depth, she shares her vulnerabilities at last, and accepts the warmth that is finally offered her. First, with the help of her nurse (the one standout hospital employee), Vivian is able to make a crucial decision about her end-of-life care, illustrating that she is now able to be gracious with herself. Then, in a moment of touching symmetry, she is visited by her former mentor, Professor Ashford, now an old woman who no longer offers admonitions, but tenderness and love. These scenes in the film version of Wit affected me like few I have ever seen, and in them one recognizes that redemption had occurred for Vivian through her suffering. At the play's tumultuous end, there is also hope. Dr Posner, the most callous of the clinical fellows, has been redeemed through a shocking epiphany, and one suspects the way he views his patients has been altered forever.

We are so privileged to live in an age of medical breakthroughs, to benefit from the hard work of researchers, the expertise of specialists, and the wonders of modern medical facilities. But what do we profit by it if we lose our souls? In reading, and watching, Wit, I was reminded of the author C.S. Lewis, who more than 50 years ago warned us that the pursuit of biological and medical conquests can, if we are not careful, obscure our very humanity. "If man chooses to treat himself as raw material, raw material he will be," he wrote, adding, "Man's final conquest has proved to be the abolition of Man." Wit, both as a play and a film, stands against our dehumanizing tendencies, and urges us to do better.

Few patients are quite like Vivian, which is probably a good thing, and few physicians are like Drs Kelekian and Posner, which is certainly a good thing. But all involved in the health care equation, laypersons and professionals, will find a bit of themselves in each of these characters; and that shock of recognition, that expression of wit, that troubling similarity in the dissimilar, cannot help but benefit everyone who reads or sees this remarkably moving piece. Be one of those if you can.◆

D U R Recommendation: continued from page 8

We recommend obtaining an annu-
al lipid panel and using the new NCEP guidelines to guide therapy. Please remember to exercise caution when considering drug therapy for children. Keep in mind that most antihyperlipidemic therapies are contraindicated in pregnancy.

We have included above several useful tables summarizing reported effectiveness of cholesterol lowering agents. Tables 1 and 2 provide various estimates of lipid lowering effectiveness of the statin drugs. Table 3 compares the effectiveness of the cholesterol lowering agents by class. Table 4 contains important data on EBM outcomes. Although Lipitor® (atorvastatin) is the current market leader with over $5 billion in annual sales and has data to support lipid lowering effectiveness, it currently has no supporting outcomes data (morbidity/mortality). There are at least eight long-term, large-scale outcome studies now underway that will provide additional crucial EBM data. Of the statin drugs, pravastatin (Pravachol®) is the only one with supporting EBM data for both primary and secondary prevention.

In summary, for patients with diabetes, check a lipid panel annually to identify those who may benefit from more aggressive lipid lowering therapy. Follow the new and more aggressive NCEP guidelines. Please consider EBM and medication costs when choosing drug therapy.

References

Questions and comments may be directed to Sharman Leinwand by telephone (919.857.4034) or by email (Sharman.Leinwand@ncmail.net) ◆
More on End-of-Life Care

To the Editor: I just finished reading [Dr Pories] article in regard to euthanasia, [Killing a Panda], in the NCMB Forum (#2, 2001). I feel compelled to write and to challenge [his] association between being a good physician and being the patient’s “suc-
cor of last resort.”

We should all pride ourselves on being caring physicians. We must love medicine but love our patients more. We need to spend time with them, to help them, to comfort them, and to protect them. On all of the above, I certainly agree with [Dr

Pories].

There comes a time, however, when loving is letting go. “Sores, bad smells, and incontinence” do not bother me as a physician. However, they certainly bother the patient. Life with quality is wonderful. Life without quality can be a true burden.

I lost my mother one year ago. I loved her dearly. She was in poor health even before her “gut” was “in knots.” It was my initial objective to make certain that we relieved her obstruction as soon as possible. However, my mother has always been smarter than I. Without hesitation, she refused the surgery. When I challenged her and told her that I was not ready to lose her, she challenged me for being so selfish and non-understanding. She pointed out that I wanted life for her for my own sake. As a physician, and as a son, I was unwilling to let her go. However, in her wisdom, she saw that life was always limited and that death was sometimes a greater gift than a painful, unhappy life.

Please do not get me wrong. I am not in favor of positive euthanasia. However, the election that my family eventually reached of relieving my mother’s pain and not putting her through further surgery, nursing home care, and possible years of suffering, was not one that I regret.

We must be willing to always place our patient’s overall welfare above our own personal desires to heal and prolong life. A good physician is one who helps his or her patient have quality in life and who sits by their side and holds their hand as they die. Your article implied that death is wrong. Death is real, and will be real for each of us. Let us hope that we, as physicians, can make the passage of our patients smoother, not only in life, but also in death.

Curtis W. Schupbach, M D
Charlotte, N C

Response

I appreciate Dr Schupbach’s thoughtful comments. His poignant description of his mother’s passing proves, indeed, that he is a “caring physician.”

I’ve thought a lot about death and how to ease its burden. I founded and directed two hospices, one in Cleveland and another in Greenville, so that our patients would have a place where death is accepted and even welcomed. I did not mean to imply that death is wrong. It may be unexpected or untimely or overdue, but it is never wrong. As Dr Schupbach reminds us, we will all die.

My mother’s end was also awful. She was lively and fun even until her 93rd birthday. She reminded me again and again that I would never let her linger, that I would allow her to have the “gift of a kind death” when her time came. “Promise me,” she said, and promise I did. Unfortunately, when she had a major stroke, someone carried out a full resuscitation that left her hanging on a ventilator for several terrible months, unable to communicate. When she was finally extubated, she spent the next eight weeks crying, “Help, help, help,” in the empty canyons of the nursing home. She could not communicate, and, frankly, I could not look into her eyes without feeling guilty. It is interesting that on the last day of her life she changed her mindless cry to, “God, please help me,” and within an hour, passed away.

Yes, Dr Schupbach, I’m right there with you in recognizing that there is a time to let go. I have no argument with your thesis. I only disagree with those who would take a life, who would rather dispose of the person than help, who find caring inconvenient.

Thank you for sharing your thoughts so well.

Walter J. Pories, M D, FACS
President, NCMB

Dr VanFrank’s Dilemma

To the Editor: I read today with a mixture of sympathy, shock, and anger Dr VanFrank’s moving account of the repercussions of inadvertently failing to renew her license [Forum #3, 2001]. I have never met nor heard of Dr VanFrank, but if, as I assume because the document was published, her story is true, this seems fairly clear evidence of a bureaucracy out of control. Not that I would countenance sloth or irresponsibility, but it does not seem like any reasonable effort was expended to effectively contact Dr VanFrank. Malting was attempted, and when that failed, it was attempted again and again. We all know how easy it is to forget to notify all the different sources when our address changes. Why the mail was not effectively forwarded, I cannot answer. Why the Board could not contact her at her known and apparently regular place of work seems worthy of exploration. It does not seem like much if any customer-friendly effort was expended.

More significantly, it seems tragic that a simple failure to make connection by mail should result in so much wasted effort, money, time, and suffering. When the lapse in licensure was discovered, it would seem some simple informal investigation would have revealed this to be an honest mistake, with appropriate and simple steps taken to clear the record without any pejorative residue. By appearances, a Brobdignagian punishment was meted out for a Lilliputian offense.

With rare exceptions, bureaucracies contribute little if anything to effective delivery of care to patients. We all struggle mightily every day with the ever-increasing volumes of paperwork, diverting useful effort to useless purposes. The North Carolina Medical Board really should have little difficulty doing their job effectively while still being compassionate. If anything, they probably owe Dr VanFrank an apology!

Karl T. Wolicki, M D
Greensboro, N C

To the Editor: I read every issue of the Forum. It is always informative, usually interesting, and occasionally worrisome. An article by Dr Alison VanFrank in the Forum, No. 3, 2001, fits the latter category.

The error of failing to register her N C license and to send the $100 annual fee in a timely manner appears to me to carry an extremely heavy consequence. Dr VanFrank had not been found to be incompetent, fraudulent, or unprofessional, which are the important measures of us as physicians. Rather, she moved her office and thereby failed to receive the annual renewal notice for registering her N C medical license. This administrative oversight led to an extreme impact on her medical practice as well as disproportionate financial and mental costs to her.

I personally think the Medical Board could take a greater degree of responsibility in reaching physicians who are delinquent in renewal of their medical licenses. Physicians, of course, have the primary responsibility to keep their licenses current. But in my 28 years of practice, I have seen a noticeable increase in the number of month-

continued on page 13
Avoid Treating Family Members!

Edward E. Hollowell, JD
Kenneth A. De Ville, JD

Most physicians enter the medical profession because it provides them with the training and opportunity to help people in need. It seems natural, therefore, that physicians might be tempted to take a professional role in providing medical care to those persons dearest and closest to them: their own families. Indeed, studies suggest many physicians regularly provide medical care for their family members. The instinct to take a professional role in providing medical care to a loved one, however, should be weighed against the overwhelming evidence from professional organizations, academic literature, and regulatory bodies that uniformly declare the treatment of family members to be professionally unwise and ethically problematic.

The North Carolina Medical Board (Board) issues Position Statements on professional and practice issues to provide guidance for physicians. While the Board's Position Statements are not legally binding, they provide clearly articulated and useful advice and reflect the Board's general view of what constitutes acceptable professional behavior.

The Board's statement, Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist, clearly states that:

...except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships.

The Board strongly believes that such treatment and prescribing is inappropriate and may result in less than optimal care being provided.

The admonition against treating close family members is longstanding and nearly ubiquitous. It is contained in the AMA's first Code of Ethics, adopted in 1847. The current AMA Council on Ethical and Judicial Affairs (Opinion 8.19) and the American College of Physicians' Ethics Manual echo the Board's warning against physicians treating family members.

