

forum

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

Advance Care Planning:
Nuts and Bolts - page 8

We Cherish the Memory: Reflections on the Life of Dr John T. Dees

Elizabeth P. Kanof, MD, Past President, NCMB

“A life of service and high ideals is an inspiration.”

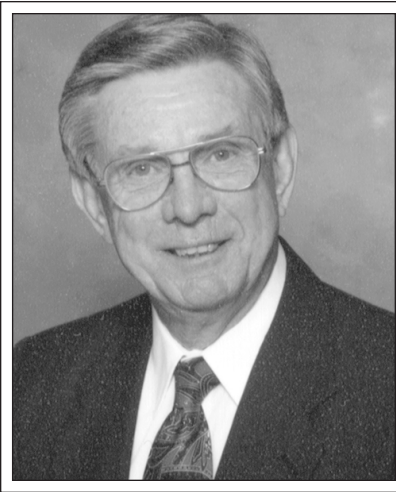
“With the passing of John Dees, all of us have lost a good friend, a sympathetic counselor, a wonderful physician, a modest and perceptive leader, and a true gentleman. He dedicated his entire life to the practice and enhancement of medicine in his home state, which we, his colleagues on the North Carolina Medical Board, are privileged to follow. His style of leadership was persuasive and courteous, yet always business-like. In dealing with troubled practitioners in a small group setting, where many of us remember working with him, he was courteous and kindly, but he would tolerate no subterfuge. Through his good works, he will always be remembered.”

“I hope, in some kind of way, we continue to uphold the standards that he established.”

“John had a special heart to see that the Physicians Health Program was successfully and professionally integrated with the Board’s stance on providing an opportunity for recovering professionals to use the PHP system to improve their lives. He also had a special sense for the medical needs of our citizens who are incarcerated in the prison system; and he constantly tried to improve the quality of health care in that environment. His true joy was the practice of family medicine in Burgaw, the many families he helped, and the community he made better because he really cared about people. I shall forever cherish the memory of his example of servanthood to his community and to the profession he dearly loved.”

These are the thoughts of John Dees’ fellow North Carolina Medical Board members. He died on February 7, 2003, presi-

dent of the Board in his sixth year of service. He chaired his last meeting in January with determination and strength. He showed all of us how to leave this world with grace and humility, and with gratitude toward colleagues and staff. He maintained command of his mental faculties and sense of humor to the end. He did everything he could to make his going unpretentious. In his last hours, he said he could want nothing more than to be a family doctor in eastern North Carolina for another 50 or 150 years.



*John T. Dees, MD
1927-2003*

Over the course of his distinguished career, John served as health director of Pender County, chief of staff of Pender Memorial Hospital, and medical director of Huntington Health Care Center. He was active in many professional organizations, including the North Carolina Academy of Family Physicians, the Southern Medical Association, the New Hanover-Pender Medical Society, the Wake County Medical Society, and the American Medical Association. He served ably in many leadership roles. After serving on many committees and as secretary-treasurer of the North Carolina Medical Society, he assumed the presidency of the Society for 1991-1992. He represented the Society on the delegation to the AMA House from 1986 to 1995. He served as president of the North Carolina Physicians Health Program from January 2001 to December 2002.

John was very active in community affairs in Burgaw, in Pender County, and at the state level. His contributions were recognized by numerous awards, among them the Pender

continued on page 3

In This Issue of the FORUM

Item	Page	Item	Page
We Cherish the Memory: Reflections on the Life of Dr John T. Dees.....	1	North Carolina Medical Board Officers.....	15
“John Dees Taught us. . .”	2	Letters to a Young Physician: <i>A Note from Dr Carolyn Hart:</i> <i>Take Time to Write to W</i>	16
Losing Freedom, or Am I Disruptive?	3	North Carolina Medical Board Releases 2002 Annual Board Activity Report	17
2001 NC Physicians: Medical School Training.....	6	Review: <i>Great Feuds in Medicine</i>	19
2001 NC Physicians: Residency Training.....	7	Position Statement on Office-Based Procedures	22
Advance Care Planning: Nuts and Bolts	8	Board Actions: 11/2002-1/2003	28
R. David Henderson, JD, Named Executive Director of North Carolina Medical Board	13	Board Calendar	32
Gov Easley Reappoints Dr Garrett and Dr Fretwell to North Carolina Medical Board	14	Change of Address Form	32

Primum Non Nocere

forum

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

Raleigh, NC

Vol. VIII, No. 1, 2003

The *Forum* of the North Carolina Medical Board is published four times a year. Articles appearing in the *Forum*, including letters and reviews, represent the opinions of the authors and do not necessarily reflect the views of the North Carolina Medical Board, its members or staff, or the institutions or organizations with which the authors are affiliated. Official statements, policies, positions, or reports of the Board are clearly identified.

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

North Carolina Medical Board

Charles L. Garrett, Jr, MD
President
Jacksonville
Term expires
October 31, 2005

Edwin R. Swann, MD
Raleigh
Term expires
October 31, 2005

Stephen M. Herring, MD
President Elect
Fayetteville
Term expires
October 31, 2004

Aloysius P. Walsh
Greensboro
Term expires
October 31, 2003

Robert C. Moffatt, MD
Secretary
Asheville
Term expires
October 31, 2004

R. David Henderson, JD
Executive Director

Bryant D. Paris, Jr
Executive Director Emeritus

Hari Gupta
Treasurer
Morrisville
Term expires
October 31, 2004

Publisher
NC Medical Board

Editor
Dale G. Breaden

E.K. Fretwell, Jr, PhD
Charlotte
Term expires
October 31, 2005

Assistant Editor
Shannon L. Kingston

Robin N. Hunter-Buskey, PA-C
Gastonia
Term expires
October 31, 2003

Street Address
1201 Front Street, Suite 100
Raleigh, NC 27609

Mailing Address
PO Box 20007
Raleigh, NC 27619

H. Arthur McCulloch, MD
Charlotte
Term expires
October 31, 2005

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

Michael E. Norins, MD
Greensboro
Term expires
October 31, 2004

Fax
(919) 326-1130

Walter J. Pories, MD
Greenville
Term expires
October 31, 2003

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

“John Dees taught us. . .”

Walter J. Pories, MD, EACS
Past President, NCMB

Prelude

Isn't it curious that with all the stuff we teach in medical school, we never teach anyone how to die? Since we all need to go through that dark door, shouldn't that be at the top of the curriculum? Think of how much time we spend on birth. Then, nothing, just silence, about death, the only other inevitable event in life.

We need, therefore, to look for examples of how to die. We need to celebrate the splendid accomplishment of a graceful death so we can all learn, so we can all cherish that example.

Dr John Dees provided such a lesson.

John Dees taught us. . .

John Dees taught us how to die.

We need to celebrate his splendid, graceful death,
the model we all seek.

He died with family,
in love I have rarely seen.

He died with a smile,
no, actually a laugh.
And, in laughing,
reduced death
to just another trip.

He died with gifts.

“I wish we'd met years earlier,”
he said to me.

“We could have been close friends.”

At the cemetery,
a friend wept:

“You know, he had no enemies, no enemies.”

We thank you for that model, John:

death with love;

death with a smile;

death,

concerned with others, rather than yourself.

Please stay around,

John,

please stay around, real close.

We Cherish the Memory

continued from page 1

County Distinguished Service Award, the North Carolina Community Man of the Year Award, the Order of the Long Leaf Pine, and his selection as a Tarheel of the Week. However, the two that meant the most to him were the Distinguished Medical Alumnus Award from the Duke University School of Medicine and the Fifty Year North Carolina Medical Society pin presented to him by his colleagues and friends the evening before he died.

“He provided incredible leadership throughout his term on the Board, leading by example. He provided a vision and strong future for the Medical Board, which will have a profound impact on physicians and their patients for many years to come. His dedication and determination during his illness demonstrated a great deal of loyalty and sacrifice on his part.”

“He personified the highest ideals of the medical profession: a life of service to his patients, his community, and our

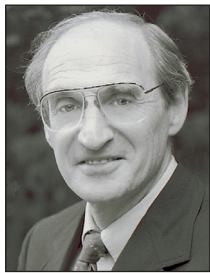
profession. I was struck by his strength of will, clothed in a gentle nature. He led without pretense. He was able to deal with contentious issues while remaining the epitome of a gentleman and providing a calming influence. He made me feel valuable and that I made a real contribution to the endeavors we shared. I enjoyed his humor, which lightened the serious work we are about.”

“It has been said: ‘Give men large dreams to dream of; small dreams put them to sleep.’ Looking at John’s list of accomplishments, it is difficult to understand how he ever slept. We offer congratulations to you and Jenny for your life’s work and for the thousands of people in whose lives you have made a difference.”

The North Carolina Medical Board extends its sympathy and heartfelt condolences to John’s wife, Jenny, his children, his extended family, and his close friends and colleagues—all deeply affected by his loss.

Losing Freedom, or Am I Disruptive?

John-Henry Pfifferling, PhD
Director, Center for Professional Well-Being



Dr Pfifferling

Physicians who are disciplined by their practices, medical executive committees, or medical boards, lose some or all of their professional freedom. The consequences of discipline are economic, status, social, emotional, and legal stressors.

We can reduce such stress by increasing physicians’ abilities to self-correct their behavior. Early and honest confrontation by peers of alleged disruptive behavior can also reduce the costs of late-stage intervention and escalation. Our objective in this guide is to focus on increasing physician self-awareness of behavior that is alleged to be—or is labeled—disruptive. Self-corrective mechanisms are the most effective and least costly primary prevention methods. Disruptive policy designs and considerations are beyond the scope of this article (Cf. Pfifferling, 1997). Each practice needs to adopt or develop a system to identify, model, rehabilitate, or mediate and educate physicians in effective, respectful professionalism.

Definition of disruptive behavior

Disruptive behavior has perceptual, cultural, and ambiguous elements. Single incidents of outrageous behavior are easier to deal with than a subtle pattern of interpersonal violations and threat. Most authori-

ties agree that a pattern of a person’s behavior that

- undermines or is felt to undermine practice morale;
- heightens unnecessary turnover;
- promotes ineffectiveness in teamwork;
- increases the risk of substandard care;
- intimidates or threatens harm to others; and
- disproportionately causes distress to peers, staff, and others in the practice,

exemplifies disruptive behavior.

Disruptive physicians provoke fear, manifest inappropriate anger, and instill in others the threat of harm (Irons, 1994). Disruptive physicians rarely acknowledge their harmful impact on others. They infrequently articulate their own awareness of others’ perception. They appear to suffer from anosognosia, a lack of insight, into their own behavior. As Richard Irons writes, “The inherent problem is that of abuse of power or position for personal gain or to avoid blame or responsibility for adverse outcomes.”

Examples of disruptive behavior

Remember to look for a *pattern*:

- fails to comply with practice standards;
- shames others for negative outcomes;
- uses foul, abusive language;
- arbitrarily sidesteps policies;
- acts in ways that are perceived as sexual harassment;
- threatens staff or associates with retribution, liti-

“Disruptive physicians provoke fear, manifest inappropriate anger, and instill in others the threat of harm”

Losing Freedom, or Am I Disruptive?

“How do you know if you are perceived of as disruptive?”

- gation, or violence;
- criticizes staff in front of others;
- discourteous to and disrespectful of others in the healthcare team;
- casts slurs on someone’s ethnic identification;
- relies on intimidation to accomplish goals;
- fails to respond to direct questions relating to patient care;
- tells others they are stupid, untrainable, or uneducable;
- disparages others’ care or behavior in front of patients/family;
- reprimands others in front of patients/family or team members;
- uses bodily contact with team members that is not therapeutic or mutual;
- refuses to interpret or write orders legibly;
- refuses to apologize after harming someone;
- shuns those with whom there is a communication problem;
- refuses to respond to constructive feedback or criticism;
- shuns the use of appropriate grievance channels;
- threatening, assaultive, and violates others’ professional space;
- repetitively cynical and aggressive;
- disregards the personal/professional comfort of colleagues.

Self-Appraisal

Above we have a partial list of items that are often used in describing disruptive behavior by professionals. How do you know if you are perceived of as disruptive? Study the list above and note whether you sense you have or currently engage in any of those behaviors. Have you ever been accused of any of those behaviors? Have your spouse/significant others or teenagers ever claimed you engaged in any of them? Have your partners, office manager, or close staff implied that you need diplomacy skills?

We need direct, honest feedback, given in a spirit of understanding, to self-correct our behavior. In the competitive environment of medicine, such feedback is not given for a variety of reasons. Usually, feedback is not given because the sender fears some defensive response. Or if feedback is given, they feel it will be discounted by the receiver. Why not propose to your group that regular behavioral feedback is a policy for delivering excellence? Athletes regularly get timely, honest feedback on their actions. That’s how they become world-class. We in the medical care domain rarely engage in such direct or even anonymous feedback. Develop a behavioral feedback instrument composed of (a) reasonable expectations and (b) unreasonable behavior. If the members of the practice, or

the team, develop reasonable expectations, we then generate some norms for professionalism.

Here are some samples of reasonable behavior.

Professionalism can include:

- compliance with practice standards;
- using conflict resolution skills in negotiating differences and disagreements;
- addressing concerns about clinical differences directly and privately;
- approaching dissatisfaction with policies through established grievance channels;
- supporting policies that promote cooperation and teamwork;
- listening to and trying to understand constructive feedback.

Unreasonable behavior includes:

- engaging in blame-casting or shaming others for alleged adverse outcomes or maloccurrences;
- engaging in repetitive cynicism, sarcasm or slurs;
- using abusive or inappropriately loud or publicly critical language;
- threatening or implying harm to those who disagree;
- showing disregard for health, dignity, or comfort of associates;
- offering inflexible responses to requests for cooperation or essential information;
- demanding sexual responses or closeness when unwelcome;
- appending requests with threats of anger or retribution.

The appendix below contains a sample self-appraisal instrument you can use to monitor your professionalism or note behaviors that are associated with disruptive allegations.

Preventive strategies

If your workplace has no mechanism to establish guidelines or to prevent disruptive behavior, here’s how to build a framework.

Define reasonable guidelines for professionalism. What interpersonal lifestyle does the group want? What level of transgression is tolerable, and is there an equitable system when transgressions are alleged? If these guidelines are developed prior to a confrontation, we can usually prevent accusations. What should be expected of professionals (or people) as they deal with patients and colleagues? Will the practice work on these guidelines so the territory and “rules of the game” are expressed? What are appropriate responses to reasonable and unreasonable demands? Apart from legal and ethical norms regarding assault, harassment,

and unethical actions, what do we define as unprofessional? (See our thoughts on defining policy in the endnote.)

Feedback ought to be collected on a routine basis and incorporated as part of practice development. What does it mean to communicate with each other? Can we improve the collegial setting so that trust and morale are uniformly high? Thus, distrust, fear, and indirect communication will be low. Such environments promote collaboration and creativity. Set aside sufficient funds and time to enhance communication skills and to prevent internal sabotage of practice or system success.

Collect communication resources for improving communication, dealing with difficult patients/people, managing conflict, and enhancing negotiation skills. These were not a formal part of most physicians' training and were infrequently used as evaluation tools when promoting medical students, residents, or fellows. If interpersonal deficiencies are confirmed, it is essential to identify remedial education programs and to assume goodwill when a colleague receives assistance or help. After attending training, graduates are often remarkably useful in improving collegial communication and enhancing practice success.

