

A publication by and for the members of the Wake County Medical Society, serving the citizens of Wake County since 1903.



# THE WAKE COUNTY PHYSICIAN

April 2005

Volume 10 No. 2



# Wake County Medical Society Officers and Executive Council 2005

## THE WAKE COUNTY PHYSICIAN

The Wake County Physician is a publication for and by the members of the Wake County Medical Society. The Physician publishes four times a year: in February, May, August and late October. We will consider for publication articles relating to medical science, editorials, opinion pieces, letters, personal accounts, photographs and drawings. Prospective authors should feel free to discuss potential articles with the editorial board.

### Manuscript Preparation

Submit a cover letter and a 3 1/2 inch computer disk that contains the text written in MS-DOS compatible format. Also enclose one hard copy of the text for review purposes. Double space text with one-inch margins and no smaller than point 12 fonts. Articles should be no longer than 500 words.

Submit photographic illustrations as high quality 5 x 7 or 8 x 10 glossy prints, or as black and white glossy prints. Label all illustrations with author's name and number them sequentially according to their position in the text and indicate the orientation of the images.

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Submit a recent black and white or color photo along with your submission for publication. The photo may be a 3x5 or 5x7 photo. Snapshots are suitable. All photos will be returned to the author. Include a brief bio including your practice name, specialty, special honors and positions on boards, etc. Please limit the length of your bio to 3 or 4 lines.

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Editor, The Wake County Physician,  
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### The Wake County Physician's motto:

**"To nurture the bonds between us."**

### Mission Statement:

**"The Mission of this publication is to educate our community, publicize physician activities, inform and educate our readership and nurture the bonds between Wake County Physicians, allied health care professionals and patients."**



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## PRESIDENT'S message

**Dan Albright, M.D.**



*Dan Albright, MD*

# Membership in the WCMS—Is it worth it?

**\$200.** That's the price for your annual membership in the Wake County Medical Society. Is it worth it? Absolutely. It's worth belonging to the WCMS because of the following reasons:

1. Supporting your Wake County community and its healthcare needs.
2. Advocating or championing the profession of medicine at our county level.
3. Socializing with your physician colleagues.

I'd like to elaborate on these reasons to justify your paid membership in the WCMS.

### **1. Supporting your Wake County community and its healthcare needs.**

The spirit of volunteerism is strong in Wake County. Many hundreds of Wake County physicians volunteer their time and skills to help our indigent. The Wake County Medical Society coordinates several programs that allow our poor people access to volunteer doctors.

Since Paul Harrison's arrival as Executive Director a few years ago, an astounding expansion of the WCMS' outreach programs has occurred. It is amazing how many thousands of people are helped through the adult Project Access program and the multiple children's access programs. Substantial grant money has been received. Wake County is a better place because of these important outreach programs. A portion of your dues continues to serve as one of the catalysts for all this good work to occur.

### **2. Advocating or championing the profession of medicine at our county level.**

For example, just before the N.C. General Assembly convened its session in January, 2005, the WCMS leadership organized a dinner with our state senators and representatives from Wake County to discuss healthcare issues. The dinner was very productive; legislator attendance was good; and physician participation was excellent. The medical liability crisis in North Carolina was discussed extensively, focusing particularly on how patients are either being harmed or substantially inconvenienced as the crisis worsens.

The WCMS has communicated for years in a variety of different ways with our politicians. Our message is getting out there. Communication matters. Politics matters. Money matters. A portion of your dues helps support our political functions.

### **3. Socializing with your physician colleagues.**

I know, I know...many physicians feel too busy to do anything except work long hours caring for patients. There is little time for other commitments. Many of us feel lucky to get home for family time.

"No man is an island, entire of itself; every man is a piece of the continent, a part of the main," wrote John Donne about 400 years ago. The same idea holds true today with physicians and their professional communities.

In general, many of us physicians (myself included) need to work a bit less in our regular medical practice and reach out differently. Think about it: how often do you get out and talk to other physicians outside your daily practice routine? Many of us rarely talk to other physicians except to discuss difficult patient problems.

Doctors are nourished through social interaction with one another. Physician socializing strengthens important bonds within our Wake County medical community. Our socializing is healthy. We benefit. Our patients indirectly benefit. It's amazing what attending a little ol' WCMS meeting can do for you!

The Wake County Physician magazine, sponsored by the WCMS, is an important medium for discussion of physician interests and healthcare issues. Doctors, politicians, and lots of other folks read the magazine. A portion of your dues supports this meaningful publication. And the added bonus: the magazine is delivered to your door so you can read it too!

Finally, physician membership in the WCMS is just the right thing to do. The same common sense reasoning holds true for physicians joining the North Carolina Medical Society and a national medical society (e.g., AMA or a national specialty society). We medical doctors and ultimately our patients benefit from our membership and our participation in these honorable organizations.

Initiate or renew your membership... today!



Dr. Assad Meymandi

## Obesity in America

Obesity has become the bane of America. Numbers from the National Institutes of Health, CDC, Medicare and Tuft University nutrition experts are frightening. The cost of health care is escalating rapidly. From nine percent gross domestic product only a decade ago, it has jumped to nearly 17% this year. The number of afflicted with

Type II diabetes mellitus, cardiovascular

problems, hypertension and eventually stroke is rapidly rising. Related illnesses such as low back pain, arthritis and other musculoskeletal problems, bad knees, bad hips etc add to the cost. A recent report tells us if you loose one pound of body weight, it will take off five lbs pressure off your back. Yet, the public seems to go its merry way, eating itself to literal death.

I believe the problem, although looking and sounding complex, is really not. The simple premise of burning more calories than consumed produces loss of weight, and consuming more than we burn leads to weight gain.

However, our society and the medical profession which is a part of the society like to make the matter of obesity more complicated than it is. Reasons are many. Among them, the multi billion dollar complex industry of dieting, diet books and diet gurus. The latest Medline check, I found over one million book and magazine titles on diets. Over one thousand magazines and publications feature weight loss on their cover. In addition there are multitude of often physician generated diets, Atkins, Ornish, weight watchers, zone diets, etc. that are subject of exhaustive discussion in medical and nutritional circles.

American society seems to idealize victimhood. Psychology, psychiatry and behavioral sciences wittingly or unwittingly have contributed to advancing this aberrant cultural stance. Over the years, in my clinical practice, I have paid special attention, wearing my clinical research hat, to learn more about why people engage in the aberrant and self destructive behavior of over eating. Excuses (not reasons) are abound. I do it because I was molested when a child...I do it because it calms my nerves...I do it because I have nothing else to get pleasure out of...I do it because my father was an alcoholic...I do it because my mother abused me and I hate her..." are just a few frequently used excuses. Last year in a piece for the News and Observer I wrote: "English is full of euphemism pandering to and excusing bad habits. We call being fat and ugly 'obese,' 'plump' and 'overweight.' Universal standards of love command us to practice the holy trilogy of not to be abusive ourselves, to our fellow humans and to allow anyone to abuse us. Getting fat is self-abuse which goes along with the use of tobacco, alcohol and drugs. Being fat is unsightly, ungodly, abusive and unloving to ones' self.

'Critical thinking suggests that publishing articles in which abusive behavior is excused and mitigated prove to be counter-productive and harmful. For one thing, articles suggesting that massage therapy may help obese diabetic patients, offers false hope to people who need to get serious about weight loss. The epidemic of obesity in America is tragic. The nation ought to get serious about preventing obesity through education and awareness. And the place to start is at home, in mother's lap, in kindergarten and public school.

'Schools ought to remove all soft drink and snack machines

from their premises, re-institute physical education and rigorous daily exercise for students (and teachers). Quit making excuses fro laziness and gluttony and get serious about losing weight. Better yet, work on prevention. Don't get fat in the first place."

Besides many letters to the editor castigating me as an insensitive soul, unfit to be a psychiatrist, I have received dozens of letters signed and unsigned, some as long as 15 pages, telling me why they were offended by my piece (we had many more positive responses than the vociferous negative ones!).

I do know that Americans who are obese and excuse their obesity because they see themselves as VICTIMS of some sort of childhood or adolescent abuse, are not as abused as the people of Ethiopia, Sudan and Sub-Saharan nations of Africa, most of whom go hungry and are emaciated. So, having been abused is not a valid excuse for over eating. Why is it that their abusive past does not cause them to be obese. Our prosperity, abundance and variety of food make us eat more than we should.

Unfortunately the medical profession has been an enabler in this equation. We often make excuses for our patients. We create new diagnoses such as fibromyalgia (FM) and chronic fatigue syndrome (CFS) to accommodate these people who just need to quit over-eating. Compassion is not permissiveness and "understanding" is not licentiousness. HMOs and limited time allowed per patient prevents clinicians to spend with patients and assist them in instilling discipline in their lives and lifestyles. It takes less time and is easier to write a prescription instead of listening, talking and explaining things. I often wonder what Sir William Osler would say about our epidemic of obesity and the way we take care of our obese patients.

*Write to us: [emeymandi@nc.rr.com](mailto:emeymandi@nc.rr.com). We'd love to hear your opinion expressed in 250 words.*

## Letters To The Editor

The Editor:

As always, you write brilliantly. Please know I share your passion for saving Dorothea Dix Hospital. Opportunities such as this does not occur for fast growing cities very often. It is hoped that our State and City leaders will have the vision to preserve the green space and create a public park. There is a definite psychological spirituality to providing a park for all the people -- including school children from all over the state who visit their State Capitol. I have been lobbying officials for the past several months and I am cautiously optimistic. Thank you for your wonderful advocacy of good health for our city.

**Jeanette W. Hyde**, Former Ambassador  
to Barbados and West Indies  
Raleigh, North Carolina

The Editor:

I read and loved every word of the editorial. And of course, the occasion to celebrate the wonderful convergence of interests in this magnificent gift is welcomed beyond measure. Wonderful choice of venue; wonderful turn of phrase; wonderful choice of recipient; and wonderful spirit of selfless giving embodied in the donor. I'm proud to be among recipients of my "personal" copy

of WCP. I was struck by the parallels in your thinking between Psychiatry and Preventive Medicine. "... To know and love what is inside of us and understand and respect what is outside of us ..." is the public health mantra! Fellow seekers of care and compassion at the cutting edge with our psychiatrist brothers, healers, philosophers, and artists.

Thank you for being ... YOU! And sharing yourself with us.

**Hugh Tilson, MD, Dr.PH**  
Professor of Public Health, UNC  
Chapel Hill, NC

To the Editor:  
Re: Funding Mental Health Programs: California is in dire straights in regards to mental health. The main inpatient facilities are at the county facilities and are under the Department of Health Services and not the Department of Mental Health. The two are in conflict about who should cover the bill. DMH supports outpatient facilities but DHS feels that their budget should help with the inpatient services. The inpatient services are so overcrowded that it is dangerous. We had a surprise JCAHO visit a few months back and got cited for the conditions in our Psych ER. There was recent death in the Psych ER of one of our sister facilities. It's an absolute mess. We used to have 64 inpatient beds but had to cut the number in half 10 years ago again for funding issues. Patients can be held in the ER for weeks before they either get a bed or get discharged. It is a tragedy!

I'm surprised and pleased that you are proposing a tax increase. The money has to come from somewhere and as with everything else in life those who have should help support those that don't, whether that be mental health, physical health, or the arts.

**Sheba K. Meymandi, MD**  
Los Angeles, California

To the Editor:  
The magazine and its content are excellent. But I am writing this letter to tell you that I sat there the other evening enjoying the Brahms's second Piano Concerto, I had to pinch myself to see if I was dreaming. To have such music in such a hall is a privilege that few people on this earth have the opportunity to experience. I would like to thank you personally for making this possible for me and for the city of Raleigh by giving us the Meymandi Concert Hall.