Ethical and professional objections to a physician treating his or her family members are based on the danger that the physician's personal feelings for his or her patient/family member will undermine rather than enhance the care the family member receives. Personal feelings and fears might compromise a physician's professional objectivity and judgment, leading him or her to either over- or under-estimate the seriousness of the patient's condition.

For example, fearing the worst, the physician may over-diagnose a condition, subjecting the patient/family member to a series of unnecessary tests, treatments, fears, and risks. Conversely, the physician, reluctant to face the possibility of a seriously ill family member, may dismiss prematurely a viable but more serious diagnosis. These tendencies may be aggravated in that the potential informality associated with treating family members sometimes leads to less scrupulous adherence to traditional protocols of history-taking, physical and diagnostic workup, and record keeping. Moreover, family members are frequently examined outside the traditional office setting, without the appropriate support and proper equipment and resources.

Personal connections may also complicate the way in which the patient/family members and physician interact. Physicians with familial connections to their patients might be less likely to ask potentially sensitive, but clinically relevant, questions or to perform intimate, but necessary, examinations. Similarly, patient/family members may be less likely to disclose personal facts. Frequently, the very advantage of speaking to an unrelated physician is that information will be kept from family members. The personal distance may enhance disclosure. On one hand, some patients, especially children, may be less likely to refuse and question treatment recommended by a family member who is a physician. On the other hand, older family members may doubt the insight and wisdom of a younger, albeit professionally trained, physician/family member, and, as a result, be less compliant.

Treating physicians must sometimes play the role of mediator, negotiating between and among family members to help them understand and resolve difficult clinical and emotional questions. Here, too, familial connections can be a handicap rather than a benefit. Familiarity and interlocking loyalties can confound the already challenging issues of confidentiality, decision making capacity, informed consent, and the host of issues surrounding end-of-life care.

While the Board's Position Statement clearly discourages physicians from treating their family members, providing such care may be appropriate in some limited circumstances. In emergencies, minor illnesses, and in isolated settings in which no other appropriate medical care is available, physicians may legitimately treat a family member. In those cases in which a physician must provide emergency care for a family member, the patient's/family member's care should be transferred to another physician as soon as it is practical. The Board reminds physicians who treat family members for emergency or minor illness that they "must prepare and keep a proper written record of that treatment, including but not limited to prescriptions written for controlled substances and the medical indications for them."

Abiding by the long-standing warning against providing medical care to family members does not mean abandoning loved ones in their time of need. Instead, physicians can best help family members by referring them to qualified and appropriate health care professionals.

Letters to the Editor

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.

Could the Medical Board staff not make one telephone call reminder to physicians who fail to renew by their birthday? Give them a two week period to update and renew, with an appropriate late-filing fee (hopefully less than Dr. VanFrank's $12,000 [attorney's fee]) to cover the additional administrative costs? If this additional reminder did not work, then let the sky fall on the poor soul.

C. Allan Eure, MD
Raleigh, NC

Comment:

The above are two of five letters received at the Board expressing concern about the Board's action in this matter. We appreciate all five letters and each writer's viewpoint. While we regret space does not allow all the letters to be published in the Forum, the two printed here well reflect the opinions of all the writers. For a response, please see the comments of the Board's executive director in his column beginning on the first page of this number of the Forum.
Position Statements of the North Carolina Medical Board

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[The principles of professionalism and performance expressed in the position statements of the North Carolina Medical Board apply to all persons licensed and/or approved by the Board to render medical care at any level.

The words “physician” and “doctor” as used in the position statements of the North Carolina Medical Board refer to persons who are MDs or DOs licensed by the Board to practice medicine and surgery in North Carolina.]

Disclaimer
The North Carolina Medical Board makes the information in this publication available as a public service. We attempt to update this printed material as often as possible and to ensure its accuracy. However, because the Board’s position statements may be revised at any time and because errors can occur, the information presented here should not be considered an official or complete record. Under no circumstances shall the Board, its members, officers, agents, or employees be liable for any actions taken or omissions made or any consequences of such reliance.

A more current version of the Board’s position statements will be found on the Board’s Web site: www.ncmedboard.org, which is usually updated shortly after revisions are made. In no case, however, should this publication or the material found on the Board’s Web site substitute for the official records of the Board.

What Are The Position Statements of the Board and to Whom Do They Apply?

The North Carolina Medical Board’s Position Statements are interpretive statements that attempt to define or explain the meaning of laws or rules that govern the practice of physicians,* physician assistants, and nurse practitioners in North Carolina, usually those relating to discipline. They also set forth criteria or guidelines used by the Board’s staff in investigations and in the prosecution or settlement of cases.

When considering the Board’s Position Statements, the following four points should be kept in mind.

1. In its Position Statements, the Board attempts to articulate some of the standards it believes applicable to the medical profession and to other health care professions it regulates. However, a Position Statement should not be seen as the promulgation of a new standard as of the date of issuance or amendment. Some Position Statements are reminders of traditional, even millennia old, professional standards, or show how the Board might apply such standards today.

2. The Position Statements are not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. Therefore, the absence of a Position Statement or a Position Statement’s silence on certain matters should not be construed as the lack of an enforceable standard.

3. The existence of a Position Statement should not necessarily be taken as an indication of the Board’s enforcement priorities.

4. A lack of disciplinary actions to enforce a particular standard mentioned in a Position Statement should not be taken as an abandonment of the principles set forth therein.

The Board will continue to decide each case before it on all the facts and circumstances presented in the hearing, whether or not the issues have been the subject of a Position Statement. The Board intends that the Position Statements will reflect its philosophy on certain subjects and give licensees some guidance for avoiding Board scrutiny. The principles of professionalism and performance expressed in the Position Statements apply to all persons licensed and/or approved by the Board to render medical care at any level.

*The words “physician” and “doctor” as used in the Position Statements refer to persons who are MDs or DOs licensed by the Board to practice medicine and surgery in North Carolina.

[Adopted November 1999]

The Physician-Patient Relationship

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

Elements of the Physician-Patient Relationship

The North Carolina Medical Board licenses physicians as a part of regulating the practice of medicine in this state. Receiving a license to practice medi-

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The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to the physician in a vulnerable condition, believing the physician has knowledge and skill that will be used for their benefit. Patient trust is fundamental to the relationship established. It requires that:
- there be adequate communication between the physician and the patient;
- there be no conflict of interest between the patient and the physician or third parties;
- intimate details of the patient’s life shared with the physician be held in confidence;
- the physician maintain professional knowledge and skills;
- there be respect for the patient’s autonomy;
- the physician be compassionate;
- the physician be an advocate for needed medical care, even at the expense of the physician’s personal interests; and
- the physician provide neither more nor less than the medical problem requires.

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

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

Termination of the Physician-Patient Relationship

The Board recognizes the physician’s right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in compliance with the physician’s obligation to support continuity of care for the patient. The decision to terminate the relationship must be made by the physician personally. Further, termination must be accompanied by appropriate written notice given by the physician to the patient, the relatives, or the legally responsible parties. The decision to terminate the relationship must be done in compliance with the physician-patient relationship and to that trust — communication, patient privacy, confidentiality, competence, patient autonomy, compassion, selflessness, appropriate care — are foremost in the hearts, minds, and actions of the physicians licensed by the Board.

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(Adopted July 1995)

MEDICAL RECORD DOCUMENTATION

- The North Carolina Medical Board takes the position that physicians and physician extenders should maintain accurate patient care records of historical, physical findings, assessments of findings, and the plan for treatment. The Board recommends the Problem Oriented Medical Record method known as SOAP (developed by Lawrence Weed).
- SOAP charting is a schematic recording of facts and information. The S refers to "subjective information" (patient history and testimony about feelings). The O refers to objective material and measurable data (height, weight, respiration rate, temperature, and all examination findings). The A is the assessment of the subjective and objective material that can be the diagnosis but is always the total impression formed by the care provided after review of all materials gathered. And finally, the P is the treatment plan presented in sufficient detail to allow another care provider to follow the plan to completion. The plan should include a follow-up schedule.
- Such a chronological document:
  - records pertinent facts about an individual’s health and wellness;
  - enables the treating care provider to plan and evaluate treatments or interventions;
  - enhances communication between professionals, assuring the patient optimum continuity of care;
  - assists both patient and physician to communicate to third party participants;
  - allows the physician to develop an ongoing quality assurance program;
  - provides a legal document to verify the delivery of care; and
  - is available as a source of clinical data for research and education.

- Certain items should appear in the medical record as a matter of course:
  - the purpose of the patient encounter;
  - the assessment of patient condition;
  - the services delivered — in full detail;
  - the rationale for the requirement of any support services;
  - the results of therapies or treatments;
  - the plan for continued care;
  - whether or not informed consent was obtained; and, finally,
  - that the delivered services were appropriate for the condition of the patient.

- The record should be legible. When the care giver will not write legibly, notes should be dictated, transcribed, reviewed, and signed within reasonable time. Signature, date, and time should also be legible. All therapies should be documented as to indications, method of delivery, and response of the patient. Special instructions given to other care givers or the patient should be documented: Who received the instructions and did they appear to understand them?

- All drug therapies should be named, with dosage instructions and indication of refill limits. All medications a patient receives from all sources should be inventoried and listed to include the method by which the patient understands they are to be taken. Any refill prescription by phone should be recorded in full retail.

- The physician needs and the patient deserves clear and complete documentation.