As Rubin has written in his masterful book on effective feedback:

Feedback offers receivers the opportunity to see themselves as truly special people, someone who the giver—an equally special human being—cares enough about to engage in this intimate exchange. In return, the giver will come away with more of the humility and grace

required to be an effective receiver. For the giver, the gift is in the giving, whether or not the received does anything with the feedback gift that was given. (Rubin, 1998:22)

References

Irons, Richard. 1994. The Behaviorally Disruptive Physician. *Metamorphosis*. North Carolina Physicians Health Program, 3,6.
 Pfifferling, John-Henry. 1997. Managing the Unmanageable: The Disruptive Physician. *Family Practice Management*. November/December: 77-92.
 Rubin, Irwin; and Campbell, Thomas. 1998. *The ABCs of Effective Feedback*. Jossey-Bass.

Endnote

Define reasonable guidelines, a policy to arbitrate when transgressions occur, and a system to collect feedback about behavior from all practice staff and colleagues. Use this feedback to schedule professional development training workshops (on managing conflict or understanding how to manage difficult interpersonal interactions). Determine when and if these behaviors are antithetical or positive regarding patient care. As you develop your guidelines, consider using NC Physicians Health Program associates, patient advocates, local family therapists, or communication authorities. At some point, it is important to use either legal counsel or risk management advice. Determine whether the results of your work are to be incorporated in bylaws/policies.

Author

Dr Pfifferling is director of the Center for Professional Well-Being, which is located in Durham, NC. He may be reached at (919) 489-9167 or at cpwb@mindspring.com.

“If interpersonal deficiencies are confirmed, it is essential to identify remedial education programs. . .”

**Appendix: Losing Freedom, or Am I Disruptive?
 Sample Instrument: Disruptive Self-Appraisal**

My name: _____ Date: _____

For each of the numbered items below, indicate how often in the last three months you noticed that someone might have perceived you to exhibit the trait.

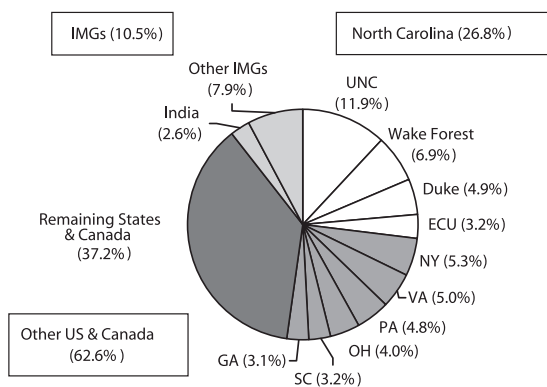
	<u>Never</u>	<u>Rarely</u>	<u>Sometimes</u>	<u>Often</u>
1. Encouraged direct communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Accepted constructive feedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Demonstrated respect for staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Responded to pages in courteous manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Arranged for coverage in a timely fashion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Clarified points of agreement in a meeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Carefully chose time for discussing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Approached “mistake” with no-fault attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Tried to repair system “failures”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Avoided dwelling on other’s vulnerabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Threatened retribution to peer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Disparaged another person’s ethnicity, gender or role	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Denigrated colleague in front of patient/family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Used cynicism or satire directed at colleague	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Displayed overt anger or outburst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Shifted blame for negative outcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Engaged in “unwelcome” sexual advance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Criticized colleagues outside of the practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Disregarded agreed-upon practice policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Used foul or profane language in practice setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2001 NORTH CAROLINA PHYSICIANS: MEDICAL SCHOOL TRAINING

North Carolina, Other U.S. & Canada, and International Medical Graduates

The medical school background of the 16,392¹ North Carolina (N.C.) physicians licensed in 2001 is highlighted in this profile. Nearly 27% (4,396) of the state's physicians graduated from a North Carolina medical school. The majority of physicians, 62.6% (10,265), completed medical school elsewhere in the U.S. or Canada. Approximately ten and a half percent (10.5%; 1,724) of the physicians are international medical graduates (IMGs) who completed their medical school training outside the U.S. and Canada.

FIGURE 1: MEDICAL SCHOOL LOCATION OF ACTIVE LICENSED NORTH CAROLINA PHYSICIANS, 2001



¹ Medical school data was missing for 7 physicians; percentages are based on the 16,385 physicians for whom medical school information was available.

See Figure 1 and notes for details.

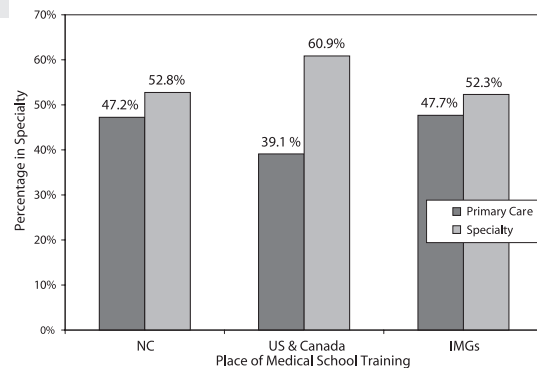
LOCATION

In North Carolina, a larger percentage of IMGs (28.0%) list a primary practice location in a nonmetropolitan county than physicians who graduated from U.S. or Canadian schools (21.1%) or North Carolina schools (20.2%). Approximately seven percent (7.0%) of IMGs locate in whole county Health Professional Shortage Areas (HPSAs) compared to 3.1% of the U.S. and Canadian graduates and 3.7% of the N.C. graduates.

HOURS

North Carolina graduates indicate that they work an average of 45.0 total clinical care hours per week, compared to 45.1 hours for U.S. and Canadian graduates, and 45.9 for IMGs.

FIGURE 2: SPECIALTY CHOICE OF ACTIVE N.C. PHYSICIANS BY MEDICAL SCHOOL LOCATION



PRACTICE SETTING

Although the majority of North Carolina physicians practice in an office setting as part of a group, there are other considerable variations according to the location of a physician's medical school education. The N.C. medical school graduates are more likely to practice in a group office, while other U.S. and Canadian graduates are more likely to practice in a hospital or a facility affiliated with a medical school, and the IMGs are more likely to be solo practitioners than their respective counterparts.

See Table 1.

AGE & GENDER

The average age of physicians shows little variation by medical school location. Graduates from N.C. schools average 46.3 years of age, compared to 46.5 for IMGs and 45.1 for graduates from other U.S. states and Canada. The gender distribution is also similar across groups: 22.9% of N.C. graduates and IMGs are women, compared to 22.3% of other U.S. and Canadian graduates.

SPECIALTY

Physicians who graduate from a North Carolina medical school (47.2%) are more likely to choose a primary care specialty than other U.S. and Canadian graduates (39.1%), but less likely than IMGs (47.7%).

See Figure 2 and notes for definition of primary care.

TABLE 1: ACTIVE N.C. PHYSICIAN PRACTICE SETTING BY LOCATION OF MEDICAL SCHOOL

Setting	% of NC Grads	% of US & Can	% of IMGs	% of Total
Solo Practitioner's Office	12.7%	12.0%	23.8%	13.4%
Free-Standing Clinic	6.2%	5.9%	5.3%	6.0%
Group Office	48.2%	42.3%	33.6%	43.0%
Staff or Group Model HMO	0.4%	0.3%	0.2%	0.3%
Hospital	18.7%	23.2%	20.6%	21.8%
Medical School or Parent University	9.6%	12.7%	10.8%	11.6%
Locum Tenens/Telemedicine	1.1%	1.0%	1.7%	1.1%
Nursing Home/Extended Care	0.4%	0.4%	0.6%	0.4%
Other	2.7%	2.2%	3.4%	2.5%

Each column adds up to 100%. Missing practice setting -- 1, 910.

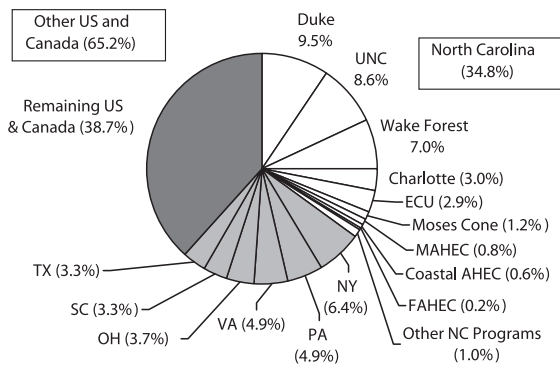
NOTE: Physicians are active, in-state, nonfederal, nonresident-in-training physicians licensed by the N.C. Medical Board as of October 2001. Primary care includes a primary specialty of family practice, general practice, internal medicine, obstetrics/gynecology, or pediatrics. Seven (7) physicians missing medical school information were not included in this profile. The 176 Canadian graduates were grouped with the U.S. graduates because of their similar training background. This fact sheet was compiled by the N.C. Health Professions Data System at the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, December 2002. This work was supported by the North Carolina Area Health Education Centers (NC AHEC) Program and the University of North Carolina Office of the Provost (Health Affairs).

2001 NORTH CAROLINA PHYSICIANS: RESIDENCY TRAINING

North Carolina and Other U.S. & Canada

The postgraduate or residency training of the 16,392² North Carolina (N.C.) physicians licensed in 2001 is highlighted in this profile. Nearly thirty-five percent (34.9%) of physicians completed their residency training in the state (5,629). Of the N.C. locations with accredited residency training programs, Wake Forest University Baptist, Duke, and UNC-Chapel Hill

FIGURE 3. RESIDENCY SCHOOL LOCATION OF ACTIVE LICENSED NORTH CAROLINA PHYSICIANS, 2001



² Residency school data was missing for 225 physicians, and 37 internationally trained physicians were not included in this analysis; percentages are based on a total of 16,130 physicians.

account for 72.0% of the N.C. trained physicians. The majority of licensed physicians (10,501) completed their graduate medical education (GME) training in other U.S. states or Canada. A total of 37 physicians reported training in another country and are not included in this analysis.

See Figure 3 and notes for details.

LOCATION

In North Carolina, 15.5% of the N.C. residency trained physicians work in nonmetropolitan counties, less than their U.S. and Canadian (24.9%) trained counterparts. A smaller percentage of the N.C. trained physicians (33.8%) work in counties that are designated as partial or whole county Health Professional Shortage Areas (HPSAs) than U.S. and Canadian trained physicians (44.1%). Approximately three percent (3.1%) of the N.C. trained physicians and four percent (4.0%) of the U.S. or Canadian trained physicians practice in whole county HPSAs.

HOURS

U.S. and Canadian trained physicians spend an average of 45.4 total hours a week in clinical care, slightly more time than their N.C. trained counterparts (44.8).

AGE & GENDER

The average age of physicians trained in N.C. and practicing in the state is 44.9, compared to 46.0 years of age for U.S. and Canadian trained physicians. A total of 27.4% of the N.C. trained physicians are women, compared to 19.9% of the physicians trained in other states or Canada.

SPECIALTY

Approximately 44.2% of the physicians who completed a residency in N.C. indicate a primary care specialty, compared to 41.1% of physicians who trained out of state.

See Figure 4 and notes for definition of primary care.

FIGURE 4: SPECIALTY CHOICE OF ACTIVE N.C. PHYSICIANS BY RESIDENCY TRAINING LOCATION

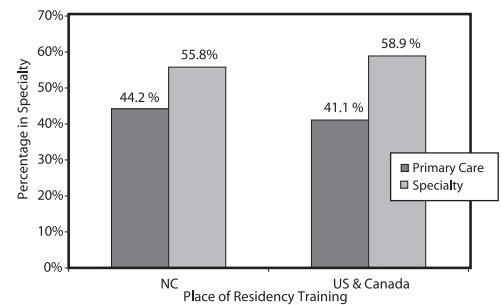


TABLE 2: ACTIVE N.C. PHYSICIAN PRACTICE SETTING BY RESIDENCY TRAINING LOCATION

Setting	% of NC Grads	% of US & Can	% of Total
Solo Practitioner's Office	13.5%	18.4%	16.6%
Free-Standing Clinic	7.7%	7.1%	7.3%
Group Office	49.6%	55.7%	53.5%
Staff or Group Model HMO	0.5%	0.4%	0.4%
Hospital	25.9%	27.5%	27.0%
Medical School or Parent University	19.3%	11.4%	14.3%
Locum Tenens/Telemedicine	1.1%	1.4%	1.3%
Nursing Home/Extended Care	0.4%	0.5%	0.5%
Other	3.1%	3.1%	3.1%

Each column adds up to 100%. Missing practice setting -- 1, 873.

PRACTICE SETTING

Most physicians practicing in North Carolina, regardless of the location of their residency training, practice in an office setting as part of a group. The N.C. residency trained physicians are more likely to practice in a medical school setting and are less likely to be solo practitioners than their U.S. and Canadian counterparts.

See Table 2.

NOTES: Physicians are active, in-state, non-federal, nonresident-in-training physicians licensed by the N.C. Medical Board as of October 2001. Primary care includes a primary specialty of family practice, general practice, internal medicine, obstetrics/gynecology, or pediatrics. The 88 physicians who completed training in Canada were grouped with U.S. trained physicians because of their similar training background. Internship data were substituted for 1,463 physicians with no residency data. For 47 individuals who graduated from North Carolina medical schools, Association of American Medical Colleges residency data were used. There were 246 individuals for whom American Medical Association residency data were used. The remaining 225 with missing residency and internship data were not included in this profile. The internationally-trained physicians were not included in this analysis because of the small sample size (37). This fact sheet was compiled by the N.C. Health Professions Data System at the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, December 2002. This work was supported by the North Carolina Area Health Education Centers (NC AHEC) Program and the University of North Carolina Office of the Provost (Health Affairs).

Advance Care Planning: Nuts and Bolts

Martha L. Henderson, MSN, MDiv, DrMin



Dr Henderson

This article will briefly describe advance care planning, present several cases, test your knowledge of basic advance directive (AD) information, briefly highlight research findings in this field, and offer some skills and procedures to help you solicit and honor your patients' wishes. Please see the North Carolina

Medical Board's position statement on this and related topics: Advance Directives and Patient Autonomy, and End-of-life Responsibilities and Palliative Care. These can be found on the NCMB Web site (www.ncmedboard.org/law.htm).

A Definition

Advance care planning (ACP) is a *process* of preparing for one's death. It includes reflecting on and articulating values, priorities, concerns, and preferences for one's medical treatment and comfort care at the end of life. Ideally, the discussion with the health care provider or designee includes clarifying the patient's health condition and listing potential treatment options, and results in the patient's statement of treatment preferences and the appointment of a surrogate decision-maker. The patient then documents a plan for decisions and care that may be appended to formal ADs, if the patient wants to complete ADs.

Introductory Cases

Mr J was a functional, 86-year-old man with a 10-year history of congestive heart failure (CHF) with co-morbidities of stable non-insulin dependent diabetes mellitus and mild chronic renal insufficiency. His CHF had been stable until the last year, with one hospitalization for pulmonary edema and a need for ongoing titration of his CHF medications. He had no ADs and had never discussed what he wanted when his heart disease became acutely life threatening.

One evening, a colleague, Dr K, was on call, and Mr J's wife telephoned reporting symptoms of worsening shortness of breath. Dr K advised the wife to take her husband to the nearby emergency department. In the ED, Mr J had a cardiac arrest, but responded to immediate CPR and intubation. However, he remained unconscious and was admitted to the intensive care unit. He did poorly despite aggressive treatment. It became apparent that Mr J's prognosis was poor.

