

# **MINUTES**

**North Carolina Medical Board**

**March 16-18, 2011**

**1203 Front Street  
Raleigh, North Carolina**

The North Carolina Medical Board met March 16-18, 2011, at its office located at 1203 Front Street, Raleigh, NC. Janice E. Huff, MD, President, called the meeting to order. Board members in attendance were: Ralph C. Loomis, MD, President-Elect; William A. Walker, MD, Secretary/Treasurer; Ms. Pamela Blizzard; Thomas R. Hill, MD; Ms. Thelma Lennon; John B. Lewis, Jr., LLB; Peggy R. Robinson, PA-C; Paul S. Camnitz, MD; Karen R. Gerancher, MD and Eleanor E. Greene, MD. Absent was Donald E. Jablonski, DO, Past President.

### **Presidential Remarks**

Dr. Huff commenced the meeting by reading from the State Government Ethics Act, "Ethics awareness and conflict of interest reminder." No conflicts were reported.

### **Minute Approval**

**Motion:** A motion passed to approve the January 16, 2011 Board Minutes and the February 17, 2011 Hearing Minutes.

### **Announcements**

1. Mr. David Henderson, Executive Director, recognized Ms. Lisa Hackney as the new Licensing Assistant with the NCMB.
2. Mr. Curt Ellis, Director of Investigations, recognized Mr. Lee Allen on his five- year anniversary at the NCMB.
3. Dr. Scott Kirby, Medical Director, recognized Dr. Michael Sheppa on his five- year anniversary at the NCMB.
4. Mr. Thom Mansfield, Director of Legal, recognized Ms. Wanda Long on her 20- year anniversary at the NCMB.
5. Dr. Hill gave a report on the FSMB Telemedicine Symposium that he recently attended.
6. Dr. Walker gave a report on the Center for Personalized Education Program (CPEP) Learning Summit he recently attended.
7. The Public Affairs department gave their annual 'Year in Review' presentation to the Board.

### **EXECUTIVE COMMITTEE REPORT**

The Executive Committee of the North Carolina Medical Board was called to order at 1:35 pm, Thursday March 17, 2011, at the offices of the Board. Members present were: Janice E. Huff, MD, Chair; Ralph C. Loomis, MD, William A. Walker, MD, and Pamela L. Blizzard. Also present were R. David Henderson (Executive Director), Hari Gupta (Director of Operations) and Peter T. Celentano, CPA (Comptroller).

## 1) Financial Statements

### a) Monthly Accounting January 2011

The Committee reviewed the January 2011 compiled financial statements. January is the third month of fiscal year 2011.

Committee Recommendation: Accept the financial statements as reported.

Board Action: The Board accepted the Committee recommendation.

### b) Investment Account Statements

The Committee reviewed the January and February 2011 investment account statements.

Committee Recommendation: Accept the investment account statements as reported.

Board Action: The Board accepted the Committee recommendation.

## 2) Old Business

### a) Investment Advisor Update

The Committee received an update regarding the investment advisor search. Staff recommended three finalists for the Committee's consideration.

Committee Recommendation: (1) Approve the three finalists. (2) Authorize the Board President and Treasurer to interview the finalists and make a selection.

Board Action: The Board accepted the Committee recommendation.

### b) Disciplinary Rules

The Committee reviewed proposed rules regarding the Board's investigative and disciplinary proceedings.

Committee Recommendation: Approve proposed rules as attached for filing with the Rules Review Commission.

Board Action: The Board accepted the Committee recommendation.

### c) Electronic Death Registration System in North Carolina

The Committee received an update regarding work done to implement an electronic death registration system in North Carolina.

Committee Recommendation: Accept report as submitted.

Board Action: The Board accepted the Committee recommendation.

### 3) New Business

#### a) Legislative Update

The Committee reviewed the legislative update provided by the Board's Legislative Liaison.

Committee Recommendation: Accept report as submitted.

Board Action: The Board accepted the Committee recommendation.

#### b) Proposed Changes to CME Rules

The Committee reviewed proposed changes to the CME Rules.

Committee Recommendation: Staff to work with Dr. Walker to make additional changes and report back to the Board in May.

Board Action: The Board accepted the Committee recommendation.

#### c) Closure Letters

The Committee reviewed proposed language to be added to closure letters that would inform licensees (1) the NCMB considers this matter an investigation, and (2) the licensee should report it to all applicable authorities.

Committee Recommendation: Insert the following statement in all closure letters:

*"In the future, information related to the above referenced investigation should be disclosed to applicable licensing authorities and credentialing agencies. You may use a photocopy of this letter in your response to such inquiries."*

Board Action: The Board accepted the Committee recommendation.

#### d) VA NPDB Reports

The Committee reviewed the process whereby VA hospitals report malpractice payments to the National Practitioner Data Bank.

Committee Recommendation: Accept report as submitted.

Board Action: The Board accepted the Committee recommendation.

The Committee adjourned at 3:15 pm.

The next regular meeting of the Executive Committee is tentatively set for May 19, 2011.

#### 21 NCAC 32N .0101 INITIATION OF FORMAL HEARINGS

~~Formal hearings shall be initiated pursuant to G.S. 90-14.1 or G.S. 90-14.2 and shall be conducted as provided in G.S. 90-14.4 through G.S. 90-14.7.~~

~~History Note: Authority G.S. 90-14.1; 90-14.2; 90-14.3; 90-14.4; 90-14.5;  
90-14.6; 90-14.7; 150B-11(1); 150B-38(h);  
Eff. March 1, 1991.~~

#### 21 NCAC 32N .0102 CONTINUANCES

~~Any person summoned to appear before the Board at a formal hearing pursuant to G.S. 90-14.1 or G.S. 90-14.2 may seek to obtain a continuance of that hearing by filing with the Executive Secretary of the Board, as soon as the reason for continuance is known, a motion for continuance setting forth with specificity the reason the continuance is desired. Motions for continuances shall be ruled upon by the President and Executive Secretary of the Board or in the absence of the President, by the Secretary and Executive Secretary. Continuances will be granted only upon a showing of good cause.~~

~~History Note: Authority G.S. 90-14.1; 90-14.2; 150B-11(1); 150B-38(h);  
Eff. March 1, 1991.~~

#### 21 NCAC 32N .0103 DISQUALIFICATION FOR PERSONAL BIAS

~~Any person summoned to appear before the Board at a formal hearing pursuant to G.S. 90-14.1 or G.S. 90-14.2 may challenge on the basis of personal bias or other reason for disqualification the fitness and competency of any member of the Board to hear and weigh evidence concerning that person. Challenges must be stated by way of motion accompanied by affidavit setting forth with specificity the grounds for such challenge and must be filed with the Executive Director of the Board on a timely basis. Nothing contained in this Rule shall prevent a person appearing before the Board at a formal hearing from making timely personal inquiry of members of the Board as to their knowledge of and personal bias concerning that person's case.~~

~~History Note: Authority G.S. 90-14.1; 90-14.2; 150B-38(h);  
Eff. March 1, 1991;  
Amended Eff. September 1, 1995.~~

#### 21 NCAC 32N .0104 DISCOVERY

~~In any formal proceeding pursuant to G.S. 90-14.1 and G.S. 90-14.2, discovery may be obtained as provided in G.S. 150B-39 by either the Board or the person summoned to appear before the Board. Any request for discovery made by a person summoned to appear before the Board shall be filed with the Executive Director of the Board.~~

~~History Note: Authority G.S. 90-14.1; 90-14.2; 150B-38(h); 150B-39;  
Eff. March 1, 1991;  
Amended Eff. September 1, 1995.~~

#### 21 NCAC 32N .0105 INFORMAL PROCEEDINGS

~~(a) In addition to formal hearings pursuant to G.S. 90-14.1 or G.S. 90-14.2, the Board may conduct certain informal proceedings in order to settle on an informal basis certain matters of dispute. A person practicing medicine pursuant to a license or other authority~~

~~granted by the Board may be invited to attend a meeting with the Board or a committee of the Board on an informal basis to discuss such matters as the Board may advise in its communication to the person inviting him or her to attend such meeting. No public record of such proceeding shall be made nor shall any individual be placed under oath to give testimony. Matters discussed by a person appearing informally before the Board may, however, be used against such person in a formal hearing if a formal hearing is subsequently initiated.~~

~~(b) As a result of such informal meeting, the Board may recommend that certain actions be taken by such person, may offer such person the opportunity to enter into a consent order which will be a matter of public record, may institute a formal public hearing concerning such person, or may take other public or non-public action as the Board may deem appropriate in each case.~~

~~(c) Attendance at such an informal meeting is not required and is at the sole discretion of the person so invited. A person invited to attend an informal meeting shall be entitled to have counsel present at such meeting.~~

~~History Note: Authority G.S. 150B-11(1); 150B-38(h);  
Eff. March 1, 1991.~~

## 21 NCAC 32N .0106 DEFINITIONS

As used in this Section:

(1) Disciplinary Proceedings means hearings conducted pursuant to 90-14.2 through 90-14.7, and Article 3A of Chapter 150B.

(2) Good cause related to motions or requests to continue or for additional time for responding includes: (a) death or incapacitating illness of a party, or attorney of a party; (b) a court order requiring a continuance; (c) lack of proper notice of the hearing; (d) a substitution of the attorney of a party if the substitution is shown to be required; (e) agreement for a continuance by all parties if either more time is demonstrated to be necessary to complete mandatory preparation for the case, such as authorized discovery, and the parties and the Board have agreed to a new hearing date or the parties have agreed to a settlement of the case that has been or is likely to be approved by the Board; and (f) where, for any other reason, either party has shown that the interests of justice require a continuance or additional time.

(3) Good cause related to motions or requests to continue or for additional time for responding shall not include: (a) intentional delay; (b) unavailability of counsel because of engagement in another judicial or administrative proceeding unless all other members of the attorney's firm familiar with the case are similarly engaged, or if the notice of the other proceeding was received subsequent to the notice of the hearing for which the continuance is sought; (c) unavailability of a witness if the witness testimony can be

taken by deposition; and(d) failure of the attorney or respondent to use effectively the statutory notice period provided in G.S. 90-14.2(a) to prepare for the hearing.

(4) Licensee means all persons to whom the Board has issued a license as defined in G.S. 90-1.1.

(5) Respondent means the person licensed or approved by the Board who is named in the Notice of Charges and Allegations.

(6) Days means calendar days.

21 NCAC 32N .0107

#### INVESTIGATIONS AND COMPLAINTS

(a) At the time of first oral or written communication from the Board or staff or agent of the Board to a licensee regarding a complaint or investigation, the Board shall provide the notices set forth in G.S. 90-14(i), except as provided in paragraph (e) below.

