North Carolina's Medical Review System: Protecting *Patients* . . . or *Physicians*?

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Consider This: The statewide public board charged with regulating the medical profession "for the benefit and protection of the people of North Carolina"1 spends its valuable resources disciplining a physician who testified against another doctor in a medical negligence case — but whose North Carolina license had lapsed and who had never treated patients in North Carolina — while allowing to languish a complaint from a patient that a physician over-prescribed narcotics to her and raped her during an office visit.

Is the public safety this board's first priority? Or is it something else?

On paper, North Carolina has a comprehensive statewide and local system for licensing, monitoring and overseeing the health industry for the protection of the public.[2] In theory, this system is designed to ensure patient safety. In two recent cases involving discipline of doctors by the North Carolina Medical Board ("Medical Board") and by a hospital in Fayetteville, though, the disciplined physicians posed no apparent threat to patients. Who then, were these medical authorities protecting?

Physicians They Went After

In April 2002, the Medical Board brought public charges against Dr. Gary Lustgarten, a neurosurgeon from Florida whose North Carolina license had been inactive since June 1998, arising out of testimony he gave in a medical malpractice action *in favor of a patient and adverse to the defendant North Carolina doctor*. Refusing to postpone the scheduled hearing in August 2002 even though Dr. Lustgarten was unable to attend, the Medical Board revoked Dr. Lustgarten's medical license on the ground that the testimony he gave amounted to "unprofessional conduct" under G.S. §90-14(a)(6). This case apparently marks the first time a physician has been disciplined by the North Carolina Medical Board as the result of expert testimony.3

Dr. Lustgarten is challenging the disciplinary action in court.

Also during 2002, Dr. Debi Chaudhuri, a trauma surgeon, was disciplined by a hospital in Fayetteville where he treated patients after he publically criticized the hospital's failure to have a neurosurgeon on call for its emergency department — a failure Dr. Chaudhuri said had affected one of his patients. Within weeks after a newspaper article regarding the staffing shortage was published,4 quoting Dr. Chaudhuri, the hospital's medical executive committee — which included two neurosurgeons who were mentioned in the newspaper article — launched an investigation of

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1 The North Carolina Medical Board is given the responsibility to regulate the practice of medicine "for the benefit and protection of the people of North Carolina." N.C.G.S. § 90-2.

2 N.C.G.S. § 90-2; §§ 90-9 through 90-14 (licensing of physicians); 10 N.C.A.C. 3C.3201, -.3602, -.3701-.3706, -3708 (licensing of hospitals, regulations regarding medical staff, risk management, quality assurance); *see also* Blanton v. Moses H. Cone Hospital, Inc., 319 N.C. 372, 354 S.E.2d 455 (1987).

3 For Dr. Lustgarten's complete public file maintained by the Medical Board, visit the Board's website at http://www.ncmedboard.org/database/search.asp, and enter Dr. Gary Lustgarten's name.

4 "Surgeon shortage 'a serious problem,'" *Fayetteville Observer*, November 24, 2001.

Dr.Chaudhuri. Two months later, the committee unilaterally determined that Dr. Chaudhuri's continued practice in the emergency department "presented a risk to patient safety" and, without so much as a hearing, relieved him of his duties in the emergency department and referred him to the Physicians Health Program for mental and physical health evaluation. The hospital also initiated a retrospective review of Dr. Chaudhuri's cases and notified the National Practitioner Data Bank that Dr. Chaudhuri's privileges had been restricted.5

Dr. Chaudhuri sued the hospital and obtained a court order enjoining the disciplinary action.6 He has resumed practicing in the hospital emergency department.

The message to North Carolina physicians from these two cases is clear: Don't break the code of silence. It could cost you your hospital privileges, or even your license.

Physicians Who Got Away

Unfortunately, medical authorities in North Carolina are sending a different message to many physicians whose mistakes have actually injured patients and portend injury to more patients: Keep your head down, cooperate with the system, and we'll protect your ability to keep practicing.