Over the next few days, the patient remained unresponsive and family members were divided about withdrawal of life support. The patient had no ADs. The wife and two of the children felt Mr J would never want to prolong his life in this situation, but

three other children wanted to wait for a "miracle" to happen. As Mr J's clinical and family situation did not change over three weeks despite social work and chaplain counseling, the MICU team decided to call an ethics consult for help. Despite facilitation of family and medical team discussion and problem solving, no consensus was achieved. Finally, after three more weeks, two of the children consented to removal of life support. The remaining child was bitter, but recognized that a decision must be made.

Consider another case. Mrs J was a 76-year-old with advanced CHF, quite similar to the case above. However, in this case, Mrs J's physician had spoken with this patient in his office about two years ago in anticipation of her death, knowing that heart disease is the number one killer and that patients can become critically ill very quickly. Within two consecutive visits, the patient had completed ADs as well as a worksheet that expressed more explicitly her wishes.

Mrs J had a similar cardiac event and she had chosen, in her worksheet, a trial of therapy if her prognosis was not clear. Within 48 hours, with family gathered, the attending, with the patient's primary care physician, told the family the patient had not responded to treatment and was not expected to recover. Though all children but one felt the patient would want the ventilator withdrawn, the youngest son felt that his mother would want more time on the ventilator. With two more days of no improvement, the poor prognosis was more evident. With the promise of expert comfort care and the support of pastoral help, the son was able to allow withdrawal of the ventilator.

The next morning, at a set time, the family and the patient's minister gathered, played the patient's favorite hymn on a tape, said prayers and good-byes. Life support was withdrawn, according to a comfort-care protocol for this procedure. The patient died without lingering or struggle; the family stayed with the body for a few minutes. Before leaving, they expressed gratitude to the staff and physician for helping them honor their mother's wishes.

Have similar episodes ever occurred with any of your patients?

Self-Assessment of Advance Directive Facts and Related Information

The following test is an assessment of basic knowledge about ADs and related end-of-life (EOL) issues. Expanded answers follow. I encourage you to take this simple test before you read further.

True-False

T F 1. ADs include living wills (LW) and health

"Advance care planning (ACP) is a process of preparing for one's death"

care powers of attorney (HCPOA).

- T F 2. The Patient Self-Determination Act requires that all patients be asked on admission to a health facility if they have an AD and be offered information on ADs.
- T F 3. Family wishes can override a patient's living will if the patient is unconscious.
- T F 4. If a patient lacks decision-making capacity, the patient's power of attorney has the most legal authority to make health care decisions.
- T F 5. ADs indicate a patient's wish to have a Do Not Resuscitate (DNR) order.
- T F 6. If a patient wants to execute an AD, a lawyer is necessary.
- T F 7. If a conflict arises about the interpretation of a patient's AD, the institutional ethics committee is a resource for help.
- T F 8. A patient with a DNR should have a portable DNR order for transport.
- T F 9. North Carolina law requires documentation of a discussion when a DNR is signed by an MD.
- T F 10. A physician's office or other health care facility can legally offer AD forms and notarization on site.

Answers

1. *True*: Either of these two legal forms must be signed voluntarily by the patient who has the capacity to understand their meaning. They must be signed in the presence of a notary and two disinterested witnesses, that is, who are not related to the patient, are not on the patient's health care team, and will not benefit from the estate. ADs are best understood as "an invitation to a conversation" and should be accompanied by a more specific advance care plan, such as the "My Thoughts on Advance Care Planning" Worksheet offered as a discussion and documentation guide. (See NCMB Web site: www.ncmedboard.org.)
2. *True*: The Patient Self-Determination Act was implemented in 1991 and means that patients must hear about ADs when they enter a health care facility. Unfortunately, this is often their first encounter with these documents and they may be acutely ill. If a patient has an AD, the physician should take the time for a discussion with the patient, asking what these documents mean to the patient and any relevance to their current illness. The physician should then discuss the patient's diagnosis and prognosis, goals of care, treatment options, and the patient's preferences. Oftentimes the physician needs to make a recommendation about treatment, based on the patient's values and wishes expressed in the context of the AD. Physician

documentation should be a summary of the discussion, including who was involved, and orders, such as DNR, no tube feeding, etc. ADs and the discussion summary should be in the patient's chart in a tabbed AD section. With the help of the facility's designated professional, the patient may complete ADs initially or again if old documents are not available. A social worker, patient relations staff, or pastoral care staff will have the forms and may assist with the process. The content of this discussion may need to take place over several visits and may be a framework for an EOL discussion whether the patient has an AD or not.

3. *False*: ADs are legal documents that stand up in court as testaments to a person's wishes. Family members, unless also a patient's HCPOA, cannot override a patient's living will. While every effort should be made to obtain all family members' agreement for following the patient's AD, the patient's wishes must be honored regardless of family wishes. If a patient does not have an AD, is unable to make a decision, and the family lacks consensus, the decision will be based on the decision of the majority of family members of the first degree: spouse, parents, children. A consult for social worker or chaplain or ethics consultation may be helpful in such a situation.
4. *False*: The legal authority for representing a patient's wishes belongs to the HCPOA. The power of attorney has authority to make only business decisions. The physician should seek the patient's HCPOA (or family, if no HCPOA) to discuss diagnosis, prognosis, treatment options, and decisions, according to the values and wishes of the patient.
5. *False*: While ADs may lead to a DNR discussion and order, ADs are legal documents that become operative only when a patient is terminally and irreversibly ill or in a persistent vegetative state and cannot make decisions at the time. If patients can engage in informed decision-making, the physician would discuss their clinical status and treatment decisions with them, including a DNR order. Otherwise, the physician would discuss the clinical status and treatment decisions, including DNR, with the HCPOA, the family, or the guardian.
6. *False*: A lawyer is not required for completion of an AD. A notary and two disinterested witnesses are required and can be found with help of the social worker or representative from the Patient Relations Department. (Witnesses can be other patients' families who attest that the signing patient seems decisionally capable and is voluntarily completing the AD.) Some lawyers offer the service of AD completion when they

"ADs are legal documents that stand up in court as testaments to a person's wishes"

Advance Care Planning: Nuts and Bolts

are completing estate documents. Anyone can take the AD forms to a bank, which will offer notary service and 2 witnesses to help a customer complete these forms.

7. *True*: Hospital or nursing home ethics committees can be very helpful if there is a question or dilemma concerning an AD or the implementation of it. In most institutions, anyone (patient, family member, or staff) can call an ethics consultation. Usually a committee member will respond, gather a small consult team to hear the issues, and then facilitate problem-solving and education to help those involved, without making a specific recommendation.
8. *True*: A patient with an inpatient DNR order should have a special portable yellow DNR form to accompany her or him when discharged from the hospital to home or to another facility. The social worker or coordinator of the discharge can obtain these for the physician. Physicians or clinics can also obtain the official DNR forms from the North Carolina Emergency Medical Services through www.ncems.org. These forms authorize an ambulance driver or emergency medical technician (EMT) to not attempt CPR if this patient arrests while en route. These forms may serve as the official DNR order for some nursing homes and assisted living facilities, according to their policy. If the patient is going home, the DNR should be posted where the EMT, if called, can see it and be supportive of family needs. For hospice patients, the hospice nurse can be called when the patient appears to be actively dying or after the death. If a non-hospice patient dies and a DNR order is posted, the EMT or family calls the physician or the nurse to declare the patient dead before transport. If this is not an expected death, the physician must be called.
9. *True*: NC law requires documentation of a DNR discussion, which should contain the basis of the decision, whether or not the patient had an AD, and a summary of the conversation. This information should be in a progress note and in the discharge summary or on the official form accompanying the DNR. A DNR Documentation Form may be obtained from North Carolina Emergency Medical Services. The DNR discussion provides the opportunity for discussion of other EOL treatment choices and orders, such as Do Not Hospitalize, no tube feeding, and specific comfort care orders (including appropriate medication for pain or other distressing symptoms, etc).

10. *True*: A physician's office or other health care facility can legally offer AD forms and notarize these on site with appropriate witnesses, such as other patients or families. This is a service for patients that facilitates ease in completing the documents and filing them in an office or clinic chart under an Advance Directive tab. The primary health care provider can quickly access information concerning patient wishes or discussion with family members about EOL treatment decisions, including the ACP worksheet, if completed by the patient. The person facilitating discussion and form completion should offer copies for the patient to distribute to anyone who will be part of EOL decisions.

Literature Review

Our society and the health care system in general highly value the ethical principle of autonomy, the right of patients to make their own decisions regarding treatment. ADs (living wills and health care powers of attorney) are an attempt to apply this principle of autonomy to EOL decision-making. The Patient Self-Determination Act of 1990 heightened consciousness about the legal rights of patients to participate in EOL decisions and potentially facilitated this process. Ten years after the passage of this act, AD studies have shown that these documents alone have yielded disappointing results of patients' influence on EOL treatment decisions. In an excellent review article, Prendergast (2001) summarizes the literature and reasons for negative AD studies and reports an emerging consensus that ADs must be part of a process of effective provider—patient communication, trust-building, and working within a patient's most important relationships.

Effective ACP planning first requires a commitment by the physician to prioritize this process, especially for patients who are at high risk for dying. Appropriate patients include those with progressive life-threatening illnesses, such as heart disease or lung disease, in addition to the more obvious terminally ill. Excellent communication is essential as well. In interviews of community physicians who care for terminally ill patients, ACP, good relationships with the patient, and family support for decisions were the primary determinants of good EOL decision-making. (Hanson, 1999).

Roter and others (2000) have focused research on the quality of EOL discussions and found that expert discussions include the following: eliciting patients' values, beliefs, experiences; patients' preferences about specific scenarios; providing support for the decision-making process; and effectively clarifying and summarizing the discussion, and eliciting questions or con-

“Our society and the health care system in general highly value the ethical principle of autonomy. . .”

cerns. The skill of empathetic listening as patients relate psychosocial information or feelings, such as fears, is essential.

Despite concern of physicians about the time-consuming nature of these discussions, Roter (2000) found that “expert” physician communicators on EOL care spent an average of only 14.7 minutes for ACP sessions, and community physicians spent an average of 8.1 minutes for an ACP conversation. Obviously, such discussions may be spread over more than one visit.

Having the Conversation

ACP conversations can be targeted first to those patients who have recently been diagnosed with a terminal illness, such as cancer; or have a potentially life-threatening illness, such as heart disease, lung disease, Alzheimers, cirrhosis; or are elderly and seem generally frail. Logical times to initiate an ACP conversation are a routine new patient work-up, gradual decline in a patient with a chronic illness, an office visit after acute exacerbation of a chronic illness or hospitalization, diagnosis of an imminently terminal illness, before elective or urgent surgery, or when your next patient does not come. The most appropriate timing of EOL conversations with each patient is an important matter of sensitivity and trust best determined by the patient or the patient’s primary provider.

Von Gunten and others (2000) offer a seven step approach for structuring the conversation that includes the physician’s review of the patient’s illness and prognosis and then assessing what the patient understands about his or her illness through an open-ended question, in addition to the content Roter outlined above.

After introducing the topic of EOL decisions, the MD may want to use the ACP Worksheet on the NC Board Web site to guide the discussion and as documentation of the conversation, thus making the process very efficient. The information in the ACP worksheet is very useful when a patient is not comfortable signing a legal document, such as the LW or HCPOA. It also prompts patients to think about their personal priorities and solicits patient preferences for comfort care as well as decisions about treatments. Patients should never be told, “there is nothing more we can do,” since there are always methods of symptom management and comfort care. There is an educational booklet that can be given to the patient to read before the ACP Worksheet discussion. (See NCMB Web site for both.) There is also an ACP booklet and worksheet for families of patients without decision-making capacity. (See www.acnpweb.org.) The following conversation is one way to engage a patient in a non-threatening way about this topic.

MD: “Mrs J, you have just gotten through a period of illness and are now doing well, so this is a good time to talk with you about some-

thing that I talk with all my patients about. We never know when our time will come to leave this world and it can happen unexpectedly.”

Mrs J: “You are so right. September 11 certainly reminded all of us about that.”

MD: “How do you see your health now and what do you expect will happen in the future?”

Mrs J: “I think I am doing great now. It’s hard to say what will happen eventually, but I know someday I will have to face a decline in my health.”

MD: “Have you ever thought about, when your time comes, how you would want your death to be?”

Mrs J: “I know I want to die at home with all my family around.”

MD: “Have you talked with your loved ones about this?”

Mrs J: “No, but I think my son would know what I want.”

MD: “It would be very helpful if your family and I have a little more information about what is important to you when you are facing a serious illness and death. I have a questionnaire I call “a worksheet” that I would like to go through with you to understand your wishes. Some of these questions may need some time to think about. Do you have a few minutes to look at this with me now?” (See Worksheet on NCMB Web site.)

[MD asks Mrs J the questions on the worksheet and records her answers as she watches.]

MD: “I would like to summarize briefly the decisions I see here.”

[MD does this and recommends future DNR order.]

Mrs J: “You got the essence of what I want. That was not so hard.”

MD: “I’d like to make a copy for your chart and then give the original and an extra copy for you to take home, think about, and discuss with your loved ones. You can always change this any time. If you would like, next visit, we can also help you complete an AD, a living will or health care power of attorney, that gives more power to this personalized form and whoever will advocate for your wishes if you cannot.”

Mrs J: “That’s fine. I know I’ve needed to do this and I kept putting it off.”

MD: “I have found it is so helpful to patients, families, and myself to know what patients want, so I can help make those wishes happen. I call this planning a gift to your family. In fact, it may be helpful if you want to bring the family member with you that you want to make decisions for you if you cannot make your own, or any family member, and espe-

“The skill of empathetic listening as patients relate psychosocial information or feelings, such as fears, is essential”

Advance Care Planning: Nuts and Bolts

cially one that may not agree with your decisions.”

The brief questionnaire is completed, signed by the patient and MD, if the patient is comfortable, with the understanding that this is personal information that can be attached as an addendum to her AD, if she chooses. It can also stand alone in the AD section of the chart as important information, although it is not a formal AD.

“Every physician can incorporate the practice of ACP into a practice. . .”

When patients are ambivalent about preferences in the face of prognostic uncertainty, a trial of aggressive therapy, including life support, should be offered, especially if, in fact, the person may benefit from such. It is a very helpful guide in such cases to get an indication of what a patient considers a “reasonable” trial (for example, in days) before withdrawing life support. This information can be included in the worksheet.

Making It Happen

The commitment of a physician to make ACP a part of daily practice is an important one and quite manageable. Two excellent articles that describe incorporation of ACP into an office practice are noted in the references attached to this article. (Carney 1997) (Aitken 1999)

Some physicians like to introduce the topic and give the patient a booklet about EOL choices to take home and read before having a discussion with them. The booklet (*What Is Advance Care Planning?*) and the worksheet (*“My Thoughts on Advance Care Planning” Worksheet*) mentioned in this article are only one such resource.

Billing for ACP discussions is described in Von Gunten’s article (2000), in which his most helpful advice is to use the E&M code according to time, documenting the amount of time spent in the visit and noting that over 50% was spent on ACP.

Physicians might consider using other personnel, such as skilled nurses or other trained facilitators, to implement an ACP program for their practice. Dr Bud Hammes (1998) of LaCross, Wisconsin, developed a community-based model in which trained facilitators conducted the ACP and achieved notable success. In the sample population of 540 persons, 85% completed ADs, 95% of these had their AD in their medical record, and deaths were consistent with patients’ wishes in 98% of the cases.

ACP facilitator workshops are available throughout North Carolina and information can be obtained through The Carolina’s Center for Hospice and End of Life Care in Cary. ACP facilitators work in collaboration with primary care providers. An excellent patient resource, *“Isn’t It Time We Talk? A Guide to Advance Care Planning,”* is also available through this

organization (www.carolinasendoflifecare.org).