(b) A licensee shall submit a written response to a complaint received by the Board within 45 days from the date of a written request by Board staff. The Board shall grant up to an additional 30 days for the response where the licensee demonstrates good cause for the extension of time. The response shall contain accurate and complete information. Where licensee fails to respond in the time and manner provided herein, the Board may treat that as a failure to respond to a Board inquiry in a reasonable time and manner as required by G.S. 90-14(a)(14).

(c) The licensee's written response to a complaint submitted to the Board in accordance with paragraph (b) above shall be provided to the complainant upon written request as permitted in G.S. 90-16(e1), except that the response shall not be provided where the Board in its discretion determines that the complainant has misused the Board's complaint process or that the release of the response would be harmful to the physical or mental health of the complainant who was a patient of the responding licensee.

(d) A licensee shall submit to an interview within 30 days from the date of an oral or written request from Board staff. The Board in its discretion may grant up to an additional 15 days for the interview where the licensee demonstrates good cause for the extension of time. The responses to the questions and requests for information, including documents, during the interview shall be complete and accurate. Where respondent fails to respond in the time and manner provided herein, the Board may treat that as a failure to respond to a Board inquiry in a reasonable time and manner as required by G.S. 90-14(a)(14).

(e) Where the Board finds that the public health, safety, or welfare requires emergency action within the meaning of G.S. 150B-3(c), a licensee shall provide the requested information or documents in response to any oral or written request from the Board or its

staff regarding the matter affecting the license or approval granted by the Board. If documents requested by the Board are not in the immediate possession and control of respondent, then respondent shall provide the documents as soon as practicable. The responses to the questions and requests for information, including documents, shall be complete and accurate. Where the licensee fails to respond in the time and manner provided herein, the Board may treat that as a failure to respond to a Board inquiry in a reasonable time and manner as required by G.S. 90-14(a)(14).

(f) The licensee who is the subject of a Board inquiry may retain and consult with legal counsel of his or her choosing in responding to the inquiries as set out in G.S. 90-14(i).

#### 21 NCAC 32N .0108 INVESTIGATIVE INTERVIEWS BY BOARD MEMBERS

(a) In addition to formal hearings pursuant to G.S. 90-14 and G.S. 90-14.2, the Board may ask a licensee to attend a non-public interview with members of the Board and staff to discuss a pending complaint or investigation. The invitation letter shall describe the matters of dispute or concern and shall enclose the notices required by G.S. 90-14(i), if not previously issued. No individual shall be placed under oath to give testimony. Statements made or information provided by a licensee during this interview may, however, be used against such licensee in any subsequent formal hearing.

(b) As a result of the interview, the Board may ask that the licensee take actions as referred to in G.S. 90-14(k), may offer the licensee the opportunity to enter into a consent order or other public agreement that will be a matter of public record, may institute a formal public hearing concerning the licensee, or may take other action as the Board deems appropriate in each case.

(c) Unless ordered by the Board pursuant to G.S. 90-8, attendance at such an interview is not required. A licensee may retain legal counsel and have such counsel present during such interview.

(d) Requests for continuances from interviews shall be filed with the President as soon as practicable and shall be granted only upon good cause shown.

#### 21 NCAC 32N .0109 PRE-CHARGE CONFERENCE

(a) Prior to issuing public Notice of Charges and Allegations against a licensee, the Board shall inform the licensee in writing of the right to request a pre-charge conference as set forth in G.S. 90-14(j). The written notice regarding the pre-charge conference shall be sent by certified mail, return receipt requested to the last mailing address registered with the Board.

- (b) A request for a pre-charge conference must be:
- (1) in writing via delivery of a letter or by facsimile or electronic mail,
  - (2) addressed to the coordinator identified in the written notice provided as set forth in paragraph (a) above, and
  - (3) received by the Board no later than 30 days from the date appearing on the written notice provided as set forth in paragraph (a) above.
- (c) Upon receipt of a request for a pre-charge conference, the coordinator shall schedule the conference to occur within 45 days and serve notice of the date and time of the conference on the licensee or on counsel for licensee, if the Board is aware licensee is represented by counsel.
- (d) The pre-charge conference shall be conducted as provided in G.S. 90-14(j). The pre-charge conference will be conducted by telephone conference unless the interests of justice require otherwise or both parties agree to conduct the conference in person. No continuances of the pre-charge conference shall be allowed except when granted by the Board for good cause shown.
- (e) The licensee may provide to the Board written documents not previously submitted by delivering those documents in electronic form to the coordinator identified in the written notice up to five days prior to the pre-charge conference.
- (f) The Board shall provide information to the licensee during the pre-charge conference regarding the possibility of settlement of the pending matter prior to the issuance of a public notice of charges and allegations.

21 NCAC 32N .0110          INITIATION OF DISCIPLINARY HEARINGS

- (a) The Board shall issue a Notice of Charges and Allegations only upon completion of an investigation, a finding by the Board or a committee of the Board that there exists a factual and legal basis for an action pursuant to any subsection of G.S. 90-14(a), and a pre-charge conference, if one was requested by the licensee.
- (b) Disciplinary proceedings shall be initiated and conducted pursuant to G.S. 90-14 through G.S. 90-14.7 and G.S. 150B-38 through G.S. 150B-42.
- (c) A pre-hearing conference shall be held not less than seven days before the hearing date unless waived by the Board President or designated presiding officer upon written request by either party. The purpose of the conference will be to simplify the issues to be determined, obtain stipulations in regards to testimony or exhibits, obtain stipulations of agreement on undisputed facts or the application of particular laws, consider the proposed witnesses for each party, identify and exchange documentary evidence intended to be introduced at the hearing, and consider such other matters that may be necessary or advisable for the efficient and expeditious conduct of the hearing.

(d) The pre-hearing conference shall be conducted in the offices of the Medical Board, unless another site is designated by mutual agreement of all parties; however, when a face-to-face conference is impractical, the Board President or designated presiding officer may order the pre-hearing conference be conducted by telephone conference.

(e) The pre-hearing conference shall be an informal proceeding and shall be conducted by the Board President or designated presiding officer.

(f) All agreements, stipulations, amendments, or other matters resulting from the pre-hearing conference shall be in writing, signed by the presiding officer, respondent or respondent's counsel and Board counsel, and introduced into the record at the beginning of the disciplinary hearing.

(g) Motions for a continuance of a hearing shall be granted upon a showing of good cause. Motions for a continuance must be in writing and received in the office of the Medical Board no less than 14 calendar days before the hearing date. A motion for a continuance filed less than 14 calendar days from the date of the hearing shall be denied unless the reason for the motion could not have been ascertained earlier. Motions for continuance shall be ruled on by the President of the Board or designated presiding officer.

(h) The Respondent may challenge on the basis of personal bias or other reason for disqualification the fitness and competency of any Board member to hear and weigh evidence concerning the Respondent. Challenges must be in writing accompanied by affidavit setting forth with specificity the grounds for such challenge and must be filed with the President of the Board or designated presiding officer at least 14 days before the hearing except for good cause shown. Nothing contained in this Rule shall prevent a Respondent appearing before the Board at a formal hearing from making inquiry of Board members as to their knowledge of and personal bias concerning that person's case and making a motion based upon the responses to those inquiries that a Board member recuse himself or herself or be removed by the Board President or presiding officer.

(i) In any formal proceeding pursuant to G.S. 90-14.1 and G.S. 90-14.2, discovery may be obtained as provided in G.S. 90-8 and 150B-39 by either the Board or the Respondent. Any discovery request by a Respondent to the Board shall be filed with the Executive Director of the Board. Nothing herein is intended to prohibit a Respondent or counsel for Respondent from issuing subpoenas to the extent that such subpoenas are otherwise permitted by law or rule. The Medical Board may issue subpoenas for the Board or a Respondent in preparation for or in the conduct of a contested case as follows:

- (1) Subpoenas may be issued for the appearance of witnesses or the production of documents or information, either at the hearing or for the purposes of discovery;
- (2) Requests by a Respondent for subpoenas shall be made in writing to the Executive Director and shall include the following:
  - (A) the full name and home or business address of all persons to be subpoenaed; and
  - (B) the identification, with specificity, of any documents or information being sought;
- (3) Where Respondent makes a request for subpoenas and complies with the requirements in the preceding sub-paragraph, the Board shall provide subpoenas promptly;
- (4) Subpoenas shall include the date, time, and place of the hearing and the name and address of the party requesting the subpoena. In the case of subpoenas for the purpose of discovery, the subpoena shall include the date, time, and place for responding to the subpoena; and
- (5) Subpoenas shall be served as provided by the Rules of Civil Procedure, G.S. 1A-1. The cost of service, fees, and expenses of any witnesses or documents subpoenaed shall be paid by the party requesting the witnesses.

(j) All motions related to a contested case shall be in writing and submitted to the Medical Board at least 14 calendar days before the hearing. Pre-hearing motions shall be heard at the pre-hearing conference described in 32 NCAC 32N .0010(c). Motions filed fewer than 14 days before the hearing shall be considered untimely and shall not be considered unless the reason for the motion could not have been ascertained earlier. In such case, the motion shall be considered at the hearing prior to the commencement of testimony. The Board President or designated presiding officer shall hear the motions and any response from the non-moving party and rule on such motions. If the pre-hearing motions are heard by an Administrative Law Judge from Office of Administrative Hearings the provisions of G.S. 150B-40(e) shall govern the proceedings.

#### 21 NCAC 32N .0111          CONDUCTING DISCIPLINARY HEARINGS

- (a) Disciplinary hearings conducted before a majority of Board members shall be held at the Board's office or, by mutual consent, in another location where a majority of the Board has convened for the purpose of conducting business. For proceedings conducted by an administrative law judge, the venue shall be determined in accordance with G. S. 150B-38(e). All hearings conducted by the Medical Board are open to the public; however, portions are closed to protect the identity of patients pursuant to G.S. 90-16(b).
- (b) All hearings by the Medical Board shall be conducted by a quorum of the Medical Board, except as provided in Subparagraph (1) and (2) of this Paragraph. The Medical Board President or his or her designee shall preside at the hearing. The Medical Board shall retain independent legal counsel to provide advice to the Board as set forth in G.S.

90-14.2. The quorum of the Medical Board shall hear all evidence, make findings of fact and conclusions of law, and issue an order reflecting the decision of the majority of the quorum of the Board. The final form of the order shall be determined by the presiding officer, who shall sign the order. When a majority of the members of the Medical Board is unable or elects not to hear a contested case:

- (1) The Medical Board may request the designation of an administrative law judge from the Office of Administrative Hearings to preside at the hearing so long as the Board has not alleged the licensee failed to meet an applicable standard of medical care. The provisions of G.S. 150B, Article 3A and 21 NCAC 32N .0105 shall govern a contested case in which an administrative law judge is designated as the Hearing Officer; or
- (2) The Medical Board President may designate in writing three or more hearing officers to conduct hearings as a hearing committee to take evidence. The provisions of G.S. 90-14.5(a) through (d) shall govern a contested case in which a hearing committee is designated.