**William W. Hedrick, MD**  
Raleigh, NC

To the Editor:  
Your speech on the occasion of endowing the Distinguished Chair of Psychiatry at UNC Medical School is very interesting. I also greatly enjoyed your talk on da ponte - Mozart has long

been one of my top favorites. I learned a lot from your discussion of Da Ponte. In the past month we have seen *Così*, *Idomeneo* (twice) *Don Giovanni*. The Los Angeles production is one of the best of Mozart's and indeed one of the best operas I've ever seen. Whimsy, joyful and FUN!

Congratulations on your philanthropy. You have truly enriched the Raleigh community by your knowledge and your generosity as well as the lives of many others. With my kindest and warmest regards

**Barry Panter, MD, PhD**  
Training Analyst,  
Los Angeles Institute of Psychoanalysis  
Los Angeles, California

To the Editor:  
Your December 3 speech in the January issue of WCP was incredible. It is rare to read an address that synthesizes so much good information and shows such a wealth of knowledge of history of ideas...Shakespeare...Saint Augustine...Handel...

Your paragraph beginning with "The distillation..." is especially beautiful, and could almost be the Folk School's mission statement." Thanks for all you do, spreading blessings in a good day's work.

**John Davidson, Director**  
The Folks School  
Member, NC Arts Council  
Brasstown, NC

The Editor:  
We acknowledge with admiration and gratitude news of your newest gift to America and North Carolina - the psychiatric chair at UNC-Chapel Hill. By any measure, you now are the fourth of the brilliant intellectual stars shining from on high! Luck for us that Dr. Overholser steered you into the White Building.

**Voit Gilmore, PhD**  
Jody Gilmore  
Pinehurst, North Carolina

The Editor:  
Congratulations on a magnificent speech (editorial in January issue of WCP)! It sounds like it was a terrific gathering for a very special occasion at UNC. I am in Washington and will share your speech with my sister, who is an Episcopal minister and former attorney with wide ranging interests in history, religion and philosophy.

**Doug Quin, PhD**  
Executive Director  
NC Humanities Council

### About the Cover . . .

The southern culture and southern literature place enormous emphasis on "place", "homeplace", "land", "landmark", and then on structure--tobacco barn, old mule house, grandmama's kitchen... In the Orient, because of paucity of space and need for privacy, the imagination takes off and vertical expansion reaching the edge of heaven becomes conceivable. In this picture, the conceptual architecture of a house in the sky is illustrated by Shintoism's (in Chinese--Mandarin--Shen, means God; to, or do, means Way) longing for "Man and God to become one..."

# KNOWLEDGE NEEDED! I WONDER. . .

Contributed by Bruce B. Blackmon

The Heimlich maneuver for choking people has been quite an improvement in treatment for critical emergencies and probably has saved more lives by general public use than by the medical profession. Great! Let us realize how fast our relationships can change in this drama. In a five minute time span, we can go from dealing with a stranger to friendship, to like family to client to patient to corpse.

As we try to analyze the problem, some interesting facts present:

1. The incriminating bolus only lodged in the trachea as the individual is inhaling. If he or she is inhaling, that means the lungs are not full of air.
2. Now, with only partially filled lungs, we expect a novice who has no experience using the Heimlich to use the little bit of residual lung air to force out a bolus of food. Then, because of the anxiety, etc., the first attempt may not be successful, but part of the residual air is lost on the first attempt. Now, the second and third attempts are made with less and less residual air available for each succeeding try. It's remarkable that any are winners, but they are.

Now:

1. Almost all chokings are with food
2. Most food is prepared in a home or a restaurant.
3. Most of that food is served close to where it was prepared.
4. Most homes and restaurants have a vacuum cleaner with a suction hose attachment.

Now, for your knowledge and brain power: Should training for the Heimlich maneuver be in two parts?

1. Our conventional training – that's great!
2. At the same time, send a bystander for a vacuum machine with a suction hose attachment to the vacuum. (Remember how you give a cow a pill? Put the pill in a short piece of garden hose, one end in the cow's mouth, one end in your mouth, and be sure you blow before the cow blows.)
3. By the time three Heimlich attempts have failed, the vacuum hose should be hooked up and ready and the hose placed in the patient's mouth, attempting to suck out the bolus. Be sure to pinch his nose.

## Questions?

Is there danger of sucking out the patient's gizzard, blood, and last three meals?

NOW IS THE TIME FOR ALL GOOD PULMONOLOGISTS TO COME TO THE AID OF THEIR COUNTRY AND FELLOW

COUNTRYMEN. Answer quickly!

Incidentally, if the idea has merit, then way down the road, should the vacuum cleaner companies print instructions on what the medical profession recommends for sucking out peanuts and boluses? (One short suck and then listen for air movement, etc.). Could this be tried in the OR, or even the ER, before bronchoscopy to to remove peanuts, pop corn, etc.?

One last scenario: Do we need to bring back the old OB practice of quilling? For you youngster M.D.s with less than fifty years of practice, quilling was used in home deliveries before hormones were available in syringes to promote quick delivery. When the patient was about ready for delivery and just needed a few more good pushes,, the neighbor lady who was serving as a nurse's assistant, would say, "It's time to quill her." Then another neighborhood lady, the second assistant, would go to the kitchen, pour some black pepper in her palm, (the original plan was to put it into a goose quill), come back to the bedside, put her laden palm next to the pregnant lady's nose and then blow the pepper into the patient's nostrils. In a matter of seconds, there could be a big sneeze, or series of big sneezes. When that was done, the baby popped out, husky and hearty, with no anesthesia in his system. (Maybe quilling would not work in choking BECAUSE one has to take a big breath before getting a big sneeze.

COME FORTH, PULMONOLOGISTS: You are at bat!

TO ANY M.D. WHO IS ALSO AN ATTORNEY:

By the third Heimlich try, the patient is about to collapse at your feet as a hunk of warm protoplasm.

1. Do you dare try the vacuum hose
2. Do you dare NOT try the vacuum hose?

Don't give us your standard routine jargon, "That depends." Do you do or Do you don't? You have about 45 seconds to save the world for one poor soul.

Truly, it depends. You win and have a friend for life. If you lose, you have one more change in relationships. Without Depends, you lose the crease in your slacks as they change from dry to wet.

Bruce B. Blackmon, M. D.  
P. O. Box 8  
Buies Creek, N. C. 27506

Two things stand like stone: kindness in another's troubles, and courage in one's own.

Contributed by Betty Madry

By Dr. Holden Thorp



Dr. Thorp

## Thorp to Lead Chemistry Department, Become Kenan Professor in July

Dr. Holden Thorp, who has served as director of the University of North Carolina at Chapel Hill's Morehead Planetarium and Science Center since 2001, has been named chairman of the department of chemistry.

He also will be named

Kenan professor, an endowed faculty position awarded to outstanding scholars and teachers. Both appointments are effective July 1. The department of chemistry is part of the College of Arts and Sciences.

"This is a great opportunity for the College of Arts and Sciences, the university and the Morehead Center," said Dr. Robert Shelton, provost and executive vice chancellor at UNC. "Our nationally ranked department of chemistry will gain an outstanding scholar and teacher with Holden Thorp at the helm. Holden's vision and expertise have led the Morehead to new heights as an innovator in science education.

"His promotion gives the Morehead Center an opportunity to continue moving forward by seeking a national leader in science outreach and interactive educational programs."

Thorp attended UNC, receiving his bachelor of science degree, with highest honors, in chemistry in 1986. He went on to receive his doctorate from the California Institute of Technology in 1989. He came to UNC in 1993 as assistant professor of chemistry and is now professor of chemistry.

A native of Fayetteville, Thorp has earned recognition as a professor and as a researcher, including the Tanner Award for Excellence in Undergraduate Teaching, the David and Lucile Packard Fellowship in Science and Engineering, and the Alfred P. Sloan Fellowship.

Fortune Small Business named Thorp one of its "Top Innovators of 2001" for his development of electronic DNA chips that have received nine patents and are currently in commercial production.

As director of the Morehead Center, Thorp expanded the original emphasis of the planetarium to encompass science education in all of the disciplines offered by the university. He initiated partnerships involving Nobel Prize-winner Dr. James Watson and Pulitzer Prize-winner

Dr. Edward O. Wilson to develop films that explore genetic research and biodiversity. He also established momentum for the Morehead Center's first major renovation since its construction in 1947.

Thorp replaces Dr. James W. Jorgenson, who ends his five-year term as chairman of the department of chemistry on June 30. Jorgenson, W.R. Kenan Jr. professor, will continue to teach and conduct research in chemistry.

Robert Gotwals, who has served as the Morehead Center's associate director and as director of science initiatives, will also leave the Morehead Center to return to the Shodor Educational Foundation, a nonprofit institution in Durham providing informal science education in computational science.

Jeff Hill, the Morehead Center's marketing and business ventures director, will be acting director of the Morehead Center during the search for a new director.

**College of Arts and Sciences contact:** Dee Reid, (919) 843-6339 or [deereid@unc.edu](mailto:deereid@unc.edu)

**News Services contact:** Deb Saine, (919) 962-8415 or [deborah\\_saine@unc.edu](mailto:deborah_saine@unc.edu)

# North Carolina Treasures

By Peter White, PhD, Director, NC Botanical Garden

## The North Carolina Botanical Garden



Peter White

The North Carolina Botanical Garden was created by the Trustees of the University of North Carolina at Chapel Hill. The Garden has many sister institutions that emphasize conservation and native plants, including the Lady Bird Johnson Wildflower Center (Austin, Texas), the New England Wildflower Society (Framingham, Massachusetts), the Rancho Santa Ana Botanic Garden (Claremont, California), and the Desert Botanical Garden (Phoenix, Arizona). The Garden's annual budget is provided by the State Legislature (50%), membership and fund raising (35%), sales and program receipts (10%), and

grants and contracts (5%). Our future development is almost fully funded by private donations, including our efforts to build a new Visitor Education Center and develop expanded gardens.

A new role for botanical gardens is being defined at the North Carolina Botanical Garden, a unit of the University of North Carolina at Chapel Hill. We call this "the conservation garden". What do we mean by this phrase?

There are two ways to answer this question. The first is to trace the history of our conservation programs. The connection between the Garden and the wild and rich plant diversity of the State started early with a focus on North Carolina's native wildflowers. And what a wildflower flora we have! Wild nature has always been the source of garden plants—and, in the 1970s, gardens, like zoos, were beginning to realize that they had an obligation to help protect the wild places and native plant diversity that give them the species to display to the public. The Garden started by popularizing the wildflowers and plant diversity in our landscapes. Because we did not want to damage wild populations, one of our first conservation programs was "conservation through propagation"—a program to show how to grow wildflowers from seeds to prevent collection pressure on wild populations. We led an effort to encourage the public to ask, when they bought plants, to make sure the plants were propagated and not dug in the wild.

We also developed programs in xeriscaping, ecoscaping, and zeroscaping. Xeriscaping is using plants that are tolerant of drought. Ecoscaping is planting with ecology in mind—plants put in the right ecological place in your yard to maximize success and reduce environmental costs of fertilizer and overwatering. Zeroscaping is to make use of the remnants of nature that maybe in your yard already—evaluating what is

there in the context of your landscape plan.

Soon we added other conservation programs. Many gardens thought of their undeveloped acres as blank spots on the map for future gardens, but we promoted the idea that nature's own gardens—wild nature—should be part of what gardens offered. Today we manage close to 700 acres of University land, complete with nature trails and educational programs, including the Mason Farm Biological Reserve, Coker Pinetum, and Battle Park.

We are also one the founding gardens of another conservation effort—the Center for Plant Conservation which is a nationwide federation of 33 gardens to protect germplasm (mostly seed) samples of endangered plants as a last resort against extinction in the wild—Noah's Ark in deep cold storage. But Noah got by with one male and female and worried only about 40 days of rain. We take a genetic sample of several thousand seeds and store the seeds for decades. We also use the seeds to help restore natural habitats in the wild.

Over the years, our conservation programs have grown and diversified. In the 1990s, we became one of the first gardens in the world to enact policies to restrict the distribution of potentially invasive plants. As a result we have won two national awards in the last year: a Program Excellence Award from the American Association of Botanical Gardens and Arboreta and an Award of Excellence from the National Garden Clubs, Inc.