One other helpful tool for putting wishes of patients into an order form is the well researched POLST, Physician Orders for Life-Sustaining Treatment, developed by Dr Susan Toole (2002). (See the Web site at www.ohsu.edu/ethics/polst.htm for a sample form and order information.)

Conclusion: A Final Case

Mrs B was an 80-year-old with a similar history to Mr J above, but her clinical course had been gradually worsening over the last year. In your review of her ADs and ACP worksheet in the office visit following her last hospitalization, she decided that she did not want to go back to the hospital if her heart disease became worse.

Two months ago, when she came for a visit with her portable oxygen and her poor prognosis became more obvious, you discussed your feeling that she was probably in her final phase of life. You recommended hospice care based on your experience of their comfort care expertise and interdisciplinary support in caring for patients like her and their families. Mrs B and her family were pleased and you made the referral.

Over the next two months, you and the hospice developed an individualized and effective comfort care plan, including extended release morphine ATC and PRN concentrated elixir in addition to her usual cardiac and other meds. The hospice kept you informed and called you when Mrs B had essentially stopped eating and drinking and was actively dying. You stopped by her house on your way home from the office, presuming it would be your last visit. You were able to tell her what a special patient she was to you and she thanked you for all your care. You were not surprised when the hospice called three days later and said the patient had died peacefully and comfortably with family around. You knew that you had given her competent and compassionate care in her dying—one of the best rewards of excellent medical practice.

Summary

Every physician can incorporate the practice of ACP into a practice to help ensure that patients and their families have an experience of death that is comfortable and in accordance with the patient’s wishes.

You will note that the case above illustrates how ACP facilitates palliative or comfort care. Honoring a patient’s wishes and comfort care are essential ingredients in excellent EOL care for patients. North Carolina has been exemplary in developing a Joint Statement on Pain Management in End-of-Life Care by the Boards of Medicine, Nursing, and Pharmacy. Another related position statement of the Medical Board is Management of Chronic Non-Malignant

Pain. (See NCMB Web site for these.) Discussing Palliative Care with Patients is an excellent article on discussions with patients as they progress and actively face their terminal illness. (Lo, 1999) See Lynn's article for hospice referral criteria. It should also be noted that the North Carolina Secretary of State's Office operates an Advance Health Care Directive Registry that features key forms, frequently asked questions, links, and a registry brochure. Information on the Registry is accessible on the Web at www.sosnc.com or www.nclifelinks.org.

Martha L Henderson, MSN, MDiv, Dr Min, is a geriatric nurse practitioner and Clinical Assistant Professor at the University of North Carolina School of Medicine, Program on Aging, and in the School of Nursing. She has specialized in the issue of advance care planning in her clinical practice, research, teaching, and her consultative role. She is on the UNC Hospitals Ethics Committee and is team leader of a consult team.

References

Aitken PV Jr. Incorporating advance care planning into family practice. *American Family Physician*. 1999; 59(3):605-14, 617-20.

Carney MT, Morrison RS. Advance directives: when, why, and how to start talking. *Geriatrics*. 1997; 52(4):65-6,

69-73.

Hammes BJ, Rooney BL. Death and end of life planning in one midwestern community. *Ann Int Med*. 1998; 158:383-390.

Hanson LC, Earp JA, Garrett J, Menon M, Danis M. Community physicians who provide terminal care. *Archives of Internal Medicine*. 1999; 159(10):1133-8.

Lo B, Quill T, Tulsky J. Discussing palliative care with patients. *Ann Int Med*. 1999; 130(9):744-9.

Lynn J. Serving patients who may die soon and their families: the role of hospice and other services. *JAMA*. 2001; 285(7):925-932.

Prendergast TJ. Advance care planning: pitfalls, progress, promise. *Critical Care Medicine*. 2001; 29 (2 Suppl):N34-9.

Roter DL, Larson S, Fischer GS, Arnold RM, Tulsky JA. Experts practice what they preach: A descriptive study of best and normative practices in end-of-life discussions. *Archives of Internal Medicine*. 2000; 160(22): 3477-85.

Tolle SW, Tilden VP. Changing End-of-Life Planning: The Oregon Experience. *J Palliat Med*. 2002; 5(2):311-7.

Von Gunten CE, Ferris FD, Kirschner C, Emanuel, E. Coding and reimbursement mechanisms for physician services in hospice and palliative care. *J Palliat Med*. 2000; 3:157-164.

Von Gunten CE, Ferris FD, Emanuel LL. The patient-physician relationship. Ensuring competency in end-of-life care: communication and relational skills. *JAMA*. 2000; 284(23):3051-7.

R. David Henderson, JD, Named Executive Director of North Carolina Medical Board

At the North Carolina Medical Board's March 2003 meeting, Charles L. Garrett, Jr, MD, president of the Board, announced that R. David Henderson, JD, had been selected as the new executive director of the Board. A member of the Board's legal staff, Mr Henderson served as interim executive director of the Board from November 2002.

"After conducting an exhaustive national search over these past months and interviewing several excellent candidates, we believe we have made a particularly good decision in choosing Mr Henderson to fill the post of executive director on a permanent basis," Dr Garrett said. "His service since last November has shown him to be a dedicated, effective, and committed leader in whom we can have confidence as we move the Board forward."

Mr Henderson joined the Board's legal staff in September 1996, becoming one of the Board's leading prosecuting attorneys. From 1991 until joining the Board, he was deputy counsel at the North Carolina State Bar. In that post, he investigated grievances filed with the Bar alleging misconduct by North Carolina attorneys, represented the Bar in disciplinary and reinstatement hearings before the Disciplinary Hearing Commission, argued cases before the North Carolina Court of Appeals, and served as administrator of the

Client Security Fund (created by the Supreme Court in 1985 to reimburse those who suffer loss due to the dishonest conduct of a North Carolina attorney).

Before joining the State Bar, Mr Henderson was a senior associate with Silverstein & Hodgdon, of Raleigh. He is a cum laude graduate of the University of North Carolina at Charlotte and took his JD degree at the Wake Forest University School of Law. He is a member, among other things, of the North Carolina Bar Association.

Special SARS Information Available

As the worldwide SARS epidemic unfolds, it has become clear that SARS has entered into the differential diagnosis of all patients presenting with an acute febrile illness associated with respiratory tract symptoms. The North Carolina Division of Public Health has prepared a memorandum to help clinicians rule out SARS quickly in their early assessment of patients. The intention is to streamline activities associated with the evaluation of acutely ill patients and to protect the public health. The full text of the Division's memorandum is available on the North Carolina Medical Board's Web site at www.ncmedboard.org.

Gov Easley Reappoints Charles L. Garrett, Jr, MD, of Jacksonville, and E. K. Fretwell, PhD, of Charlotte, to the North Carolina Medical Board

R. David Henderson, executive director of the North Carolina Medical Board, has announced that Governor Easley has reappointed Charles L. Garrett, Jr, MD, of Jacksonville, and E.K. Fretwell, PhD, of Charlotte, as members of the North Carolina Medical Board. Mr Henderson said, "The members and staff of the Board are deeply pleased that Dr Garrett and Dr Fretwell will continue to serve the Board and the people of North Carolina. They have brought a remarkable depth of experience with them to the Board, and have an understanding of the challenges medical boards face and the responsibilities they bear."

Dr Garrett



Dr Garrett

Dr Garrett was first named to the Board in January 2001. He served as the Board's secretary/treasurer from February 2002 through October 2002 and became president elect of the Board on November 1, 2002. In February, 2003, he became president of the Board on the death of the Board's president, John T. Dees, MD. Besides his service as a Board officer, he has served as chair of the Board's Policy Committee and as a member of the Investigative, Executive, and Legal Committees.

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

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

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

Society in 1998. He continues his work with the Medical Society today in several capacities and is a Society delegate to the American Medical Association. He is also on the Board of Directors of the AMA's Political Action Committee.

Dr Fretwell



Dr Fretwell

Dr Fretwell is the chancellor emeritus of the University of North Carolina at Charlotte. Born in New York City, he took his BA at Wesleyan University (CT), his Master's at Harvard University, and his PhD at Columbia University. His long and distinguished career in higher education has included serving as assistant to the Dean of

Columbia's Teachers College; assistant commissioner for higher education in New York; university dean for academic development at the City University of New York; president of the State University of New York College at Buffalo; chancellor of the University of North Carolina at Charlotte; senior associate of MDC, Inc, of Chapel Hill; interim president of the University of Massachusetts five-campus system; and interim president of the University of North Florida.

Among Dr Fretwell's many honors have been honorary doctorates from the Technical University of Wroclaw, Poland, Wesleyan University, and UNC at Charlotte. In 1998, he was presented the Hugh McEniry Award for outstanding service to North Carolina Higher Education. Over the years, he has served on or chaired a wide range of special committees and boards at the local, state, and national level. He was chair of the North Carolina Education Standards and Accountability Commission from 1993 to 1997; a member of the North Carolina Medical Society's Bioethics Subcommittee on Managed Care in 1999. He is a member of the Charlotte Symphony Orchestra Board of Directors, a trustee of Peace College, Raleigh, and the North Carolina Transportation Museum Foundation. He was president of the Charlotte Rotary Club in 1994-1995. In 1990-1992, he worked with the Federation of State Medical Boards of the United States on that group's special task force on assessing the work of state medical boards. In his first term on the Board, Dr Fretwell served on its Licensing, Investigative, Research, and Allied Health Committees.

He has written several books and articles on higher education, including *Wise Moves in Hard Times: Creating and Managing Resilient Colleges and Universities* (David Leslie, senior author), in 1996; and *System Heads, Boards, and State Officials: More Than Management*, in 2000.

North Carolina Medical Board Officers:

Charles L. Garrett, Jr, MD, Jacksonville, President; Stephen M. Herring, MD, Fayetteville, President Elect; Mr Hari Gupta, Morrisville, Treasurer; Robert C. Moffatt, MD, Asheville, Secretary

R. David Henderson, executive director of the North Carolina Medical Board, has announced that at the Board's meeting on February 19, the members and staff of the Board honored the memory of John T. Dees, MD, the Board's president, who died on February 7. "All of us at the Medical Board have been deeply affected by the death of Dr Dees. He was a gracious and wise man whose thoughtful leadership will be missed," said Mr Henderson. "We now move on in his spirit, doing the work he believed in for the people of North Carolina."

He also announced that the Board's president elect, Charles L. Garrett, Jr, MD, of Jacksonville, became Board president on Dr Dees' death. At the February 19 meeting, Stephen M. Herring, MD, of Fayetteville, the Board's secretary, was elected to fill the vacant position of president elect, and Robert C. Moffatt, MD, of Asheville, was elected to fill the post of secretary. Mr Hari Gupta, of Morrisville, continues in the office of treasurer.

Charles L. Garrett, Jr, MD, President



Dr Garrett

Dr Garrett was first named to the Board in January 2001. He served as the Board's secretary/treasurer from February 2002 through October 2002 and served as president elect of the Board from November 1, 2002, until assuming the office of president. Besides his service as a Board officer, he has chaired the

Board's Policy Committee and is a member of the Investigative, Executive, and Legal Committees.

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

Dr Garrett did his postgraduate training at the

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

A fellow of the College of American Pathologists, the American Society of Clinical Pathology, and the American Academy of Forensic Sciences, Dr Garrett is active in a large number of professional organizations and served as president of the North Carolina Medical Society in 1998. He continues his work with the Medical Society today in several capacities and is a Society delegate to the American Medical Association. He is also on the Board of Directors of the AMA's Political Action Committee.

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

Stephen M. Herring, MD, President Elect



Dr Herring

Stephen M. Herring, MD, of Fayetteville, a native of Chapel Hill, North Carolina, took his BA degree at the University of North Carolina, Chapel Hill. He earned a DDS from the University of North Carolina School of Dentistry, followed by an MD from the Wake Forest University/Bowman Gray

School of Medicine. He did his internship in general surgery and a residency in general surgery and plastic surgery at Bowman Gray. He is certified by the American Board of Plastic Surgery and holds licenses in both medicine and dentistry.

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

Gov Easley Reappoints

Dr Herring was first named to the Board in 1998. He has served on several Board committees and currently chairs the Policy Committee and the Investigative Committee. He served as Board secretary from November 1, 2002, until his election as president elect.

Mr Hari Gupta, Treasurer



Mr Gupta

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

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

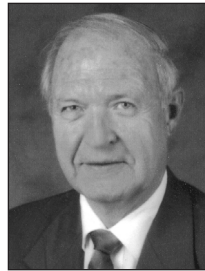
In 2001, Mr Gupta became director of SAS Consulting Partners, responsible for building and managing alliances with key SAS partners and for developing and monitoring guidelines for the SAS Consulting Partners program.

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

Mr Gupta was appointed to the Board in February 2002. He has served on the Board's Legal and Complaints Committees and took the position as treasurer on November 1, 2002.

Robert C. Moffatt, MD, Secretary

Robert C. Moffatt, MD, of Asheville, now secretary of the Board, is a native of Tennessee and took his BA degree from East Tennessee State University. He earned his MD degree at the University of Tennessee Center for Health Sciences, Memphis, and did his internship at Memorial Mission Hospital in Asheville. He completed his residency training in surgery at the University of Georgia College of Medicine and did a surgical oncology fellowship at Memorial Sloan Kettering Cancer Center. He holds certification from



Dr Moffatt

the American Board of Surgery, is a fellow of the American College of Surgeons, and is licensed in North Carolina, Georgia, and Mississippi. He was appointed to the Board in 2001 and has served on the Investigative, Licensing, and Physicians Health Program Committees.

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

Letters to a Young Physician

A Note from Dr Carolyn Hart: Take Time to Write to W

Dear Readers:

I hope you enjoyed my correspondence with my young friend, W, that appeared in the *Forum* this past year. He and his fiancée, B, have asked me to thank you for your interest and especially for your wishes of support following B's injury. Being a little younger than W, B had not yet committed to a career in medicine, and her experiences as a PT patient have now led her to favor a career as a physical therapist instead.

I must tell you that most of what I wrote about them is true, although I occasionally exercised a little literary license and added a few fictional elements, too! In any case, W and I would like to invite you to continue this correspondence and write him and/or B. You can write care of the *Forum* at public.affairs@ncmedboard.org or care of me at cchart@meckneurology.com. Several of you have mentioned to me your own ideas and advice for W about his engagement, choice of specialty, etc. Please share your ideas with him and with other readers: Take Time to Write to W!

Fondly,
Carolyn

North Carolina Medical Board Releases 2002 Annual Board Activity Report

On behalf of the North Carolina Medical Board and its president, Charles L. Garrett, Jr, MD, of Jacksonville, the executive director of the Board, R. David Henderson, has released the Board's 2002 Annual Activity Report. The report focuses on actions taken by the Board during 2002 and on a wide range of information relating to the work of the Board.

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

Altogether, the Board took 168 formal actions related to 101 individuals in 2002, compared to 218 actions related to 123 individuals in 2001. That total includes both prejudicial and non-prejudicial actions. (Non-prejudicial actions are those that initially derived from a disciplinary action but do not reflect a new action—such as the extension of a temporary license for a person who is practicing satisfactorily.) Prejudicial actions numbered 107 against 71 persons (58 physicians, 12 physician assistants, and 1 NP). (In 2001, the numbers were 117 actions against 87 persons—76 physicians, 10 PAs, and 1 EMT.) Non-prejudicial actions numbered 61 related to 39 persons (36 physicians, 2 physician assistants, and 1 EMT). (In 2001, the numbers were 101 actions related to 57 persons—49 physicians and 8 physician assistants.)