(c) If any party or attorney of a party or any other person in or near the hearing room engages in conduct which obstructs the proceedings or would constitute contempt if done in the General Court of Justice, the Board may apply to the applicable superior court for an order to show cause why the person(s) should not be held in contempt of the Board and its processes.

(d) During a hearing, if it appears in the interest of justice that further testimony should be received and sufficient time does not remain to conclude the testimony, the Medical Board may continue the hearing to a future date to allow for the additional testimony to be taken by deposition or to be presented orally. In such situations and to such extent as possible, the seated members of the Medical Board shall receive the additional testimony. If new members of the Board or a different independent counsel must participate, a copy of the transcript of the hearing shall be provided to them prior to the receipt of the additional testimony.

(e) All parties have the right to present evidence, rebuttal testimony, and argument with respect to the issues of law, and to cross-examine witnesses. The North Carolina Rules of Evidence in G.S. 8C apply to contested case proceedings, except as provided otherwise in this Rule, G.S. 90-14.6 and G.S. 150B-41.

#### 21 NCAC 32N .0112 POST HEARING MOTIONS

(a) Following a disciplinary hearing either party may request a new hearing or to reopen the hearing for good cause as provided in G.S. 90-14.7. For the purposes of this Rule, good cause is defined as any of the grounds set out in Rule 59 of the North Carolina Rules of Civil Procedure and complying with the following requirements:

- (1) Following hearings conducted by a quorum of the Board, a motion for a new hearing or to reopen the hearing to take new evidence shall be served, in writing, on the presiding officer of the disciplinary hearing no later than 20 days after service of the final order upon the respondent. Supporting affidavits, if any, and a memorandum setting forth the basis of the motion together with supporting authorities, shall be filed with the motion. The opposing party has 20 days from service of the motion to file a written response, any reply affidavits, and a memorandum with supporting authorities. A quorum of the Board shall rule on the motion based on the parties' written submissions and oral arguments, if the Board permitted any; and
- (2) Following hearings conducted by a hearing panel pursuant to G.S. 90-14.5, a motion for a new hearing or to reopen the hearing to take new evidence shall be served, in writing, on the presiding officer of the hearing panel no later than 20 days after service of the recommended decision upon the respondent or respondent's counsel. Supporting affidavits, if any, and a memorandum setting forth the basis of the motion together with supporting authorities, shall be filed with the motion. The opposing party has 20 days from service of the motion to file a written response, any reply affidavits, and a memorandum with supporting authorities. The hearing panel shall rule on the motion based on the parties' written submissions and oral arguments, if the Board permitted any.

(b) Either party may file a motion for relief from the final order of the Board based on any of the grounds set out in Rule 60 of the North Carolina Rules of Civil Procedure. Relief from the final order of the Board shall not be permitted later than one year after the effective date of the final order from which relief is sought. Motions pursuant to this section will be heard and decided in the same manner as motions submitted pursuant to 21 NCAC 32N .0111(a)(1) above.

(c) The filing of a motion under 21 NCAC 32N .0111(a)(1) or 21 NCAC 32N .0111(b) above does not automatically stay or otherwise affect the effective date of the final order.

#### 21 NCAC 32N .0113 CORRECTION OF CLERICAL MISTAKES

Clerical mistakes in orders or other parts of the record from a formal hearing and errors therein arising from oversight or omission may be corrected by the Board President or designated presiding officer at any time on his or her own initiative or on the motion of any party and after such notice, if any, as the Board President or designated presiding officer orders. After the filing by a respondent of an appeal to the Superior Court of the Board's imposition of public disciplinary action as set forth in G.S. 90-14.8, such mistakes may be so corrected before the record of the case is filed by the Board with the clerk of the Superior Court as required by G.S. 90-14.8.

## **POLICY COMMITTEE REPORT tab130**

Committee Members: Dr. Loomis, Chairman; Dr. Camnitz and Dr. Greene  
Staff: Todd Brosius, Nancy Hemphill, Scott Kirby, MD and Wanda Long

### 1. Old Business

#### a. Position Statement Review

##### i. – Office Based Procedures (ATTACHMENT “A”)

Issue: In November 2009, the Board approved the Policy Committee’s recommendation to review Position Statements at least once every four years. A review schedule has been formulated for the Committee’s consideration.

9/2010 Committee Recommendation: Table this issue to allow comments from the full Board to be received. All comments will be considered at the November Committee meeting.

9/2010 Board Action: Adopt the Committee recommendation

11/2010 Committee Recommendation: Table this issue. Request input from standard distribution list, as well as, plastic surgeon speciality, dermatology speciality, OBGYN speciality, GI speciality, and insurance companies.

11/2010 Board Action: Adopt Committee recommendation.

1/2011 Committee Discussion: The Committee discussed comments received from various parties. The Committee agreed that the position statement is lengthy, but included important and useful information. The Committee instructed the staff to inquire about the inclusion of language addressing “expenses of accreditation.” The Committee also suggested that language may be added to better explain what the Board views as “reasonable proximity.”

1/2011 Committee Recommendation: Table issue until the March 2011 meeting. Legal will wordsmith the position statement to incorporate suggested changes and attempt to reorganize the position statement to make it more accessible.

1/2011 Board Action: Adopt Committee recommendation.

3/2011 Committee Discussion: The Committee reviewed the current position statement with new formatting that the staff felt would make it easier to negotiate its content. The staff reported that the language addressing “expenses of accreditation” was considered fundamental at the time of the position statement’s creation. The Committee made suggestions regarding the formatting of the preface section. It was suggested that “reasonable proximity” might be 30 minutes. The staff recommended adding “reasonable proximity” to the definition section. Additionally, it was suggested that the definition section be renamed Definitions and Acronyms.

3/2011 Committee Recommendation: Remain tabled until a draft encompassing the suggested changes could be prepared. The proposed position statement will be submitted to the Policy Committee prior to the May Board meeting.

3/2011 Board Action: Adopt Committee recommendation.

1. Old Business

a. Position Statement Review continued:

ii. Writing of Prescriptions (ATTACHMENT "B")

Issue: In November 2009, the Board approved the Policy Committee's recommendation to review Position Statements at least once every four years. A review schedule has been formulated for the Committee's consideration.

1/2011 Committee Discussion: The Committee discussed the current position statement. It was pointed out that many practitioners currently do not spell out the quantity but simply write the numerical amount on prescriptions. Additionally, many practices and hospitals have computers systems that only use the numerical amount. The Committee considered whether the sentence in question was useful, and decided to bring it to the full Board for discussion.

1/2011 Committee Recommendation: Present for full Board discussion for consideration regarding changing: "Quantities should be indicated in both numbers AND words, e.g., 30 (thirty)."

1/2011 Board Action: Table issue for Committee to do further research.

3/2011 Committee Discussion: The Committee discussed the increasing use of electronic prescriptions. Dr. Loomis mentioned the potential for fines if electronic prescriptions are not used. Additionally the Committee agreed that it was not their intention to require practices to have their system re-written to include the written out quantity.

3/2011 Committee Recommendation: (PC/EG) The Committee recommends omitting from the current position statement: "Quantities should be indicated in both numbers AND words, e.g., 30 (thirty)."

3/2011 Board Action: Amend position statement to reflect that only hand written controlled substance prescriptions are required to indicate the quantity in both numbers and words.

1. Old Business:

b. Practice Drift Committee (ATTACHMENT "C")

1/2011 Committee Discussion: Nancy Hemphill reviewed the executive summary of the Special Committee on Practice Drift with the Policy Committee. The Committee discussed the struggle of holding licensees accountable and also allowing for professional growth. The Committee also discussed the need for access to care. The Committee agreed that licensees should be held to the prevailing standards of practice

relevant to the area of specialty or modality in which they are practicing regardless of the area in which they received their formal training.

1/2011 Committee Recommendation: Adopt proposed Position Statement.

1/2011 Board Action: Table issue until it can be determined if the final version of the proposed Position Statement was reviewed by the Special Committee prior to being presented to the Board. The Board would like the Policy Committee to consider editing the last sentence of the third paragraph of the proposed position statement.

3/2011 Committee Discussion: Nancy Hemphill reported to the Committee that we had received some feedback which was mostly positive and complementary.

3/2011 Committee Recommendation: Adopt position statement as presented. The Committee also discussed the language regarding liability insurance and agreed that it was appropriate for this sentence to remain in the proposed position statement as practice guidance.

3/2011 Board Action: Adopt Committee recommendation.

## 2. New Business:

### a. Position Statement Review (ATTACHMENT "D")

1/2010 Committee Recommendation: (Loomis/Camnitz) Adopt a 4 year review schedule as presented. All reviews will be offered to the full Board for input. Additionally all reviews will be documented and will be reported to the full Board, even if no changes are made.

1/2010 Board Action: Adopt the recommendation of the Policy Committee.

### i. Laser Surgery (ATTACHMENT "E")

Issue: In November 2009, the Board approved the Policy Committee's recommendation to review Position Statements at least once every four years. A review schedule has been formulated for the Committee's consideration.

3/2011 Committee Discussion: The Committee reviewed the position statement and deemed it appropriate as currently written.

3/2011 Committee Recommendation: Deem position statement appropriate. No changes are suggested.

3/2011 Board Action: Adopt Committee recommendation.

### ii. Self- Treatment and Treatment of Family Members and Others With Whom Significant Emotional Relationships Exist (ATTACHMENT "F")

Issue: In November 2009, the Board approved the Policy Committee's recommendation to review Position Statements at least once every four years. A review schedule has been formulated for the Committee's consideration.

3/2011 Committee Discussion: Mr. Brosius suggested that the Board may need to establish some bright lines, because the current position statement leaves room for some treatments that the Board may deem unethical depending on physician interpretation. Dr. Loomis suggested that he preferred a hardline approach and would recommend eliminating minor treatment of illness. He indicated that the Board's interest is for the patients to receive the best care. Dr. Greene agreed that eliminating treatment of minor illness would remove any room for confusion, but also felt we should leave the ability to treat during an emergency in the position statement. Dr. Camnitz indicated that he did not like the vagueness of the position statement and would prefer it be more specific regarding over-the-counter medications and prescription medications, possibly indicating specific schedules that would be restricted. The Committee further discussed chronic versus acute. It was also recommended that "physician" should be replaced with "licensee" to be consistent with edits made in previous position statement reviews.

3/2011 Committee Recommendation: Table issue for the Legal Department to incorporate the recommendations from the Committee discussion.

3/2011 Board Action: No Action necessary.