At the beginning of this article I said there were two ways to define "conservation garden", so let me turn to the second way. Several years ago Bill McDonough, a leader in sustainable design, gave a talk at the Garden in which he said that all human activities should be discussed under five headings: Air (for air quality), Earth (for reuse, recycling and avoiding toxic materials), Fire (for energy conservation and renewable energy sources), Water (for water use and water quality, water being the life blood of all gardens), and Spirit (the spirit of all living things—at the Garden, the visitors, staff, volunteers, birds, butterflies and other living creatures). So McDonough gave us our second definition of the conservation garden: sustainable gardening as Air, Earth, Fire, Water, and Spirit. One of the exciting prospects at the Garden right now is the proposed Visitor Education Center, which will be a pioneering building in North Carolina for its "green" architecture. It has won an award from Sustainable North Carolina for its innovative design. We are at about 65% of the 7.1 million we need to begin construction, so keep an eye on this project over the next year or so. It will give us much needed facilities to do our important work.

At the North Carolina Botanical Garden we believe that gardens play an essential role—they create places we live and work and thus the human habitat. Gardens should also recognize the value of nature itself and present the interface between human-dominated places and human-dominated

## To Fund Mental Health Programs and Build the City Park “Have your cake and eat it too”

Our able colleague and regular WCP mental health columnist, Dr. Nicholas Stratas calls the North Carolina's mental health a non-system, non-program mishmash of adverse events that is in need of dire help. We agree.

Since the 1960s, in relative value, the funding of mental health programs in NC has declined drastically. With the proposed closing of Dorothea Dix Hospital (DDH) in 2007, our fellow citizens who need mental health care and in-patient treatment are left in the cold. We see these displaced patients in emergency rooms of area hospitals, on the streets and in county jails and prisons.

Earlier in 2004, we made a good case for transforming DDH land into a city park. Many citizens wrote and objected to the plan. These very wise and thoughtful advocates for the mentally ill strongly suggested that the 300 acres of land should be sold and the proceeds go directly to the care of mentally ill, funding programs that secure their future. The News and Observer columnist, Dennis Rogers, in a stirring piece (April 21, 2004) expressed his opinion that turning the DDH land into a city park is an opportunity of a life time, and an imperative for the city fathers. “Just imagine a spring day 10 years from now: Families stroll well-manicured paths that crisscross rolling hills. Horse drawn carriages carry lovers and tourists on winding roads beneath towering trees. Softball players, Frisbee throwers and kite enthusiasts dance in the sunny meadows. Over at the amphitheater, the symphony is preparing for an evening of music under the stars while picnickers find their favorite spot to kick back and listen to music...” wrote Dennis Rogers.

On the other hand, what about the displaced patients wondering the streets and filling ER's and jails? These patients used to be cared for at Dorothea Dix Hospital...

Frankly, I have been conflicted about these issues. Being an advocate of both, funding programs for the mentally ill and building a city park has become intolerable. I have been wondering how we can accomplish both missions. A city park, like Central Park in New York City will give Raleigh an identity and make our beloved city a destination.

But I agree with Raleigh Planning Director George Chapman that the task is complex. But I submit that the summit is surmountable and we can find a solution to the enormous problem of loyalty to the mentally ill and commitment to beautification of the city.

### Reflections

Here are some reflections: funding programs for the mentally ill is NC's covenant with its citizens which is enshrined in its constitution. Shirking that sacred duty and promise as we have done for the past 30 years is ethically bothersome and morally bankrupt. In the meantime, passing up the opportunity to turn DDH land into a world class park, like New York City's Central

Park, would be another unforgivable travesty that North Carolinians should not accept. We need the park to turn Raleigh into a destination where children can play, visitors bring their families and yes, developers can enjoy building attractive buildings around the park, just as developers did in 1870 after New York's Central Park was completed. This city park would give Raleigh the soul it so badly needs. It will give Raleigh an identity as an attractive city. Cities are like people. They can be caring, altruistic and beneficent to their citizens, or ugly and narcissistic and self serving. With the construction of this city park, Raleigh has an opportunity to become an altruistic city for all its citizens, young and old.

Earlier this year, I studied the feasibility of planning and constructing a city park. My thoughts are to develop a comprehensive plan for the space between DDH and Wake Med to involve development of southeast Raleigh. This would include Shaw and Saint Augustine Universities and housing and commercial establishments in that region. Since 1961, I have heard about developing southeast Raleigh. Yet there has been very little done. This is a good opportunity to advance that goal and offer the citizens of southeast Raleigh the break they have needed and asked for in the past 43 years. For this purpose, I made a substantial financial commitment to the city. I am happy to report that there are many friends and citizens who see the benefit of this proposal and are willing to contribute to that fund. While working on those plans, I also have thought about the plight of the mentally ill, and the need for our state to develop a comprehensive, sustainable source of revenue dedicated to the mentally ill.

Going against the eleventh commandment of the Republican Party, "Thou shall not raise taxes", I am proposing that the State tax the rich to support its mental health program. California has succeeded in passing Proposition 63, which will impose a tax surcharge of one percent on taxable personal income above one million dollars to pay for services offered through the state's existing mental health system. To pass such a law much leg work needs to be done, an infra-structure laid down, and coalitions developed. I have been closely watching and following the development of Proposition 63 in California since August 2004. A huge mixture of powerful alphabet soup lobby, consisting of the National Association for Mental Illness (NAMI), California Psychiatric Association District Branch (CPA), California's six major unions, AARP-California, The California Teachers' Association (CTA), along with American Medical Association, and American Psychiatric Association, just to name a few, participated in forming the Campaign for Mental Health (CMA). The initial initiative will raise \$700 million dollars this year. I submit that we start such a campaign today.



## Issues on Care at the End of Life

By Edward B. Yellig, MD, FACP  
Medical Director Hospice of Wake County

### Hospice 101 for Physicians

More and more physicians are becoming familiar with hospice services and the benefit to their patients. Physicians now understand how much hospice can help them directly as they care for patients at the end of life. As a result, referrals to Hospice of Wake County (HOWC) have increased in the last six months and our Hospice daily census has risen from 125 a year ago to the current level of 180 patients per day. This article is presented to review some of the essentials of hospice care including the opportunities and responsibilities of the attending physician as well as the billing procedures associated with hospice care.

To review: "Hospice is comprehensive and coordinated care for patients with limited life expectancy, provided both at home and in institutional settings. Hospice care is based on a "biopsychosocial" model rather than a "disease" model of care. The essential philosophy of hospice care is the focus on comfort, dignity, and personal growth at life's end. This encompasses biomedical, psychosocial, and spiritual aspects of the dying experience, emphasizing quality of life and healing or strengthening interpersonal relationships rather than prolonging the dying process at any and all cost. Hospice care also supports the well being of those (usually family members) in caregiving roles and provides bereavement care for survivors, both during the dying process and after the death occurs." (P. Fine, [www.medscape.com](http://www.medscape.com), 9/3/04)

Hospice of Wake County, like most other hospices, was created by a grassroots movement initiated by interested Wake County citizens including health professionals. Our country has seen the expansion of this movement through the creation of now over 3300 hospices serving over 950,000 patients in the last year of record, 2003. The Medicare Hospice Benefit (MHB), created in 1982, gave a needed boost to the awareness of the needs of the terminally ill by providing a financial mechanism by which patients can receive medical services. This benefit pays for all the costs attributable to the terminal diagnosis including durable medical equipment and medications and on-site nursing, social work, chaplain, home health aide, dietician, and appropriate physical therapy. Like most non-profit hos-

pices, HOWC is indebted to the many volunteers who help with the provision of care to these patients. Payment is made on a per diem basis to the hospice and must also cover all administration expenses and follow-up bereavement care to the family during the following 13 months after the death of the patient. Medicaid and most major medical insurance plans provide similar coverage for these services.

Eligibility criteria for these services are that a patient must be terminally ill with a life expectancy of 6 months or less if the disease follows its natural course, the patient must choose to receive hospice care rather than curative or life-prolonging treatments, and the patient must have Medicare Part A coverage. The 6-month expectancy certification is based on the combination of the physician's best clinical judgment and Local Coverage Determinations for Hospice Eligibility. These determination guidelines were developed by the National Hospice and Palliative Care Organization and are available in a down-loadable PDF format from the HOWC website, [www.hospiceofwake.org](http://www.hospiceofwake.org), to assist physicians in this type of prognostication. Contrary to popular belief, the MHB and HOWC do not require that patients have DNR orders in order to qualify for services.

It is worth noting that Medicare costs for patient care under hospice are generally lower than for a comparable population without hospice care. (Pyenson et al., *J Pain & Sx Mgt.*, Sept, 2004) It is also worth noting that terminally ill patients who receive end-of-life care from for-profit hospices receive a full range of services only half the time compared with patients treated by nonprofit hospice organizations. Bereavement services and the presence of volunteers were lacking in many for-profit hospices. (*Med. Care.* 2004; 432-38)

Most hospice referrals are made by physicians through their nurses or through social workers and discharge planners from the hospital. A handful of referrals come from families themselves. In both situations, the attending physician plays the key role in medical decision-making and becomes the quarterback of patient care management. The relationship between the attending and the hospice can best be compared to that with a hospital or nursing home:

orders come from the physician; they are recorded and carried out by a registered nurse, and then signed later by the physician, usually through fax communication. When a patient is admitted, he or she will be seen on a regular basis by the RN case manager, one to three times or more per week depending on the clinical stability of the patient. In those patients where critical changes are occurring more frequently, the nurse may see the patient once or twice daily. The RN case manager will usually report to the physician on a scheduled frequency requested by the physician. A group of professionals review the patient every two weeks in an Interdisciplinary Team Meeting consisting of a hospice physician, a pharmacist, and the patient's nurse, social worker, and chaplain. Deliberations from these meetings may result in recommendations to the attending for her or his approval. The hospice medical director may assume care for a patient at the request of the attending; however, hospices generally encourage the attending to maintain their relationship with their patient at this crucial time in the patient's illness.

While caring for the patient, the attending may continue to see her or him at home, in the nursing home and hospital, or in the office and then bill according to the standard evaluation and management (E&M) CPT codes. Four levels of hospice care are available: routine home care, continuous home care, respite care, and general inpatient care. Billing Medicare by the attending physician is done through Medicare Part B as opposed to billing for services by the hospice, which is through Medicare Part A. Payment for services is made directly to the physician at 80% of the Medicare reasonable charge. Hospice patients are responsible to the physician for the usual Medicare co-pay just as a non-hospice patient would be. Hospice programs must notify the Medicare Part B carrier that the physician has been

designated as the hospice patient's attending physician so that he or she will receive payment for submitted charges. Technical services, such as x-rays and laboratory tests, performed by a physician or other healthcare professional are covered in the program's per diem rate. (AAHPM Physician self-study Program, UNIPAC ONE, 2003) (See Table 1 below)

If the attending wishes to refer the patient to a consultant for evaluation and treatment of a condition related to the terminal diagnosis, approval must first be obtained from the hospice and the consultant must have a contractual relationship with the hospice, much like existing rules for other insurance agencies. The consultant then bills the hospice directly for services rendered. These methods of coding and billing largely prevent rejection of claims by Medicare and other insurance companies. Questions about billing problems should be brought to the attention of the CFO of the hospice.

The goal of hospice is to maximize the quality of living during the last stages of life. Although it emphasizes dying well, there is a strong emphasis on living well in the time that a patient has remaining. Singer and colleagues (JAMA. 1999; 281: 163-8) have identified 5 factors that terminally ill patients felt were most important in their care:

1. Relief from unpleasant symptoms
2. Avoidance of a prolonged dying process
3. Control over care decisions
4. Relieving loved ones of excessive burdens of care
5. Strengthening relationships with loved ones

The physicians who attend to the care of their patients at the end of life can make positive contributions not only to the quality of their patients' lives but also to the quality of the family's memories of the passing of their loved one.