A family practice doctor was sued by his female patient who alleged he over-medicated her with methadone, engaged in serious boundary violations (*i.e.*, personal telephone calls from home involving extensive exchange of personal information, including discussions of his martial problems, sexual matters and pornography), and eventually raped her after inviting her to the office for medical care on a Saturday.7 This lawsuit did not generate any local publicity, but current and former nurses' testimony corroborated this physician's tendencies toward inappropriate conduct with this and other patients, as well as the patient's impairment from over-medication. That lawsuit was resolved and dismissed in October 1998, and at that time the depositions and all witness information were made available to the Medical Board. As of the writing of this article — four years later — the Medical Board has brought no public charges against the doctor, and he continues to practice with impunity.

In 1995, two patients sued a Cary family practitioner, Dr. Wallace Evans, for inappropriate conduct during physical examinations.8 As a result of publicity about the lawsuit, more than 60 other patients, most of them women, called to report similar misconduct by Dr. Evans, in some cases extremely harmful, *dating back to the year he opened his practice in 1974*. From these additional witnesses it became apparent that the medical community — including his professional colleagues, HMOs and the Medical Board — had been aware for many years that Dr. Evans was engaging in inappropriate behavior with patients on more than an occasional basis, and yet apparently had failed to discipline him or take action to limit his access to patients. Within one week of the lawsuit being filed and the publicity over it, Dr. Evans was terminated by his practice and placed "on leave." He never returned to the practice of medicine.

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5 The facts concerning this controversy are contained within the pleadings in Dr. Chaudhuri's lawsuit, including his affidavit. Chaudhuri v. Cumberland County Hospital System, Inc., 02 CVS 1785, Cumberland County Superior Court.

6 Id.

7 Kuniholm Law Firm represented the plaintiff in this action. This case is not being identified to protect the plaintiff's identity and because her complaint is still pending at the North Carolina Medical Board.

8 Santitoro v. Evans, 95 CVS 6931, Wake County Superior Court. The information described herein is contained within the depositions and pleadings. *See also* news reports appearing in the *Raleigh News and Observer.* http://www.newsobserver.com.

Over the course of the litigation, which eventually included 15 plaintiffs,9 certain other facts surfaced: complaints about Dr. Evans' conduct had been reported to the Medical Board and at least two HMOs; he had been terminated from the panel of participating physicians by at least one HMO; a physician management company had purchased his practice and had given him a contract to see patients in spite of knowing of complaints; he had apparently been forbidden by the Medical Board from prescribing narcotic medication for a year; and he had self-referred to the North Carolina Physicians Health Program (an impaired physician program) after a series of complaints surfaced. Of course, only information known incidently by lay witnesses was obtainable, as an absolute privilege of confidentiality protects from discovery all information maintained by the Medical Board about complaints not resulting in public charges, about a physician's nonpublic file, about informal discipline, or about participation in the impaired physician program.[10] Several witnesses reported that Dr. Evans had bragged about his ability to "handle" the Medical Board with respect to patient complaints.

Unbelievably, Dr. Evans had *no public record* of any kind at the Medical Board or elsewhere. After the litigation resulted in the flood of information about Dr. Evans' misconduct, the Medical Board began an inquiry into his misconduct, which was terminated when Dr. Evans surrendered his license by reason of medical disability11—he claimed he was disabled from post traumatic stress disorder *as a result of the publicity from the litigation*.12 Although no reason appears of record, the only explanations for the termination of the inquiry by the Medical Board could be an agreement surrounding the surrender of his license or possibly that the Medical Board believed it lacked jurisdiction to discipline him as he was no longer licensed. Such a concern apparently, though, did not deter the Medical Board from disciplining Dr. Lustgarten, whose license was and had been on "inactive" status but whose actions apparently had threatened financial harm to a physician rather than harm to a patient.13

Sometimes a doctor's mishaps and misconduct are so extreme that medical authorities take real action. But their pattern is one of forgiveness, with restoration of the license after some period of time, even as short as months.14

Several years ago the North Carolina Medical Board took formal action against Dr. Raymond Sattler, a neurosurgeon in Wilmington who had left a patient on the operating table for a half hour, with her head cut open and no other doctor attending, to go get a bite to eat. More than two months after the incident, the Medical Board suspended Dr. Sattler's license on an "emergency" basis. An order for that suspension cited complaints that Dr. Sattler had on other occasions instructed an untrained nurse to drill holes in a patient's skull; requested intravenous fluids for himself when he began feeling weak during an operation; and altered or falsified patient records. Dr. Sattler admitted some of these charges. But five months later, after working out an agreement that required him to receive mental health treatment, the Medical Board restored his license. A petition by 40 operating

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9 Stangl v. Evans, 95 CVS 11214, Wake County Superior Court; Baker v. Evans, 95 CVS 11257, Wake County Superior Court; Pritchett v. Evans, 95 CVS 11258, Wake County Superior Court.