#### b. Reporting Primary Specialty and Subspecialty

Issue: Should the Board change the board certification headline on the licensee information page to accurately reflect the Board's new position statement?

3/2011 Committee discussion: Mr. Brosius explained the potential for misleading information on the licensing information page. A licensee can list a subspecialty that is not an ABMS or AOA certification but meets the criteria delineated in the Board's position statement on Advertising and Publicity. Dr. Loomis suggested that we add an additional section entitled "Other Certifications."

3/2011 Committee Recommendation: Invite for full Board discussion.

3/2011 Board Action: Add Royal College of Surgeons to the current heading. Add an additional section entitled "Other" and provide a statement referencing our current position statement.

### **LICENSE COMMITTEE REPORT**

The License Committee of the North Carolina Medical Board was called to order at 1:20 p.m., March 17, 2011, at the office of the Medical Board. Members present were: Thomas Hill, MD, Chair, Karen Gerancher, MD, and Mr. John Lewis. Also present was: Scott Kirby, MD, Michael Sheppa, MD, Thom Mansfield, Patrick Balestrieri, Marcus Jimison, Carren Mackiewicz, Wanda Long, Michelle Allen, Mary Rogers, Lisa Hackney

Open Session

Old Business

### 1. Guidelines for Reporting Withdrawal and Denial of Applications to NPDB, HIPDB and FSMB

Issue: There has been discussion regarding exactly what license application “withdrawals and denials” should be reported to FSMB, NPDB and HIPDB. We have contacted all three entities and recently received guidance and direction regarding the reporting issues. See bookmarked copy of Mr. Balestrieri’s January 4, 2011 memorandum outlining the reporting guidelines.

Committee Recommendation: Continue discussion at May meeting following FSMB discussion at the Annual Meeting. Patrick to provide update.

Board Action: Table until May meeting.

### 2. Fines

Issue: There has been some discussion regarding implementation of fines. Additional information will be forthcoming following 1/13/11 conference call.

Staff Recommendation: Recommendation will be forthcoming.

Committee Recommendation: Staff will be coming forward with a recommendation to deal with administrative fines that will not be posted on the licensee information page as opposed to fines associated with public disciplinary actions which will be posted on the LI permanently.

Board Action: Table until March or May Board meeting.

For March Discussion: From Dr. Kirby

Recommendations for imposition of fines are prompted by physician neglect in complying with specific regulations related to their application for a North Carolina medical license. Physicians often claim their obligations in these matters are either ambiguous or uncertain. Physicians who interpret their obligations as ambiguous have a tendency to provide incorrect, misleading, or incomplete information. Review and investigating these matters consumes large amounts of Board time. If significant sanctions (fines) for non-compliance or misinformation exist physicians may be likely interpret perceived ambiguities in favor of full disclosure.

- Fines, of any amount, imposed as a component of, or related to, other disciplinary actions will be public and published as a part of the Board’s public disciplinary action and displayed along with the other components of the underlying disciplinary action. These fines will be displayed on the “LI page” under “Actions – Regulatory Board, Agency, & Health Care Institution - North Carolina Medical Board Public Actions”.

Discussion continues about what to do with:\*

- Fines of less than \$500 imposed as the result of incorrect answers to initial license application questions, such as unreported medical school probation, prior misdemeanor arrests, etc. These include errors and

omissions which would normal result in a license with letter of advisement or PLOC.

- Suggestions for reporting/publishing these fines include:
  - A. Tabular list of licensees' name, offense, and fine amount in a single issue of the Forum.
  - B. Tabular list of offense and fine amount (without identification of licensee) in single issue of Forum.
  - C. List of licensees name, offense, and fine amount in the minutes of the Board meeting for the month the fine is imposed.
  - D. Permanent notice of the fine (without amount) and offense on the licensee's LI page under a new tab called "Board Administrative Actions" (or some variant thereof).
  - E. Temporary insertion of the fine (without amount) and offense on the licensee's LI page under a new tab called "Board Administrative Actions" (or some variant thereof) for a period of 1 year (or other suitable time period).

Choice "A" would avert accusations of "secret" fines by the Board, limit long term derogatory impact on licensees for relatively minor offenses, and still promote general deterrence for other licensees as it would be seen by other licensees. This general deterrence would be lacking with choices C, D, and E as other licensee are unlikely to read the Board minutes or randomly view licensees' LI page.

#### Recommendations:

1. The NCMB should begin with imposition of non-disciplinary fines\*\* for clearly identifiable license application errors, omissions, or false information on a license application.
  - a. Proposed Rule: CONSEQUENCES OF FAILURE TO PROVIDE ACCURATE AND COMPLETE ANSWERS ON AN APPLICATION FOR A LICENSE. The Board shall fine a license applicant when he or she fails to provide accurate, forthright, and complete answers on a license application. The presumptive fine shall be \$500. However, the Board may reduce the fine based on the following mitigating factors: applicant promptly responded to Board inquiries regarding the matter; applicant corrected the application in a timely manner, economic hardship. The Board may increase the amount of the fine, not to exceed \$1,000 based on the following aggravating factors: applicant failed to respond to a Board inquiry within a reasonable time; applicant failed to correct the error(s) in a timely fashion; evidence of willful attempt to deceive, prior or multiple errors.
2. A prominent warning should be added to the license application and renewal form.
3. Reporting to either the NPDB or FSMB will be considered on an individual basis (as are all other NCMB decisions and actions). Fines and other monetary sanctions unaccompanied by other licensure action, such as revocation, suspension, censure, reprimand, probation, or surrender would not be reported to the NPDB (NPDB Handbook; Pg. E-25). For instance:
  - b. License application omissions were the applicants were fined, but otherwise issued a license with a PLOC, would not be reported to either the NPDB or the FSMB.

\*Fines of less than \$500 imposed the result of deficient CME, minor incorrect answers on license renewal, failure to update LI page, and other matters to be determined by the Board have also been discussed at length. It is my understanding this category of administrative or non-disciplinary fine **may** require new legislation or rules and that it might be imprudent to pursue this matter further at this time.

\*\*Regarding concerns about fines (of less than \$500) being considered “non-disciplinary”. Please note that NCGS §90 14, entitled “Disciplinary Authority” includes, in the same paragraph, provisions for both public letters of concern and fines. Public letters of concern are specifically designated “non-disciplinary”. Fines of less than \$500 could be considered in a similar manner to PubLOC. Admittedly the \$500 limit is arbitrary, however it has generally been thought that fines above \$500 are less defensible as “non-disciplinary”

#### Committee Recommendation:

1. Defer to Full Board discussion. Committee recommends one of the following options:
  - C. List of licensees name, offense, and fine amount in the minutes of the Board meeting for the month the fine is imposed.
  - D. Permanent notice of the fine (without amount) and offense on the licensee’s LI page under a new tab called “Board Administrative Actions” (or some variant thereof).
  - E. Temporary insertion of the fine (without amount) and offense on the licensee’s LI page under a new tab called “Board Administrative Actions” (or some variant thereof) for a period of 1 year (or other suitable time period).

#### Board Action:

1. Tabular list of offense and fine amount (without identification of licensee) in single issue of Forum and
2. List of licensees name, offense, and fine amount in the minutes of the Board meeting for the month the fine is imposed.
3. Physician’s license not to be issued until the Board receives the legal documentation and administrative fine.

#### New Business:

##### 1. Medical School Faculty Limited Fee

Issue: The new rule on Medical School Faculty Limited Licenses was approved by the Rules Review Commission on February 17 and was supposed to go into effect March 1. Unfortunately, the rule is now in limbo. The problem is that the rule increases the application fee from \$150 (set in 1993) to \$350 (what we charge applicants for “regular” unlimited physician licenses.) Before the rule increasing the fee can take effect, it must go through the Joint Legislative Commission on Governmental Operations.

#### Staff Recommendation:

#### Options:

1. Request the fee increase. Because no one has been appointed to the Joint Commission, our request would go to the legislative leadership, Sen. Berger and Rep. Tillis. Legislative staff informed us that the Joint Commission is unlikely to be impaneled during the legislative session. If the Joint Commission doesn’t meet, then the fee

increase automatically becomes effective 90 days after filing, or early June. Or, if the Joint Commission does meet, we can go before the legislators and argue on behalf of the fee increase. The issue here is whether we even want to put the Board's name in front of the legislators. I have attached a copy of the letter we might send to Sen. Berger and Rep. Tillis.

2. Move to amend the rule immediately, going back to the \$150 application fee. This would be easy, and we could have the rule in effect by August 1. There's not much economic impact either way.
3. We cannot do nothing. The entire rule is pending either Joint Commission approval or denial, or RRC amendment.

Committee Recommendation: Move to amend the rule immediately, going back to the \$150 application fee.

Board Action: Amend rule immediately, going back to the \$150 application fee.

## 2. Proposed changes to RTL rule 21 NCAC 32B. 1402

Issue: To be consistent with the rule changes already made to the full license application, the following modifications need to be made to the RTL rule:

- Replace (3) with proposed (3) re: immigration status. NCMB does not need to do this because the GME offices are already doing it.
- Replace (4) with proposed (4) re: medical school certification form.
- Edit (11) limiting the number of attempts for passing USMLE 1&2 or COMLEX 1&2 to 3.

## 21 NCAC 32B .1402 APPLICATION FOR RESIDENT'S TRAINING LICENSE

(a) In order to obtain a Resident's Training License, an applicant shall:

(1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;

(2) submit documentation of a legal name change, if applicable;

~~(3) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;~~

~~(4) submit a recent photograph, at least two inches by two inches, affixed to the Board's Medical Education Certification form. The dean or other official of the applicant's medical school shall certify this as a true likeness of the applicant, and that the applicant has completed at least 130 weeks of medical education. The applicant's date of graduation from medical school shall be written in the designated space, and the school seal shall be stamped over the photograph;~~

(3) submit a recent photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public.

(4) submit proof on the Board's Medical Education Certification form that the applicant has completed at least 130 weeks of medical education. The applicant's date of graduation from medical school shall be written in the designated space, and the school seal shall be

stamped on the form; the dean or other official of the applicant's medical school shall sign the form verifying the information.