		*Bill Hospice:	
		Hospice Bills	*Bill Hospice:
		Intermediary and	Covered under
Description of Service	Bill Medicare Part B	Reimburses Physician	Hospice Benefit per Diem
Attending Physician			
Professional services	v		
Covering (stand in) Physician			
Professional services	v		
Consulting Physician			
Professional services		v	
Hospice Medical Director (or other hospice physician)			
Professional services		v	
Administrative services			v
Technical services			v



# Physician Profile



Dr. Ng

## Godofredo (Fred) T. Ng, MD

By Peter Ng

Editor's Note: I have known Fred for many years. I have known him not only as a colleague, an able surgeon, a truly self-effacing benevolent and beneficent altruist who gives so much to his native country of Phillipines, but to his adopted community of Raleigh. He has been instrumental in many projects that have touched the lives of many, among them fulfillment of his dream to build a new Cardinal Gibbons High School in Raleigh. Fred is a giver. He is a generous man.

He has generosity of intellect, generosity of possession, generosity of time and generosity of the soul. He is truly a model citizen, a model child of God, a model child of humanity and love. So, with all this knowledge I have had of him, throughout the past ten years, the life of Wake county Physician, I have been trying to "corner" him to sit still long enough for me to interview him for a profile. He has been elusive, incredibly self denying and just unavailable for "that kind of thing."

Since his retirement, he is even more unavailable, because he spends so much of his time tending to the health care needs of his fellow country people in Phillipines. In desperation, we used a different angle, and that was approaching his very co-operative and gentle son, Peter, a practicing surgeon in Raleigh to assist us in profiling his father. We are indebted to Peter and his sister for the following profile.

Wake County Physician celebrates Dr. Fred Ng's generosity, altruism, and humanity. He is a role model for all physicians. He is a consummate example of priesthood of medicine. To Dr. Abu Ali Sina (Avicenna), Dr. Moses Maimonedes of Cordoba, Sir William Osler and that bunch who are eager to admit Fred to their exclusive midst, I say hold off, Fred has another 30-40 years here on earth to help his sick and suffering fellow beings.

Our father taught us that the strength of a man is not defined by the power that he commands. It is defined by the respect that he invokes.

For over 35 years, practiced as a General Surgeon in Raleigh, NC, and during that time, he earned great respect from his patients, colleagues, and community by serving as a skilled healer, understanding mentor and compassionate friend. As a physician myself, I strive to one day mirror my father's outstanding care and long-term dedication to his patients. Needless to say, few people fit in his shoes; but as far as shoes go, I figure these look like are good ones to try on.

After graduating from The University of the Philippines Medical School, Dr. Ng arrived in the United States in 1962 to complete his internship and residency training. He moved to the Raleigh area in 1967, and began his General Surgery practice as a staff physician with then-Wake Memorial Hospital. As Dr. Ng's practice evolved, he strongly supported the growth of community hospitals, such as Apex and Raleigh Community. As the founding partner of Wake Surgical Center, Dr. Ng relished his position as a community physician. His practice reflected his belief that medicine was a service, and that each patient deserved excellent care, generosity and courtesy.

As children, we not, perhaps not so fondly, remember my father being "on-call" 24/7. I remember him making the occasional house

calls, cheerfully taking patient calls at home, and even welcoming patient's questions while he stood in the grocery line. He was always happy to share his abilities, lend an ear, or give a much-needed hug. Patients and their families still stop me to tell me how much they appreciate my father's care... and his caring.

Dr. Ng retired in December 2003, but he is making no plans of slowing down in retirement. The skill and compassion that my father shared with his patients over his many years of practice continue into retirement, as he now devotes extraordinary time, effort and resources to the service and care of those less-fortunate.

In the early 1990's, Dr. Ng returned to the Philippines for two weeks as a volunteer with a medical mission. That mission experience triggered something great in him, and in 1993, Dr. Ng co-founded the Carolina Medical Mission (CMM). CMM, a humanitarian project of the Philippine-American Association of North Carolina, Inc., is an organization of dedicated professionals who are committed to serving the poorest of the poor in the Philippines. Since 1993, CMM volunteers have provided free Medical, Ophthalmic, Surgical, and Dental services to the many disadvantaged, health-impaired individuals in the rural areas of the Philippines.

During the past decade, Dr. Ng has traveled regularly to the Philippines and worked tirelessly on behalf of the mission and its patients, while balancing

his active General Surgery practice in Raleigh. Since his retirement, Dr. Ng has been able to devote more time to his mission work; in 2004, he spent five months of the year volunteering with the mission. My father and his mission colleagues have treated over 50,000 patients through the mission. Many of these patients are horribly disfigured from cleft palates and large goiters, or are affected by other serious and life threatening medical conditions. Dr. Ng not only serves in a medical capacity to CMM, but he also enthusiastically supports the mission through funding, through collection of donations, medical and surgical supplies, and through planning and coordination.

Fred Ng brings enthusiasm and sincerity to everything he does, whether it is in his humanitarian endeavors or in his "job" as grandfather to six spirited grandchildren.

His strength of heart and spirit inspires people to do their best. He deserves the recognition and respect he has earned as a physician, a father, and one who has contributed to humanity in a lasting and important way. As a leader, physician, mentor, and friend, his footprints have cleared a wide path and marked a road worth following. That is the pathway of caring, of seeing the human behind the suffering, and of understanding that no one person is better or more important than another.

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## Botanical Garden continued.

ones. We can make them support both people and nature.

Our mission reflects this idea: To inspire understanding, appreciation, and conservation of plants in gardens and natural areas and to advance a sustainable relationship between people and nature.

We have wonderful plant collections at both the Garden and at the Coker Arboretum on the main University campus, miles of nature trails, Battle Park, and Mason Farm Biological Reserve. We have plant sales, educational exhibits, and programs to take in everything from home gardening and landscaping to ecology and plant illustration. Come enjoy the Garden and our educational programs. For hours, directions, membership, volunteer opportunities, and contact information visit our web site: [www.ncbg.unc.edu](http://www.ncbg.unc.edu).

*Peter White received his BA from Bennington College and his PhD in plant ecology from Dartmouth College. He served as a post-doctoral fellow at The Missouri Botanical Garden and as a Research Biologist for Great Smoky Mountains National Park before moving to the University of North Carolina at Chapel Hill in 1986. He has published many scientific papers and a popular book, "Wildflowers of the Smokies" (Great Smoky Mountains Association) which was given an award as the best book on the natural history of our National Parks in 1996. He is editor of the Journal of Vegetation Science and serves as Chair of the All Taxa Biodiversity Inventory in Great Smoky Mountains National Park.*



Marc Benevides MD

## Medical Liability Reform 101 A History Lesson from California

As a result of an explosion of rampant litigation and astronomical jury awards in the early 1970's, California physicians banded together to advocate for legislative reform. Between 1965 and 1971, California physicians saw liability premiums escalate by 400 to 600 percent. As a result of their grass root effort, the Medical Injury Compensation Reform Act was passed in 1975. After a decade of bitter battles in the courts, MICRA's medical tort reforms were upheld by the California Supreme Court in 1986.

The key provisions of MICRA include:

- A limit of \$250,000 on non-economic damages (pain and suffering)
- Disclosure of collateral source payment (such as personal health insurance)
- Limits on attorney contingency fees
- Periodic payments of damages (vs. lump sum payment)
- Binding arbitration of future disputes
- Requiring plaintiffs to provide 90 days notice before filing suit (in hopes of encouraging settlement)

Has MICRA worked for California over the last 20 years? According to a study released last summer by the nonprofit, nonpartisan RAND Institute for Civil Justice, MICRA's cap on non-economic damages resulted in a 30% decrease in awards for cases that went to trial from 1991 to 1995. The study obtained its data from examining a large number of malpractice cases and the final settlements and is available on-line at [www.rand.org](http://www.rand.org). The study also showed that patients were not seeing a 30% reduction of the rewards. An important aspect of MICRA is the limit on attorney fees. A combination of awards cap and attorney fee limits decreased attorney collection by 60%. Consequently, the plaintiff only realized a 15% reduction in awards for pain and suffering. After the MICRA reductions, the total awards in most cases were still more than one million dollars.

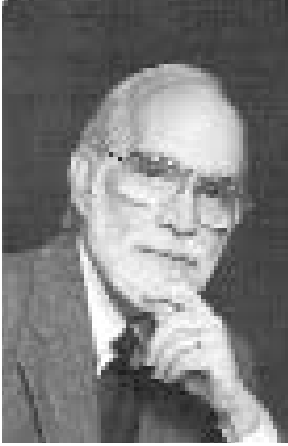
MICRA has prevented medical liability premiums from skyrocketing in California. For example, rates for obstetricians and gynecologists in Pennsylvania have increased 165% between 1999 and 2002. In California, the average increase has been only 9% in the same specialty. (AP 7/29/3) According to an article in the Charlotte Observer in 2003

(6/15/2003), the US Department of Health and Human Services reported that since MICRA was passed liability premiums have increased 167% across the board for all California physicians compared to a national average of 505%. Another advantage is the speed at which disputes are settled in California. Medical malpractice cases are settled an average of 23% faster in California at a reduced cost of 53% lower than the national average.

An important issue in North Carolina is the loss of physicians, particularly specialists in rural areas, due to the expense of malpractice premiums. With 65 of North Carolina's 100 counties considered rural, malpractice woes echo as loud in smaller communities as in urban tertiary care centers. A telling example is the currently available obstetric care for pregnant women in Lincoln County. According to the Lincoln Times-News in November 2004, one of the two obstetricians in the county will no longer treat women past 14 weeks pregnant. Dr. Bernice Redmond was forced to stop delivering babies when her insurance premiums increased to \$61,000 a year. Between 1999 and 2002, the growth rate of specialty physicians in rural counties increased 1.3% while the growth of the general population in rural NC increased 7.1%.

What are we doing about medical malpractice reform in NC? In 2003 the Senate passed a diluted bill that would have done little to address the underlying problems. Democratic Senators watered down the bill's reforms and House Democrats allowed the bill to die. Senate Bill 44 was recently introduced by Republican Robert Pittinger in late January with bipartisan support. This bill currently addresses Non-Economic damages and sets limitations on contingency fees. Another key provision requires plaintiffs to file a report by a medical expert stating that the patient has legitimate grounds to move forward with litigation. Unfortunately, reform will be a long, hard fought battle that has just begun.

Marc Benevides MD  
North Carolina Urological Associates  
226 Ashville Ave  
Cary, NC 27511



Dr. Stratas

## ANTIDEPRESSANTS and YOUTH SUICIDE

Antidepressants for young people can be extremely helpful as part of a comprehensive treatment plan where the driving treatment is psychotherapy for the individual child and with the child's family. Suicide is a significant risk of depression. Suicide rates in children have

dropped since the advent of the antidepressants. The biggest threat to a depressed child's well-being is to receive no care at all. The recent "black box" warning of the FDA has already lowered treatment rates. Patients currently being treated successfully should not stop taking their medications and certainly not without close collaboration with the physician. Abrupt cessation of the antidepressants can compound the problem. Indeed treatment of children with antidepressants should only occur after the diagnosis of depression is made and must include close monitoring by physicians and families which is needed for depressed children regardless of whether antidepressants are used. Nicholas E. Stratas, M.D.

In response to requests that I expand on my letter to the editor, the number of suicides among 10 to 19 year olds has actually decreased in areas where prescription of antidepressants (ADs) has increased.

The FDA issued a public health advisory warning of increased risk of suicidal thinking and behavior in children or teenagers taking ADs. FDA will require a strong cautionary package labeling. They also directed manufacturers to add a "black box" warning to describe the risks and the need for close monitoring. This applies to all ADs new and old because data analyses did not suggest that any ADs were free of the risk. FDA is developing a medication guide to be given to patients with each prescription or refill to advise of risks. They will prescribe frequency of visits following initiation of ADs - weekly the first month, two times a week for a month and again at the 12th week and more often if there are questions. They reference a large study which "combined the results of 24 different smaller studies" of 5,000 children and teenagers "who took either sugar pills or ADs for one to four months". They note "Although no one committed suicide in these

studies, some young patients had suicidal thoughts. On sugar pills, 2 out of every 100 became suicidal. On the ADs 4 out of 100 young patients became suicidal." FDA reasoning may well be that if the rate of improvement in depression with ADs is not much above the already high rate of response that young patients show with placebo, then why take even a small potential risk of a bad outcome?