10 *See* G.S. §§90-8, -16, -21.22(e), -21.22A, 131E-95; 21 N.C.A.C. 32K.0101 *et seq.*; Shelton v. Morehead Memorial Hospital, 318 N.C. 76, 347 S.E.2d 824 (1986); Sharpe v. Worland, 137 N.C. App. 82, 527 S.E.2d 75, *discr. rev. denied,* 352 N.C. 150, 544 S.E.2d 228 (2000). *See also* N.C.G.S. §§90-8, 90-16.

11 See Surrender of License at http://www.ncmedboard.org/database/search.asp (Wallace Evans, M.D.).

12 Dr. Evans testified to this in his deposition.

13 *See* Dr. Lustgarten's public file at http://www.ncmedboard.org/database/search.asp (Gary Lustgarten, M.D.),

14 *See* public files for, *e.g.,* Barry Moore, M.D., Alan Lester, M.D., Raymond Sattler, M.D., at www.ncmedboard.org/database/search.asp.

room personnel urged the hospital, however, to deny restoration of his privileges,[15] and he is now, according to Medical Board records, practicing child psychiatry in Virginia.[16]

The Medical Oversight System

The quality of medical care in North Carolina is controlled, at least theoretically, through physicians' licensing by the state Medical Board and credentialing systems at medical institutions, primarily hospitals. Doctors who hurt or endanger patients can be formally disciplined by hospital administrators and/or by the Medical Board. But the general public, including patients, will never know about many incidents of physician mishap or misconduct, because of the routine practice of "informal action" by health care system officials, combined with a statutory privilege for peer review information and matters referred to a rehabilitation program for "impaired" physicians.[17]

If a doctor in a hospital commits error or misconduct, it may come to the attention of hospital officials, who can revoke, suspend, or limit the doctor's privileges to treat patients at the hospital. The hospital must report formal disciplinary action to the Medical Board.[18] As an alternative to such formal action, however, the doctor and hospital officials may agree on an informal solution, such as counseling, further education, or monitoring of the doctor's practice. Some hospital officials may even let the doctor agree to limit his practice without calling it formal action. Such matters are usually resolved through the hospital's medical review committee, so that the incident or conduct at issue can be thoroughly investigated and discussed without the risk of disclosure.[19] Theoretically, a doctor could commit a gross and fatal error, such as removing a healthy kidney and leaving the diseased one, but so long as he persuades the hospital medical review committee that it was error and not likely to happen again, the committee may resolve it informally and the Medical Board may not learn about the incident. Nor would the public learn. Not unless the patient's family sued. Even then, records from the medical review committee are immune from discovery.[20]

If a medical review committee or a colleague believes a doctor at issue is "impaired," the doctor can be referred to the North Carolina Physicians Health Program (NCPHP) rather than to the Medical Board. The NCPHP is a program for treating, monitoring, and rehabilitating impaired physicians.[21] The North Carolina Administrative Code defines "impairment" as "mental illness, chemical dependency, physical illness, and aging problems."[22] The implementation of this definition, however, is apparently broader in practice than as written. The NCPHP's self-published manual includes within its descriptions of impairment the following: alcoholism or alcohol abuse,

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15 "Surgeon Seeking Operating Privileges," *Wilmington Star-News*, May 18, 1995.

16 *See* http://www.ncmedboard.org/database/search.asp (Raymond Sattler, M.D.).

17 This practice of informal intervention when physicians cooperate has been confirmed by the authors through experience and through consultation with counsel who have participated in the process.