(5) If the graduate of a medical school other than those approved by LCME, AOA, COCA or CACMS, shall furnish an original ECFMG certification status report of a currently valid certification of the ECFMG. The ECFMG certification status report requirement shall be waived if:

(A) the applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or

(B) the applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;

(6) submit an appointment letter from the program director of the GME program or his appointed agent verifying the applicant's appointment and commencement date;

(7) provide two original references from persons with no family or marital relationship to the applicant. These references must be:

(A) from physicians who have observed the applicant's work in a clinical setting;

(B) on forms supplied by the Board;

(C) dated within six months of the application; and

(D) bearing the original signature of the writer;

(8) submit two completed fingerprint record cards supplied by the Board;

(9) submit a signed consent form allowing a search of local, state, and national files for any criminal record;

(10) pay a non-refundable fee pursuant to G.S. 90-13.1(b), plus the cost of a criminal background check;

(11) provide proof that the applicant has taken and passed:

(a) the COMLEX Level 1 and both components of COMLEX Level 2 (cognitive evaluation and performance evaluation); or

(b) the USMLE Step 1 and both components of the USMLE Step 2 (Clinical Knowledge and Clinical Skills);

(12) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(b) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

Committee Recommendation: Accept following changes to the RTL rule:

1. Replace (3) with proposed (3) re: immigration status. NCMB does not need to do this because the GME offices are already doing it.
2. Replace (4) with proposed (4) re: medical school certification form.
3. Edit (11) limiting the number of attempts for passing USMLE 1&2 or COMLEX 1&2 to 3.

Board Action:

1. Replace (3) with proposed (3) re: immigration status. NCMB does not need to do this because the GME offices are already doing it.
2. Replace (4) with proposed (4) re: medical school certification form.
3. Table decision regarding limit USMLE 1&2 and COMLEX 1&2 to 3 attempts until additional information is obtained from the GME office, USMLE and the Deans of the Medical Schools regarding how this rule would impact them.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Eleven licensure applications were reviewed. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

#### PHYSICIANS PRESENTED AT THE MARCH 2011 BOARD MEETING

Abbott, Mark Fredric	Botnick, Warren Clifford
Abdullah, Raed Saed	Boyd, Lillian Kizer
Agrawal, Abhishek R	Brake, Mary Catherine
Ahmed, Khaleel Mohammed	Breault, Steven Robert
Albaugh, Chad Allen	Bright, Crystal Deon
Alder, Timothy Leslie	Brooks, Heather Dawn
Alvarez Gonzalez, Gemayaret	Brownstein, Michelle Richardson
Amirichetty, Satyakumar	Burroughs Pena, Melissa Suzanne
Antosek, Louis Edward	Callahan, Joel Travis
Appel, Richard Gary	Canchola, Daniel Ramiro
Aravapalli, Amit	Carr, John Ferguson
Ayres, Natalie Anne	Caruso, John R
Balfour, Pelbreton Collymore	Cates, Nady Milton
Barnes, Calvin Langston Toure	Caton, Mamie
Barry, Kendra Kathleen Martin	Caywood, Devin Traer
Bennett, Howard Mather	Chancey, Rebecca Jean
Beran, Matthew Craig	Chand, Prem
Berry, Thomas Kester	Chandrasekhar, Tara
Bestha, Durga Prasad	Changappa, Reshma Baduvanda
Bhalodia, Uchit Vallabhdas	Chatrath, Monika Puri
Bhusal, Yogesh	Cheetham, Brian Curtis
Bizzell, Cary Frederick	Chen, Ashton
Blackman, Michael Brian	Chen, Brian Liang-yu
Bobek, Lesley Nicole	Chouksey, Akhilesh Kumar
Bobek, Samuel Louis	Chretien, John Anthony
Bohnsack, Brenda Lynn	Chukwumah, Letitia Danielle
Bonkowske, Jeremy James	Chung, Richard Joonoh

Cillo, Jason Alexander  
Clark, Justin James  
Cohen, Evan Phillip  
Coleman, Stanley Roger  
Collier, Suzanne Benton  
Collins, Matthew Alan  
Conner, Matthew James  
Conti, Dinah Michelle  
Cook, Nathan Paul  
Crocker, Erin Marianne  
Crosley, Debby  
Dakshaw, Sean David  
Dambro, Anthony Brice  
Dao, Hiep Trong  
Dao, Jennifer Bagdady  
Davis, Paul Lawson  
De Trizio Carotenuto, Isabel  
Deneys, Michele Lynn  
Disser, Hollace Marie  
Donnenfeld, Alan Erwin  
Drower, Christine Marie  
D'Souza, Maria Frances  
Dula, Linda Yanik  
Dye, Scott Forsyth  
Dzirasa, Erika Daniene  
Earla, Janaki Ram Prasad  
Edwards, Paul Kendall  
Ekangaki, Ruth Mokeba  
Emami, Shahram Sean  
England, Eric Bryan  
Engstrom, Bjorn Ingemar  
Erpelding, Timothy Joseph  
Faber, Sara Bigelow  
Fang, Amy Minchi  
Fasanya-Uptagraft, Helen Olushola  
Findley, Austin Daniel  
Foley, Jillian Roxanna  
Forest, Jack Landon  
Fort, Leslie Felicia  
Franklin, Quentin James  
Fulcher, James William  
Gabitto, Roberto Santiago  
Garri, Richard Francis

Gassemi, Mike Malek  
Glenn, David Locke  
Goel, Raven Abhilasha  
Gowans, Melissa Jean  
Greystock, Nicole Gaskins  
Griffin, Sean Michael  
Griffin, Thomas Andrew  
Hagaman, Lindsay Kalani  
Hamill, James Foxgrover  
Hashmi, Zubair Ali  
Henderson, Jeffrey Harris  
Hickman, Ryan-Niko  
Hidalgo, Guillermo  
Himmelfarb, Eric Andrew  
Hoole, Axalla John  
Hsu, Johann Hsin-heng  
Hsu, Mei-Yu  
Hubert, Amy Salness  
Iannaccone, Raymond  
Jayatilaka, Suresh Gehan  
Jensen, Susan  
Johnson, Amy Lee  
Johnson, Mark Cundiff  
Johnson, Matthew Michael  
Jones, Christopher Warren  
Jones, Heather Angela  
Jones, Michelle Suzanne  
Jorgensen, Tyler Scott  
Kalirao, Sonia Kaur  
Keane, Thomas Earl  
Keen, Stephen Michael  
Kennard, Jennifer Michalec  
Kessi, Monica Jean  
Kihlstrom, Margaret Jackson  
Kim, Huyi Jin  
Koonce, James Duval  
Krishnan, Sriyesh  
Kwan, William Allen  
Lambert, Brent Rogers  
Lanting, Brent Andrew  
Latter, Macy Little  
Lavelle, John Christopher  
Levi, Erika Elkina

Levin, David Eric  
Lieber, Michael Maurice  
Littleton, Jeremy Charles  
Lotfizadeh, Seyed Hossein  
Lozano, Kristina Marie  
Lyles, Graham Warner  
Maddukuri, Vinaya Chandra Sekhar  
Malinoski, Frank Joseph  
Malowitz, Jonathan Robert  
Marlowe, Mindy Deason  
Martin, Rebecca Mathilde  
Marvania, Julie Jayantilal  
Mason, Stephen Edward  
Maust, Nathan Lee  
Maxey, Thomas Scott  
Mayes, Lena Maritza  
Mazepa, Marshall Andrew  
McCalla, Chad David  
McComas, Carl Frederick  
McKenna, Sharon Ann  
McLain, Landon Douglas  
Mimy, Florence  
Moeller, Matthew Joseph  
Morosan, Cristian Gabriel  
Munro, Brian Eric  
Murphy, Stephanie Elizabeth  
Natarajan, Sheila  
Neitlich, Jeffrey David  
Neutze, Dana Michelle  
Newton, Terel  
Nichols, Clay Allen  
Ninan, Neil Abraham  
Onasanya, Olukayode Oluseun  
Otuguor, Akpomudiare Samuel  
Pachence, Babette Marchand  
Pate, James Carey  
Patel, Ravikumar K  
Patel, Utpal K.  
Patterson, Shawn Christopher  
Paul, Timir Kumar  
Pavic, Dag  
Paxton, Ben Eugene  
Petrola, Frank Lewis

Petzing, Christine Ann  
Pevzner-Kalika, Anna  
Philip, Ranjit Raju  
Piscoya, Jose Luis  
Pomerantz, Jay Ira  
Potter, Ornella Judith  
Powell, Alison Schmidt  
Quaye, Roland Anetey  
Ratner, Shana Patrice  
Ray, Julia  
Rayala, Brian Zaguirre  
Reddy, Lankala Chandra Shekar  
Rege, Aparna Sharad  
Reichel, Marc Taro  
Reyman, Lynn Deborah  
Riefkohl, Waldemar Luis  
Rodgers, Sarah  
Rodriguez, Joel Abelardo  
Routh, Jonathan Charles  
Saber, Ali  
Sanders, Keith Alan  
Sarwal, Aarti  
Sayour, Elias Joseph  
Schipper, David William  
Scott, Tiffany Lynn  
Seetharaman, Mysore  
Serrano, Neha Priyavadan  
Shah, Hemang Kalpeshkumar  
Shah, Sonal Ashok  
Shepherd, Matthew Scott  
Shields, John Shepherd  
Shields, Thomas Weadock  
Shori, Pardeep Kumar  
Shumway, David Lucius  
Singh, Jasmine  
Smith, Bryan Dorsey  
Smitherman, Andrew Brian  
Stanley, Kevin Jon  
Stewart, Christopher Manley  
Sutton, David Kristofer  
Syvanthong, Chockeo  
Taylor, Angeleta  
Thompson, Jennifer Lynn Kauffman

Thordsen, John Edward  
Thordsen-Velez, Marilu  
Turner, Eddie Joe  
Velazquez, Elsa Felicita  
Waas, Andrew Alton  
Walle, Nicholas Leo  
Walton, Perry James  
Warren, Ward Randall  
Welling, Rodney Duane  
Wilder, Julius Middleton  
Williams, Brian Lee  
Williams, James Houston  
Winter, De Benjamin  
Wood, Gregory Kelly  
Worthington-Kirsch, Robert Lee  
Wu, Anita T.  
Yount, Laura Elizabeth  
Zeid Keilani, Zeid Mahmoud  
Zook, Jason David

## LICENSE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Three licensure interviews were conducted. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