In the October, 2003 issue of the Archives of General Psychiatry Olfson et al report an analysis of prescription data of the nation's largest pharmacy benefit management organization, national suicide mortality files, and regional socio-demographic data from the 1990 and 2000 U.S. Census and regional data on physicians per capita. Participants studied were youth aged 10 to 19 years who filled prescriptions for ADs and same aged completed suicides from 588 ZIP code regions in the United States. There was a significant adjusted negative relationship between regional change in AD treatment and suicide. Increased use of ADs was associated with a decrease of suicides. Also, a report from the CDC cites suicide rates for adolescents (15 -- 19 year-old) dropped from 11.1/100,000 in 1990 to 7.4/100,000 in 2002 -- a reduction of over 30%. Verbal report, to me from David Fassler, that in 8,000 children in 150 schools in Vermont, children reporting they made a suicidal plan is down from 22% in 1995 to 13% in 2003.

Interesting counterpoint is provided by Webster et al, in JAMA, August 2004, that decline in suicide rate among adolescents coincides with decline in fire arm access after child access state laws and following federal assault weapon ban act of 1994. The declining rate is entirely due to suicide by fire-arms and, 60% of adolescent completed suicides are due to fire arms. Suicide rate had been on the rise since the mid 1980s and peaked in 1994. Prozac was launched in 1986 and suicide rate is only down post 1994.

However SSRI and SNRI ADs are very safe and effective. In TADS (Treatment for Adolescent Depression study) Prozac if combined with CBT (Cognitive Behavioral Therapy) is safe and effective. Risk of completed suicide is very low. Are we better at recognizing depression in children and adolescents and more are getting treatment? Rate of suicide in untreated depression is 10%.

In the FDA list of ADs below, I have noted in parentheses their classification: tricyclics (TCA) and tetracyclics (TetraCA) named so

because of their three or 4 ring chemical makeup; selective serotonin reuptake inhibitors (SSRI) named because of their action of enhancing levels of this chemical messenger in the brain; selective serotonin noradrenalin reuptake inhibitors (SNRI) named because of their action of enhancing levels of both serotonin and noradrenalin in the brain; monoamine oxidase inhibitors (MAOI) named because of their action of inhibiting the enzyme monoamine oxidase. TCA's are highly lethal because of their cardiotoxicity and it was common in the past to have young people in emergency rooms in a critical condition with overdose. MAOI's are potentially fatal, in certain medical conditions, in combination with several other drugs including TCA's and in combination with cheese or other foods with high tyramine content. Because of these problems the SSRI's, SNRI's and Wellbutrin are now most commonly prescribed.

Currently, Prozac (fluoxetine) is the only medication approved by the FDA to treat major depression in children and adolescents. Prozac, Zoloft (sertraline), fluvoxamine maleate (Luvox), and Anafranil (clomipramine) are approved for obsessive-compulsive disorder in pediatric patients. None of the other ADs is approved by the FDA for treatment of any psychiatric condition in children. Not too widely known, the last American Psychiatric Association guidelines for the treatment of depression recommend lamotrigine, an anticonvulsant as first line treatment for adults with recurrent depression in addition to the SSRIs.

FDA uses the general term "antidepressants" to include combination drugs with an AD component.

Anafranil (clomipramine HCl) TCA  
Aventyl (nortriptyline HCl) TCA  
Celexa (citalopram HBr) SSRI  
Cymbalta (duloxetine HCl) SNRI  
Desyrel (trazodone HCl) SSRI  
Effexor (venlafaxine HCl) SNRI  
Elavil (amitriptyline HCl) TCA  
fluvoxamine maleate TCA  
Lexapro (escitalopram oxalate) SSRI  
Limbital (chlordiazepoxide/amitriptyline HCl) TCA  
Ludiomil (maprotiline HCl) TetraCA  
Marplan (isocarboxazid) MAOI  
Nardil (phenelzine sulfate) MAOI  
Norpramin (desipramine HCl) TCA  
Pamelor (nortriptyline HCl) TCA  
Parnate (tranylcypromine sulfate) MAOI  
Paxil (paroxetine HCl) SSRI  
Pexeva (paroxetine mesylate) SSRI  
Prozac (fluoxetine HCl) SSRI



Dr. Engel

## Trends in Sexually Transmitted Diseases: New Treatment Recommendations for Gonorrhea

Gonorrhea and chlamydia remain the most commonly reported communicable diseases in North Carolina. Preliminary numbers for 2004 show over 15,000 and 29,000 new cases reported respectively, which represents case-rates of nearly 200 and 400 per 100,000 population.

The 6-year trend for gonorrhea case-rates in the United States, North Carolina, and Wake County is shown in Figure 1. By region, the southeast United States remains the highest in gonorrhea incidence. In 2003,

Figure 1

North Carolina reported the 7<sup>th</sup> highest rate in the nation at 181.7 cases per 100,000 population. From 1998 to 2002, Wake County experienced a steady decrease in incidence, but 2003 case counts returned to the 2001 level and slightly exceeded the state rate for the first time since 1998.

Since the early 1990s, a single dose of an oral fluoroquinolone, such as ciprofloxacin, was the treatment of choice for uncomplicated gonorrhea of the cervix, urethra, and rectum in non-pregnant adults. However, data from the Center for Disease Control and Prevention (CDC) Gonococcal Isolate Surveillance Project (GISP) has shown a disturbing and striking increase in the incidence of fluoroquinolone-resistant gonorrhea, especially prevalent in men who have sex with men (Figure 2).

Figure 2

The 3-year GISP data trend for 2001-2003 for the United States showed a 10-fold increase from 1.5% to 15% in men who have sex with men. Even in heterosexuals, the ciprofloxacin-resistance rate climbed 3-fold from 0.5% to 1.5%.

On January 27, 2005, the HIV/STD Prevention and Care Branch of the North Carolina Division of Public Health officially changed its treatment regimen for uncomplicated gonorrhea from ciprofloxacin to cefpodoxime, an oral broad-spectrum cephalosporin. Beginning February 1, public STD clinics participating in the state drug shipment program began receiving cefpodoxime.

According to Peter Leone, M.D., Medical Director of the HIV/STD Prevention and Care Branch, the decision to switch from ciprofloxacin to cefpodoxime for all uncomplicated gonorrhea cases in North Carolina differed from the current CDC guideline that still allows fluoroquinolone treatment in heterosexuals. Because fluoroquinolone-resistance is likely to increase over time in heterosexuals, and sexual orientation is unreliably ascertained in many clinical settings, North Carolina decided not to recommend sexual orientation specific treatment for gonorrhea.

Two other reasons were cited for the drug switch policy. Because gonococcal infections are frequently asymptomatic, especially in women, monitoring for symptomatic treatment failures alone does not provide a reliable indication of antimicrobial resistance. Secondly, most clinics have only nucleic acid detection methods for diagnosis of gonorrhea, whereas culture methods are required to monitor and document antimicrobial resistance.

The new gonorrhea treatment recommendations and test-of-cure indications for North Carolina are summarized in the text box.

1. Avoid the use of fluoroquinolones (ciprofloxacin, ofloxacin, and levofloxacin) to treat gonorrhea in North Carolina.
2. The antibiotics of choice to treat uncomplicated gonococcal infections of the cervix, urethra, and rectum include:
  - Ceftriaxone** 125 mg intramuscularly in a single dose;
  - OR
  - Cefpodoxime** 400 mg orally in a single dose;
  - OR
  - Cefixime** 400 mg orally in a single dose<sup>1</sup>
3. Alternative antibiotic regimens for the treatment of uncomplicated gonococcal infections of the cervix, urethra, and rectum include:
  - Single-dose injectable cephalosporins:
  - Ceftizoxime** 500 mg intramuscularly,
  - Cefoxitin** 2 g intramuscularly with **Probenicid** 1 g orally,
  - Cefotaxime** 500 mg intramuscularly;
  - OR
  - Spectinomycin** 2 g intramuscularly in a single dose<sup>2</sup>;
  - OR
  - Azithromycin** 2 g orally in a single dose;
  - OR
  - Cefuroxime axetil** 1 g orally in a single dose
4. The antibiotics of choice to treat gonococcal infections of the pharynx include:
  - Ceftriaxone** 125 mg intramuscularly in a single dose;
  - OR
  - Azithromycin** 2 g orally in a single dose
5. For patients with significant anaphylaxis-type (IgE-mediated) allergies to penicillin, where the use of cephalosporins is a concern, or patients with allergies to cephalosporins:
  - Spectinomycin** 2 g intramuscularly in a single dose;
  - OR
  - Azithromycin** 2 g orally in a single dose;
  - OR
  - A fluoroquinolone (ciprofloxacin, ofloxacin, and levofloxacin) with a test-of-cure

**TEST-OF-CURE INDICATIONS**

# A shot of medical history with a twist or an olive!

By David Rendleman, MD, Orthopaedic Surgeon

## Absinthe... The Fuel of the Belle Epoch

*(This effort is an off shoot of the Toulouse-Lautrec piece of a few issues ago)*

In my research of Toulouse-Lautrec I became curious about the drink that seemed to influence many of the artists, authors and entertainers of the time. The list of Absinthe users (and some of their works) included:

- Edouard Manet (The Absinthe Drinker)
- Charles Baudelaire
- Paul Verlaine ("For me glory is an Humble ephemeral absinthe drunk on the sly, with fear of treason and if I drink it no longer, it is for a good reason.")
- Honore Daumier (Absinthe Lithographs)
- Oscar Wilde ("After the first glass you see things as you wish they were. After the second, you see things as they are not. Finally you see things as they really are, and that's the most horrible thing in the world.")
- Edgar Degas (L'Absinthe)
- Vincent Van Gogh (Still Life with Absinthe)
- Paul Gauguin
- Pablo Picasso (Harlequin and his Companion, The Absinthe Drinker)
- Ernest Hemmingway ("Got tight last night on Absinthe. Did knife tricks.")

Many of the pieces of art reflect the café society in which the drink was consumed. The actual mechanics of consuming the beverage became part of its mystique. Absinthe was known as la Fee Verte; or The Green Fairy. The waiter usually brought the bitter green beverage in a clear glass. The consumer then poured cold water over a sugar cube held in a slotted spoon over the liquid. This turned the drink from emerald green to an opalescent white as the oils precipitated out. The drink was then slowly sipped over an hour or so. The effect was a slowly advancing calm euphoria in which the senses seemed to awaken.

The effects of the drink on creativity are still being debated; it was certainly addictive.

The main ingredient, and some say the only active component, is alcohol. Undiluted, absinthe is 75% ethanol. Although a few could take large quantities neat, most did dilute this sub-

stance. This has led to the belief that other ingredients are responsible for it's unique effect.

The ingredient most suspect is thujone. This chemical is extracted from the wormwood plant. Both the extracted thujone and wormwood plants are known to have psychoactive as well as epileptogenic and analgesic effects. Wormwood has been smoked, chewed and otherwise consumed by many cultures and has biblical references. Vermouth, from the German wer-muth is an example. A theory that this molecule attached at cannabinibis receptor sites has been disproven.

In reality, the alcohol probably limits the amount of thujone that can be consumed at one sitting to very low levels. Pharmacologically, this works out to far less thujone consumed than can be shown to demonstrate any effect in experiments on rats. Chronic use is another matter. Thujone doses accumulated it's long-term effect has not been measured. There is not much good science on this substance and it can neither be confirmed nor denied that thujone is the active ingredient responsible for the special effects. There are many other substances in absinthe that have never been studied. It is conclusive that absinthe, chronically used, is toxic. Whether or not it lends to creativity is speculation. It was certainly embedded in the bohemian culture adopted by many of the creative people of the time.