Mr Henderson also noted the Board had revoked 3 licenses, denied 9, and suspended 15 (10 of which were stayed on specific conditions). Two licenses were summarily suspended.

The Annual Report contains three sections. In Section A can be found general information about the number of physicians (27,307, of whom 19,281 are in-state), physician assistants (2,384), nurse practitioners (2,073), residents (2,001), and clinical pharmacist practitioners (42) regulated by the Board. Data on the Board's licensing activities, complaints received by the Board, and other details about the Board's disciplinary processes are included. Also presented are data on the causes of disciplinary action and the most common elements found in consent orders issued by the Board. Finally, there is a brief summary of activity by the North Carolina Physician Health Program. In each case, the figures for 2002 are accompanied by comparable figures for 2001. This section of the report gives some sense of the scope of the Board's work.

Section B contains four segments focused on data about various actions, both prejudicial and non-prejudicial, related to the Board's disciplinary role: (I) a

summary of specific Board actions, both prejudicial and non-prejudicial, with comparative figures for 2002 and 2001; (II) an expanded version of the summary that includes the names and locations of those concerning whom actions were taken in 2002; (III) an alphabetical list, with locations, of those against whom prejudicial actions were taken in 2002, and an alphabetical list, with locations, of those about whom non-prejudicial acts were taken in 2002; (IV) and an alphabetical list of all those concerning whom actions were taken in 2002. Segment I of Section B is presented below.

Section C provides a narrative context for looking at and understanding the work of the Board.

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

SECTION B

I. NCMB Board Action Summary—2002

[Comparative figures for 2001 appear in brackets and italics.]

Part 1—2002 Actions by Category

PREJUDICIAL ACTIONS:

License Denied: 9 actions (6 physicians, 1 PA)

[2001: 5 Actions (5 physician)]

Annulments: NONE

[2001: None]

Revocations: 3 actions (2 physicians, 1 PA)

[2001: 8 Actions (8 physicians)]

Suspensions: 15 actions [10 stayed; 12 by CO] (11 physicians, 4 PAs)

[2001: 13 Actions [8 stayed; 8 by CO] (12 physicians, 1 PA)]

Summary Suspensions: 2 actions (2 physicians)

[2001: 5 Actions (5 physicians)]

Miscellaneous Board Orders: 2 actions (2 physicians)

[2001: 1 Action (1 physician)]

Consent Orders: 36 Actions—36 Persons (29 physicians, 6 PAs, 1 NP)

[2001: 48 Actions—45 persons [12 modifying previous COs] (41 physicians, 3 PAs, 1 EMT)]

[Note that COs limit and/or restrict the practitioner in some way. They may also result in

2002 Annual Board Activity Report

the revocation, suspension, or surrender of a license, the dismissal of charges as a result of other action taken, and/or the issuance of a temporary/dated license. Such results are reflected in the appropriate sections of this report. In some cases, a CO may modify a previous CO in some way, and that will be indicated by (mod) appearing after the person's name.]

Denials of Reconsideration/Modification: 1 action (1 physician)

[2001: NONE]

Surrenders: 27 actions [1 by CO] (23 physicians, 4 PAs)

[2001: 27 Actions [4 from COs] (20 physicians, 7 PAs)]

Temporary/Dated Licenses Issued (via Consent Order): 12 actions (9 physicians, 3 PAs)

[2001: 9 Actions (8 physicians, 1 PA)]

Temporary/Dated Licenses Allowed to Expire: NONE

[2001: 1 Action (1 physician)]

NON-PREJUDICIAL ACTIONS:

Dismissals: 1 action (1 physician)

[2001: 5 Actions [0 by reversal, 1 with inactive status, 2 by CO, 2 with RTL termination] (5 physicians)]

Temporary/Dated Licenses Extended: 27 actions—17 persons (15 physicians, 2 PAs)

[2001: 51 Actions—29 persons (24 physicians, 5 PAs)]

Temporary/Dated Licenses Became Full and Unrestricted: 14 actions (14 physicians)

[2001: 22 Actions (19 physicians, 3 PAs)]

Consent Orders Lifted: 19 actions (18 physicians, 1 EMT)

[2001: 23 Actions (20 physicians, 3 PAs)]

Revocations Reinstated: NONE

[2001: NONE]

[Item below provided for information only—not Board action as such and not included in overall totals.]

Court Appeals/Stays: 2 cases (1 physician)

[2001: NONE]

Part 2—2002 Total Actions and Breakdown

— TOTALS —

168 Board Actions of all Types Relating to 101 Persons

[2001: 218 Actions for 123 persons]

107 Prejudicial Actions Related to 71 Persons

(58 Physicians, 12 PAs, 1 NP)

[2001: 117 Actions Related to 87 Persons (76 Physicians, 10 PAs, 1 EMT)]

61 Non-Prejudicial Actions Relating to 39 Persons (36 Physicians, 2 PAs, 1 EMT)

[2001: 101 Actions Related to 57 persons (49 Physicians, 8 PAs)]

— BREAKDOWN —

Some individuals fall in both the Prejudicial and Non-Prejudicial categories of action noted immediately below. However, duplicate names within each category are eliminated for the calculation of that category's total (eg, a total of 58 individual physicians had 86 prejudicial actions taken against them). The Combined Total segment, at the bottom of this page, eliminates all duplicates in both categories and simply presents the total number of individuals concerning whom any action was taken.

PREJUDICIAL TOTALS: 2002

58 Physicians (86 actions)

12 PAs (20 actions)

1 NP (1 action)

71 Persons (107 actions)

NON-PREJUDICIAL TOTALS: 2002

36 Physicians (57 actions)

2 PAs (3 actions)

1 EMT (1 action)

39 Persons (61 actions)

PREJUDICIAL TOTALS: 2001

76 Physicians (104 actions)

10 PAs (12 actions)

1 EMT (1 action)

87 Persons (117 actions)

NON-PREJUDICIAL TOTALS: 2001

49 Physicians (79 actions)

8 PAs (22 actions)

57 Persons (101 actions)

COMBINED TOTAL OF PERSONS, WITHOUT DUPLICATIONS:

2002		2001	
Physicians	87	Physicians	109
PAs	12	PAs	13
NPs	1	NPs	0
EMTs	<u>1</u>	EMTs	<u>1</u>
101	123		

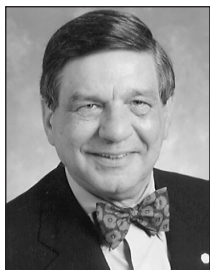


REVIEW



Great Feuds in Medicine: Ten of the Liveliest Disputes Ever

Walter Roufail, MD, Past President NCMB
Professor of Medicine, Wake Forest University School of Medicine



Dr Roufail

Mortimer Adler, philosopher and past chairman of the *Encyclopedia Britannica*, wrote a classic volume titled *How to Read a Book*. Among other things, he suggests one read the prologue and the epilogue, if any, and review the table of contents. Applying those simple criteria, *Great Feuds in Medicine: Ten of the Liveliest Disputes Ever* appears to be worthwhile reading.

As the subtitle implies, the author has chosen ten feuds which seem to him “to have special drama or scientific interest, that in some way influenced the future course of medical science.” They occurred over a period of four centuries (seventeenth to twentieth). The protagonists should be familiar to those in the health field, mostly because their names are attached to a syndrome or to an anatomical or histological finding. The author dwells on each individual’s life, succinctly highlighting the political, religious, and national background of each. The antagonists could be colleagues, looking at the same problem but arriving at different conclusions, a few contemporary scholars, or the whole medical and or religious establishment.

Harvey. . .

William Harvey (1578-1657), physician and anatomist, challenged two millennia of established belief that blood was formed in the liver and that it obtained two types of “spirits,” one from the heart and one from the brain, and then flowed to the periphery attracted by an unspecified force. Harvey, through animal vivisection and experimentation, suggested that the heart was, indeed, “. . .the beginning of life. . .for it is the heart by whose virtue and pulse the blood is moved, perfected, and made nutrient, and is preserved from corruption and coagulation.” The blood moved in a closed, circular system through the arteries and returned through the veins. He also theorized, but could not demonstrate, that the arteries and veins were connected somehow. It took Malpighi and his microscope to visualize, a third of a century later, the delicate capillaries that closed the circuit.

It was not long after his book was published in 1628 that it attracted the ire of the medical establishment of the day, led by James Primrose, MD. The thought that the principles of medical science as transmitted by Hippocrates (the four Humors), Aristotle (“Nature does nothing without a purpose”), and particularly Galen (“I can perceive the purpose”) could be challenged was ludi-

crous. Primrose was soon joined by prominent physicians across Europe and by the recently formed Anglican Church. Even Descartes, philosopher and mathematician, (“I think ,therefore I am”) entered the fray and ventured his own theory about the circulation of the blood. Harvey’s discovery was not appreciated until centuries later. Physicians continued to bleed and leech as a favorite therapy whether the blood was spirited or not.

Nevertheless, Harvey lived to the then ripe age of 79, a wealthy man and physician to two kings, one of whom he followed into exile when Cromwell took power in England. He was obviously a survivor and was even offered the presidency of the College of Physicians, which he magnanimously turned down. It is said that in his youth he always carried a dagger, a wise move apparently in a century when controversy was often settled at the stake or in a dark alley.

Galvani. . .

A century or so later, another bizarre idea surfaced in the mind of a physician and professor of medicine at the famous University of Bologna. Luigi Galvani (1737-98) or, as history would have it, Mrs Galvani, observed the actual twitching of a dead frog’s thigh when touched by a metal instrument. Dr Galvani extended those observations by using different kinds of metals and a multitude of frogs and came to the conclusion that animals had their own electrical system that produced muscle contraction—at least in the frog. The new science of electrophysiology was born. Alessandro Volta (1745-1827), a physicist, thought that was hogwash, that only physicists could harness electricity, and that muscle contraction occurred only when outside current was applied. Volta went on to invent the “pile,” demonstrated it to Napoleon, was showered with honors and wealth, and had a statue erected in his honor. Galvani, on the other hand, refused to pledge allegiance to the republic that Napoleon had installed in his region of Italy. He was stripped of his professorship, exiled from Bologna, and died bitter and destitute. Years later, another physicist, Leopoldo Nobili, made another “pile,” placing the trunk of some frogs on the legs of others. The weak current produced was measured by a galvanometer.

Both Galvani’s and Volta’s experiments generated a lot of interest in the application of electric shocks to animals, including humans. A wave of quacks claimed that galvanism increased virility and even cured infertility when applied to the proper organs. Mary Shelly’s *Frankenstein* is also said to be the artistic child of that period. Hollywood owes a debt of gratitude to both Professor

Review

Galvani and Volta.

The moral of this story, I assume, is that politics can delay the advance of science. Nothing has changed much, has it?

Semmelweiss. . .

All that Dr Semmelweiss (1818-1865) wanted was for medical students finishing postmortem dissections to wash their hands before examining pregnant women in the free clinic where he practiced. Puerperal fever took the life of up to 30 percent of his patients. In another part of the clinic, where medical students had no access, the rate was only 5 percent. Washing with plain water was first practiced, but he became more aggressive, using brush, soap, and chlorine. A dramatic decline in the rate of infection ensued. Although he presented his findings to small medical audiences in Vienna, Semmelweiss had two problems. First, he was Hungarian and suspected of being incapable of coming up with any bright idea by the German and Austrian medical circles (including Virchow) of his time. Second, his German syntax, both in his presentations and writings, was clumsy and obscure.

He refused to publish until late in his lifetime. When cut off by the establishment, both professionally and financially, he decided to fight back by publishing his *Etiology*, which received unanimously negative reviews.

"Publish or perish" is an axiom alive and well in academia. Perish he did at the age of 47 from what may have been Alzheimer's disease. He was institutionalized and apparently beaten by the guards at the asylum. His wounds became infected. The postmortem diagnosis was generalized pyemia.

Posthumously, he was claimed by both Vienna and Budapest, where he now rests and has a statue erected in his honor. Too little too late, particularly for the thousands of European women who died from puerperal fever for want of physicians with clean hands!

Pasteur. . .

Five years following Semmelweiss' death in the late 1870s, a leading physician at the Academy of Medicine in Paris was expounding the theory that puerperal fever was a metabolic disorder. "Suddenly a voice bellowed from the rear of the hall: 'the thing that kills women with childbed fever isn't anything like that! It is you doctors who carry deadly microbes from sick women to healthy ones. . . .'" The voice was that of Louis Pasteur (1822-95), a chemist amidst physicians. Of all the scientists of the nineteenth century, Pasteur would certainly qualify as the one for all seasons. Considering a career in painting, he wisely decided to switch to science. With a chemistry degree from the Ecole Normale Supérieure, he first turned his attention to crystals, work that landed him a professorship at the age of 27. He succeeded in the commercial field, saving the French wine, beer, and silk industries. He then moved to postpone food spoilage by the

process known as pasteurization. He dabbled in veterinary medicine by developing vaccines against chicken cholera and against anthrax, the focus of so much concern today, that was devastating the country's cattle. In human clinical medicine, his achievement was the treatment of rabies by a series of increasingly virulent injections of the infectious material. The thread that winds through most of these successes is his belief that microorganisms were the basis for fermentation, putrefaction, and probably all infectious diseases: the so called "germ theory." This insight ushered in the era of modern medicine and public health, and, to this date, is responsible for the survival of millions of humans throughout the world.

A man of such talent was bound to provoke a multitude of feuds, but none more virulent than with the medical establishment. A chemist meddling in medicine was anathema to most physicians. Even Koch, the

German legend of microbiology, doubted the purity of Pasteur's vaccines and sneered at French microbiology in general. Nationalism is said to have played a great part in this particular feud, which, as we will see, has continued to plague the scientific world ever since. The most scathing criticism, however, appeared in the 1990s. Gerald Greison accuses Pasteur of "deception and downright fraud." Deconstruction of heroes seems to be an accepted part of our modern culture. In this case, a defender, Max Perutz, a noted British biochemist, took to task Mr Greison in the *New York Review of Books*. This apparently led to a lively and irreverent exchange in four issues of that journal.

Bernard. . .

Claude Bernard (1813-79) moved medicine from the hospital to the laboratory and was the founder of experimental physiology. In his *Introduction to the Study of Experimental Medicine*, he outlined the basis for future medical research and the use of animal models to investigate the physiological functions of anatomical organs that closely resemble those of humans. Not unexpectedly, he raised the ire of physicians who thought medicine's arena was the hospital and of chemists who asserted that the laboratory was the domain of chemistry. In addition, he had to deal with a new movement of "antivivisectionists" that started in England and has to date made its presence known all over the world, and particularly in the United States.

Golgi. . .

Camillo Golgi (1843-1926), an Italian physician, graduated and taught at the famous Universities of Pavia and Sienna, known since the Renaissance, which gave him access to the great scientific meccas of the time: French and German universities. His interest was in the microscopic structure of the nervous system. His name is attached to a stain that delineated neurons, dendrons, and the like, as well as a structure in the cell (the Golgi Apparatus) the function of which it took a century to figure out.