(Adopted May 1994)
(Amended May 1996)

ACCESS TO PHYSICIAN RECORDS

- A physician’s policies and practices relating to medical records should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient’s care when such a transfer is requested by the patient or anyone authorized by law to act on the patient’s behalf.
- It is the position of the North Carolina Medical Board that notes made by a physician in the course of diagnosing and treating patients are primarily for the physician’s use and are therefore the property of that physician. Moreover, the resulting record is a confidential document and should only be released with proper written consent of the patient. Each physician has a duty on the request of a patient to release a copy or a summary of the record in a timely manner to the patient or anyone the patient designates. If a summary is provided, it should include all the information and data necessary to allow continuity of care by another physician.
- The physician may charge a reasonable fee for the preparation and/or the photocopying of the materials. To assist in avoiding misunderstandings, and for a reasonable fee, the physician should be willing to review the materials with the patient at the patient’s request. Materials should not be held because an account is overdue or a bill is owed.
- Should it be the physician’s policy not to include in either the copied or the summarized record those materials that were provided by other physicians regarding the patient’s former or current care, he or she should advise the patient of that fact and of ways those materials might be obtained.
- Should it be the physician’s policy to complete insurance or other forms for established patients, it is the position of the Board that the physician should complete those forms in a timely manner. If a form is simple, the physician should perform this task for no fee. If a form is complex, the physician may charge a reasonable fee.
- To prevent misunderstandings, the physician’s policies about providing copies or summaries of patient records and about completing forms should be made available in writing to patients when the physician-patient relationship begins.

(Adopted November 1993)
(Amended May 1996, September 1997)

RETENTION OF MEDICAL RECORDS

The North Carolina Medical Board supports and adopts the following language of Section 7.05 of the American Medical Association’s current Code of Medical Ethics regarding the retention of medical records by physicians.

7.05: Retention of Medical Records

Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist
Position Statement

physicians in meeting their ethical and legal obligations:
(1) Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.

(2) If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.

(3) In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.

(4) Whatever the statute of limitations, a physician should measure time from the last professional contact with the patient.

(5) If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority.

(6) Immunization records always must be kept.

(7) The records of any patient covered by Medicare or Medicaid must be kept at least five years.

(8) In order to preserve confidentiality when discarding old records, all documents should be destroyed.

(9) Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

Please Note:

a. North Carolina has no statute relating specifically to the retention of medical records.

b. Several North Carolina statutes relate to time limitations for the filing of malpractice actions. Legal advice should be sought regarding such limitations.

(Adopted May 1998)

Departures from or Closings of Medical Practices

Departures from (when one or more physicians leave and others remain) or closings of medical practices are trying times. They can be busy, emotional, and stressful for all concerned: practitioners, staff, patients, and other parties that may be involved. If mishandled, they can significantly disrupt continuity of care. It is the position of the North Carolina Medical Board that during such times practitioners and other parties that may be involved in such processes must consider how their actions affect patients. In particular, practitioners and other parties that may be involved have the following obligations.

Permit Patient Choice

It is the patient's decision from whom to receive care. Therefore, it is the responsibility of all practitioners and other parties that may be involved to ensure that:

- patients are notified of changes in the practice, which is often done by newspaper advertisement and by letters to patients currently under care;
- patients are told how to access their medical records;
- patients are told how to reach any practitioner(s) remaining in practice; and
- patients clearly understand that the choice of a health care provider is the patient's.

Provide Continuity of Care

Practitioners continue to have obligations toward patients during and after the departure from or closing of a medical practice. Except in case of the death or other incapacity of the practitioner, practitioners may not abandon a patient or abruptly withdraw from the care of a patient. Therefore, patients should be given reasonable advance notice to allow their securing other care. Good continuity of care includes preserving, keeping confidential, and providing appropriate access to medical records.* Also, good continuity of care may often include making appropriate referrals. The practitioner(s) and other parties that may be involved should ensure the requirements for continuity of care are effectively addressed.

No practitioner, group of practitioners, or other parties that may be involved should interfere with the fulfillment of these obligations, nor should practitioners put themselves in a position where they cannot be assured these obligations can be met.

*The Board's position statement on the Retention of Medical Records applies, even when practices close permanently due to the retirement or death of the practitioner.

(Adopted January 2000)

The Retired Physician

- The retirement of a physician is defined by the North Carolina Medical Board as the total and complete cessation of the practice of medicine and/or surgery by the physician in any form or setting. According to the Board's definition, the retired physician is not required to maintain a currently registered license and SHALL NOT:
  - provide patient services;
  - order tests or therapies;
  - prescribe, dispense, or administer drugs;
  - perform any other medical and/or surgical acts; or
  - receive income from the provision of medical and/or surgical services performed following retirement.

- The North Carolina Medical Board is aware that a number of physicians consider themselves "retired," but still hold a currently registered medical license (full, volunteer, or limited) and provide professional medical and/or surgical services to patients on a regular or occasional basis. Such physicians customarily serve the needs of previous patients, friends, nursing home residents, free clinics, emergency rooms, community health programs, etc. The Board commends those physicians for their willingness to continue service following "retirement," but it recognizes such service is not the "complete cessation of the practice of medicine" and, therefore, must be joined with an undiminished awareness of professional responsibility. That responsibility means that such physicians SHOULDN'T:
  - practice within their areas of professional competence;
  - prepare and keep medical records in accord with good professional practice; and
  - meet the Board's continuing medical education requirement.

- The Board also reminds "retired" physicians with currently registered licenses that all federal and state laws and rules relating to the practice of medicine and/or surgery apply to them, that the position statements of the Board are as relevant to them as to physicians in full and regular practice, and that they continue to be subject to the risks of liability for any medical and/or surgical acts they perform.

(Adopted January 1997)

(Amended January 2001)

Advance Directives and Patient Autonomy

Advances in medical technology have given physicians the ability to prolong the mechanics of life almost indefinitely. Because of this, physicians must be aware that North Carolina law specifically recognizes the individual's right to a peaceful and natural death. N.C. Gen. Stat. §90-320 (a) (1993) reads: The General Assembly recognizes as a matter of public policy that an individual's rights include the right to a peaceful and natural death and that a patient or his representative has the fundamental right to control the decisions relating to the rendering of his own medical care, including the decision to have extraordinary means withheld or withdrawn in instances of a terminal condition. They must also be aware that North Carolina law empowers any adult individual with understanding and capacity to make a Health Care Power of Attorney (N.C. Gen. Stat. §32A-17 (1995)) and stipulates that, when a patient lacks understanding or capacity to make or communicate health care decisions, the instructions of a duly appointed health care agent are to be taken as those of the patient unless evidence to the contrary is available (N.C. Gen. Stat. §32A-24(b) (1995)).

- It is the position of the North Carolina Medical Board that it is in the best interest of the patient and of the physician-patient relationship to encourage patients to complete documents that express their wishes for the kind of care they desire at the end of their lives. Physicians should encourage their patients to appoint a health care agent to act with the Health Care Power of Attorney...
It is also the position of the Board that physicians are ethically obligated to follow the wishes of a patient whenever it is needed or to assure that proper physician backup is available to take care of the patient during or outside normal office hours. If the physician is not generally available outside normal office hours and does not have an arrangement whereby another physician is available at such times, this fact must be clearly communicated to the patient, verbally and in writing, along with written instructions for securing care at such times.

If the condition of the patient is such that the need for care at a time the physician cannot be available is anticipated, the physician should consider transfer of care to another physician who can be available when needed.

(Adopted July 1993)
(Amended May 1996)

**AVAILABILITY OF PHYSICIANS TO THEIR PATIENTS AFTER HOURS**

It is the position of the North Carolina Medical Board that once a physician-patient relationship is created, it is the duty of the physician to provide care wherever it is needed or to assure that proper physician backup is available to take care of the patient during or outside normal office hours. If the physician is not generally available outside normal office hours and does not have an arrangement whereby another physician is available at such times, this fact must be clearly communicated to the patient, verbally and in writing, along with written instructions for securing care at such times.

If the condition of the patient is such that the need for care at a time the physician cannot be available is anticipated, the physician should consider transfer of care to another physician who can be available when needed.

(Adopted July 1993)
(Amended May 1996, January 2001)

**GUIDELINES FOR AVOIDING MISUNDERSTANDINGS DURING PHYSICAL EXAMINATIONS**

It is the position of the North Carolina Medical Board that proper care and sensitivity are needed during physical examinations to avoid misunderstandings that could lead to charges of sexual misconduct against physicians. In order to prevent such misunderstandings, the Board offers the following guidelines.

1. Sensitivity to patient dignity should be considered by the physician when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy and should never be asked to disrobe in the presence of the physician. Examining rooms should be safe, clean, and well maintained, and should be equipped with appropriate furniture for examination and treatment. Gowns, sheets and/or other appropriate apparel should be made available to protect patient dignity and decrease embarrassment to the patient while a thorough and professional examination is conducted.

2. Whatever the sex of the patient, a third party acceptable to the patient should be readily available at all times during a physical examination, and it is strongly advised that a third party acceptable to the patient be present when the physician performs an examination of the breast(s), genitalia, or rectum. When appropriate or when requested by the patient, the physician should have a third party acceptable to the patient present throughout the examination or at any given point during the examination.

3. The physician should individualize the approach to physical examinations so that each patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation of the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing may be necessary in order to minimize the patient's possible misunderstanding.

4. The physician and staff should exercise the same degree of professionalism and care when performing diagnostic procedures (e.g., electro-cardio-grams, electromyograms, endoscopic procedures, and radiological studies, etc.), as well as during surgical procedures and postsurgical follow-up examinations when the patient is in varying stages of consciousness.

5. The physician should be on the alert for suggestive or flirtatious behavior or mannerisms on the part of the patient and should not permit a compromising situation to develop.

(Amended May 1991)

**SEXUAL EXPLOITATION OF PATIENTS**

It is the position of the North Carolina Medical Board that entering into a sexual relationship with a patient, consensual or otherwise, is unprofessional conduct and is grounds for the suspension or revocation of a physician's license. Such conduct is not tolerated. As a guide in defining sexual exploitation of a patient by a licensee, the Board will use the language of the North Carolina General Statutes, Chapter 90, Article 1F (Psychotherapy Patient/Client Sexual Exploitation Act), §90-21.41.

As with other disciplinary actions taken by the Board, Board action against a medical licensee for sexual exploitation of a patient or patients is published by the Board, the nature of the offense being clearly specified. It is also released to the news media, to state and federal government, and to medical and professional organizations.