18 N.C.G.S. § 90-14.13 & 131E-87. Hospitals also must report when a doctor resigns. Id. This obligation also applies to Health Maintenance Organizations. Id.

19 N.C.G.S. § 131E-95.

20 Id.

21 The North Carolina Physicians Health Plan is established pursuant to the authority of N.C.G.S. §90-21.22, which authorizes the North Carolina Medical Board to enter into agreements with the North Carolina Medical Society to conduct peer review activities. These activities are limited to programs to treat impaired physicians, and the Medical Society is instructed to "adopt rules with provisions for definitions of impairment; guidelines for program elements; procedures for receipt and use of information of suspected impairment; procedures for intervention and referral; monitoring treatment, rehabilitation, post-treatment support and performance; report of individual cases to the Board; periodic reporting of statistical information; assurance of confidentiality of nonpublic information and of the review process." N.C.G.S. §90-21.22(c).

22 21 N.C.A.C. 32K.0101(3).

drug addiction or abuse, sexual misconduct/harassment, psychiatric disorder, behavioral disorder, and dual diagnosis (psychiatric disorder and addiction).23 The NCPHP has represented to the North Carolina Court of Appeals that the program provides treatment for "conditions such as substance abuse, alcoholism, mental illness, sexual misconduct, aging and similar difficulties."24

The NCPHP may receive referrals from physicians, family members, and others, including the impaired physician. This is called "self-referral." 25 The program is conceived of as primarily confidential or secret: "Any confidential patient information or nonpublic information acquired, created, or used in good faith" must remain confidential and is immune from discovery in any civil case.26

There are no statutory or regulatory limitations upon the number of times a physician may be referred to the NCPHP, nor any limitations on this absolute confidentiality on re-referral for relapse. Further, there are no limitations on confidential referral depending upon the circumstances, such as where the physician has committed crimes, has involved patients in crimes, or where other circumstances indicate increased public danger.

Further, the concept of a physician being "impaired" by sexual misconduct or by a behavioral disorder and thus entitled to secrecy is disturbing. This kind of behavior would usually be considered unacceptable and something the physician can control, rather than an illness. The NCPHP's self-published manual describes the kinds of symptoms that indicate an impairment. The manual lists the following symptoms among those possibly indicating the existence of an impairment of "behavioral disorder":

- is generally one of the most intelligent physicians in the group or on staff
- is intolerant of what he or she believes to be sub-standard medical care
- is vocal to hospital authorities, newpapers, peers – anyone who will listen
- usually is at least partially right in an argument but overreacts on most every occasion
- is often backed by other members of the hospital staff because they wish they had the same degree of "courage"
- has a sense of entitlement and bristles at the very thought of being questioned about abilities or behaviors
- is quick to threaten a lawsuit and may actually file one
- loves to goad other people professionally and may be caustic with criticism
- does not learn from mistakes because cannot admit making one
- has significantly more complaints written to authorities by patients and ancillary personnel
- lawsuits are not rare
- must be taken to the highest level of authority (Medical Executive Committee, Board of Trustees) before being willing to consider a change of behavior

Certainly these "symptoms" describe problem behaviors that may impair a physician's ability to function effectively as a member of a medical staff or group or to communicate effectively with patients. Do these symptoms indicate "illness" justifying secret referral and confidential treatment? Is this kind of impairment what the General Assembly had in mind when it authorized the creation of an "impaired physician" program?

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23 North Carolina Physicians Health Program Manual, NCPHP.

24 Sharpe v. Worland, 137 N.C. App. 82, 83, 527 S.E.2d 75, 77 (2000) (quoting from the brief of *Amicus Curiae* NCPHP).

25 21 N.C.A.C. 32K 0201.

26 N.C.G.S. § 90-21.22(e); Sharpe v. Worland, 137 N.C. App. 82, 527 S.E.2d 75, *discr. rev. denied,* 352 N.C. 150, 544 S.E.2d 228 (2000).