Chronic use of absinthe became a significant problem in the late 1800s. A syndrome termed absinthism was known to include addiction, seizures hallucinations, dementia and violent acts. Awareness of the problem gradually spread and became a political issue across Europe.

In France, wine was considered a healthy habit. Belief at the time had it that wine would not cause alcoholism. Wine was also economically important and well entrenched in the French culture. The target of prohibition became absinthe and ultimately led to near universal ban in the early 1900s.

If you're interested, you can get some next time you're in Prague. I must warn you of a little-known fact about Prague. That city leads the world in defenestration. Make someone unhappy in a bar in Prague you are more likely to be thrown out of a window there than anywhere in the world. Now that's creativity.

Remeron (mirtazapine) SNRI

### Mental Health Corner continued

Sarafem (fluoxetine HCl) SSRI

Serzone (nefazodone HCl) SSRI

Sinequan (doxepin HCl) TCA

Surmontil (trimipramine) TCA

Symbyax (olanzapine/fluoxetine HCl) SSRI

Tofranil (imipramine HCl) TCA

Tofranil-PM (imipramine pamoate) TCA

Triavil (perphenazine/amitriptyline HCl) TCA

Vivactil (protriptyline HCl) TCA

Wellbutrin (bupropion HCl) unknown

Zoloft (sertraline HCl) SSRI

Zyban (bupropion HCl) unknown

It is well known that depression carries with it the risk of suicide. It is also well known that ADs of all kinds, particularly early in treatment may increase the risk of suicide. Patients who have been too depressed to act may be energized sufficiently

to carry out a suicide plan. Did the AD cause the suicide? Is the suicide the inevitable outcome of some improvement in the illness? Although the medication has been faulted, these questions are not yet answered.

The majority of ADs are written by non-psychiatrists. It is important to note that some children and teenagers may experience agitation and increased behavioral activity with ADs. They may exhibit restlessness, irritability, anxiety or mood instability. As well, ADs can sometimes precipitate emergence of bipolar disorder. The patient may be seen to swing from depression to euphoria and hyperactivity and it is important to make the appropriate diagnosis.

The bottom line is suicide planning and suicide in youth have decreased, ADs have

shown some efficacy, and more so with CBT and increased vigilance in diagnosis and monitoring of treatment must occur. One child psychiatrist I know will spend more time with parents to provide an accurate risk-benefit discussion before use of ADs. He will discuss and continue to do so, emergency plans if parents suspect suicidality. He will vigorously try to prevent access to firearms in the households. He will ask for weekly contact and will follow for side effects and suicidality. He will recommend CBT in addition to ADs in youth who are suicidal.

*Questions, suggestions and comments are welcome. Nicholas E. Stratas, MD, DLFAPA c/o Raleigh Psychiatric Associates, 3900 Browning Place, Raleigh, NC 27609, Tel: 9197877125; Fax 9197819952; e-mail: <stratas1@mindspring.com>*

# Patrick Henry: His Legacy and the National Memorial at Red Hill

By Thomas Gregory Ward, President Patrick Henry Memorial Foundation Board\*

Do you remember Patrick Henry and his contributions to democracy in America? I hope you do, but it is amazing how many people do not. Polls show that Henry, George Washington, Benjamin Franklin, James Madison, George Mason and others are slipping out of our cultural memory. Jefferson seems to be the only one that continues to have wide recognition.

As president of the Patrick Henry Memorial Foundation that owns and runs Red Hill, the National Memorial to Patrick Henry in Brookneal, Virginia, I spend days volunteering to keep Henry's ideas and legacy alive and working with a national board of trustees. The foundation is a non-profit corporation that receives no funding from the State of Virginia or the federal government. Through donations, a large group of local volunteers and a small staff the foundation maintains archives, presents Henry artifacts in a state-of-the-art museum, conducts research, publishes a quarterly newsletter, develops educational material and provides tours of the rural plantation: Red Hill Patrick Henry's last home and burial place. A website, [www.RedHill.org](http://www.RedHill.org) enhances the reach of the foundation to a national audience.

Most people that know of Henry associate him with the "give me liberty or give me death" lines from his speech before the Virginia Convention in Richmond, Virginia on March 23, 1775. Arguing in favor of his resolutions to form a militia to defend Virginia against the gathering forces of the crown, Henry made the case for fighting to protect liberty—to protect the power of independent men to rule themselves. Many think that this is one of the most important speeches the world has ever heard and that it set the stage for the American revolution.

Henry's boldness and ideas on self government were not new to Henry in 1775. Earlier, in the 1763 Parson's Cause case, Henry had the same boldness. King George II had sided with the clergy in their efforts to increase the tax on tobacco sales that had been set by law in 1758. In the historic and precedent setting case, Henry railed against efforts by the clergy and the king to raise the tobacco tax without submitting the new tax to the House of Burgesses. In winning this case and thwarting the effort to change established law without following regular processes, he became a hero to the common man. Henry's advocacy of the idea of a mutually-agreed-to compact between the king and the people, set the stage for subsequent refusals by the colonists to obey laws that did not respect the rights of the crown's American subjects. His victory in the Parson's Cause began Henry's rise to fame and leadership in pre-Revolutionary America.

Similarly, the same views on self government were evident when Henry opposed the Stamp Act in 1765. As a new member of the House of Burgesses, Henry presented resolutions against the new stamp tax that had been enacted by the British Parliament without any representation by the colonists. In essence the resolutions restated the colonists right to govern themselves and make their own laws, rights that Henry felt were their legacy as Englishmen. The resolutions spread throughout the colonies and the Stamp Act was repealed. But in spite of the king's conciliation, the fires of independence were kindled. Henry's fame as an orator spread to all of the colonies and he established his position as a champion of the right of the colonists to govern themselves.

A little known indicator of Henry's deeply felt philosophy about individual rights appears in his defense of freedom of religion in the 1770's. A new brand of Christianity was sweeping through Virginia—the Baptists had arrived. Holding tent meetings and ignoring traditional practice, they preached from any stage and welcomed everyone, including poor people and slaves.

Fearing that the Baptists were threatening the established order, local leaders tried to silence their message and their messengers. Preachers were mauled, beaten and jailed for practicing their emotional brand of Christianity. In defending the Baptists and going against the mood of his upper class associates, Henry furthered the cause of religious freedom.

Henry's love of liberty and the sanctity of the natural right of free people to govern themselves remained central to his political philosophy until his death. His devotion to liberty was at the core of his arguments against the ratification Constitution in 1788. During the Virginia ratification convention he stated over and over his fear that too much power had been given to the central government without the necessary guarantees of individual rights. His arguments along with those of George Mason and others in Virginia and throughout the colonies—including North Carolinians—insured that a Bill of Rights would be added to the Constitution. He lost the debate on ratification when Virginia ratified in a close vote—89 for, 79 against. But the power of his political philosophy and his dynamic oratory were key factors in establishing government as we know it today. In my view his advocacy and personal support for the Bill of Rights are his greatest legacy. His arguments during the ratification debates give the clearest and most well developed record of his political philosophy.

I invite all readers to visit Red Hill in Brookneal, Virginia. See the largest collection of Henry artifacts in the world and stand before Rothermel's 1851 magnificent history painting Patrick Henry Before the Virginia House of Burgesses presenting the Stamp Act resolutions. Delve deeper into Henry's ideas and legacy. Learn about the operation of his plantation and how it developed under the ownership of his descendants until 1944 when the Patrick Henry Memorial Foundation was founded. Visit his grave, law office, reconstructed house, other reconstructed dependencies and remnants of original structures.

But just as exciting as the intellectual experience at Red Hill is the step back in time to a bygone era. Upon arriving at the historic site, the calm quietness of the rural setting slows the heart beat and induces tranquillity. With few intrusions from the 20th century—most notably a railroad track from the 19th century with its stone and iron whistle-stop gate, a visitor enters the world that Henry knew. The rolling hills looking down to the Staunton River, the open fields that were tended by the plantation slaves and the wonderful vistas that led Henry to call this place "one of the garden spots of the world." capture your mind and allow you to escape from the hustle and bustle of modern life.

The foundation's 600 acres, part of the original plantation's original 2,900 acres, allow for peaceful communing with nature along trails through fields and forests with abundant native plants and animals. Come to Red Hill, the National Memorial to Patrick Henry and step back in time. Experience the back country that was his home. Learn more about the man about whom Thomas Jefferson said "It is not now easy to say what we should have done without Patrick Henry...He was before us all in maintaining the spirit of the Revolution."

If you happen to be a descendant of his many children, join the Descendants Branch of the foundation, an independent organization that brings together people from all over the country to remember his legacy and strengthen family ties. If you need to check out your ancestry, the foundation's genealogist can help you.

And now in the privacy of your home, around the dinner



By George M Stephens

## WILL IN THE WORLD How Shakespeare Became Shakespeare By Stephen Greenblatt

W.W. Norton & Company  
New York, London, 2004, \$26.95

"This is a book, then, about an amazing success story that has resisted explanation: it aims to discover the actual person who wrote the most important body of imaginative literature of the last thousand years . . . to tread the shadowy paths that lead from the life he lived into the literature he created." So says Stephen Greenblatt, distinguished Shakespearean scholar at Harvard University who has written eight books about the man and his world and edited six others.

Many scholars wrote about the great playwright. "Already in the nineteenth century, Greenblatt explains, there were fine, richly detailed, and well-documented biographies, and each year brings a fresh crop of them . . . (yet) readers rarely feel closer to understanding how the playwright's achievements came about . . . nothing of the kind survives, nothing that provides a clear link between the timeless work with its universal appeal . . . work so astonishing, so luminous that it seems to have come from a god and not a mortal, let alone a mortal of provincial origins and modest education." His purpose was to explain "How Shakespeare Became Shakespeare."

"Nothing provides a clear link," says Greenblatt, so his technique involves considerable highly-educated guessing, e.g. **may** have witnessed a certain execution, **may** have lived for a while in Lancashire where he **may** have been under Catholic influence. Almost every paragraph contains this kind of conjecture, on which, along with facts, the author builds his case about how the playwright's life and works were shaped, and because of his expertise he **may** be correct. Another technique is quoting lines from the plays which illustrate the biographer's points.

To help his readers "discover the actual person," "tread the shadowy paths" and understand the playwright's achievements Greenblatt describes Elizabethan England's society, economy, politics and church-state relations. It is not a broad-brush history, but a detailed description of the influences which bore on Shakespeare in the area in which he lived, principally Stratford

in the Midlands and London.

Will was the eldest son in the large family of a glover and his wife who could read but not sign their names, yet they had Will learn Latin to help mark him as a gentleman, and they bought a coat of arms. Even so, he was at a social disadvantage later with university educated poets. Greenblatt cites passages in several of his plays in which characters comment on their status or that of others to illustrate that his own bothered him.

Actors were important in the entertainments of the time, principally in presenting morality plays. The troopers were licensed and supported by important noblemen to avoid being labeled vagrants while on tour. Elizabeth visited the Stratford area several times, which required plays and players for her pleasure, though Will Shakespeare did not perform before her when she was there. Her favorite, Robert Dudley, Earl of Leicester, whose estate was near Stratford, incurred heavy financial burdens in hosting her.

She was the daughter of Henry VIII, who had broken with the pope, and she succeeded her Catholic sister, Mary Queen of Scots. The doctrinal battles were fierce, and doctrine and adherence to it were written into law. Shakespeare came from a divided family with a Protestant father and a Catholic mother, so great care was taken to maintain a safely Protestant appearance.

The state ruled the Church of England, and there was no tolerance for Catholics. Priest Thomas Cottam, for example, was tortured with a hoop of iron which bent his spine almost double. He did not reveal enough to warrant an immediate trial, so he spent a year in the Tower of London. He was executed by the common procedure of being dragged on a hurdle to Tyburn where he was hanged, taken down while still alive and castrated. His stomach was opened and his intestines burned before his eyes, whereupon he was beheaded and his body cut in quarters, the pieces displayed as a warning. Heads were often mounted on pikes. Shakespeare may have witnessed this execution and almost certainly heard about it.