This position also applies to mid-level health care providers such as physician assistants, nurse practitioners, and EMTs authorized to perform medical acts by the Board.

(Adopted May 1991)
(Amended April 1996, January 2001)

**CONTACT WITH PATIENTS BEFORE PRESCRIBING**

It is the position of the North Carolina Medical Board that prescribing drugs to an individual the prescriber has not personally examined is inappropriate except as noted in the paragraph below. Before prescribing a drug, a physician should make an informed medical judgment based on the circumstances of the situation and on his or her training and experience. Ordinarily, this will require that the physician personally perform an appropriate history and physical examination, make a diagnosis, and formulate a therapeutic plan, a part of which might be a prescription. This process must be documented appropriately.

Prescribing for a patient whom the physician has not personally examined may be suitable under certain circumstances. These may include admission orders for a newly hospitalized patient; prescribing for a patient of another physician for whom the prescriber is taking call, or continuing medication on a short-term basis for a new patient prior to the patient's first appointment. Established patients may not require a new history and physical examination for each new prescription, depending on good medical practice.

It is the position of the Board that prescribing drugs to individuals the physician has never met based solely on answers to a set of questions, as is common in Internet or toll-free telephone prescribing, is inappropriate and unprofessional.

(Amended November 1999)
(Amended February 2001)

**WRITING OF PRESCRIPTIONS**

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

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

No prescriptions, including those for controlled substances or mind-altering chemicals, should be issued for a patient in the absence of a documented physician-patient relationship.
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- No prescription for controlled substances or mind-altering chemicals should be issued by a practitioner for his or her personal use.
- The practice of pre-signing prescriptions is unacceptable to the Board.

(Amended May 1991; September 1992)

(SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS AND OTHERS WITH WHOM SIGNIFICANT EMOTIONAL RELATIONSHIPS EXIST*)

- It is the position of the North Carolina Medical Board that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. The Board strongly believes that such treatment and prescribing practices are inappropriate and may result in less than optimal care being provided. A variety of factors, including emotional feelings and attitudes that will inevitably color judgment, will compromise the objectivity of the physician and make the delivery of sound medical care problematic in such situations, while real patient autonomy and informed consent may be sacrificed.
- When a minor illness or emergency requires self-treatment or treatment of a family member or other person with whom the physician has a significant emotional relationship, the physician must prepare and keep a proper written record of that treatment, including but not limited to prescriptions written for controlled substances and the medical indications for them. Record keeping is too frequently neglected when physicians manage such cases.
- The Board expects physicians to delegate the medical and surgical care of themselves, their families, and those with whom they have significant emotional relationships to one or more of their colleagues in order to ensure appropriate and objective care is provided and to avoid misunderstandings related to their prescribing practices.

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

(Amended May 1991; May 1996)

THE USE OF ANORECTICS IN TREATMENT OF OBESITY

- It is the position of the North Carolina Medical Board that under particular circumstances certain anorectic agents may have an adjunctive use in the treatment of obesity. Good medical practice requires that such use be guided by a written protocol that is based on published medical data and that patient compliance and progress will be documented.
- It remains the policy of the Board that there is no place for the use of anorectics in the treatment of obesity.

(Amended October 1987)

(PRESCRIBING LEGEND OR CONTROLLED SUBSTANCES FOR OTHER THAN VALIDATED MEDICAL OR THERAPEUTIC PURPOSES, WITH PARTICULAR REFERENCE TO SUBSTANCES OR PREPARATIONS WITH ANABOLIC PROPERTIES)

General

It is the position of the North Carolina Medical Board that prescribing any controlled or legend substance for other than a validated medical or therapeutic purpose is unprofessional conduct.

The physician shall complete and maintain a medical record that establishes the diagnosis, the basis for that diagnosis, the purpose and expected response to therapeutic medications, and the plan for the use of medications in treatment of the diagnosis.

The Board is not opposed to the use of innovative, creative therapeutics; however, treatments not having a scientifically validated basis for use should be studied under investigational protocols so as to assist in the establishment of evidence-based, scientific validity for such treatments.

Substances/Preparations with Anabolic Properties

The use of anabolic steroids, testosterone and its analogs, human growth hormone, human chorionic gonadotrophin, other preparations with anabolic properties, or autotransfusion in any form, to enhance athletic performance or muscle development for cosmetic, nontherapeutic reasons, in the absence of an established disease or deficiency state, is not a medically valid use of these medications.

The use of these medications under these conditions will subject the person licensed by the Board to investigation and potential sanctions.

The Board recognizes that most anabolic steroid abuse occurs outside the medical system. It wishes to emphasize the physician's role as educator in providing information to individual patients and the community, and specifically to high school and college athletes, as to the dangers inherent in the use of these medications.

(Amended May 1998)

(MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN)

It has become increasingly apparent to physicians and their patients that the use of effective pain management has not kept pace with other advances in medical practice. There are several factors that have contributed to this. These include a history of relatively low priority given pain management in our health care system, the incomplete integration of current knowledge in medical and clinical practice, a sparsity of practitioners specifically trained in pain management, and the fear of legal consequences when controlled substances are used — fear shared by physician and patient.

There are three general categories of pain:

Acute Pain is associated with surgery, trauma and acute illness. It has received its share of attention by physicians, its treatment by various means is widely accepted by patients, and it has been addressed in guidelines issued by the Agency for Health Care Policy and Research of the U.S. Department of Health and Human Services.

Cancer Pain has been receiving greater attention and more enlightened treatment by physicians and patients, particularly since development of the hospice movement. It has also been addressed in AHCPR guidelines.

Chronic Non-Malignant Pain is often difficult to diagnose, often intractable, and often undertreated. It is the management of chronic non-malignant pain on which the North Carolina Medical Board wishes to focus attention in this position statement.

The North Carolina Medical Board recognizes that many strategies exist for treating chronic non-malignant pain. Because such pain may have many causes and contributing factors, treatment will vary from behavioral and rehabilitation approaches to the use of a number of medications, including opioids. Specialty groups in the field point out that most chronic non-malignant pain is best managed in a coordinated way, using a number of strategies in concert. Inadequate management of such pain is not uncommon, however, despite the availability of safe and effective treatments.

The Board is aware that some physicians avoid prescribing controlled substances such as opioids in treating chronic non-malignant pain. While it does not suggest those physicians abandon their reservations or professional judgment about using opioids in such situations, neither does the Board wish to be an obstacle to proper and effective management of chronic pain by physicians. It should be understood that the Board recognizes opioids can be an appropriate treatment for chronic pain.

It is the position of the North Carolina Medical Board that effective management of chronic pain should include:

- thorough documentation of all aspects of the patient's assessment and care;
- a thorough history and physical examination, including a drug and pain history;
- appropriate studies;
- a working diagnosis and treatment plan;
- a rationale for the treatment selected;
- education of the patient;
- clear understanding by the patient and physician of methods and goals of treatment;
- a specific follow-up protocol, which must be adhered to;
- regular assessment of treatment efficacy;
- consultation with specialists in pain medicine, when warranted; and

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- use of a multidisciplinary approach, when indicated.
- The Board expects physicians using controlled substances in the management of chronic pain to be familiar with conditions such as:
  - physical dependence;
  - respiratory depression and other side effects;
  - tolerance; and
  - pseudo addiction.

There is an abundance of literature available on these topics and on the effective management of pain. The physician’s knowledge should be regularly updated in these areas.

- No physician need fear reprisals from the Board for appropriately-prescribing, as described above, even large amounts of controlled substances indefinitely for chronic non-malignant pain.

- Nothing in this statement should be construed as advocating the imprudent use of controlled substances.

(Adopted September 1996)

END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE

Assuring Patients

Death is part of life. When appropriate processes have determined that the use of life-sustaining or invasive interventions will only prolong the dying process, it is incumbent on physicians to accept death “not as a failure, but the natural culmination of our lives.”

It is the position of the North Carolina Medical Board that patients and their families should be assured of competent, comprehensive palliative care at the end of their lives. Physicians should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided.

Palliative Care

There is no one definition of palliative care, but the Board accepts that found in the Oxford Textbook of Palliative Medicine: “The study and management of patients with active, progressive, far advanced disease for whom the prognosis is limited and the focus of care is the quality of life. This is not intended to exclude remissions and requires that the management of patients be comprehensive, embracing the efforts of medical clinicians and of those who provide psychosocial services, spiritual support, and hospice care.

A physician who provides palliative care, encompassing the full range of comfort care, should assess his or her patient’s physical, psychological, and spiritual conditions. Because of the overwhelming concern of patients about pain relief, special attention should be given the effective assessment of pain. It is particularly important that the physician frankly but sensitively discuss with the patient and the family their concerns and choices at the end of life. As part of this discussion, the physician should make clear that, in some end-of-life care situations, there are inherent risks associated with effective pain relief.

Opioid Use

The Board will assume opioid use in such patients is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan. (See the Board’s position statement on the Management of Chronic Non-Malignant Pain for an outline of what the Board expects of physicians in the management of pain.) Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.

Selected Guides


*Steven A. Schroeder, M.D., President, Robert Wood Johnson Foundation.

(Adopted October 1999)

Joint Statement on Pain Management in End-of-Life Care
(Adopted by the North Carolina Medical, Nursing, and Pharmacy Boards)

Through dialogue with members of the healthcare community and consumers, a number of perceived regulatory barriers to adequate pain management in end-of-life care have been expressed to the Boards of Medicine, Nursing, and Pharmacy. The following statement attempts to address these misperceptions by outlining practice expectations for physicians and other health care professionals authorized to prescribe medications, as well as nurses and pharmacists involved in this aspect of end-of-life care. The statement is based on:
- the local scope of practice for each of these licensed health professionals;
- professional collaboration and communication among health professionals providing palliative care; and
- a standard of care that assures on-going pain assessment, a therapeutic plan for pain management interventions, and evidence of adequate symptom management for the dying patient.