Great Feuds in Medicine: Ten of the Liveliest Disputes Ever

Hal Hellman

John Wiley & Sons, Inc, New York, 2001
256 pages, \$24.95 (hardback) \$15.95 (paper)

Ramon Cajal (1852-1934) graduated from the University of Saragoza in Spain. He spoke and wrote only Spanish, which made him, a priori, a scientific suspect. Although most of his work was built on improving Golgi's stain, he had much more ambitious goals: defining the electrophysiological functions of the nervous system (back to Galvani) and ultimately deciphering the secret of thought itself. He managed to publish his work to the scientific community and had a successful speaking tour in the United States, during which he remarked that "the United States seems to be wonderfully endowed to triumph in the arena of scientific research," an insight that was certainly validated in the twentieth century.

Both Golgi and Cajal shared the Nobel Prize in 1906. Golgi was less than kind towards Cajal at the Academy's meeting. The latter pondered: "I have never understood those strange mental constitutions which are devoted throughout life to the worship of their own egos, hermetically sealed to all innovation and impermeable to the incessant changes taking place in the intellectual environment." Hear, hear!

Freud. . .

Freud (1856-1939) started his career as a neurologist under the mentorship of Charcot. He went after the "Mind" by first interpreting its dreams. He then designed a template of its workings, devising a construct of the Ego and the Super Ego, childhood experiences, sexual attraction to the mother, and love-hate relationship towards the father. None of it had any solid experimental basis but it certainly was the first attempt at the scientific exploration of the mind, spirit, or soul. His concentration on childhood sexual experiences as a cause of a variety of mental illnesses led to the disintegration of his circle of disciples and subsequent feuds that lingered for the best part of the twentieth century. Jung was the first to dissent, followed by a variety of mostly American psychiatrists, neuropsychiatrists, and, finally, chemopsychiatrists—who gave us LSD, Thorazine®, and finally Prozac® for the common folks: the shortcut to nirvana that was hard work under Buddhism. The feud is still going on; but nobody will argue that Freud was a boon for psychiatrists, psychologists, and therapists, particularly in California, where it is expected everyone should have or have had one.

Sabin. . .

The feud between Sabin and Salk was rather sad, petty, and pitiful. Both were rewarded by national recognition but were never presented the Nobel Prize. President Franklin D. Roosevelt was one of the casualties of poliomyelitis, which reached epidemic proportions throughout the world and in the United States in the first half of the twentieth century. The stricken president-to-be galvanized the scientific world into vaccine research. Both Sabin and Salk achieved the goal, relegating the disease to the dustheap of history. The feud involved whether to kill or attenuate the virus and whether to give it by injection or in a sugar cube. (I opted for the latter.) With all that, however, polio, like smallpox, is now history, like Salk and Sabin themselves.

Gallo. . .

Neither Gallo (of the NIH) nor Montagnier (of the Pasteur Institute) have helped Franco-American relationships. Who discovered the proper strain of virus responsible for the AIDS epidemic, and when, became a matter of national honor for the French and one of plain facts for Americans. Both of them should be thanked as more effective and horribly expensive treatments are now available. I think this epidemic, and we have had worse, will go down in human history as the worst example of mixing politics and science. While millions will die of the disease in Africa and Southeast Asia in the next decade, we are still exploring the politically correct way of dealing with this new plague. I humbly predict that neither Gallo nor Montagnier will win the coveted prize, but somewhere in a dark laboratory, "she" or "he" will develop a vaccine and will win a free trip to Sweden.

Franklin. . .

I have taken the liberty above of switching chapters at times but have kept the best for last. The feud itself is rather pathetic, but the discovery, I think, is pivotal. James Watson, Francis Crick, and Maurice Wilkins were awarded the Nobel Prize for Medicine and Physiology in 1962 for their discovery of the DNA double-stranded helix. The feud was mostly posthumous. Rosalind Franklin was hired as the project director at King's College in Cambridge, England, to explore the DNA molecule. This was prompted by the interest of Linus Pauling (of anti-nuclear and vitamin C for colds fame) in the matter. Franklin saw it as a three-stranded molecule, Wilkins as a two-stranded one. Wilkins was right. Watson, 15 years later, wrote a book that should be required reading for all interested in science, but he did not give the proper credit to Franklin. That, in turn, stimulated Anne Sayre to write a book about Franklin, subtitled: *A Vivid View of What It Is Like to Be a Gifted Woman in an Especially Male Profession*. Political correctness and Nobel Prize shenanigans might have played a role in this omission. I think she deserves credit.

Conclusion

The author, Mr Hellman, has chosen his 10 feuds/disputes quite well. However, his handling of the material is at times confusing and does not lead to smooth reading. I have had to go back and forth between paragraphs to find a logical string of events that may have led to the controversies being discussed. I think the main impact of this book is to remind us of our rich medical history and of the men and women who made the practice of medicine in the twenty-first century possible.

I should mention that this book is a follow-up to Mr Hellman's *Great Feuds in Science*. He has written 27 books on science, including a six-book series called the *World of the Future*. He also writes on science for the *New York Times*, *Omni*, *Reader's Digest*, *Psychology Today*, and *Geo*.



POSITION STATEMENT OF THE NORTH CAROLINA MEDICAL BOARD



OFFICE-BASED PROCEDURES

PREFACE

This Position Statement on Office-Based Procedures is an interpretive statement that attempts to identify and explain the standards of practice for Office-Based Procedures in North Carolina. The Board's intention is to articulate existing professional standards and not to promulgate a new standard.

This Position Statement is in the form of guidelines designed to assure patient safety and identify the criteria by which the Board will assess the conduct of its licensees in considering disciplinary action arising out of the performance of office-based procedures. Thus, it is expected that the licensee who follows the guidelines set forth below will avoid disciplinary action by the Board. However, this Position Statement is not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. The silence of the Position Statement on any particular matter should not be construed as the lack of an enforceable standard.

GENERAL GUIDELINES

THE PHYSICIAN'S PROFESSIONAL AND LEGAL OBLIGATION

The North Carolina Medical Board has adopted the guidelines contained in this Position Statement in order to assure patients have access to safe, high quality office-based surgical and special procedures. The guidelines further assure that a licensed physician with appropriate qualifications takes responsibility for the supervision of all aspects of the perioperative surgical, procedural and anesthesia care delivered in the office setting, including compliance with all aspects of these guidelines.

These obligations are to be understood (as explained in the Preface) as existing standards identified by the Board in an effort to assure patient safety and provide licensees guidance to avoid practicing below the standards of practice in such a manner that the licensee would be exposed to possible disciplinary action for unprofessional conduct as contemplated in N.C. Gen. Stat. § 90-14(a)(6).

EXEMPTIONS

These guidelines do not apply to Level I procedures.

WRITTEN POLICIES AND PROCEDURES

Written policies and procedures should be maintained to assist office-based practices in providing safe and quality surgical or special procedure care, assure consistent personnel performance, and promote an awareness and understanding of the inherent rights of patients.

Emergency Procedure and Transfer Protocol

The physician who performs the surgical or special procedure should assure that a transfer protocol is in place, preferably with a hospital that is licensed in the jurisdiction in which it is located and that is within reasonable proximity of the office where the procedure is performed.

All office personnel should be familiar with and capable of carrying out written emergency instructions. The instructions should be followed in the event of an emergency, any untoward anesthetic, medical or surgical complications, or other conditions making hospitalization of a patient necessary. The instructions should include arrangements for immediate contact of emergency medical services when indicated and when advanced cardiac life support is needed. When emergency medical services are not indicated, the instructions should include procedures for timely escort of the patient to the hospital or to an appropriate practitioner.

Infection Control

The practice should comply with state and federal regulations regarding infection control. For all surgical and special procedures, the level of sterilization should meet applicable industry and occupational safety requirements. There should be a procedure and schedule for cleaning, disinfecting and sterilizing equipment and patient care items. Personnel should be trained in infection control practices, implementation of universal precautions, and disposal of hazardous waste products. Protective clothing and equipment should be readily available.

Performance Improvement

A performance improvement program should be implemented to provide a mechanism to review yearly the current practice activities and quality of care provided to patients.

Performance improvement activities should include, but are not limited to, review of mortalities; the appropriateness and necessity of procedures performed; emergency transfers; reportable complications, and resultant outcomes (including all postoperative infections); analysis of patient satisfaction surveys and complaints; and identification of undesirable trends (such as diagnostic errors, unacceptable results, follow-up of abnormal test results, medication errors, and system problems). Findings of the performance improvement program should be incorporated into the practice's educational activity.

Medical Records and Informed Consent

The practice should have a procedure for initiating and maintaining a health record for every patient evaluated or treated. The record should include a procedure code or suitable narrative description of the procedure and should have sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the outcome and required follow-up care.

Medical history, physical examination, lab studies obtained within 30 days of the scheduled procedure, and pre-anesthesia examination and evaluation information and data should be adequately documented in the medical record.

The medical records also should contain documentation of the intraoperative and postoperative monitoring required by these guidelines.

Written documentation of informed consent should be included in the medical record.

CREENTIALING OF PHYSICIANS

A physician who performs surgical or special procedures in

an office requiring the administration of anesthesia services should be credentialed to perform that surgical or special procedure by a hospital, an ambulatory surgical facility, or substantially comply with criteria established by the Board.

Criteria to be considered by the Board in assessing a physician's competence to perform a surgical or special procedure include, without limitation:

1. state licensure;
2. procedure specific education, training, experience and successful evaluation appropriate for the patient population being treated (i.e., pediatrics);
3. for physicians, board certification, board eligibility or completion of a training program in a field of specialization recognized by the ACGME or by a national medical specialty board that is recognized by the ABMS for expertise and proficiency in that field. For purposes of this requirement, board eligibility or certification is relevant only if the board in question is recognized by the ABMS, AOA, or equivalent board certification as determined by the Board;
4. professional misconduct and malpractice history;
5. participation in peer and quality review;
6. participation in continuing education consistent with the statutory requirements and requirements of the physician's professional organization;
7. to the extent such coverage is reasonably available in North Carolina, malpractice insurance coverage for the surgical or special procedures being performed in the office;
8. procedure-specific competence (and competence in the use of new procedures and technology), which should encompass education, training, experience and evaluation, and which may include the following:
 - adherence to professional society standards;
 - credentials approved by a nationally recognized accrediting or credentialing entity; or
 - didactic course complemented by hands-on, observed experience; training is to be followed by a specified number of cases supervised by a practitioner already competent in the respective procedure, in accordance with professional society standards.

If the physician administers the anesthetic as part of a surgical or special procedure (Level II only), he or she also should have documented competence to deliver the level of anesthesia administered.

ACCREDITATION

After one year of operation following the adoption of these guidelines, any physician who performs Level II or Level III procedures in an office should be able to demonstrate, upon request by the Board, substantial compliance with these guidelines, or should obtain accreditation of the office setting by an approved accreditation agency or organization. The approved accreditation agency or organization should submit, upon request by the Board, a summary report for the office accredited by that agency.

All expenses related to accreditation or compliance with these guidelines shall be paid by the physician who performs the surgical or special procedures.

PATIENT SELECTION

The physician who performs the surgical or special procedure should evaluate the condition of the patient and the potential risks associated with the proposed treatment plan. The physician also is responsible for determining that the

patient has an adequate support system to provide for necessary follow-up care. Patients with pre-existing medical problems or other conditions, who are at undue risk for complications, should be referred to an appropriate specialist for pre-operative consultation.

ASA Physical Status Classifications

Patients that are considered high risk or are ASA physical status classification III, IV, or V and require a general anesthetic for the surgical procedure, should not have the surgical or special procedure performed in a physician office setting.

Candidates for Level II Procedures

Patients with an ASA physical status classification I, II, or III may be acceptable candidates for office-based surgical or special procedures requiring conscious sedation/ analgesia. ASA physical status classification III patients should be specifically addressed in the operating manual for the office. They may be acceptable candidates if deemed so by a physician qualified to assess the specific disability and its impact on anesthesia and surgical or procedural risks.

Candidates for Level III Procedures

Only patients with an ASA physical status classification I or II, who have no airway abnormality, and possess an unremarkable anesthetic history are acceptable candidates for Level III procedures.

SURGICAL OR SPECIAL PROCEDURE GUIDELINES

Patient Preparation

A medical history and physical examination to evaluate the risk of anesthesia and of the proposed surgical or special procedure, should be performed by a physician qualified to assess the impact of co-existing disease processes on surgery and anesthesia. Appropriate laboratory studies should be obtained within 30 days of the planned surgical procedure.

A pre-procedure examination and evaluation should be conducted prior to the surgical or special procedure by the physician. The information and data obtained during the course of this evaluation should be documented in the medical record.

The physician performing the surgical or special procedure also should:

1. ensure that an appropriate pre-anesthetic examination and evaluation is performed proximate to the procedure;
2. prescribe the anesthetic, unless the anesthesia is administered by an anesthesiologist in which case the anesthesiologist may prescribe the anesthetic;
3. ensure that qualified health care professionals participate;
4. remain physically present during the intraoperative period and be immediately available for diagnosis, treatment, and management of anesthesia-related complications or emergencies; and
5. ensure the provision of indicated post-anesthesia care.

Discharge Criteria

Criteria for discharge for all patients who have received anesthesia should include the following:

1. confirmation of stable vital signs;
2. stable oxygen saturation levels;
3. return to pre-procedure mental status;
4. adequate pain control;
5. minimal bleeding, nausea and vomiting;
6. resolving neural blockade, resolution of the neuraxial blockade; and

Position Statement

7. eligible to be discharged in the company of a competent adult.

Information to the Patient

The patient should receive verbal instruction understandable to the patient or guardian, confirmed by written post-operative instructions and emergency contact numbers. The instructions should include:

1. the procedure performed;
2. information about potential complications;
3. telephone numbers to be used by the patient to discuss complications or should questions arise;
4. instructions for medications prescribed and pain management;
5. information regarding the follow-up visit date, time and location; and
6. designated treatment hospital in the event of emergency.

REPORTABLE COMPLICATIONS

Physicians performing surgical or special procedures in the office should maintain timely records, which should be provided to the Board within three business days of receipt of a Board inquiry.

Records of reportable complications should be in writing and should include:

1. physician's name and license number;
2. date and time of the occurrence;
3. office where the occurrence took place;
4. name and address of the patient;
5. surgical or special procedure involved;
6. type and dosage of sedation or anesthesia utilized in the procedure; and
7. circumstances involved in the occurrence.

EQUIPMENT MAINTENANCE

All anesthesia-related equipment and monitors should be maintained to current operating room standards. All devices should have regular service/maintenance checks at least annually or per manufacturer recommendations. Service/maintenance checks should be performed by appropriately qualified biomedical personnel. Prior to the administration of anesthesia, all equipment/monitors should be checked using the current FDA recommendations as a guideline. Records of equipment checks should be maintained in a separate, dedicated log which must be made available to the Board upon request. Documentation of any criteria deemed to be substandard should include a clear description of the problem and the intervention. If equipment is utilized despite the problem, documentation should clearly indicate that patient safety is not in jeopardy.

The emergency supplies should be maintained and inspected by qualified personnel for presence and function of all appropriate equipment and drugs at intervals established by protocol to ensure that equipment is functional and present, drugs are not expired, and office personnel are familiar with equipment and supplies. Records of emergency supply checks should be maintained in a separate, dedicated log and made available to the Board upon request.

A physician should not permit anyone to tamper with a safety system or any monitoring device or disconnect an alarm system.

COMPLIANCE WITH RELEVANT HEALTH LAWS

Federal and state laws and regulations that affect the practice should be identified and procedures developed to comply with those requirements.

Nothing in this position statement affects the scope of activities subject to or exempted from the North Carolina health care facility licensure laws.*

PATIENT RIGHTS

Office personnel should be informed about the basic rights of patients and understand the importance of maintaining patients' rights. A patients' rights document should be readily available upon request.