Although NCPHP is required to report a participating physician to the Medical Board under certain circumstances, these standards provide little in the way of imperatives for the NCPHP, a group obviously focused on treatment rather than discipline.27 Regardless of whether an incident of error or misconduct falls within the definition of "impairment," the NCPHP need not report the details of any investigation, review, or evaluation to the Medical Board unless the subject doctor (1) constitutes "an imminent danger" to the public or himself; (2) refuses to cooperate with the impaired physicians program; or (3) other grounds exist for disciplinary action.28

These standards for mandatory reporting are subject to wide latitude in discretionary interpretation and thus subject to abuse by those intent upon protecting and treating those they consider to suffer from an illness or impairment, by those intent upon protecting a physician's livelihood regardless of the short-term or even long-term risk to patients, or by those whose primary bias or agenda is the protection of physicians rather than patient safety.29 Statistics from NCPHP reveal that in 2001, there were 88 physicians referred to the NCPHP and 145 physicians actively participating in the program. Incredibly, there were only seven physicians who lost their anonymity or were disciplined during 2001.30

Confidentiality for the details of doctors' mishaps and misconduct also arises from North Carolina's statutory privilege for "peer review" information and materials, placing a cloak of secrecy over all details, discussion, and reasoning for scrutiny of a doctor's conduct and practice methods.31 Even a patient harmed by the doctor can have no access to this information. The broadest privilege applies to HMOs, whose medical review committees can review the quality, cost, and necessity of health care services, including doctors' credentialing, and all materials and testimony considered by the committees are deemed confidential and specifically not subject to discovery in a civil action against the doctor.32

Even if a hospital reports to the Medical Board that a doctor's privileges have been lifted, and even if NCPHP reports to the Medical Board that a doctor's conduct is an "imminent danger" or otherwise requires reporting to the Medical Board, the Medical Board has wide discretion regarding whether to discipline the doctor. Although there are statutory grounds for allowing the Medical Board to discipline a physician,33 there are no statutory standards *requiring* discipline by the Medical Board in any circumstance. Without formal disciplinary action, nothing is reported to the public, or available upon request.34

The Medical Board and The Medical Society: Hand-in-Glove?

Why does the North Carolina Medical Board allow some doctors' misconduct to go unpunished and unaccounted to the public and patients? Why has the Medical Board disciplined a physician for conduct unrelated to patient care? Is the Medical Board serving a different master than

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27 *See* description and discussion of the program contained in the NCPHP Manual published by the Medical Board.

28 N.C.G.S. § 90-21.22(d).

29 Although on paper NCPHP appears to be an independent entity, a close look at the board of directors reveals that eight of 14 directors represent the Medical Society and the Medical Board. Given the other indications of inappropriate control of the Medical Board by the Medical Society, this fact alone suggests a closer look at the independence of NCPHP. *See* List of NCPHP Board Members in NCPHP Manual.

30 *See* the Medical Board's 2001 Annual Report at http://www.ncmedboard.org/ann.02/quick.htm.

31 N.C.G.S. §§ 90-21.22, -.22A & 131E-95.

32 N.C.G.S. § 90-21.22A.

33 N.C.G.S. § 90-14.

34 G.S. §§ 90-8 & 90-16.

the law mandates? Has the Medical Board thrown aside the public to serve physician interests? Answers to these questions may lie in the legal structure and the symbiosis between the Medical Board and the North Carolina Medical Society, a voluntary professional association that superficially appears to be separate and distinct from the Medical Board.35

The North Carolina Medical Society, a professional association advancing the interests of physicians since the 1800's, is recognized by statute as "a body politic and corporate."36 It is North Carolina's version of the American Medical Association. Membership is voluntary. The Medical Society boasts of having more than 11,000 members of the nearly 26,000 physicians licensed by the Medical Board in 2002.37 Those familiar with the history of the Medical Society indicate that until the 1960's, doctors who were not male or white were excluded from membership.