It is the position of all three Boards that patients and their families should be assured of competent, comprehensive palliative care at the end of their lives. Physicians, nurses and pharmacists should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided.

Because of the overwhelming concern of patients about pain relief, the physician needs to give special attention to the effective assessment of pain. It is particularly important that the physician frankly but sensitively discuss with the patient and the family their concerns and choices at the end of life. As part of this discussion, the physician should make clear that, in some end-of-life care situations, there are inherent risks associated with effective pain relief. The Medical Board will assume opioid use in such patients is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan. Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.

With regard to pharmacy practice, North Carolina has no quantity restrictions on dispensing controlled substances including those in Schedule II. This is significant when utilizing the federal rule that allows the partial filling of Schedule II prescriptions for up to 60 days. In these situations it would minimize expenses and unnecessary waste of drugs if the prescriber would note on the prescription that the patient is terminally ill and specify the largest anticipated quantity that could be needed for the next two months. The pharmacist could then dispense smaller quantities of the prescription to meet the patient’s needs up to the total quantity authorized. Government-approved labeling for dosage level and frequency can be useful as guidance for patient care. Health professionals may, on occasion, determine that higher levels are justified in specific cases. However, these occasions would be exceptions to general practice and would need to be properly documented to establish informed consent of the patient and family.

Federal and state rules also allow the fax transmittal of an original prescription for Schedule II drugs for hospice patients. If the prescriber notes the hospice status of the patient on the faxed document, it serves as the original. Pharmacy rules also allow the emergency refilling of prescriptions in Schedules III, IV, and V. While this does not apply to Schedule II drugs, it can be useful in situations where the patient is using drugs such as Vicodin for pain or Xanax for anxiety.

The nurse is often the health professional most involved in on-going pain assessment, implementing the prescribed pain management plan, evaluating the patient’s response to such interventions and adjusting medication levels based on patient status. In order to achieve adequate pain management, the prescription must provide dosage ranges and frequency parameters within which the nurse may adjust (titrate) medication in order to achieve adequate pain control. Consistent with the licensee’s scope of practice, the RN or LPN is accountable for implementing the pain management plan utilizing his/her knowledge base and documented assessment of the patient’s needs. The nurse has the authority to adjust medication levels within the dosage and frequency ranges described on the prescription according to the agency’s established protocol. If the nurse is aware of such levels and feels that further titration is necessary, he or she should consult the prescriber.

However, the nurse does not have the authority to change the medical pain management plan. When adequate pain management is not achieved under the existing plan, the physician should be notified as soon as possible and should further assess the patient’s needs. Continued failure to attain adequate pain control should result in the nurse’s prompt notification of the requirement for a new treatment plan developed by the health care team including the pain management specialist. The nurse is then responsible for implementing the new plan as prescribed, and for ongoing evaluation of the patient’s response to the plan.

(Adopted October 1999)
Position Statement

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the currently prescribed treatment plan, the nurse is responsible for reporting such findings to the prescriber and documenting this communication. Only the physician or other health professional with authority to prescribe may change the medical pain management plan.

Communication and collaboration between members of the healthcare team, and the patient and family are essential in achieving adequate pain management in end-of-life care. Within this interdisciplinary framework for end-of-life care, effective pain management should include:

- thorough documentation of all aspects of the patient's assessment and care;
- a working diagnosis and therapeutic treatment plan including pharmacologic and non-pharmacologic interventions;
- regular and documented evaluation of response to the interventions and, as appropriate, revisions to the treatment plan;
- evidence of communication among care providers;
- education of the patient and family; and
- a clear understanding by the patient, the family and healthcare team of the treatment goals.

It is important to remind health professionals that licensing boards hold each licensee accountable for providing safe, effective care. Exercising this standard of care requires the application of knowledge, skills, as well as ethical principles focused on optimum patient care while taking all appropriate measures to relieve suffering. The healthcare team should give primary importance to the expressed desires of the patient tempered by the judgement and legal responsibilities of each licensed health professional as to what is in the patient's best interest.

(October 1999)

OFFICE-BASED SURGERY

Office-based surgery is surgery performed outside a hospital or an outpatient facility accredited by the North Carolina Division of Facility Services. Although surgery is not a perfect science in any setting, office-based surgery is generally safe, effective, and efficient, provided proper measures are taken in each licensee accountable for providing safe, effective care. Exercising this standard of care requires the application of knowledge, skills, as well as ethical principles focused on optimum patient care while taking all appropriate measures to relieve suffering. The healthcare team should give primary importance to the expressed desires of the patient tempered by the judgement and legal responsibilities of each licensed health professional as to what is in the patient's best interest.

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POSITION STATEMENT

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*This position statement was formerly titled, "Ophthalmologists Care of Cataract Patients"*

(Adopted September 1991)
(Asmended March 2001)

PROFESSIONAL OBLIGATION TO REPORT INCOMPETENCE, IMPAIRMENT, AND UNETHICAL CONDUCT

It is the position of the North Carolina Medical Board that physicians have a professional obligation to act when confronted with an impaired or incompetent colleague or one who has engaged in unethical conduct.

When appropriate, an offer of personal assistance to the colleague may be the most compassionate and effective intervention. When this would not be appropriate or sufficient to address the problem, physicians have a duty to report the matter to the institution best positioned to deal with the problem. For example, impaired physicians and physician assistants should be reported to the North Carolina Physicians Health Program. Incompetent physicians should be reported to the clinical authority empowered to take appropriate action. Physicians also may report to the North Carolina Medical Board, and when there is no other institution reasonably likely to be able to deal with the problem, this will be the only way of discharging the duty to report.

This duty is subordinate to the duty to maintain patient confidences. In other words, when the colleague is a patient or when matters concerning a colleague are brought to the physician’s attention by a patient, the physician must give appropriate consideration to preserving the patient’s confidences in deciding whether to report the colleague.

(Adopted November 1998)
(Asmended May 1996)

ADVERTISING AND PUBLICITY*

It is the position of the North Carolina Medical Board that physician advertising or publicity that is deceptive, false, or misleading is unprofessional conduct. The key issue is whether advertising and publicity, regardless of format or content, are true and not materially misleading.

Information conveyed may include:
- a) the basis on which fees are determined, including charges for specific services;
- b) methods of payment;
- c) any other non-deceptive information.

Advertising and publicity that create unjustified medical expectations, that are accompanied by deceptive claims, or that imply exclusive or unique skills or remedies must be avoided. Similarly, a statement that a physician has cured or successfully treated a large number of patients suffering a particular ailment is deceptive if it implies a certainty of results and/or creates unjustified or misleading expectations. If patient photographs are used, they should be of the physician’s own patients and demonstrate realistic outcomes.

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

(Adopted November 1999)
(Asmended March 2001)

SALE OF GOODS FROM PHYSICIAN OFFICES

The physician-patient relationship constitutes a fiduciary relationship between the physician and the patient in the strictest sense of the word “fiduciary." In this fiduciary capacity, physicians have a duty to place the interests of their patients above their own financial or other interests. Inherent in the in-office sale of products is a perceived conflict of interest with regard to physicians’ fiduciary duty. Further, the for-profit sale of goods by physicians to patients raises ethical questions that should not intrude on the physician-patient relationship, as does the sale of products that can easily be purchased by patients locally.

On this issue, it is the position of the North Carolina Medical Board that the following guidelines should inform the conduct of physicians.

- Practice related items (such as ointments, creams, and lotions by dermatologists; splints and appliances by orthopedists; eye glasses by ophthalmologists; etc.) may be dispensed only after the patient has been told if those items, or generally similar items, can be obtained locally from another source. Any charge made should be reasonable.
- Due to the potential for patient exploitation, physicians are encouraged not to engage in exclusive distributorship and/or personal branding.
- Physicians should not sell any non-health related goods from their offices or other treatment settings. (This does not preclude the selling of low-cost, non-health related items for the benefit of charitable or community organizations, provided the physician receives no share of the proceeds, that such sales are conducted only on an occasional basis, and that patients are not pressured into making purchases.)

(Adopted March 2001)

FEE SPLITTING

The North Carolina Medical Board endorses the AMA Code of Medical Ethics Opinions 6.02, 6.03, and 6.04 condemning fee splitting. Fee splitting may be receipt of money or something else of value in return for referrals or remuneration from a drug or device manufacturer/distributor, a sales representative, or another professional as an incentive for the use of that interested party’s product.

Except in instances permitted by law (NC Gen Stat §55B-14(c)), it is the position of the Board that sharing profits between a non-physician or para-professional and a physician partner on a percentage basis is also fee splitting and is grounds for disciplinary action.

(Adopted November 1993)
(Asmended May 1996)

UNETHICAL AGREEMENTS IN COMPLAINT SETTLEMENTS

It is the position of the North Carolina Medical Board that it is unethical for a physician to settle any complaint if the settlement contains an agreement by a patient not to complain or provide information to the Board.

(Adopted November 1993)
(Asmended May 1996)
NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
August/September/October 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 the practitioner regarding the annulment, revocation, or suspension of the authorization to practice or the conditions and/or limitations placed on the authorization to practice. (A method for resolving disputes through informal procedures.)

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

Information not available.

NCPH: North Carolina Physicians Health Program.

RTL: Resident Training License.

Revocation: Cancellation of the authorization to practice.