ENFORCEMENT

In that the Board believes that these guidelines constitute the accepted and prevailing standards of practice for office-based procedures in North Carolina, failure to substantially comply with these guidelines creates the risk of disciplinary action by the Board.

LEVEL II GUIDELINES

PERSONNEL

The physician who performs the surgical or special procedure or a health care professional who is present during the intraoperative and postoperative periods should be ACLS certified, and at least one other health care professional should be BCLS certified. In an office where anesthesia services are provided to infants and children, personnel should be appropriately trained to handle pediatric emergencies (i.e., APLS or PALS certified).

Recovery should be monitored by a registered nurse or other health care professional practicing within the scope of his or her license or certification who is BCLS certified and has the capability of administering medications as required for analgesia, nausea/vomiting, or other indications.

SURGICAL OR SPECIAL PROCEDURE GUIDELINES

Intraoperative Care and Monitoring

The physician who performs Level II procedures that require conscious sedation in an office should ensure that monitoring is provided by a separate health care professional not otherwise involved in the surgical or special procedure. Monitoring should include, when clinically indicated for the patient:

1. direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
2. pulse oximetry should be performed continuously (an alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness);
3. an electrocardiogram monitor should be used continuously on the patient;
4. the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes; and

*See N.C. Gen. Stat. § 131E-145 et seq.

5. the body temperature of a pediatric patient should be measured continuously.

Clinically relevant findings during intraoperative monitoring should be documented in the patient's medical record.

Postoperative Care and Monitoring

The physician who performs the surgical or special procedure should evaluate the patient immediately upon completion of the surgery or special procedure and the anesthesia.

Care of the patient may then be transferred to the care of a qualified health care professional in the recovery area. A registered nurse or other health care professional practicing within the scope of his or her license or certification and who is BCLS certified and has the capability of administering medications as required for analgesia, nausea/vomiting, or other indications should monitor the patient postoperatively.

At least one health care professional who is ACLS certified should be immediately available until all patients have met discharge criteria. Prior to leaving the operating room or recovery area, each patient should meet discharge criteria.

Monitoring in the recovery area should include pulse oximetry and non-invasive blood pressure measurement. The patient should be assessed periodically for level of consciousness, pain relief, or any untoward complication. Clinically relevant findings during post-operative monitoring should be documented in the patient's medical record.

EQUIPMENT AND SUPPLIES

Unless another availability standard is clearly stated, the following equipment and supplies should be present in all offices where Level II procedures are performed:

1. full and current crash cart at the location where the anesthetizing is being carried out (the crash cart inventory should include appropriate resuscitative equipment and medications for surgical, procedural or anesthetic complications);
2. age-appropriate sized monitors, resuscitative equipment, supplies, and medication in accordance with the scope of the surgical or special procedures and the anesthesia services provided;
3. emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours;
4. electrocardiographic monitor;
5. noninvasive blood pressure monitor;
6. pulse oximeter;
7. continuous suction device;
8. endotracheal tubes, laryngoscopes;
9. positive pressure ventilation device (e.g., Ambu);
10. reliable source of oxygen;
11. emergency intubation equipment;
12. adequate operating room lighting;
13. appropriate sterilization equipment; and
14. IV solution and IV equipment.

LEVEL III GUIDELINES

PERSONNEL

Anesthesia should be administered by an anesthesiologist or a CRNA supervised by a physician. The physician who performs the surgical or special procedure should not administer the anesthesia. The anesthesia provider should not be otherwise involved in the surgical or special procedure.

The physician or the anesthesia provider should be ACLS

certified, and at least one other health care professional should be BCLS certified. In an office where anesthesia services are provided to infants and children, personnel should be appropriately trained to handle pediatric emergencies (i.e., APLS or PALS certified).

SURGICAL OR SPECIAL PROCEDURE GUIDELINES

Intraoperative Monitoring

The physician who performs procedures in an office that require major conduction blockade, deep sedation/analgesia, or general anesthesia should ensure that monitoring is provided as follows when clinically indicated for the patient:

1. direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
2. pulse oximetry should be performed continuously; any alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness;
3. an electrocardiogram monitor should be used continuously on the patient;
4. the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes;
5. monitoring should be provided by a separate health care professional not otherwise involved in the surgical or special procedure;
6. end-tidal carbon dioxide monitoring should be performed on the patient continuously during endotracheal anesthesia;
7. an in-circuit oxygen analyzer should be used to monitor the oxygen concentration within the breathing circuit, displaying the oxygen percent of the total inspiratory mixture;
8. a respirometer (volumeter) should be used to measure exhaled tidal volume whenever the breathing circuit of a patient allows;
9. the body temperature of each patient should be measured continuously; and
10. an esophageal or precordial stethoscope should be utilized on the patient.

Clinically relevant findings during intraoperative monitoring should be documented in the patient's medical record.

Postoperative Care and Monitoring

The physician who performs the surgical or special procedure should evaluate the patient immediately upon completion of the surgery or special procedure and the anesthesia.

Care of the patient may then be transferred to the care of a qualified health care professional in the recovery area. Qualified health care professionals capable of administering medications as required for analgesia, nausea/vomiting, or other indications should monitor the patient postoperatively.

Recovery from a Level III procedure should be monitored by an ACLS certified (PALS or APLS certified when appropriate) health care professional using appropriate criteria for the level of anesthesia. At least one health care professional who is ACLS certified should be immediately available during postoperative monitoring and until the patient meets discharge criteria. Each patient should meet discharge criteria prior to leaving the operating or recovery area.

Monitoring in the recovery area should include pulse oximetry and non-invasive blood pressure measurement. The

Position Statement

patient should be assessed periodically for level of consciousness, pain relief, or any untoward complication. Clinically relevant findings during postoperative monitoring should be documented in the patient's medical record.

EQUIPMENT AND SUPPLIES

Unless another availability standard is clearly stated, the following equipment and supplies should be present in all offices where Level III procedures are performed:

1. full and current crash cart at the location where the anesthetizing is being carried out (the crash cart inventory should include appropriate resuscitative equipment and medications for surgical, procedural or anesthetic complications);
2. age-appropriate sized monitors, resuscitative equipment, supplies, and medication in accordance with the scope of the surgical or special procedures and the anesthesia services provided;
3. emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours;
4. electrocardiographic monitor;
5. noninvasive blood pressure monitor;
6. pulse oximeter;
7. continuous suction device;
8. endotracheal tubes, and laryngoscopes;
9. positive pressure ventilation device (e.g., Ambu);
10. reliable source of oxygen;
11. emergency intubation equipment;
12. adequate operating room lighting;
13. appropriate sterilization equipment;
14. IV solution and IV equipment;
15. sufficient ampules of dantrolene sodium should be emergently available;
16. esophageal or precordial stethoscope;
17. emergency resuscitation equipment;
18. temperature monitoring device;
19. end tidal CO₂ monitor (for endotracheal anesthesia); and
20. appropriate operating or procedure table.

DEFINITIONS

AAAASF - the American Association for the Accreditation of Ambulatory Surgery Facilities.

AAAHC - the Accreditation Association for Ambulatory Health Care

ABMS - the American Board of Medical Specialties

ACGME - the Accreditation Council for Graduate Medical Education

ACLS certified - a person who holds a current "ACLS Provider" credential certifying that they have successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the Advanced Cardiovascular Life Support Program.

Advanced cardiac life support certified - a licensee that has successfully completed and recertified periodically an advanced cardiac life support course offered by a recognized accrediting organization appropriate to the licensee's field of practice. For example, for those licensees treating adult patients, training in ACLS is appropriate; for those treating children, training in PALS or APLS is appropriate.

Ambulatory surgical facility - a facility licensed under Article 6, Part D of Chapter 131E of the North Carolina General Statutes or if the facility is located outside North Carolina, under that jurisdiction's relevant facility licensure laws.

Anesthesia provider - an anesthesiologist or CRNA.

Anesthesiologist - a physician who has successfully completed a residency program in anesthesiology approved by the ACGME or AOA, or who is currently a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before 1982.

AOA - the American Osteopathic Association

APLS certified - a person who holds a current certification in advanced pediatric life support from a program approved by the American Heart Association.

Approved accrediting agency or organization - a nationally recognized accrediting agency (e.g., AAAASF; AAAHC, JCAHO, and HFAP) including any agency approved by the Board.

ASA - the American Society of Anesthesiologists

BCLS certified - a person who holds a current certification in basic cardiac life support from a program approved by the American Heart Association.

Board - the North Carolina Medical Board.

Conscious sedation - the administration of a drug or drugs in order to induce that state of consciousness in a patient which allows the patient to tolerate unpleasant medical procedures without losing defensive reflexes, adequate cardio-respiratory function and the ability to respond purposefully to verbal command or to tactile stimulation if verbal response is not possible as, for example, in the case of a small child or deaf person. Conscious sedation does not include an oral dose of pain medication or minimal pre-procedure tranquilization such as the administration of a pre-procedure oral dose of a benzodiazepine designed to calm the patient. "Conscious sedation" should be synonymous with the term "sedation/analgesia" as used by the American Society of Anesthesiologists.

Credentialed - a physician that has been granted, and continues to maintain, the privilege by a hospital or ambulatory surgical facility licensed in the jurisdiction in which it is located to provide specified services, such as surgical or special procedures or the administration of one or more types of anesthetic agents or procedures, or can show documentation of adequate training and experience.

CRNA - a registered nurse who is authorized by the North Carolina Board of Nursing to perform nurse anesthesia activities.

Deep sedation/analgesia - the administration of a drug or drugs which produces depression of consciousness during which patients cannot be easily aroused but can respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

FDA - the Food and Drug Administration.

General anesthesia - a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required

because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Health care professional - any office staff member who is licensed or certified by a recognized professional or health care organization.

HFAP - the Health Facilities Accreditation Program, a division of the AOA.

Hospital - a facility licensed under Article 5, Part A of Chapter 131E of the North Carolina General Statutes or if the facility is located outside North Carolina, under that jurisdiction's relevant facility licensure laws.

Immediately available - within the office.

JCAHO - the Joint Commission for the Accreditation of Health Organizations

Level I procedures - any surgical or special procedures:

- a. that do not involve drug-induced alteration of consciousness;
- b. where preoperative medications are not required or used other than minimal preoperative tranquilization of the patient (anxiolysis of the patient);
- c. where the anesthesia required or used is local, topical, digital block, or none; and
- d. where the probability of complications requiring hospitalization is remote.

Level II procedures - any surgical or special procedures:

- a. that require the administration of local or peripheral nerve block, minor conduction blockade, Bier block, minimal sedation, or conscious sedation; and
- b. where there is only a moderate risk of surgical and/or anesthetic complications and the need for hospitalization as a result of these complications is unlikely.

Level III procedures - any surgical or special procedures:

- a. that require, or reasonably should require, the use of major conduction blockade, deep sedation/analgesia, or general anesthesia; and
- b. where there is only a moderate risk of surgical and/or anesthetic complications and the need for hospitalization as a result of these complications is unlikely.

Local anesthesia - the administration of an agent which produces a transient and reversible loss of sensation in a circumscribed portion of the body.

Major conduction blockade - the injection of local anesthesia to stop or prevent a painful sensation in a region of the body. Major conduction blocks include, but are not limited to, axillary, interscalene, and supraclavicular block of the brachial plexus; spinal (subarachnoid), epidural and caudal blocks.

Minimal sedation (anxiolysis) - the administration of a drug or drugs which produces a state of consciousness that allows the patient to tolerate unpleasant medical procedures while responding normally to verbal commands. Cardiovascular or respiratory function should remain unaffected and defensive airway reflexes should remain intact.

Minor conduction blockade - the injection of local anesthesia to stop or prevent a painful sensation in a circumscribed area of the body (i.e., infiltration or local nerve block), or the block of a nerve by direct pressure and refrigeration. Minor conduction blocks include, but are not limited to, intercostal, retrobulbar, paravertebral, peribulbar, pudendal, sciatic nerve, and ankle blocks.

Monitoring - continuous, visual observation of a patient and regular observation of the patient as deemed appropriate by the level of sedation or recovery using instruments to measure, display, and record physiologic values such as heart rate, blood pressure, respiration and oxygen saturation.

Office - a location at which incidental, limited ambulatory surgical procedures are performed and which is not a licensed ambulatory surgical facility pursuant to Article 6, Part D of Chapter 131E of the North Carolina General Statutes.

Operating room - that location in the office dedicated to the performance of surgery or special procedures.

OSHA - the Occupational Safety and Health Administration.

PALS certified - a person who holds a current certification in pediatric advanced life support from a program approved by the American Heart Association.

Physical status classification - a description of a patient used in determining if an office surgery or procedure is appropriate. For purposes of these guidelines, ASA classifications will be used. The ASA enumerates classification: I-normal, healthy patient; II-a patient with mild systemic disease; III a patient with severe systemic disease limiting activity but not incapacitating; IV-a patient with incapacitating systemic disease that is a constant threat to life; and V-moribund, patients not expected to live 24 hours with or without operation.

Physician - an individual holding an MD or DO degree licensed pursuant to the NC Medical Practice Act and who performs surgical or special procedures covered by these guidelines.

Recovery area - a room or limited access area of an office dedicated to providing medical services to patients recovering from surgical or special procedures or anesthesia.

Reportable complications - untoward events occurring at any time within forty-eight (48) hours of any surgical or special procedure or the administration of anesthesia in an office setting including, but not limited to, any of the following: paralysis, nerve injury, malignant hyperthermia, seizures, myocardial infarction, pulmonary embolism, renal failure, significant cardiac events, respiratory arrest, aspiration of gastric contents, cerebral vascular accident, transfusion reaction, pneumothorax, allergic reaction to anesthesia, unintended hospitalization for more than twenty-four (24) hours, or death.

Special procedure - patient care that requires entering the body with instruments in a potentially painful manner, or that requires the patient to be immobile, for a diagnostic or therapeutic procedure requiring anesthesia services; for example, diagnostic or therapeutic endoscopy; invasive radiologic procedures, pediatric magnetic resonance imaging; manipulation under anesthesia or endoscopic examination with the use of general anesthesia.

Surgical procedure - the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments and includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skill, post-operative management, and follow-up.

Topical anesthesia - an anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

[A Position Statement on Office-Based Surgery was adopted by the Board on September 2000. The statement above (Adopted January 2003) replaces that statement.]

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

November - December 2002/January 2003

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

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

Consent Order:

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

Denial:

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

Information not available.

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program.

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

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

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

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

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

The practitioner's relinquishing of the authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.

ANNULMENTS

NONE

REVOCATIONS

GLASS, Ted Alan, MD

Location: Fredericksburg, VA

DOB: 3/22/1950

License #: 0000-26246

Specialty: R (as reported by physician)

Medical Ed: University of Virginia (1977)

Cause: Conviction of a felony in United States v Ted Alan Glass, U.S. District Court, Eastern District of Virginia.

Action: 1/13/2003. Entry of Revocation issued: Dr Glass' medical license was revoked by operation of law on 11/07/2002.

SUSPENSIONS

FOLKERTS, AnnaMaria, Physician Assistant

Location: Stoney Creek, NC (Guilford Co)

DOB: 8/24/1961

License #: 0001-02206

PA Education: College of West Virginia (1996)

Cause: Following a hearing held on 11/22/2002, the Board found that Ms Folkerts answered three questions falsely on her application for a PA license, thus failing to reveal disciplinary action commenced against her by the New Jersey Board of Medical Examiners based on charges she falsified responses on her application for a residency training permit and submitted a counterfeit document indicating she had passed the ECFMG examination. She also failed to reveal she entered into a Consent Order with the New Jersey Board of Medical Examiners in 1993 as a result of its investigation of her.