### Nurse Practitioner & Clinical Pharmacist Practitioner Approvals Issued Since January 2011

Peggy Robinson, PA-C, Chair; William Walker, MD; and Pamela Blizzard

#### List of Initial Applicants

	NAME	PRIMARY SUPERVISOR	PRACTICE CITY
NP	BAKER, JULIE	BYRD, ERIC	HENDERSONVILLE
	BELBASE, SASMRITA	DAUBERT, JAMES	DURHAM
	BROWNE, LAUREN	VINCENT, MARK	CHARLOTTE
	DUYCK, ELLEN	HIESTAND, BRIAN	WINSTON-SALEM
	EDWARDS JR, WILLIAM	PACOS, ANDREW	KINGSTON
	GOODWIN, MARY	MERCER, MICHELE	FOREST CITY
	HANCOCK, LAUREN	SAGERMAN, PAUL	RANDLEMAN
	HIPPLE, SANDRA	MCLAURIN, AMY	STATESVILLE
	JOHNSON, KIMBERLY	WILLIAMSON, STEVEN	DAVIDSON
	SAMPLE, DENISE	GILMER-SCOTT, MELISSA	CARBORRO
	SCHWARTZ, PAUL	KNERR, JULIA	CHAPEL HILL
	SHORT, BETH	LAWRENCE, MARK	WAYNESVILLE
	TIPTON, BOBBY	VIAR, JEFFREY	SALUDA
	WILSON DEFELICE, JEANETTE	LEHR, JANET	YANCEYVILLE
	ABEYOUNIS, AMY	SHARMA, SUNIL	GREENVILLE
	GOODWIN, CLAIRE	MEDINA, VICTOR	CARY
	HEGGIE, MARLENE	KICKLIGHTER, STEPHEN	RALEIGH
	INMAN, DIANNA	POTH, ROBERT	CHARLOTTE
	KAYE-SACK, JULIE	WEATHERLY-JONES, CATHI	RALEIGH
	KESTER, AMY	GARDNER, TODD	STATESVILLE
	LEFTWICH, KIMBERLY	GOAD, BRADLEY	GALAX
	MANLEY, EDDIE	GARRETT, JAMES	JACKSONVILLE
	PETERS, HEATHER	INGLEDUE, VICKIE	JEFFERSON

**March 16-18, 2011**

SCHORR, KATHERINE  
SEWARD, KELLY  
SHREVE, KATHRYN  
SOLOMON, SONDR  
BEASLEY, NATASH  
COSTNER, ASHELEY  
DRATWINSKI, LEESA  
FIELDS, JENNIFER  
HAMRICK, CHELLYN  
HOONHOUT, JANE  
LAUGHLIN, AMANDA  
MCLEAN, ALLISON  
MURPHY, KALA  
WRIGHT, TRACEY  
BEAULIEU, YVONNE  
BYELENE, RACHEL  
FREY, MARIE  
HESS, KIMBERLY  
KELLUM, KELTSIE  
LARREUR, AMY  
LOWRY, ANGIE  
MCGINTY, KRISTEN  
MITCHELL, CHRYSANTHI  
MURNER, NANCY  
NORRIS, ANNA  
OUTLAW, BRITTANY  
PRIDY-SOUTHERN, JOAN  
SHIELDS, STACEY  
SHOUN, FRANCESCA  
STOKES, ALAN  
TONEY, TERRY  
TONGER, CONNIE

JACUBOWITZ, SAM  
BROUSE, GREGORY  
VICK, TARA  
JARRETT, DAVID  
LOBDELL, KEVIN  
MATHEW, RANO  
MORETZ, REBECCA  
SAHA, ANIMITA  
CLONINGER, KENNETH  
DANSIE, KIM  
BEAMER, MARK  
LAWRENCE, MARK  
POWERS, JOHN  
PASI, DEEPAK  
BRUGH, VICTOR  
LIN, SHU  
RAASCH, ERIC  
GORMAN, RICHARD  
GARRETT, JAMES  
STORY, JOHN  
RICH, ROBERT  
OSTA, ELIE  
DAILEY, TIMOTHY  
DAMBECK, ALLYN  
GESSLER, WALTER  
KORNEGAY, CHRISTOPHER  
RAUCK, RICHARD  
TIELBORG, MICHAEL  
UHREN, ROBERT  
LARCOMBE, JOEL  
CALABRIA, WILLIAM  
ALEJANDRO, LUIS

GREENSBOR  
MONROE  
CHARLOTTE  
DURHAM  
CHARLOTTE  
WILMINGTON  
BOONE  
CHARLOTTE  
LAWNDALE  
HIGH POINT  
BELHAVEN  
MURPHY  
WINSTON-SALEM  
RALEIGH  
CHARLOTTE  
DURHAM  
RALEIGH  
NEW BERN  
JACKSONVILLE  
CHARLOTTE  
ELIZABETHTOWN  
SNOW HILL  
BOONE  
GOLDSBORO  
STATESVILLE  
KENANSVILLE  
WINSTON-SALEM  
CHAPEL HILL  
SPRUCE PINE  
CAMP LEJEUNE  
SHELBY  
GREENSBORO

#### NP ADDITIONAL SUPERVISOR LIST

ANTHONY, ARENNETTE  
BALLARD, MARCIA  
BEAN, ALLISON  
BELL, REAGAN  
BELL, JUDY  
BROWN, LISA  
BUTLER, CAROL  
CARTER, JESSICA  
COUSINS, MELISSA  
DIXON, CAROLYN

FLOWE, KENNETH  
ELLISTON, WINSTON  
SIMONDS, WICKHAM  
PETERS, DOUGLAS  
THOMASON, ROBERT  
EDWARDS, ANGELA  
MARTIN, DAVID  
CLARK, MICHAEL  
TRIPP, HENRY  
MOORE, DONALD

GREENSBORO  
ASHEVILLE  
DURHAM  
WILMINGTON  
WINSTON SALEM  
WINSTON-SALEM  
WHITEVILLE  
GREENSBORO  
HIGH POINT  
CHARLOTTE

**March 16-18, 2011**

DOCKERY, JENNIFER  
EATON, CYNTHIA  
EVERETT, GILDA  
FEDZIUK, BERNADETTE  
FERREE, BETTE  
GILMER, CASI  
GOLDEN, MAUREEN  
HAMILTON, KARA  
HAMLIN, CAROL  
HILL, DORIS  
HOPSON, LELA  
JACKSON, MARY  
JENKINS, DAWN  
JOHNSON, BRIAN  
JONES, KAREN  
JORDAN, LESLIE  
LEIF, PAULA  
MARTIN, DORINE  
MARTIN WATSON, BETTY  
MASTERS, TRICIA  
MEELHEIM, HELEN  
MURPHY, LUANNE  
MURRAY, CAROL  
NIFONG, DEBORAH  
O'HARA, MYRA  
PENN, ANGELA  
ROBBINS, JOAN  
SMITH, DEBORAH  
SNOW, AMY  
SPELL, SUSAN  
SPENCER, ELSIE  
TABRON, TONIQUE  
TERRELL, KYLE  
TODD, HEATHER  
VANVIEGEN, MARK  
VICKERS, HELEN  
VOGRINC, ASHLEY  
WOLFF, MERRI  
WOMBLE, CAROL  
WRIGHT, AMANDA  
WRIGHT, AMANDA  
WRIGHT, AMANDA  
WRIGHT, AMANDA  
WRIGHT, AMANDA  
YOUNG, BRADLEY  
BARNHARDT, DEBRA

BRACEY, LISA  
HORNER, BRIAN  
TAYLOR, MARSHALL  
MINTZER, MELANIE  
FLOWE, KENNETH  
WELLS, ROXIE  
SWAD, SAMUEL  
FLEISHMAN, LAWRENCE  
BARNHILL, PEGGY  
NAZER, KARIM  
BUGLISI, LUCILLE  
MEINE, FREDERICK  
TRAN-PHU, LAN  
PACOS, ANDREW  
COOK, CHARLES  
CLIFFORD, BARBARA  
MONROE, YVONNE  
COWARD, HOLLY  
MOORE, DONALD  
DODDS, TERRY  
WILLIS, KERRY  
MOORE, JEFFREY  
CHARLESWORTH, AMY  
THOMASON, ROBERT  
CURRAN, DIANA  
HIGH, KEVIN  
MITTAL, MADHUR  
HEAVNER, TERESA  
THOMASON, ROBERT  
TROIANO, JASON  
LAWRENCE, MARY  
TABE, WILSON  
HOLT, JAMES  
HARDEN, WILLIAM  
L'ITALIEN, ANITA  
GARRETT, JAMES  
FLOWE, KENNETH  
THOMASON, ROBERT  
KAPLAN, DAVID  
JACOBSEN, CHAD  
MCMAHON, DANIEL  
GALL, SARAH  
OESTERHELD, JAVIER  
KAPLAN, JOEL  
ALDRIDGE, JULIAN  
CLONTZ, TED

WADESBORO  
CHARLOTTE  
GREENVILLE  
ROCKY MOUNT  
KERNERSVILLE  
STEDMAN  
GREENSBORO  
CHARLOTTE  
LUMBERTON  
MOORESVILLE  
RICHLANDS  
WILMINGTON  
FAYETTEVILLE  
THOMASVILLE  
RALEIGH  
WINSTON-SALEM  
DURHAM  
CHAPEL HILL  
CHARLOTTE  
LENOIR  
BEAUFORT  
LAURINBURG  
BEAUFORT  
WINSTON SALEM  
ASHEVILLE  
WINSTON-SALEM  
JACKSONVILLE  
MURPHY  
WINSTON SALEM  
WAKE FOREST  
MOREHEAD CITY  
WILSON  
PITTSBORO  
ROCKY MOUNT  
RALEIGH  
JACKSONVILLE  
OAK RIDGE  
WINSTON SALEM  
CHARLOTTE  
CHARLOTTE  
CHARLOTTE  
CHARLOTTE  
CHARLOTTE  
CHARLOTTE  
DURHAM  
CHARLOTTE

**March 16-18, 2011**

BOLLING, AMY  
BROOKS, HELEN  
BYRD, TEMPLE  
CAVELLI, RACHAEL  
CHISUM, PATRICIA  
COUSINS, MELISSA  
CURRAN, MARY ALYCE  
DEATON, ELIZABETH  
DOCKERY, JENNIFER  
DOCKERY, JENNIFER  
FLAUGHER, CAROL  
GAMEWELL, MARILYN  
GETTELFINGER, JOAN  
GLEESON, CYNTHIA  
GOLDEN-MYERS, SHARON  
GOLDEN-MYERS, SHARON  
HARMAN, STEFANIE  
HAYNES, CHRISTOPHER  
HENSLEY, CHAD  
HILES, HEATHER  
HOSLER, MARY  
HOTELLING, BARBARA  
HOUSEAL, MARIE  
JEFFCOAT, VALENCIA  
JUDSON, MELISSA  
LONG, TERRESA  
LORE, DIANNE  
LOVETTE, MELISSA  
LU, CINDY  
LUTTRELL, MICHAEL  
LYALL, MONICA  
MCDANIEL, CATHERINE  
MCDOWELL, KAREN  
MCKENZIE, ILA  
MINTZ-SMITH, RASHONDA  
MORRISON, CYNTHIA  
PRICE, ELAYNE  
PUCKETT, KAREN  
RICHARD, SUSAN  
SHOOK, CYNTHA  
SILSBY, RUTH  
SMITH, KIM  
SMITH, SHERRY  
SMITHERMAN, SHONDA  
SPURBECK, BRENDA  
STARRETT, JENNIFER