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

SUSPENSIONS

GRANT, John Leland, MD
Location: Chesapeake, VA
DOB: 8/06/1946
License #: 0000-29113
Specialty: NS (as reported by physician)
Medical Ed: Ohio State University (1975)
Cause: Hearing held on 8/16/2001 on charges filed on 3/22/2001 alleging Dr Grant's conviction in federal court of a felony in the acquisition of a controlled substance by fraud and the suspension of his Virginia medical license as a result of that conviction. He is North Carolina license was summarily suspended effective 4/23/2001. By his own admission, he recognized his unprofessional conduct and that he improperly prescribed to several persons, including one with whom he had a sexual relationship and who he knew abused narcotics and believed to have been convicted of drug dealing. He also admitted indiscriminately and excessively prescribing medications with high abuse potential to persons not his patients. In February 2000, his Virginia license was reinstated on a probational basis subject to certain terms. In June 2001, the Virginia Board found him in compliance with its order of February 2000 and reinstated his full and unrestricted status.

Action: 10/10/2001. Findings of Fact, Conclusions of Law, and Order issued: Dr Grant's North Carolina medical license is revoked.

ROBERTS, Ifor John Wynn, MD
Location: Caversham Reading, UK
DOB: 8/18/1940
License #: 0095-00202
Specialty: FPG (as reported by physician)
Medical Ed: Edinburgh University, UK (1966)
Cause: Hearing held on 7/20/2001 on charges filed on 4/05/2000 alleging violation of his Consent Order with the Board of 10/16/1997, in which he agreed to obtain a mentor acceptable to the president of the Board. Based on the evidence before it, the Board found the charges were true.

Action: 7/26/2001. Findings of Fact, Conclusions of Law, and Order issued: Dr Roberts' license is suspended indefinitely.

VERELL, Karen Lea, MD
Location: Jacksonville, NC (Onslow Co)
DOB: 3/05/1953
License #: 0000-26608
Specialty: P/ADL (as reported by physician)
Medical Ed: University of Mississippi (1978)
Cause: Hearing held on 7/20/2001 on charges filed on 8/12/1999 alleging Dr Verell's violation of a Consent Order with the Board of 7/20/2001. Before he may resume practice in North Carolina, he shall obtain a satisfactory evaluation from the NCPHP and meet with a committee of the Board to consider what, if any, restrictions shall be placed on his practice.

ANNULMENTS

NONE

REVOCATIONS

KW Ah, Mikyung, MD
Location: San Francisco, CA
DOB: 3/07/1969
License #: 0096-01652
Specialty: OPH/GP (as reported by physician)
Cause: Hearing held on 10/10/2001. Findings of Fact, Conclusions of Law, and Order issued: Dr Kwah's North Carolina medical license is revoked.

Nara, David Alan, MD
Location: Hancock, MI
DOB: 4/28/1960
License #: 0000-39450
Specialty: GP (as reported by physician)
Medical Ed: Michigan State University (1986)
Cause: Hearing on 8/16/2001 concerning charges dated 6/14/2000. The Board found that a disciplinary committee of the Michigan State Board of Medicine filed an Administrative Complaint against Dr Nara on 3/22/2000 alleging he abused alcohol and self-prescribed controlled substances for other than lawful purposes. On 3/13/2000, Michigan summarily suspended his medical license. It also found that on 4/11/2000, the Michigan Board and Dr Nara entered into a Consent Order in which he admitted the facts alleged in the Administrative Complaint. In June 2001, the Virginia Board found him in compliance with its order of February 2000 and reinstated his full and unrestricted status.

Action: 10/10/2001. Findings of Fact, Conclusions of Law, and Order issued: Dr Grant's North Carolina medical license, summarily suspended effective 4/23/2001, remains suspended through 9/22/2001: before he may resume practice in North Carolina, he shall obtain a satisfactory evaluation from the NCPHP and meet with a committee of the Board to consider what, if any, restrictions shall be placed on his practice.

WHITENER, Betty Lou, MD
Location: Oak Ridge, LA
DOB: 1/20/1930
License #: 0000-20895
Specialty: FP (as reported by physician)
Medical Ed: University of Oklahoma (1959)
Cause: Hearing on 6/22/2001 concerning charges dated 2/22/2001. The Board found that, pursuant to a Consent Order of 5/24/2000, the Louisiana Board of Medical Examiners suspended Dr Whitener's license for one year, staying all but the first three months on certain conditions, as a result of her pleading no contest to one count of Medicaid fraud.

Action: 7/09/2001. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Whitener's license to practice medicine in North Carolina is revoked.
alleging Dr Verell, despite numerous requests that she do so, failed to come to the hospital emergency room to see an infant patient she had treated less than 24 hours earlier. Based on its findings at hearing, the Board concluded the facts supported the charges and that Dr Verell engaged in unprofessional conduct, including departing from or failing to conform to the standards of acceptable and prevailing medical practice or the ethics of the medical profession in North Carolina.

Action: 9/26/2001. Findings of Fact, Conclusions of Law, and Order issued: Dr Verell’s North Carolina medical license is suspended for 60 days, which suspension is immediately stayed.

See Consent Orders: ESSEX, Charles Phillip, MD
Location: Greensboro, NC (Guilford Co)
DOB: 7/12/1959
License #: 0093-00190
Specialty: FP (as reported by physician)
Medical Ed: Georgetown University (1987)
Cause: Until September 1998, Patient A worked as Dr Essex’s medical assistant, during which time they became close friends. Patient A returned to school in September 1998 and the friendship continued through April 1999, romantic feelings developing during that period. In April 1999, Patient A sought medical treatment from Dr Essex for chronic headaches. During the April office visit, Dr Essex and Patient A acknowledged their romantic feelings. Soon after, a sexual relationship began. Dr Essex continued to treat Patient A through September 1999, then transferred her to another physician. His sexual relationship with Patient A constituted unprofessional conduct. In this case, the sexual relationship grew out of a personal relationship that existed prior to the physician-patient relationship, but Dr Essex acknowledges he should have immediately referred Patient A to another physician following the April 1999 office visit because his sexual relationship with her could have obscured his objective judgment concerning her health. In November 2000, Dr Essex voluntarily obtained an assessment at the Behavioral Medicine Institute of Atlanta. That assessment concluded that he is not a sexual predator and that he could practice medicine safely subject to certain conditions. Dr Essex reports he has voluntarily complied with the conditions recommended by the Institute. He has obtained cognitive-behavioral treatment on an outpatient basis with Dr Gullick, who reports that, in her view, he is not a sexual predator and is not a danger to patients. Dr Essex has signed a contract with the NCPHP; he shall attend AA and/or Caduceus meetings as recommended by the NCPHP; he may not work more than 40 hours per week; he must provide a copy of this Consent Order to all current and prospective employers; must comply with other conditions. The numbered paragraphs of this Consent Order supersede and take the place of any prior consent order, except those regarding the public nature of such consent orders.

Action by another state constitutes grounds for action by North Carolina. The basis for Florida’s action was an instance of medical malpractice in the care of one patient in late 1993 and early 1994. No other instances of malpractice committed by Dr Colina have been identified.

Action: 8/25/2001. Consent Order executed: Dr Essex’s medical license is suspended indefinitely, that suspension being stayed upon the following terms. He shall ensure a female chaperone who has read the Consent Order is present any time he examines a female patient who is partially or fully undressed; the chaperone shall document she was present and that no bound-
any violations or other misconduct occurred. Dr Essex shall post a copy of the "Principles of Medical Practice" on his office wall, examination room walls, reception area walls, and any other places it can be easily read by patients; each month, he shall ask three members of his staff who have read the Consent Order to complete a "Staff Surveillance Form"; the forms shall be forwarded to Dr Gullick or her successor for inclusion in her quarterly reports to the Board; during one week each quarter, Dr Essex or his staff will ask all patients seen that week to complete a "Patient/Patient's Family Satisfaction Survey"; the forms shall be forwarded to Dr Gullick or her successor for inclusion in her quarterly report to the Board; at his own expense, he shall undergo a polygraph examination every six months to determine if he has been involved in sexual misconduct with his patients or female staff members; the polygraph results shall be forwarded to Dr Gullick or her successor for inclusion in her quarterly report to the Board; he shall continue his outpatient therapy with Dr Gullick (or a successor approved by the president of the Board) and shall comply with her recommendations regarding his practice; he shall direct Dr Gullick to provide quarterly reports of his progress to the Board; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

HEINER, Daniel Edward, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 7/06/1964
License #: Resident Training License
Specialty: ORS (as reported by physician)
Medical Ed: University of Kansas (1997)
Cause: On application for RTL to practice at Carolinas Medical Center, the Board finds Dr Heiner has admitted that, in 1999-2000, he wrote prescriptions for Wellbutrin®, Zoloft®, and propranolol hydrochloride for himself, in his name, and diverted the Wellbutrin® and propranolol hydrochloride to his own use; during an interview with the Board in July 2001, he initially denied he had ever written any prescription for his wife; he later admitted writing the prescriptions but denied diverting any medications for his own use; upon further inquiry, he admitted the diversion of Wellbutrin® to himself and claimed he had diverted the acyclovir to a friend; he later admitted diverting the acyclovir for his own use; in March 2000, he struck two 16-year-old girls with a softball bat, fracturing one girl's jaw; he also used the bat to break the driver's window of the vehicle in which the girls left the scene.

Action: 10/24/2001. Consent Order executed: Dr Heiner is issued a resident's training license to expire on the date shown on the license; the Board reprimands Dr Heiner for his false statements to the Board, his diversion of drugs, and his violent behavior; he shall inform the director of his residency program of his false statements, drug diversion, and violent behavior by providing or her a copy of the Consent Order within five days; he shall arrange for the director of his residency program to provide the Board with monthly reports of Dr Heiner's performance, conduct, and adherence to rules; within 120 days, he shall obtain an assessment at the Center for Professional Well-Being and direct the Center to send a copy of the assessment to the Board; must comply with other conditions.