Action: 12/19/2002. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Ms Folkerts' license as a physician assistant is suspended indefinitely effective 12/15/2002. She may petition for reinstatement no sooner than 12/15/2003.

See Consent Orders:

BREWER, Thomas Edmund, Jr, MD
McGUIRT, William Frederick, Jr, MD
SAPPINGTON, John Shannon, MD
SINGH, Prachee, Physician Assistant

SUMMARY SUSPENSIONS

ROSNER, Michael John, MD

Location: Hendersonville, NC (Henderson Co)

DOB: 12/4/1946

License #: 0000-26865

Specialty: NS/NCC (as reported by physician)

Medical Ed: Medical College of Virginia (1972)

Action: 11/13/02. Order of Summary Suspension issued: Dr Rosner's medical license is suspended effective upon service of the Order in accord with the law. (Served: 11/15/02.) Dr Rosner may be unable to practice medicine with reasonable skill and safety to patients as shown by the Notice of Charges and Allegations dated 11/13/2002.

CONSENT ORDERS

BREWER, Thomas Edmund, Jr, MD

Location: Denton, NC (Davidson Co)

DOB: 11/04/1956

License #: 0000-28141

Specialty: GP/OM (as reported by physician)

Medical Ed: Bowman Gray School of Medicine (1983)
 Cause: Dr Brewer violated his Consent Order of 1999 by testing positive for cocaine use in June 2002. He voluntarily surrendered his license on June 17, 2002. He has signed a contract with the NCPHP and is reported to be in compliance with that contract.
 Action: 12/10/2002. Consent Order executed: Dr Brewer's medical license is suspended indefinitely; he may not request restoration of his license before June 18, 2003.

McGUIRT, William Frederick, Jr, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 6/06/1963
 License #: 0095-01002
 Specialty: OTO/PDO (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1989)
 Cause: While conducting pharmacokinetic studies of two drugs used following tympanostomy tube surgery in pediatric and young adult patients, Dr McGuirt failed to conduct follow-up visits with participating patients within two to five days after surgery as required by the research protocols. However, he recorded in the research charts that he had visited the patients as required, that he had examined the surgery sites, and that he had taken the patients' vital signs. He signed these charts, indicating he had done what, in fact, he had not done. His violation of the research protocols and his entry of improper data in the charts constitute unprofessional conduct.
 Action: 12/19/2002. Consent Order executed: Dr McGuirt's license is suspended for a period of six months; the suspension is stayed immediately; he shall provide a copy of the Consent Order to all prospective persons interested in having him perform clinical trial research.

SAPPINGTON, John Shannon, MD

Location: Linville, NC (Avery Co)
 DOB: 1/30/1962
 License #: 0094-00628
 Specialty: P/CHP (as reported by physician)
 Medical Ed: University of Texas (1989)
 Cause: Dr Sappington has a history of substance abuse, details of which are set out in a Consent Order of 2/21/2001. A condition of that Consent Order was that he should refrain from use or possession of all mind- or mood-altering substances and all controlled substances and alcohol unless lawfully prescribed for him by someone other than himself. On 8/02/2002, at Cannon Memorial Hospital, Dr Sappington was found to have locked himself in his office, having been unavailable to hospital staff for over 12 hours. The president of the hospital used a passkey to gain entrance to Dr Sappington's office. Dr Sappington admitted that on the previous day a patient had left him three bottles of medication and that he had ingested some Concerta®. On 8/05/2002, Dr Sappington's hospital privileges were suspended. On that same day, Dr Sappington surrendered his medical license.
 Action: 12/19/2002. Consent Order executed: Dr Sappington's license is suspended indefinitely and he shall not apply for reinstatement for a minimum of one year.

SESSOMS, Rodney Kevin, MD

Location: Clinton, NC (Sampson Co)
 DOB: 12/13/1961
 License #: 0000-33927

Specialty: IM (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1989)
 Cause: In 1995, Dr Sessoms confronted a physical therapist regarding the care of a patient and became loud, argumentative, and disruptive. In 1997, he became involved in a disagreement with nursing staff at Sampson Memorial Hospital over patient charts and became loud, used profanity, and slammed patient charts onto a rack. Also in 1997, he confronted a nurse regarding a patient's care and became loud, argumentative, and used profanity. In 1998, he was involved in a discussion with a nurse about a patient and, when the nurse walked away, became loud and grabbed her by the arm. In 1999, a social worker at Sampson Memorial Hospital phoned him on several occasions about the discharge of a patient and he angrily advised her not to call him for those reasons and said she was unprofessional. He was diagnosed with a mood disorder and has received treatment since 2000, is taking psychotropic medication, and has agreed to be evaluated by the NCPHP. Numerous physicians at Sampson Memorial Hospital have advised that Dr Sessoms has made great improvement in his behavior.
 Action: 1/22/2003. Consent Order executed: Dr Sessoms is reprimanded for his conduct; he shall submit to an NCPHP evaluation and follow any recommendations made; must comply with other conditions.

SINGH, Prachee, Physician Assistant

Location: Gastonia, NC (Gaston Co)
 DOB: 8/16/1976
 License #: 0001-03694
 PA Education: University of Texas, Pan American (2001)
 Cause: When applying for her PA license, Ms Singh submitted a letter of recommendation from a physician with whom she worked that stated he had her perform cryosurgery, doing punch biopsies and suturing. These acts were performed while Ms Singh was in the process of completing her application for her license, the physician mistakenly believing such acts were permissible under his supervision.
 Action: 12/10/2002. Consent Order executed: Ms Singh is issued a PA license to expire on the date shown on the license; Ms Singh's license is suspended for 30 days; suspension is stayed immediately upon conditions set forth in the Consent Order, including obeying all laws and returning to the Board for an informal interview in 12 months.

WHITMER, Gilbert Gomer, Jr, MD

Location: Rocky Mount, NC (Nash Co)
 DOB: 9/04/1961
 License #: 0000-36854
 Specialty: ORS/SOH (as reported by physician)
 Medical Ed: The Johns Hopkins University School of Medicine (1987)
 Cause: In 1996 or 1997, Dr Whitmer began treating a patient, a surgical technician at Nash Day Hospital, for carpal tunnel syndrome. He performed surgery on this patient in 1997. In 1998, Dr Whitmer and the patient acknowledged romantic feelings for each other and soon thereafter kissed on a least one occasion. On several occasions in 1997, Dr Whitmer inappropriately obtained a Schedule II controlled substance by directing three employees to fill prescriptions he wrote in their names

and then deliver the drugs to him. Around 1999, Dr Whitmer began taking Ultram® that he obtained from office samples and by self-prescribing. He signed a contract with the NCPHP and the NCPHP reports he complied with the contract, which was terminated in 2001.

Action: 1/30/2003. Consent Order executed: Dr Whitmer is reprimanded; unless lawfully prescribed for him by someone else, he shall refrain from the use or possession of all mind- or mood-altering substances and all controlled substances; he shall notify the Board within 10 days of his use of such medications, identifying the prescriber and the pharmacy filling the prescription; he shall supply bodily fluids or tissue at the Board's request for drug screening purposes; he shall comply with the Board's position statements on "Self-Treatment" and "Sexual Exploitation"; must comply with other conditions.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

NONE

SURRENDERS

BUZZANELL, Charles Anton, MD

Location: Asheville, NC (Buncombe Co)
 DOB: 9/23/1956
 License #: 0098-00481
 Specialty: AN/APM (as reported by physician)
 Medical Ed: Georgetown University (1984)
 Action: 11/01/2002. Voluntary surrender of medical license.

COLLINS, Natalear Rolline, MD

Location: Franklinton, NC (Franklin Co)
 DOB: 10/22/1955
 License #: 0000-27108
 Specialty: GP (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1981)
 Action: 1/27/2003. Voluntary surrender of medical license.

SEAL, James Hargett, Physician Assistant

Location: Ocracoke, NC (Hyde Co)
 DOB: 4/07/1969
 License #: 0001-02454
 PA Education: Medical University of South Carolina (1997)
 Action: 12/10/2002. Voluntary surrender of PA license.

SOLAN, Gwen Emily, MD

Location: Holly Ridge, NC (Onslow Co)
 Hampstead, NC (Pender Co)
 DOB: 6/25/1958
 License #: 0094-00399
 Specialty: GP/FP (as reported by physician)
 Medical Ed: George Washington University (1985)
 Action: 11/21/2002. Voluntary surrender of medical license.

COURT APPEALS/STAYS

ROSNER, Michael John, MD

Location: Hendersonville, NC (Henderson Co)
 DOB: 12/4/1946
 License #: 0000-26865
 Specialty: NS/NCC (as reported by physician)
 Medical Ed: Medical College of Virginia (1972)
 Action: 12/09/2002. Wake County Superior Court Order on appeal by Dr Rosner: the Board's 11/13/02 Order of Summary Suspension of Dr Rosner's license is stayed; however, Dr Rosner is not to perform or participate in any surgical procedure described as being not medically indicated in the Board's Notice of Charges and Allegations of 11/13/2002. Specifically, he shall not perform or participate in suboccipital craniectomies, cervical laminectomies, and/or resection of cerebellar tonsils. Other conditions noted. Hearing on the Board's charges is ordered to begin 1/23/2003.
 12/11/2002. North Carolina Court of Appeals Order on petition by the Board for a temporary stay of the Wake County Superior Court's Order: a temporary stay on the Order of the Wake Superior Court's order is granted.
 12/27/2002. North Carolina Court of Appeals Order on Petition for Writ of Supersedeas by the Board: the petition is allowed and the 12/09/2002 Order of the Wake Superior Court is stayed pending the outcome of the appeal to the Appeals Court.

CONSENT ORDERS LIFTED

CONNINE, Tad Robert, MD

Location: Great Mills, MD
 DOB: 1/19/1964
 License #: 0099-00193
 Specialty: RO (as reported by physician)
 Medical Ed: University of Southern Florida (1992)
 Action: 11/11/2002. Order issued lifting Consent Order of 11/11/2001.

RIDDLE, William Mark, MD

Location: Faison, NC (Duplin Co)
 DOB: 3/20/1956
 License #: 0000-39871
 Specialty: FP/ADDM (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1985)
 Action: 11/11/2002. Order issued lifting Consent Order of 11/11/2001.

SHERMAN, Randall Lester, MD

Location: Allentown, PA
 DOB: 6/13/1949
 License #: 0000-33891
 Specialty: NS (as reported by physician)
 Medical Ed: University of Oklahoma (1978)
 Action: 1/21/2003. Order issued lifting Consent Order of 10/18/2000.

SKWERER, Robert Gordon, MD

Location: New Bern, NC (Craven Co)
 DOB: 7/29/1956

License #: 0099-00134
 Specialty: P/N (as reported by physician)
 Medical Ed: State University of New York, Brooklyn (1982)
 Action: 1/10/2003. Order issued lifting Consent Order of 1/24/2002.

YOUNG, Richard Lane, MD

Location: Sunset Beach, NC (Brunswick Co)
 DOB: 8/12/1951
 License #: 0000-31090
 Specialty: ORS (as reported by physician)
 Medical Ed: Medical University of South Carolina (1979)
 Action: 1/16/2003. Order issued lifting Consent Order of 8/16/2000.

TEMPORARY/DATED LICENSES:

ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

COYNE, Mark Dennis, MD

Location: Stoney Creek, NC (Guilford Co)
 DOB: 8/12/1949
 License #: 0000-33493
 Specialty: EM/OS (as reported by physician)
 Medical Ed: Chicago Medical School (1983)
 Action: 11/21/2002. Full and unrestricted license reinstated.

GUALTEROS, Oscar Mauricio, MD

Location: Pinehurst, NC (Moore Co)
 DOB: 5/11/1964
 License #: 0099-00236
 Specialty: IM (as reported by physician)
 Medical Ed: University of Navarra, Spain (1991)
 Action: 1/22/2003. Temporary/dated license extended to expire 1/31/2004.

KEEVER, Richard Alan, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 6/11/1941
 License #: 0000-16400
 Specialty: OTO (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1969)
 Action: 1/22/2003. Temporary/dated license extended to expire 1/31/2004.

MAYFIELD, Kelli Burgin, MD

Location: Ellenboro, NC (Rutherford Co)
 DOB: 8/15/1963
 License #: 0095-00998
 Specialty: FP (as reported by physician)
 Medical Ed: East Tennessee State University (1993)
 Action: 11/21/2002. Temporary/dated license extended to expire 5/31/2003.

PARK, Hyunsoon Edie, MD

Location: Greenville, NC (Pitt Co)
 DOB: 3/06/1968
 License #: 2002-00581
 Specialty: P (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1994)
 Action: 11/21/2002. Temporary/dated license extended to expire 4/30/2003.

PRESSLY, Margaret Rose, MD

Location: Sylva, NC (Jackson Co)
 DOB: 5/05/1956
 License #: 0000-34548
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1990)
 Action: 12/18/2002. Temporary/dated license extended to expire 6/30/2003.

SHAFTNER, Kimberly K., MD

Location: Princeton, NC (Johnston Co)
 DOB: 12/09/1954
 License #: 0000-25426
 Specialty: FP/AN (as reported by physician)
 Medical Ed: Ohio State University (1980)
 Action: 12/19/2002. Temporary/dated license extended to expire 12/31/2003.

SHERMAN, Randall Lester, MD

Location: Allentown, PA
 DOB: 6/13/1949
 License #: 0000-33891
 Specialty: NS (as reported by physician)
 Medical Ed: University of Oklahoma (1978)
 Action: 12/19/2002. Full and unrestricted license reinstated.

SKWERER, Robert Gordon, MD

Location: New Bern, NC (Craven Co)
 DOB: 7/29/1956
 License #: 0099-00134
 Specialty: P/N (as reported by physician)
 Medical Ed: State University of New York, Brooklyn (1982)
 Action: 11/21/2002. Full and unrestricted license reinstated.

STROUD, Joan Marie, Physician Assistant

Location: Gastonia, NC (Gaston Co)
 DOB: 4/24/1956
 License #: 0001-01476
 PA Education: Pennsylvania State University (1980)
 Action: 11/21/2002. Temporary/dated license extended to expire 5/31/2003.

YOUNG, Richard Lane, MD

Location: Sunset Beach, NC (Brunswick Co)
 DOB: 8/12/1951
 License #: 0000-31090
 Specialty: ORS (as reported by physician)
 Medical Ed: Medical University of South Carolina (1979)
 Action: 11/21/2002. Full and unrestricted license reinstated.

See Consent Orders:

SINGH, Prachee, Physician Assistant

DISMISSALS

NONE

CHANGE OF ADDRESS FORM

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

Please print or type. Date: _____

Full Legal Name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

Business: _____

Phone:(____)____ Fax:(____)____

Home: _____

Phone:(____)____ Fax:(____)____

The Board requests all licenses 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.

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: May 14-16, 2003; June 18-19, 2003; July 16-18, 2003; August 20-21, 2003;
September 17-19, 2003; October 15-16, 2003

Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the North Carolina Medical Board's Web site at <http://www.ncmedboard.org/exam.htm>. If you have additional questions, please e-mail Tammy O'Hare, GME/Examination Coordinator, at tammy.ohare@ncmedboard.org.

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 PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

Prstt Std
US Postage
PAID
Permit No. 1486
Raleigh, NC

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