PATEL, MANISH  
HUSSEY, MICHAEL  
WATTS, LAWRENCE  
BROOKS, DOUGLAS  
OSEKI, COLLINS  
FLOWE, KENNETH  
LUOMA, DAVID  
POLLOCK, HOKE  
JOEFIELD, JERMAINE  
JEWELL, GARY  
HAQ, MUHAMMAD  
BEYER, SARA  
SMITH, ROBERT  
VINCENT, MARK  
PARDO, SANDRA  
METZGER, GEORGE  
JOACHIM, JAMES  
GANDLA, VIJAYA  
HOWARD, WILLARD  
KHAN, FOZIA  
IYENGAR, PHANIRAJ  
WEIR, SAMUEL  
AHMED, MAQSOOD  
MATKINS, PREETI  
JAIKUMAR, SIVAKUMAR  
NIEMEYER, MEINDERT  
MACKINNON, CHRISTOPHER  
SAILER, KAAREN  
VREDENBURGH, JAMES  
GUZMAN, MYRA  
MARTIN, DAVID  
PARDO, SANDRA  
MITTAL, MADHUR  
HAMMER, DOUGLAS  
WALL, JAMES  
JONES, LAWRENCE  
SIGMON, JAMES  
MAJURE, DAVID  
BLUE, DEBRA  
MATKINS, PREETI  
ROYER, HARRELL  
JONES, DEANNA  
BLAKE, KHASHANA  
MOORE, DONALD  
MARTIN, DAVID  
SUTTON-SURAK, AUDREY

MOORESVILLE  
HIGH POINT  
CLINTON  
CONCORD  
LUMBERTON  
GREENSBORO  
CONCORD  
WILMINGTON  
WADESBORO  
WADESBORO  
FAYETTEVILLE  
LENOIR  
CHARLOTTE  
MATTHEWS  
PATTERSON  
PATTERSON  
JACKSONVILLE  
HIGH POINT  
RUTHERFORDTON  
BURLINGTON  
CHARLOTTE  
CHAPEL HILL  
GOLDSBORO  
CHARLOTTE  
CHAPEL HILL  
ELON COLLEGE  
WENDELL  
CHARLOTTE  
DURHAM  
CARY  
ROCKY MOUNT  
COLLETTSVILLE  
JACKSONVILLE  
FRANKLIN  
CONCORD  
ASHEVILLE  
WILSON  
MOUNT AIRY  
RALEIGH  
CHARLOTTE  
ALBEMARLE  
BURLINGTON  
KINSTON  
YADKINVILLE  
ROCKY MOUNT  
WILMINGTON

**March 16-18, 2011**

STRAYHORN, CHRISTINE  
SULLIVAN, CINDY  
THONGTEUM, BOONPON  
VAUGHAN, ANITA  
WILLIAMS, MEGAN  
WILSON, LORETTA  
WILSON DEFELICE, JEANETTE  
ALBANO, DENISE  
AMOAKO, EMELIA  
BINTZ, PEGGY  
CARMAN, MARGARET  
CARR, KIMBERLY  
CLARK, KAY  
COUSART, TABITHA  
CRYER, VICTORIA  
CUNHA, CHRISTINE  
DARST, MARGARET  
DAVIDSON, DEBORAH  
FORSTHOEFEL, ANN  
FRAZIER, MYRA  
KANNE, GERALDINE  
KESTER, AMY  
MCLAURIN, ELLEN  
MCNEIL HALL, AMANDA  
NOOE, MARY ANN  
OWENBY, RHONDA  
PRUITT, LYSIANE  
RICHARDS, BETSY  
SEIDEL, CORALINN  
SUGG, BRINKLEY  
WHALEY, LINDA  
WHISNANT ROPER, REGINA  
ADAMS, JILL  
AIREY, DENISE  
ASHBY, TERRY  
BAILEY, RHONDA  
BALLARD, MELISSA  
BARNES, MARTHA  
BAUMGARTNER, ANNE  
BOARDMAN, CYNTHIA  
BOEDEKER, DEBORAH  
BOST, NATALIE  
BURRELL, STACI  
BUSH, TARA  
CHURCH, THOMAS  
COCHRAN, KELLIE

VUKOSON, MATTHEW  
BRANCH, CHARLES  
MITCHELL, MARK  
MORTON, TERRENCE  
JORGE, CARLOS  
HOGSETTE, GERALD  
FLOWE, KENNETH  
EVANS, CHARLOTTE  
BEITTEL, TIMOTHY  
BIERRENBACH DECAST, RICARDO  
ROSENBAUM, DAVID  
DUNN, LAURIE  
TUTEN, CINDY  
THOMASON, ROBERT  
KRISHNA, KALPANA  
STOUDMIRE, JONATHAN  
MCDONALD, THADDEUS  
MASCIELLO, ANTHONY  
NOVECK, ROBERT  
ZIOLKOWSKA, ALDONA  
COWARD, HOLLY  
KIMBALL, ROBERT  
PARKER, DAVID  
CURL, KENNETH  
NYLAND, LEONARD  
LORELLI, LISA  
FLORIAN, THOMAS  
CABRAL, GONZALO  
WELLMAN, SAMUEL  
SEN, ANANYA  
MCCALEB, JANE  
FRASCA, ANTHONY  
WILSON, BRYAN  
ZUBER, THOMAS  
PERSAUD, KAVITA  
KANN, JOEL  
PRUITT, WESLEY  
PRICE, CECIL  
SMITH, JAMES  
KELLEY, JOHN  
GREGORY, DIXON  
KIEFER, MARK  
SUMMERS, SHANE  
MACOMBER, JOSHUA  
FREEMAN, JOHN  
ANDERSON, TROY

CHAPEL HILL  
WINSTON SALEM  
WINSTON-SALEM  
CHARLOTTE  
CHARLOTTE  
WINSTON SAALEM  
ROXBORO  
MOORESVILLE  
WILMINGTON  
HENDERSONVILLE  
CARY  
RALEIGH  
ASHEVILLE  
WINSTON-SALEM  
FAYETTEVILLE  
ALBEMARLE  
RALEIGH  
WINSTON SALEM  
DURHAM  
HIGH POINT  
CHAPEL HILL  
STATESVILLE  
FAYETTEVILLE  
NORTH WILKESBORO  
MADISON  
MORGANTON  
LUMBERTON  
WILSON  
HICKORY  
MORRISVILLE  
ROANOKE RAPIDS  
MORGANTON  
CHARLOTTE  
BOONE  
WILMINGTON  
CHAPEL HILL  
ASHEVILLE  
WINSTON-SALEM  
RALEIGH  
RALEIGH  
WILMINGTON  
TAYLORSVILLE  
KINGS MOUNTAIN  
CARY  
BOONE  
RALEIGH

**March 16-18, 2011**

CONNOR, MARLON  
COOPER, PENNY  
CORN, LISA  
DEAL, ANNIE  
DESAI, SHAKTI  
DICKERSON, BETH  
DOWD, LISA  
DRY, REBECCA  
ENNIS, KEENA  
ERVIN, VIRGINIA  
EVERLY, CAROL  
FELL, DEBRA  
FERRARA, JENNIFER  
FLOWERS, LINDA  
GALLAGHER, AMANDA  
GUIN, TIMOTHY  
HARRIS, TARA  
HILL, RHONDA  
HILL, DORIS  
HINNANT, CONNIE  
HIPPLE, SANDRA  
HOLT, ROGER  
HUNTSINGER, LISA  
HUPP, DEBORAH  
JACOBS, SUSANNE  
JENKINS, KAY  
JORAN, ELIZABETH  
KOLKMAN, ERIN  
LAND, TRACY  
LAYDEN, SANDRA  
LEFAIVE, MICHAEL  
LUPIENSKI, CHRISTINE  
MADDEN, REGINALD  
MADDEN, REGINALD  
MANLEY, EDDIE  
MARKS, MICHAEL  
MATZKE, TERESA  
MCFARLANE, KAREN  
MEHTA, SUSAN  
MONTGOMERY, KIMBERLY  
MOORE, MARIE  
MOORE, MARK  
MYERS, DEBORAH  
NESBITT, SHIRLEY  
OSBORNE, SHERRI  
PAWLAK, COLLEEN

BLOK, ROBERT  
BROYLES, WILLIAM  
MORTON, TERRENCE  
BEYER, SARA  
KANN, JOEL  
POTH, ROBERT  
FARKAS, LINDA  
HANDA, KUSHAL  
MANOUSOS, GEORGE  
SUMMERS, SHANE  
KELLEY, JOHN  
MARANA, ENRIQUE  
BUCHANAN, SONYA  
ADEDIRAN, ABAYOMI  
NORMAN, BRUCE  
DALY, CLAUDIA  
ADAMS, ROBERT  
MERCER, MICHELE  
JAROSZEWSKI, DAVID  
NJAPA, ANTHONY  
DEMETRI, CHARALAMBOS  
PEKAREK, ELIZABETH  
MOSS, ALFRED  
KANN, JOEL  
KANN, JOEL  
ELLIS, CHARLES  
PRUTHI, RAJ  
DESAI, PRATIK  
BARNES, DANIEL  
WATTS, LAWRENCE  
MCKINNEY, PARISH  
KANN, JOEL  
MANGANO, CHARLES  
DESAI, SUNIL  
HINES, MARCONO  
NJAPA, ANTHONY  
MERGY, JAMES  
BUNN, BARRY  
KOOHESTANI, AMIR  
PARKER, THOMAS  
CONWAY, JILL  
MISTRY, KSHITIJ  
GIRMAY, AREGAI  
BRADSHAW, WILLIAM  
VILLACORTE, LIZETTE  
ROBINSON, LINDWOOD

SALISBURY  
DURHAM  
BELMONT  
LENOIR  
CARY  
CHARLOTTE  
RALEIGH  
MONROE  
CHARLOTTE  
KINGS MOUNTAIN  
RALEIGH  
FARMVILLE  
CHARLOTTE  
WARSAW  
RALEIGH  
GREENVILLE  
KNIGHTDALE  
RUTHERFORDTON  
DENVER  
JACKSONVILL  
STATESVILLE  
LEXINGTON  
GAFFNEY  
WAKE FOREST  
KNIGHTDALE  
FAYETTEVILLE  
CHAPEL HILL  
CARY  
PINEHURST  
CLINTON  
GREENSBORO  
CARY  
RALEIGH  
RALEIGH  
SMITHFIELD  
JACKSONVILL  
FAYETTEVILLE  
TARBORO  
ALBEMARLE  
CHARLOTTE  
CHARLOTTE  
CHARLOTTE  
STATESVILLE  
ASHEVILLE  
HICKORY  
RALEIGH