McINTOSH, John Clare, MD
Location: Asheville, NC (Buncombe Co)
DOB: 7/16/1956
License #: 0000-36570
Specialty: PD/PDP (as reported by physician)
Medical Ed: State University of New York, Downstate (1981)
Cause: Dr McIntosh admits he engaged in unprofessional conduct while practicing in Asheville from July 1997 to February 2001. In two cases, he advised the mothers of pediatric patients to stop smoking to help deal with the respiratory problems of their children. He established a physician-patient relationship with the mothers and prescribed bupropion hydrochloride for them. In doing this, he performed physical examinations on them, including breast and pelvic examinations, with the fathers of the children present. He was observed to have an ejection during the examinations. The breast and pelvic examinations were not necessary in prescribing the drug and no chaperone was present at either examination. He also gave ongoing treatment to a 21-year-old female patient for respiratory problems while she was admitted to the hospital for delivery of her child. In connection with her respiratory problem, he examined this patient a few days after she gave birth, performing an inappropriate and medically unnecessary pelvic examination. He also provided medical treatment to staff members of the hospital without creating a medical record, and he made inappropriate comments to one or more female staff members about his desire to have an affair with her and touched her breast and buttocks over her clothes. In April 2001, Dr McIntosh was assessed at the Behavioral Medicine Institute of Atlanta and it was recommended he engage in psychotherapy with Eugenia Gullick, PhD. He began that treatment shortly after his assessment and has continued it. He signed and is complying with a contract with NCPHP, recently completed a CME course at Vanderbilt Medical Center on maintaining proper boundaries, has not practiced since 2/08/2001, and surrendered his North Carolina medical license on 5/15/2001.

Action: 10/18/2001. Consent Order executed: Dr McIntosh's license is suspended effective 2/08/2001; suspension is stayed effective the date of the Consent Order, and he is permitted to practice subject to conditions; he shall ensure a female chaperone is present when he is in an examination room with a female patient or female family member or caretaker of any pediatric patient; the chaperone shall document her presence and that no boundary violations or other misconduct took place; he shall never examine adult caretakers or adult family members of his pediatric patients; he shall make a chart on every patient he treats, evaluates, or consults with, including his own or hospital; even if no charge is made; he shall post a copy of the Principles of Medical Practice on his office wall, examination room walls, and other places where it can be easily read by patients, their families, and others; each month he shall ask three staff members who have read the Consent Order to complete a surveillance form that will be forwarded by the office manager to Dr Gullick for inclusion in her quarterly reports to the Board; during one week each quarter, he or his staff shall ask all patients who are at least 18 years old and all parents or caretakers to complete the Patient/Patient's Family Satisfaction Survey that will be forwarded to Dr Gullick for inclusion in her quarterly reports to the Board; he shall undergo a polygraph examination every six months to determine if he has been involved in boundary violations with his patients, their families or caretakers, or his female staff members, and the results shall be forwarded to Dr Gullick for inclusion in her quarterly reports to the Board; he shall continue his therapy with Dr Gullick (or her successor as approved in writing by the president of the Board) and shall comply with all Dr Gullick's recommendations regarding his practice; he shall direct Dr Gullick to provide quarterly reports to the Board; in addition to and above any other CME requirements of the Board, he shall complete a CME course at Vanderbilt Medical Center on maintaining proper boundaries and document six hours of CME on boundary violations or sexual harassment each year; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

TAMONEY, Harry Jerome, Jr, MD
Location: Highlands, NC (Macon Co/Jackson Co)
DOB: 11/16/1921
License #: 0000-30501
Specialty: FP (as reported by physician)
Medical Ed: State University of New York, Downstate (1946)
Cause: Dr Tamoney admits and the Board finds that in April 1999, in a judgment in a criminal case before the General Court of Justice of North Carolina, District Court Division, Macon County, Dr Tamoney pled no contest and received a prayer for judgment continued for one year. In connection with the charge of possession of a Schedule II controlled substance, the judgment is not a conviction under North Carolina law. The plea Dr Tamoney entered constitutes an admission of the violation of a law involving the practice of medicine.

Action: 10/29/2001. Consent Order executed: Dr Tamoney surrenders his medical license which judgment is forming an inappropriate and medically unnecessary pelvic examination. He also provided medical treatment to staff members of the hospital without creating a medical record, and he made inappropriate comments to one or more female staff members about his desire to have an affair with her and touched her breast and buttocks over her clothes. In April 2001, Dr McIntosh was assessed at the Behavioral Medicine Institute of Atlanta and it was recommended he engage in psychotherapy with Eugenia Gullick, PhD. He began that treatment shortly after his assessment and has continued it. He signed and is complying with a contract with NCPHP, recently completed a CME course at Vanderbilt Medical Center on maintaining proper boundaries, has not practiced since 2/08/2001, and surrendered his North Carolina medical license on 5/15/2001.

Action: 10/18/2001. Consent Order executed: Dr McIntosh's license is suspended effective 2/08/2001; suspension is stayed effective the date of the Consent Order, and he is permitted to practice subject to conditions; he shall ensure a female chaperone is present when he is in an examination room with a female patient or female family member or caretaker of any pediatric patient; the chaperone shall document her presence and that no boundary violations or other misconduct took place; he shall never examine adult caretakers or adult family members of his pediatric patients; he shall make a chart on every patient he treats, evaluates, or consults with, including his own or hospital; even if no charge is made; he shall post a copy of the Principles of Medical Practice on his office wall, examination room walls, and other places where it can be easily read by patients, their families, and others; each month he shall ask three staff members who have read the Consent Order to complete a surveillance form that will be forwarded by the office manager to Dr Gullick for inclusion in her quarterly reports to the Board; during one week each quarter, he or his staff shall ask all patients who are at least 18 years old and all parents or caretakers to complete the Patient/Patient's Family Satisfaction Survey that will be forwarded to Dr Gullick for inclusion in her quarterly reports to the Board; he shall undergo a polygraph examination every six months to determine if he has been involved in boundary violations with his patients, their families or caretakers, or his female staff members, and the results shall be forwarded to Dr Gullick for inclusion in her quarterly reports to the Board; he shall continue his therapy with Dr Gullick (or her successor as approved in writing by the president of the Board) and shall comply with all Dr Gullick's recommendations regarding his practice; he shall direct Dr Gullick to provide quarterly reports to the Board; in addition to and above any other CME requirements of the Board, he shall complete a CME course at Vanderbilt Medical Center on maintaining proper boundaries and document six hours of CME on boundary violations or sexual harassment each year; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

TSAI, Jen-Lo, MD
Location: North Wilkesboro, NC (Wilkes Co)
DOB: 12/20/1942
License #: 0000-22639
Specialty: PD/N
Medical Ed: Taipei Medical College, Taipei (1970)
Cause: To resolve the Notice of Charges and Allegations against Dr TSAI dated 1/31/2001. Dr TSAI admits and the Board finds that
Dr T sai received a call from a local hospital requesting help in the care of a premature infant that weighed one pound, one ounce. He examined the infant and determined it was too small to survive, and he made a comment to that effect. He also commented that the cost of treatment would be extremely high. He made these comments while he removed the baby's breathing tube. The hospital staff reasonably concluded that he intended to forgo life-sustaining treatment. Within five minutes, Dr T sai reassessed the baby, reinserted the breathing tube, and arranged for transport to a regional hospital. There is no evidence Dr T sai's withdrawal of the breathing tube caused any detrimental effect to the baby. Even if the decision to forgo life-sustaining treatment was medically appropriate under the circumstances, it was inappropriate to do so without first (1) reviewing the patient's medical chart; (2) discussing the case with those at the hospital treating the case; (3) telephoning a neonatologist to discuss the case; and (4) meeting with the patient's mother, who was at the hospital. Dr T sai's failure to do these things is unprofessional conduct, including, but not limited to, departure from or failure to conform to the standards of acceptable and prevailing medical practice or the ethics of the medical profession.

Action: 10/24/2001. Consent Order executed: Dr T sai's North Carolina medical license is suspended for six months, beginning 10 days from the date of the Consent Order; before he returns to practice, he shall document that he has attended and successfully completed six hours of Category I CME in neonatology and three hours in ethics; he shall obtain written approval from the president of the Board prior to taking each CME course; he must deliver his license and registration certificates to the Board's office within 20 days of the date of the Consent Order.

WHITNEY, Gwendolyn Ruth, MD
Location: Concord, NC  (Cabarrus Co)
DOB:  1/30/1954
License # :  0000-35785
Specialty:  FP  (as reported by physician)
Medical Ed:  University of South Carolina  (1987)
Cause:  Following Dr Whitney's closing of Patchwork Family Physicians in Concord in November 2000, the Board received numerous complaints from her former patients that they were unable to obtain copies of their medical records. The Board asked her to respond to these complaints on numerous occasions, but she failed to do so. Failure to provide copies of medical records in a timely manner is unprofessional conduct and failure to respond to the requests of the Board for information is in violation of the statute. Dr Whitney has now responded and it appears all former patients who requested copies of files have received them. She has made arrangements to handle future requests in a timely way.


MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

SMITH, Solomon Brookman, MD
Location:  Columbia, SC
DOB:  10/07/1956
License #:  N one
Specialty:  None noted
Medical Ed:  Meharry Medical School  (1982)
Cause:  Dr Smith failed to satisfy the Board of his qualifications. His Alabama license was suspended on 9/02/1997.
Action:  9/04/2001. Application for North Carolina medical license denied. He may request a public hearing within 10 days of receiving notice of this denial.