Prominent on its website is the Medical Society's focus on legislative matters.38 Although the Medical Society declares as its second purpose "protecting the quality of patient care,"39 its legislative lobbying function is dominant (although the details are for members only), and it boasts that

> [p]ositively no other organization or entity pursues the professional interests of physicians in the public sector as aggressively as the North Carolina Medical Society.40

The Medical Society Political Action Committee (MEDPAC) is active, reporting more than $160,000 in its January 2002 report.41

What evidence is there of advocacy within the Medical Society for improving patient care that does not simultaneously protect the interests of physicians? On issues such as legal liability for medical errors, the Medical Society hardly advances the interests of patients and the general public. The Medical Society makes no secret of its agenda to advocate for changes to the civil justice system. Its lobbyists proposed and pushed hard for the 1995 legislation adding certification requirements42 and restrictive qualifications for expert witnesses43 in medical malpractice cases, and for limits on punitive damage awards.44 As far back as the late 1980's, the Medical Society lobbied for legislation providing immunity from liability for obstetricians and hospitals in certain birth injury cases. Now, it is leading the charge on limiting damage awards in medical malpractice cases.

The Medical Society is hardly in the same position, however, as every other professional association whose efforts at influencing public policy are limited to the halls of the legislature. Not only is it declared a "body politic" by the General Statutes,45 it virtually appoints a voting majority of the members of the Medical Board. Of the 12 members of the Medical Board, seven "shall be duly licensed physicians elected and nominated to the Governor by the North Carolina Medical Society."46 Other health care professional boards are selected by the governor from a list of nominees provided by a professional organization–usually three names are nominated for each open

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35 *See* the official website of the North Carolina Medical Society at http://www.ncmedsoc.org.
36 N.C.G.S. § 90-1.
37 www.ncmedsoc.org; www.ncmedboard.org/ann.02/quick.htm.
38 www,ncmedsoc.org.
39 Id.
40 www.ncmedsoc.org.
41 GET THIS CITE FROM BILL WILSON.
42 N.C.G.S. § 1A-1, Rule 9(j).
43 N.C.G.S. § 8C-1, Rule 702(b).
44 N.C.G.S. § 1D-1, *et seq.*
45 N.C.G.S. § 90-1.
46 N.C.G.S. § 90-2.

position.47 By contrast, *every single nominee of the Medical Society is guaranteed appointment to the Medical Board*. Likewise, the nominees are not elected by all doctors licensed in North Carolina, but only by those active in the Medical Society. This is the equivalent of the Academy of Trial Lawyers or the Association of Defense Attorneys directly appointing a majority of the State Bar.

Not surprisingly, appointees to the Medical Board often are doctors who have been active on behalf of the Medical Society in lobbying for the interests of physicians, sometimes with respect to issues that come before the Medical Board. If the Medical Board is asked to decide whether to adopt standards for mandatory action against a doctor — say, for example, for a doctor whose misconduct is both criminal and causes actual harm to a patient — members who were placed on the Medical Board by the Medical Society (*i.e.* the physician lobby) are unlikely to agree to a policy change that conflicts with the interests of physicians who are active in the Medical Society or who participate in the NCPHP, the impaired physician program.

Allocation of Resources by the Medical Board _ What Are Their Priorities?

Significant resources of the Medical Board were consumed during 2002 to discipline Dr. Lustgarten _ *a physician whose license at the time was inactive and who had never even practiced medicine in North Carolina under that license while it was active*.48 Between April and December 2002, the Medical Board noticed a hearing, denied several requests to continue the hearing because Dr. Lustgarten was unable to attend, held a hearing (in the physician's absence), denied a motion to rehear the matter, issued a revocation of the physician's license, resisted a motion to stay the order, and proceeded to defend an appeal of the stay order.49 The file reads as if the Medical Board were compelled to act urgently to remove a dangerous doctor from having access to patients _ although there was and could not have been a danger to patients had this disciplinary action been deferred to allow resources to be focused on situations that could pose a danger to patients.

Every resource of the Medical Board expended during 2002 on Dr. Lustgarten — including valuable time of the Medical Board itself spent in hearing — was then unavailable for focus on a physician whose conduct or practice poses an ongoing threat to patients. These choices of allocation of resources by the Medical Board reflect priorities. Clearly, during 2002, the Medical Board was more interested in the issue of testimony against a North Carolina defendant in a medical malpractice case than it was in the issues of over-prescription of narcotics and rape, for it expended its valuable time and resources pursuing the expert witness and took no action against the alleged rapist.