Shakespeare's religious credentials were safe enough to allow him to depart Stratford for the big city in the mid-1580s, leaving his wife, Anne Hathaway, and their daughter. He began as an actor but turned increasingly to writing plays, and professor Greenblatt believes that he never grasped that print would be his road to fame even though folios of his works were published and were popular in his lifetime.

Will Shakespeare became celebrated and influential, so much so that the author thinks that Macbeth was written to make King James feel secure about his ancestry. His celebration also meant he was wealthy enough to buy real estate in Stratford and to become an investor in the Globe Theatre in London. He retired to Stratford about 1611 where, consistent with his neglect of Anne during his years in London, he spent most of his time with his daughter Suzanna.

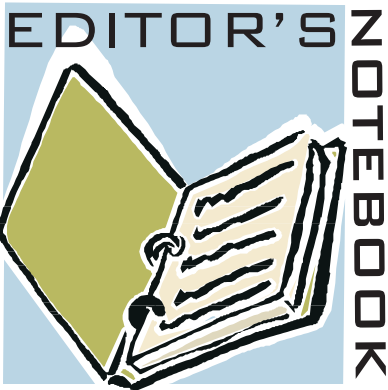
Will in the World is a mixture of fact and shrewd speculation. The latter is at once the book's strength and its weakness. It likely is correct, but it is not fact. Despite it, and because of it, this book enriches the lore of Shakespeare.

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table or when you visit Red Hill, reflect on Henry's final admonition. "(Whether America's independence) . . . will prove a Blessing or Curse will depend on the Use our people make of the Blessings which a gracious God hath bestowed on us. If they are wise, they will be great and happy. If the are of a contrary Character, they will be miserable. Righteousness alone can exalt them as a Nation. Reader! whoever thou art, remember this, and in thy Sphere, practice Virtue thyself, and encourage it in others."

*Address: Red Hill, Patrick Henry National Memorial, 1250 Red Hill Road, Brookneal, Virginia. 1-800-524-7463. www.RedHill.org. Red Hill is about two and one half hours from the Triangle. Take Route 501 through Durham and Roxboro through South Boston to Brookneal and follow the signs for about 5 more miles.*

*Thomas G. Ward is a retired education consultant. He and his wife Mary live in Raleigh*



By Assad Meymandi, MD, Ph.D.,  
DLFAPA

## Examining the Ethics of the Internal Operation of NCPA

It is disheartening to hear the President-Elect of the American Psychiatric Association to confess that the APA is in bed with the drug companies. It is unconscionable to learn that

over one third of the APA's annual budget is paid by the revenues from drug companies' advertising in APA's various publications. On the local scene, I attended the annual meeting of the North Carolina Psychiatric Association (NCPA) in Charlotte. The drug companies, as usual were pushing their products by feeding the herd breakfast, partially underwriting the cost of the meeting and pushing cups, pens and notepads.

APA and NCPA do have ethics committees. Perhaps the mission and the charge of the ethics committee should be revisited. Freud was an expert in advancing the knowledge of introspection and intrapersonal examination. The ethics committee of NCPA ought to engage in examining its own conduct. I submit that being in bed with drug companies is unethical. I want to focus on the conduct of NCPA. I submit that NCPA should examine the practice of accepting sponsorship from drug companies. This practice is abominable, hypocritical and should be unacceptable to membership of NCPA. The present practice is tantamount to a commercial bribe by, and consequent servitude to, the drug companies.

I know that the cost of running an office is high and increases each year. I know that "drug money" is necessary to balance the bottom line. I also know that dependence on drug companies has been traditionally accepted. To my knowledge it has never been questioned. It is analogous to the patient I saw not long ago who engages in prostitution "to make money so I can feed my kids."

But I submit that it is a wrong tradition. It is an immoral tradition. It is an unethical practice and we should discontinue it.

Then, how do we pay the bills? I suggest that NCPA mount a capital campaign to raise a few million dollars. Form a not for profit foundation with 501C-3 status. Use the foundation as a financial instrument to invest the money, never touch the corpus and use the interest to defray the cost of the annual operation. Such foundation needs to have a governing body apart from the present structure of NCPA Executive Council. The Foundation becomes the "Savings" account of NCPA, and the annual budget takes the form of the "checking" account. Their need to be strict accountability, auditing and a bit of creative tension between the governing board and the foundation board is healthy and productive. Besides, I know that most doctors can buy their own breakfasts, pens and notepads.

## Stemming a Shortage

Reprinted by permission from the News & Observer

The scientific papers are reporting that German surgeons have successfully used stem cell from a 7-year-old girl's fat to help repair severe damage to her skull.

Using fat as a source of harvesting stem cells is very good news for America. We have plenty of it!

## Thirst for Money is Robbing the Office of Presidency of the Dignity it Deserves

Reprinted by permission from Q Section of the News & Observer

Sunday's Q Section on the presidency prompted me to comment on a large piece of mail I received yesterday. The sender, with elaborate calligraphy in Italics, identifies itself as "The Committee for The Presidential Inaugural. Washington, D. C. 20599. The addressee's name, too, was printed in even more calligraphic form with added warning on the envelop "DO NOT BEND".

Inside, there were two very well presented invitations with fancy seals, protected by onion skin paper, and ostentatious but empty language, inviting me to the January 20 Inaugural Ball in Washington, DC. It was signed by "The 55th Presidential Inaugural Committee, Commemorative Invitation, 1889 -2005." I could tell that probably 20 million copies of these "exclusive" invitations have been issued.

However, along with all this elaborate but fake presentation, there was a mass produced cheap eight page insert cataloging what you can buy for as little as \$28.95. Yes, in a language designed for children television shows, "Be the first one on your bloc to own a crystal ice bucket commemorating the inauguration of the 43rd president (batteries, of course not needed), the sale pitch exhorted potential buyers to seize the opportunity and order the prestigious gifts...

I implore the President and our lovely First Lady to rein in these tacky and cheap practices, and restore dignity to the office of the Presidency. The quest for money has become sickening.

Assad Meymandi, MD

## Meritocracy vs. Aristocracy

Reprinted by permission from Q- Section of the News and Observer

Among many appealing legacies of our founding fathers is bringing to the market place the essence of meritocracy, that is to say who you are, what you know and what you can do. They did away with aristocracy, that is to say royalty, connection with people of higher places and cronyism.

It is regrettable to see that people who contribute heavily to political campaigns get to spend the night at the White House or Camp David and are assigned to lucrative jobs as envoys and ambassadors. The resurgence of this unwelcome and disturbing trend is most disheartening and against the wishes of our founding fathers. We should replace cronyism with meritocracy and not sully the dignity of the high political offices of the land.

Assad Meymandi, MD

*Continued on next page.*

*We have received a number of requests for a copy of the following prayer which was given to the joint meeting of the WCMS Legislative meeting and the Wake County Legislative delegation on Jan 11, 2005. Pictures from this meeting are printed elsewhere in this issue.*

Let's bow our heads and pray:

Dear Lord,

We come before you to primarily thank you for you, for your love, for the life you have given us, for the miracle of family, connectedness, and friends...

We thank you for the beauty of nature, trees, flowers, birds, animals, the arts, music, language, dance and poetry...

We thank you for our beloved America, the most decent and generous nation on earth...  
we thank you for our founding fathers, the framers of our

sacred constitution, for America's reverential devotion to the supremacy of the rule of law, and respect for individual rights...

We thank you Lord for our profession. Medicine is a noble profession. It is indeed a priesthood. The day we received the degree of Doctor of Medicine, we were also ordained into this coveted priesthood where cutting edge skill, knowledge and excellence may be used with compassion, humility, and wisdom. We entered the holy temple of service to our fellow humans suffering from illness and pain. We drank from the sacred chalice of altruism and self denial. We are thankful for this privilege and opportunity...

We thank you for the occasions of fellowship such the one here this evening to promote what is best for our patients and constituents and how we can together serve our brothers and sisters in need of help. We hereby deepen our commitment to humility and altruism, to heal and to use our knowledge and wisdom in your service .

Amen

## IN MEMORY

### **Dr. Louis T. Kermon**

June 20, 1920-January 30, 2005

*Dr. Louis T. Kermon died on Sunday January 30, '05. He was 84 years old. His friends and colleagues who knew him well feel orphaned. Our sorrow is deep. The following is a reprint of Dr. Kermon's Profile of the Month printed in a 2002 issue of WCP.*

#### *The Editor*

I have always been curious about my good friend and colleague, Louis Kermon's last name. I was born in a city in Iran (formerly Persia) called Kerman. There is an illustrious author of many textbooks on the history of music, and a towering scholar of the Biennese classic era composers, Joseph Kerman, with whom I have been in contact, tells me that he has traced his genealogy to my hometown. So with that knowledge under my belt, I originally approached Louis to see if he knew the story of his ancestry. To understand the fascinating arabesque of connections a bit of history is in order:

Around 680 when Islam penetrated the Persian empire, the national Persian religion was Zoroastrianism. The government edict was for all Persians to convert into Islam. But there were Persians who did not wish to convert and did not want to live under the yolk of a new imposed religion. They chose to flee Persia. The bulk of these pure Persians (mostly from the province of Kerman which housed the largest Zoroastrian Temple, and was the home of the Bishop) fled to India and formed what today is known as the "Parsis," very much like "little Havana" in Florida. They preserved the practice of their religion. The famed conductor Zubin Mata and his 94 year old father, who is still actively teaching music to young people in Los Angeles, are descendants of one to those Persian immigrants. Other Persians fled to all parts of Europe, including England and France. Louis' forefathers were most likely one of those people who hailed from Kerman and settled in England. So, you see, Louis and I are cousins!

With Persian/Anglo blood running in his veins, Dr. Kermon was born in Wilmington, NC four score year ago. He graduated

from New Hanover High School in May 1937. An aunt, who was a nurse, influenced him to become a doctor. He made the decision to be a doctor at the age of nine. Louis was a brilliant student, had a lot of friends and was active in competitive sports. He had no trouble gaining admission to Wake Forest College whence he graduated with a BS degrees in 1941. He served in the Navy from August 1942 until October 1945. The service brought him the Bronze Star and Presidential Unit Citation as Lt. USN. He had two command posts: L.G.I 78 in the Pacific and LSSL 3#1 (I am not going into detail of spelling out what these letter and axronymsn stand for.)

### **Wedding Bells**

While attending Wake Forest in 1940 he had met a pretty coed, Mary Francis Wardle of Kentucky who was attending business school. They were an item for several years. Fran tells me that at 4:00 am, one morning, she was awakened to the shrill ring of the telephone. She was both disturbed and frightened thinking a call at that hour usually carries bad news. It was Louis calling from a bar in Texas. He was calling to propose marriage! To this day the extent of imbibing prior to the phone call is not known! However, it is known that Fran accepted the proposal. The couple was married in Orange, Texas in 1943.

They returned to NC. Louis was admitted to UNC School of Medicine, which was only two years of pre-clinical curriculum. The couple lived in the legendary Victory Village, making ends meet on the GI Bill. The family ate rabbits that Louis would bring home from the lab. Fran learned how to turn the tough rabbit meat into delicious meals. Children started to come, altogether four of them. They have given Fran and Louis three grand children who are now grown and educated.