SURRENDERS

BERRY, David, MD
Location:  Winston-Salem, NC  (Forsyth Co)
DOB:  4/20/1952
License #:  0000-30288

SAPHLRA, Marla Lynn, MD
Location:  Jacksonville Beach, FL
DOB:  12/31/1956
License #:  0099-00640
Specialty:  FP/EM  (as reported by physician)
Medical Ed:  Mayo Medical School  (1994)

DENTON, Beecher Tate, III, Physician Assistant
Location:  Salisbury, NC  (Rowan Co)
DOB:  1/03/1955
License #:  0001-00993
PA Education:  Bowman Gray School of Medicine  (1987)

EURE, Luther Haywood, Jr, MD
Location:  New Bern, NC  (Craven Co)
DOB:  9/11/1963
License #:  0093-00102
Specialty:  OB/GYN  (as reported by physician)
Medical Ed:  Bowman Gray School of Medicine  (1989)

HART, Robert, MD
Location:  Clyde, NC  (Hawoody Co)
DOB:  3/20/1934
License #:  0094-00829
Specialty:  FP  (as reported by physician)
Medical Ed:  University of Arkansas  (1981)

KILGORE, Larry Charles, MD
Location:  Fayetteville, NC  (Cumberland Co)
DOB:  12/20/1950
License #:  0000-26550
Specialty:  FP  (as reported by physician)
Medical Ed:  University of North Carolina School of Medicine  (1979)

LOVETTE, Kenneth Maurice, MD
Location:  Tarboro, NC  (Edgecombe Co)
DOB:  12/27/1949
License #:  0000-24606
Specialty:  GYN  (as reported by physician)
Medical Ed:  University of North Carolina School of Medicine  (1979)

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

MUNCHING, Aaron A., Physician Assistant
Location:  Wilmington, NC  (New Hanover Co)
DOB:  1/20/1961
License #:  0001-01325
PA Education:  Alderson-Broaddus  (1990)

SAPHLRA, Marla Lynn, MD
Location:  Jacksonville Beach, FL
DOB:  12/31/1956
License #:  0099-00640
Specialty:  FP/EM  (as reported by physician)
Medical Ed:  Mayo Medical School  (1994)
SKWERER, Robert Gordon, MD  
Location: Charlotte, NC (Mecklenburg Co)  
DOB: 7/29/1954  
License #: 0099-00134  
Specialty: FP (as reported by physician)  
Medical Ed: Autonomous University Tamaulipas, Mexico (1987)  

SOLOMON, Robert Douglas, MD  
Location: Hammond, NC (Stark Co)  
DOB: 7/29/1954  
License #: 0000-24240  
Specialty: PD/PDC (as reported by physician)  
Medical Ed: University of Wisconsin Medical College, Madison (1982)  

ANDRINGA, Richard Cornell, MD  
Location: Greensboro, NC (Pitt Co)  
DOB: 12/29/1946  
License #: 0000-30895  
Specialty: PTH/GER (as reported by physician)  
Medical Ed: State University of New York Medical College, Brooklyn (1983)  

BJORK, Paul Edward, Jr, MD  
Location: Laurinburg, NC (Scotland Co)/Aberdeen, NC (Moore Co)  
DOB: 3/06/1956  
License #: 0000-36146  
Specialty: GN (as reported by physician)  
Medical Ed: University of South Carolina (1983)  

CLAYTON, Thomas Vann, MD  
Location: Andrews, NC (Cherokee Co)  
DOB: 9/20/1956  
License #: 0000-30895  
Specialty: FP (as reported by physician)  
Medical Ed: St George's University, Grenada (1983)  

VAUGHAN, Howell Anderson, Physician Assistant  
Location: Durham, NC (Durham Co)  
DOB: 3/31/1958  
License #: 0001-01513  
PA Education: Wake Forest University (1992)  

CROMER, William Browning, MD  
Location: Kinston, NC (Lenoir Co)  
DOB: 11/16/1931  
License #: 0000-24240  
Specialty: FP (as reported by physician)  
Medical Ed: Bowman Gray School of Medicine (1956)  

ROGERS, Paul A., MD  
Location: Evergreen, NC (Columbus Co)  
DOB: 5/15/1946  
License #: 0099-00042  
Specialty: IM (as reported by physician)  
Medical Ed: Autonomous University Tamaulipas, Mexico (1987)  

GUALTEROS, Oscar Mauricio, MD  
Location: Pinehurst, NC (Moore Co)  
DOB: 5/11/1964  
License #: 0099-00042  
Specialty: IM (as reported by physician)  
Medical Ed: University of Navarra, Spain (1991)  

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

JORDAN, Richard Liming, MD  
Location: Clyde, NC (Haywood Co)  
DOB: 3/06/1954  
License #: 0000-31218  
Specialty: U (as reported by physician)  
Medical Ed: University of Southern Alabama (1982)  

WILLIAMS, David Randall, MD  
Location: Hendersonville, NC (Buncombe Co)  
DOB: 6/1/1950  
License #: 0000-31218  
Specialty: U (as reported by physician)  
Medical Ed: University of Southern Alabama (1982)  

LOVE, David William, MD  
Location: Clyde, NC (Haywood Co)  
DOB: 8/31/1960  
License #: 0000-31226  
Specialty: FP (as reported by physician)  
Medical Ed: University of Florida (1984)  

LOVE, David William, MD  
Location: Clyde, NC (Haywood Co)  
DOB: 8/31/1960  
License #: 0000-31226  
Specialty: FP (as reported by physician)  
Medical Ed: University of Florida (1984)  

See Consent Orders: TAMBONE, Harry Jerome, Jr, MD

COURT APPEALS

NONE

CONSENT ORDERS LIFTED

GROGAN, Patricia Jo, MD  
Location: Smith River, CA  
DOB: 7/15/1954  
License #: 0000-34020  
Specialty: P (as reported by physician)  
Medical Ed: St. Mary's University, Grenada (1985)  

PFLIEGER, Kurt Loring, MD  
Location: Mount Pleasant, TX  
DOB: 5/16/1955  
License #: 0000-00113  
Specialty: PD/PDC (as reported by physician)  
Medical Ed: St. George's University, Grenada (1987)  
Cause: Consent Order of 2/29/2000 granted Dr Pflieger a six-month license. Following an interview in July 2000, Dr Pflieger was granted a one-year license. He voluntarily chose not to pursue further extensions of his temporary license beyond July 2001. The Consent Order of 2/29/2000, therefore, is no longer necessary, his license having expired.

Action: 10/10/2001. Order executed: The terms and conditions in the numbered paragraphs of the Consent Order of 2/29/2000 are no longer in effect, except those regarding the public nature of the Consent Order.

WILLIAMS, David Randall, MD  
Location: Hendersonville, NC (Buncombe Co)  
DOB: 6/1/1950  
License #: 0000-31218  
Specialty: U (as reported by physician)  
Medical Ed: University of Southern Alabama (1982)  

DECLERCK, Paul A., MD  
Location: Kinston, NC (Lenoir Co)  
DOB: 10/10/1947  
License #: 0000-04580  
Specialty: FP (as reported by physician)  
Medical Ed: University of New Hampshire (1979)  

GUALTEROS, Oscar Mauricio, MD  
Location: Pinehurst, NC (Moore Co)  
DOB: 5/11/1964  
License #: 0099-00042  
Specialty: IM (as reported by physician)  
Medical Ed: Autonomous University Tamaulipas, Mexico (1987)  

DIAMOND, Patrick Francis, MD  
Location: Evergreen, NC (Columbus Co)  
DOB: 5/15/1946  
License #: 0009-00042  
Specialty: IM (as reported by physician)  
Medical Ed: Autonomous University Tamaulipas, Mexico (1987)  

JORDAN, Richard Liming, MD  
Location: Jacksonville, NC (Onslow Co)  
DOB: 6/14/1946  
License #: 0000-19612  
Specialty: FP (as reported by physician)  
Medical Ed: University of Florida (1984)  

LOVE, David William, MD  
Location: Clyde, NC (Haywood Co)  
DOB: 8/31/1960  
License #: 0000-31226  
Specialty: FP (as reported by physician)  
Medical Ed: University of Florida (1984)  

ANDRINGA, Richard Cornell, MD  
Location: Greensboro, NC (Pitt Co)  
DOB: 12/29/1946  
License #: 0000-24063  
Specialty: AN/PD (as reported by physician)  
Medical Ed: University of Wisconsin (1974)  
No. 4  2001

MORRIS, Robert Harry, Physician Assistant
Location: Fayetteville, NC  (Cumberland Co)
DOB: 11/18/1950
License #: 0001-00110
PA Education: Howard University (1975)
[License surrendered 10/01/2001.]

NABORS, Dennis Ray, Physician Assistant
Location: Greensboro, NC  (Guilford Co)
DOB: 7/26/1950
License #: 0001-02153
PA Education: University of Washington (1976)

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

VANZANTEN, Pamela Mae, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 5/02/1971
License: Resident Training License
Specialty: FP  (as reported by physician)
Medical Ed: Oregon Health Sciences University (1998)

DISMISSALS

CEPEDA, Jaime, Jr, MD
Location: Greenville, NC  (Pitt Co)
DOB: 4/07/1970
License: Resident Training License
Specialty: GS  (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1997)
Action: 9/26/2001. Board Order issued following a hearing of 9/21/2001 on the motion for dismissal: the Board found there was good cause to dismiss without prejudice the Notice of Charges and Allegations of 7/26/2001, and dissolved the Order of Summary Suspension of 7/26/2001. [The motion for dismissal noted that Pitt County Memorial Hospital had terminated Dr Cepeda's employment/residency by a letter of 8/01/01. Under the law, that termination also terminated his resident's training license, thus ending the Board's authority in this matter.]

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

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

North Carolina Medical Board
January Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

North Carolina Medical Board
February Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

North Carolina Medical Board
March Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

North Carolina Medical Board
April Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

North Carolina Medical Board
May Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

North Carolina Medical Board
June Meeting Deadlines:
Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

Residents Please Note USMLE Information

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

Special Purpose Examination (SPEX)
The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at 400 Fuller Wiser Road, Suite 300, Euless, TX 76039 or telephone (817) 868-4000.
CHANGE OF ADDRESS FORM

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

Please print or type. Date:______________

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

(Check preferred mailing address)

❏ Business:_____________________________________________________________________

❏ Business:_____________________________________________________________________

❏ Business:_____________________________________________________________________

Phone:(______)_________________________Fax:(_______)____________________________

❏ Home: ______________________________________________________________________

❏ Home: ______________________________________________________________________

Phone:(______)_________________________Fax:(_______)____________________________

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

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