The public must ask why — why has the Medical Board chosen these priorities? At least a partial answer may lie in the overlapping loyalties between patient safety and political agenda that may intrude to cloud the vision of the members of the Medical Board. Appearances, at least, suggest that the physician lobby — the Medical Society — controls the agenda of the supposed watchdog for patient safety — the Medical Board. A truly independent Medical Board would not be beholden to two masters, and would not squander its scarce resources on an agenda chosen by the physician lobby.

Proposals for Change

The medical profession is not, under the current system, effectively policing itself. For the

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47 *See, e.g.,* N.C.G.S. §§ 90-116 (N.C. Board of Opticians), 90-130 (N.C. Board of Osteopathic Examination and Registration), 90-270.6 (N.C. Psychology Board).
48 *See* Dr. Lustgarten's Motion for Stay of Operation (Lustgarten Public File Document # 00012126), at 2, N.C. Medical Board, http://www.ncmedboard.org/database/search.asp.
49 *See* Dr. Lustgarten's Public File, N.C. Medical Board, http://ncmedboard.org/database/search.asp.

system to begin to function as it should, and to give the public confidence in the system's ability to protect patients, several changes must be considered and implemented:

(1) The Medical Board must be truly independent of the physician lobby.

The quasi-judicial body charged with the public trust for patient safety must be independent of the physician lobby. This can be easily accomplished by ending the control that the Medical Society exercises over the Medical Board. During 2001, Senator Frank Ballance introduced a bill in the North Carolina Senate designed to do just that, calling for the members of the Medical Board to be elected by all physicians rather than appointed by the physician lobby.50 The Legislature adjourned without taking action on this bill.51 The Legislature must solve this issue immediately.

(2) There should be mandatory public reporting of information regarding physician discipline and settlements and verdicts.

The Medical Board should be compelled to report publicly information regarding physician discipline, including settlements and verdicts. At a minimum, the Medical Board should be required to publish information concerning how many physicians have 10 or more settlements or verdicts, how many have between five and 10, how many have up to five, and how many have none. In addition, if any physicians have more than a certain number of verdicts or settlements, perhaps five, this should be published on the website as to these individuals. Further, when a physician has had privileges revoked, this information should be made public.

(3) There should be limitations on the circumstances in which "informal" or "nonpublic" action may be taken with respect to a physician.

The Medical Board should be prohibited from taking informal action for any misconduct that reaches a certain level of severity. It seems that what occurs now is that if a physician cooperates with Medical Board requests and recommendations — "falls on his sword" — all Medical Board intervention and action may be nonpublic or informal, so that no one will ever find out about it, so long as the physician continues to cooperate. This is unacceptable. The Medical Board should not have unlimited discretion in these matters. Such discretion is subject to extreme manipulation by an accused physician or a Medical Board with divided loyalties.

(4) The North Carolina Physicians Health Plan should have standards and limitations to avoid abuse and manipulation of the system and to protect the public.

Under the current system, there are no objective limitations on the number of times a physician may be referred to the NCPHP without automatic disclosure of the referral to the Medical Board. While there may be justification initially for a confidential treatment approach, repeat tours through the program should not enjoy the same level of confidentiality. Further, if criminal behavior has occurred, or if the physician has involved patients in the acquisition of drugs, this alone should eliminate the option of confidential referral. While notions of "illness" and "treatment" are helpful in assuring referrals, personal responsibility is not encouraged by unlimited options for confidential treatment.

Further, the definitions that the Medical Board has placed on "impairment" are entirely too broad, including currently "sexual misconduct/harassment" and "behavioral disorder." While these

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50 Senate Bill 1067 ("An Act to Provide for the Election of Physician Members of the North Carolina Medical Board"), April 5, 2001, General Assembly of North Carolina, Session 2001.
51 *See* http://www.ncleg.net/gascripts/BillLookUp/BillLookUp.pl?Session=2001&BillID=S1067.

issues may be evidence that someone is not able to practice medicine safely, they should not trigger an opportunity to obtain confidential assessment and treatment, with the option to retain a completely clean record with the Medical Board. Being a physician should not result in special treatment in these important matters, particularly given the extreme harm that may flow from such behaviors. The discretion to hide these disciplinary matters from the public should be removed from the Medical Board.