### **Renaissance Man**

The family went to Philadelphia for dad to finish up medical school at Jefferson. Like the school's namesake, I have found Louis to be very much like our third president. He is a talented inventor, tinkerer and thinker. His Jeffersonian political philosophy, dedication to transcendent American ideals, and passion

## Memorials continued

for conservative small government make one believe that Louis has read everything ever written by Thomas Jefferson. Also, like T.J., from his childhood Louis has a passion for music. He played the violin in New Hanover High School Symphony. He was a star drum player in the marching band at Wake Forest, and after entering Jefferson Medical School, he was inseparable from a giant size harmonica, which he played all hours of the night. Fran tells me that she was a bit jealous of Louis' penchant for music and found herself competing with his harmonica, and later, after they moved to Raleigh, with a second hand Hammond Organ he brought himself. She said at Jefferson he was "spending more time on that Harmonica than on the kids and me." One day the harmonica mysteriously got soaked in a glass of beer by a "friend". That was the end of Louis' musical activities until they came to Raleigh. We don't know if the Hammond Organ was drowned in a tub of beer! The Kermons continued to enjoy classical music, but now only as listeners and consumers and not as providers. The Kermons have had a profound influence on the lives of their grand Children, because they all lived with them during their teens. Granddaughters are Elizabeth and Rebecca, and their father Lewis T. Kermon, Jr, is a pharmacist with Eckerd Drug Company at Creedmore Crossing. The adopted grandson, Daniel Marshall Kermon is employed by the NC State Department of Transportation. His son Marshall just graduated from NC State University and is now employed at Nortel in Research Triangle Park.

### Professional Life

After receiving his MD from Jefferson in 1950, Louis interned at Rex Hospital in 1951 and served as instructor in internal medicine at UNC Schools of Medicine from 1952 to 1959, after which he climbed the academic ladder, becoming Assistant Clinical Professor of Medicine. In 1961, he became Associate Clinical Professor. He retired from teaching after 25 years.

When he first came to Raleigh, he entered the practice of internal medicine with Dr. Charles P. Eldridge. He continued his private practice until his retirement in 1986. The state of NC recognizing Louis' talents and wealth of clinical experience, recruited him as a consultant to Disability Determination Services where he worked until February 1, 1996.

He has had an astonishing and distinguished 46-year career in caring for the sick and teaching the art and science of medicine.

Other professional distinctions and achievements include: Presidency of Wake County Medical Society, Raleigh Society of Internal Medicine, Rex Hospital Medical Staff, Raleigh Academy of Medicine and NC Board of Medical Examiners. Dr. Louis Kermon served on the Federation of State Medical Boards from 1976 until 1984.

### Life After Retirement

Fran describes her husband as a compassionate "Dr. Welby" type. Perhaps it is because of this, since his final retirement, Louis completed a five year Bible Study Fellowship, then entered the Stephen Ministry progressing to a position of leadership. He is a lay minister for White Memorial Presbyterian Church. Wake County Physician is proud to present Dr. Louis T. Kermon, a Jeffersonian thinker and patriot, a renaissance compendium of intellectual luminacy and curiosity touched by the miracle of music, a man of many talents and humanistic resources, a loving husband and family man, a loyal friend, a doctor loved by thousands of his patients and their families and

a role model as our illustrious physician of the month. We salute you, Louis!

## Dr. Albert Hugh T. Doss

August 22, 1909-January 20, 2005

Colleague, learned, mystical, sweet, gentle, always smiling and upbeat, Albert Doss died at 95. Albert was born in Egypt to a Coptic Christian family. His studies in Egypt, London and America complemented his atavistic yen for knowledge. He was a polylog and polymath. Having an evening of conversation with him was entertaining, always stimulating and engaging. I first met him when he came to NC in the early 70's. I knew that he has already practiced surgery in London and was a member of the Royal College of Surgeons. I also knew that he and his wife, Madge Bennett Conyers, had a successful travel business in California. With that background and his quest for further education to obtain credentials for a medical license in America prompted many of his colleagues to assist in welcoming him to NC. He took his residency in Psychiatry at Dorothea Hospital and two years of Fellowship in gero-psychiatry at Duke. I recall the late Dr. Ewald "Bud" Bussey, long time Chair of Psychiatry at Duke, and later head of Geriatric Psychiatry, referring to Dr. Doss, as a "Poster Boy of meeting human potential". It was not until 1974, age 65, that he was finished with his formal training, and began his private practice in Raleigh.

Albert Doss was a renaissance man. He was conversant and interested in DNA, genomic project, psychobiology and dynamic psychiatry. He was a product of classical Egyptian and European education. But above all, he was very much involved in metaphysics and mysticism. In 1947, he joined the Rosicrucian Order, a metaphysical fraternity headquartered in San Jose, California where he became a leader and regular instructor. He and his wife were married in 1959, and had one daughter, Aida, an attorney in Raleigh. All of this re-enforced his strong belief in the power of mind and spirit to solve human problems. How we handle life's adversities, such as catastrophic health events determines the balance and stability of our life.

Indeed by example, he demonstrated his resilience to the impact of a severe stroke in 1995. His recovery was slow, yet complicated by the passing of his beloved Madge in 1998. Albert continued to live a life of grace, dignity, productivity and love until his death. His many devoted friends and family will miss him while we celebrated his remarkable life of 95 years.

## Dr. William Warner Shingleton

November 26, 1917 to January 2, 2005

A native Tar Heel, Bill grew up in Stantonsburg, NC. He majored in pre-med at UNC, earned his MD from Bowman-Grey, and did his residency in Surgery at Duke. Bill served in WWII and was stationed in Italy. He completed his residency in 1950. He joined the Duke faculty in 1952, and through rapid ascension became Chief of General Surgery Division, a position he held until 1982. But he was best known as "Mr. Cancer Man" in academic and oncological circles. Educated health consumers and cancer survivors, like myself, learned about him through not only his reputation, but extensive writings and contributions to oncology literature.

I recall his interaction with patients, colleagues and medical staff as gentle, compassionate and cheerful, yet in a probing and inquisitive manner. The combination of his intellectual curiosity and compassionate approach made him a giant in the field of oncology.

## **Dr. Dale Thomas Millins, Sr.**

June 26, 1921 to January 10, 2005

Dale was a Tar Heel transplant. He chose North Carolina in 1953, and brought his wife and four children to New Bern.. A fifth child was born in New Bern. He received his MD from Case Western Reserve, and trained in urology. Bill was a public spirited pioneer in the profession. He and a few of his colleagues purchased St. Luke's Hospital in New Bern and founded Craven Regional Medical Center. He also served as Mayor of New Bern. I knew Dr. Millins through his service to organized medicine and committees of the North Carolina Medical Society. He was an incisive and focused leader with conservative values. He will be missed by his family, friends and the city of New Bern.

## **William Laupus**

1921-2005

Dr. William Laupus, the first Dean of East Carolina University Medical School, died at age 83. He came to ECU in 1975, two years before the four-year medical students were admitted. He left the deanship in 1988. In 1993, the Health Sciences Library at ECU was renamed for him. He received the O. Max Gardner Award, the highest honor given by the University of North Carolina Board of Governors, in 1989.

The son of a blue collar father, hardware store owner and an English teacher mother, born and raised in Seymore, Indiana, he love North Carolina. He is survived by his wife, two sons and a daughter and several grandchildren.

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# **ANNUAL STELLA AWARDS**

It's once again time to review the winners of the annual Stella Awards. The Stella's are named after 81 year old Stella Liebeck who spilled coffee on herself and Successfully sued McDonald's.

That case inspired the 'Stella Awards' for the most frivolous successful lawsuits in the United States.

THIS YEAR'S AWARDS GO TO:

### **5th Place (Tied)**

Kathleen Robertson of Austin, Texas was awarded \$780,000 by a jury of her peers after breaking her ankle tripping over a toddler who was running inside a furniture store. The owners of the store were understandably surprised at the verdict, considering the misbehaving toddler was Ms. Robertson's son.

### **5th Place (Tied)**

19 year old Carl Truman of Los Angeles won \$74,000 and medical expenses when his neighbor ran over his hand with a Honda Accord. Mr. Truman apparently did not notice there was someone at the wheel of the car when he was trying to steal the hubcaps.

### **5th Place (Tied)**

Terrence Dickson of Bristol, Pennsylvania was leaving a house he had just finished robbing by way of the garage. He was not able to get the garage door to go up since the automatic door opener was malfunctioning. He could not re-enter the house because the door connecting the house and garage locked when he pulled it shut. The family was on vacation and Mr.

Dickson found himself locked in the garage for 8 days. He subsisted on a case of Pepsi he found and a large bag of dry dog food. He sued the homeowner's insurance claiming the situation caused him undue mental anguish. The Jury agreed to the tune of \$500,000.

### **4th Place**

Jerry Williams of Little Rock, Arkansas was awarded \$14,500 and medical expenses after being bitten on the buttocks by his next door neighbor's Beagle dog. The Beagle was on a chain in its owner's fenced yard. The award was less than sought because the jury felt the dog might have been a little provoked at the time as Mr. Williams, who had climbed over the fence into the yard, was shooting it repeatedly with a pellet gun.

### **3rd Place**

A Philadelphia restaurant was ordered to pay Amber Carson of Lancaster, Pennsylvania \$113,500 after she slipped on a soft drink and broke her coccyx (tailbone). The beverage was on the floor because Ms. Carson had thrown it at her boyfriend 30 seconds earlier, during an argument.

### **2nd Place**

Kara Walton of Claymont, Delaware sued the owner of a Night Club in a neighboring city when she fell from the bathroom window to the floor and knocked out two of her front teeth. This occurred whilst Ms. Walton was trying to sneak in the window of the Ladies Room to avoid paying the \$3.50 cover charge. She was

awarded \$12,000 and dental expenses.

### **1st Place**

This year's runaway winner was Mr. Merv Grazinski of Oklahoma City, Oklahoma.

Mr. Grazinski purchased a brand new Winnebago Motor home. On his trip home from an OU football game, having driven onto the freeway, he set the cruise control at 70 mph and calmly left the driver's seat to go into the back and make himself a cup of coffee.

Not surprisingly the RV left the freeway, crashed and overturned. Mr. Grazinski sued Winnebago for not advising him in the owner's manual that he could not actually do this.

The jury awarded him \$1,750,000 plus a new Winnebago Motor home. The company actually changed their manuals on the basis of this suit just in case there were any other complete morons buying their recreational vehicles.

*Contributed by Dan Albright, MD and Damian McHugh*

# WHO'S news

## Thorp to lead chemistry department, become Kenan professor in July

CHAPEL HILL - Dr. Holden Thorp, who has served as director of the University of North Carolina at Chapel Hill's Morehead Planetarium and Science Center since 2001, has been named chairman of the department of chemistry.

He also will be named Kenan professor, an endowed faculty position awarded to outstanding scholars and teachers. Both appointments are effective July 1. The department of chemistry is part of the College of Arts and Sciences. "This is a great opportunity for the College of Arts and Sciences, the university and the Morehead Center," said Dr. Robert Shelton, provost and executive vice chancellor at UNC. "Our nationally ranked department of chemistry will gain an outstanding scholar and teacher with Holden Thorp at the helm. Holden's vision and expertise have led the Morehead to new heights as an innovator in science education.

Thorp attended UNC, receiving his bachelor of science degree, with highest honors, in chemistry in 1986. He went on to receive his doctorate from the California Institute of Technology in 1989. He came to UNC in 1993 as assistant professor of chemistry and is now professor of chemistry.

Fortune Small Business named Thorp one of its "Top Innovators of 2001" for his development of electronic DNA chips that have received nine patents and are currently in commercial production.

## Meymandi Adjunct Professor of Psychiatry

Chapel Hill -- Dr. Assad Meymandi's appointment as Adjunct Professor of Psychiatry at UNC School of Medicine at Chapel Hill has been extended by Dr. William Roper, Vice Chancellor for Health Affairs, Dean of Medical School and UNC Provost Robert Sheldon.

**Scott Adleman**, the son of Dr. and Mrs. Richard Adleman, will be inducted into Phi Beta Kappa on April 5th. He graduates on May 9th.

He is the first PBK graduate in the family in approximately 85 years. Myrtice Matthews was the first female PBK graduate from Duke.

**The Wake County Medical Alliance** presented the Triangle chapter of the American Red Cross with a check for \$1000 to help with the Southeast Asian Tsunami. Over \$485,000 in Wake County has been raised to help with the ongoing relief effort.

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**THE WAKE COUNTY MEDICAL SOCIETY**  
**2500 BLUE RIDGE ROAD**  
**SUITE 312**  
**RALEIGH, NC 27607**

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