**March 16-18, 2011**

PENN, LASHANDA	NIFONG, TED	LEXINGTON
PETTUS, KESHIA	READLING, RANDY	SALISBURY
RAGAN, MICHAEL	PRIDGEN, JAMES	WILMINGTON
ROBERTS, KARI	GOVERT, JOSEPH	DURHAM
RUSSO, REBECCA	ZACCO, ARTHUR	APEX
SAUNDERS, DEW	KANN, JOEL	WAKE FOREST
SEWARD, KELLY	ROBERTS, JAMES	CHARLOTTE
SHARPE, ANGELA	BULLARD, ANDREW	SALISBURY
SHEETS, TRACEY	ALBERT, SUSAN	WILKESBORO
SHERMAN, COURTNEY	MERGY, JAMES	FAYETTEVILLE
SHUMATE, WENDY	MCEWEN, LUTHER	LARGO
SMITH, KERRI	WELLMAN, SAMUEL	HICKORY
SMITH, ROBIN	YATES, STEVEN	GASTONIA
SPAKE, MARY	KOTULLA, JERRY	TRYON
STARR, ROBIN	WATTS, LAWRENCE	CLINTON
STRAYHORN, CHRISTINE	DAVIS, CARA	RALEIGH
TABRON, TONIQUE	RAWLS, STACEY	ROCKY MOUNT
TAYLOR, JAMIE	DOLACK, CHRISTINA	CONCORD
TOLLEY, MARGARET	TEATER, DONALD	ROBBINSVILLE
VINZANI, CATHERINE	KANN, JOEL	WOONSOCKET
VOLLBRECHT, MARLAR	MORTON, TERRENCE	HUNTERSVILLE
WADE, RENEE	SUNDARAM, SENTHIL	RALEIGH
WADE, RENEE	MACOMBER, JOSHUA	RALEIGH
WOMBLE, CAROL	BADGER, MICHAEL	SUMMERFIELD
WOODRUFF, SARAH	FLOWE, KENNETH	DURHAM
WORSHAM, LEANNA	COVINGTON, VALENCIA	WILMINGTON
ZEIGLER, SONYA	KOTULLA, JERRY	TRYON

#### Clinical Pharmacist Practitioners

No CPP applications approved since last report

#### **Anesthesiologist Assistant, Perfusionist & Provisional Perfusionist Licenses Issued Since January 2011**

Peggy Robinson, PA-C, Chair; William Walker, MD; and Pamela Blizzard

March 16, 2011

#### Perfusionists:

Linder, Dean Francis

Alexander, Stanlin (Provisional license converted to Full)

#### Provisional Perfusionists:

None

#### Anesthesiologist Assistants:

Schilling, Amie Lohr

**March 16-18, 2011**

PA Licenses Approved  
March 2011

Initial PA Applicants Licensed 01/01/11 – 02/28/11

PA-Cs

Name

Adair, Lawrence Edwin Carlton	01/20/2011
Alexander, Megan Elizabeth	01/20/2011
Allred, Brittany	02/02/2011
Baxley, Jennifer Carmack	01/14/2011
Boehlke, Brittani Rose	02/21/2011
Britt, Ashley Renee	02/14/2011
Brower, Stacey Erin	02/22/2011
Bruggers, Jessica Leigh	02/09/2011
Butterworth, Kimberly Anne	01/26/2011
Castillo-Powell, Maria Carmen	01/18/2011
Chase, Shana Noel	02/24/2011
Cook, Todd Eric	01/14/2011
Cool, Jay Mark	01/21/2011
Cox, Andrew Stephen	02/10/2011
Cozzati, Daniel James	02/22/2011
Dinger, Shawna	02/24/2011
Dunne, Stacy Marie	01/31/2011
Exter, Jeffrey Craig	02/21/2011
Flores, Tobey Michael	01/12/2011
Foy, Dale Anthony	02/22/2011
Godley, Melissa Martinez	01/06/2011
Gombar, Kathryn Leigh	01/18/2011
Greenlee, Quante Lamont	01/03/2011
Gumpert, Julia Anna Lyn	01/21/2011
Healey Osinski, Kathleen Rose	02/09/2011
Hoepner, Lance Patrick	02/23/2011
Jackson, Samantha Jo	01/20/2011
Johnson, Robert William	02/08/2011
Joines, Breland Meany	01/03/2011
Jones, Mia	01/14/2011
Kalevas, Karen McGinnis	02/14/2011
Kinsler, Laura Ann	01/24/2011
Lang, David Brian	02/28/2011
Laughlin, David Stephen	01/14/2011
Le, Bach Tuyet Thi	01/20/2011
Little, Kathryn Walser	01/20/2011

March 16-18, 2011

Macemore, Amber Nicole	01/14/2011
Martin, Shannon Danielle	01/06/2011
McClough, Rebecca Lea	01/25/2011
McCoy, Elizabeth Admire	01/05/2011
Mezera, Tony James	01/20/2011
Morgan, Andrea Marie	02/22/2011
Murphy, Catherine Taylor	01/14/2011
Myers, Brittany Nicole	02/02/2011
Newman, Jason Bradley	02/22/2011
Nguyen, Hoa Quynh	02/21/2011
Parker, Heather Smith	01/21/2011
Parshley, Kathryn Erin	02/15/2011
Peacock, Robin Lear	01/24/2011
Petty, Lainey Medine	01/28/2011
Pierino, Alexis Leigh	01/31/2011
Price, Abigayle Lee	01/21/2011
Raspa, Robert	02/16/2011
Rawls, Ashley Ryan	01/20/2011
Reisinger, Eric Isom	01/10/2011
Robinson, Sarah Elizabeth	01/28/2011
Rothwell, Stephan Michael	01/18/2011
Ruoff, Teresita Claret	01/24/2011
Schulz, Heidi	02/21/2011
Shepherd, Angela Cheryl	02/03/2011
Sims, Tori Yamika	02/14/2011
Smith, Megan Angela	01/26/2011
Smith, Stacy Pauley	01/12/2011
Thomas, Adam J	02/17/2011
Tinsley, Audrey Michele	02/22/2011
Tran, Ngoc-Tuyen	01/21/2011
Turner, Mary Tyson	02/24/2011
Vaughn, Moira Casten	01/03/2011
West, Leigh Armstrong	01/20/2011
Williams, Gloria Diane	01/26/2011
Woodall, Emily Claire	01/06/2011

PA-Cs Reactivations/Reinstatements/Re-Entries  
Name

Blanchard, Patricia Bauserman	02/14/2011
Bresnahan, James David	02/23/2011
Bushardt, Reamer Loren	01/21/2011
Buzzerd, Adam Patrick	02/08/2011
Guthrie, Joseph Clark	01/26/2011
Patrick, Frank Charles	01/31/2011
Woodall, Emily Claire	01/06/2011

**March 16-18, 2011**

## **ALLIED HEALTH COMMITTEE REPORT-PA/EMS**

Committee Members present were: Peggy Robinson, PA-C, Chairperson, William Walker, MD, and Pamela Blizzard. Also present were: Marcus Jimison, Lori King, CPCS, Quanta Williams, Jane Paige, Katharine Kovacs, PA, and Don Metzger, PA.

Committee Members absent: None.

### 1. Old business. PAs with Five or More Primary Supervising Physicians.

Issue: Follow-up update from the January, 2011 Board Action regarding the status of PAs with five or more primary supervising physicians and audits on these PAs. Marcus Jimison to discuss random audits vs. targeted audits.

Committee Recommendation: Marcus Jimison discussed targeted audits. Incorporate PAs with five or more primary supervising physicians into the audits each year. Discuss with the full Board whether or not to create a separate Rule vs. Policy for targeted audits vs. random audits. Staff to determine whether rule is warranted and if so, draft a proposed rule. L. King informed the Committee that Mr. Gupta added the audit information to the PA renewal process and that Ms. Fisher will incorporate the 2010 PA Compliance Review Report to the April issue of the Forum.

Board Action: Marcus Jimison discussed targeted audits. Incorporate PAs with five or more primary supervising physicians into the audits each year. Discuss with the full Board whether or not to create a separate Rule vs. Policy for targeted audits vs. random audits. Staff is to determine whether the rule is warranted and if so, draft a proposed rule. L. King informed the Committee that Mr. Gupta added the audit information to the PA renewal process and that Ms. Fisher will incorporate the 2010 PA Compliance Review Report to the April issue of the Forum. Staff is to write an article for the Forum regarding PA Audits.

Open Session NC Emergency Medical Services

1. None.

Committee Adjourned: 2:50 p.m.

The next regular meeting of the Allied Health Committee Meeting is tentatively set for the May, 2011 Board Meeting.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

One licensee application was reviewed. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

**March 16-18, 2011**

## **ALLIED HEALTH COMMITTEE REPORT – LP/AA/CPP**

The Allied Health Committee of the North Carolina Medical Board was called to order at 1:30 pm, March 16, 2011 at the office of the North Carolina Medical Board. Members present were: Peggy Robinson, PA-C, Chair; William Walker, MD; and Pamela Blizzard. Also present were Marcus Jimison, Jane Paige, Lori King, Katharine Kovacs, and Quanta Williams.

1. Open Session Anesthesiologist Assistants
  - a. No items for discussion
  
2. Open Session Nurse Practitioners
  - a. Midwifery Joint Subcommittee report to the legislature
    - i. The MJS Chair, Maureen Darcey, has not submitted the report regarding CPM licensure to the legislature. The Committee has asked Marcus to bring this up in the next meeting of the workgroup. They would also like the article (dated 07/26/10) be included in the report as supporting evidence.  
  
Committee Recommendation: To be discussed at the next meeting of the workgroup.  
  
Board Action: To be discussed at the next meeting of the workgroup. The Board would like for staff inform the Board of Nursing that the Medical Board expects this to be resolved expeditiously. The workgroup will meet on March 21.
  
3. Open Session Clinical Pharmacist Practitioners
  - a. No Items for discussion
  
4. Open Session Perfusionists
  - a. Open session portion of the minutes of the January PAC meeting.
    - i. The open session minutes of the January PAC meeting have been sent to the Committee members for review.  
  
Committee Recommendation: Accept as information  
  
Board Action: Accept as information
  
  - b. ABCP Recertification Process
    - i. Dr. Hines provided an update on this item. The PAC has requested that staff do further research on this matter. They will revisit this at the July meeting.  
  
Committee Recommendation: Accept as information  
  
Board Action: Accept as information
  
  - c. PAC Vacancy
    - i. Since Dr. Hines has accepted a position in Texas, he has informed us that the March PAC meeting will be the last meeting he attends. There is a notice on the Board's website requesting cardiothoracic surgeons or cardiovascular anesthesiologists that

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may be interested in serving on the PAC to submit a letter of interest. This information has also been sent to the NC Medical Society, Old North State Medical Society, NC Osteopathic Medical Association, NC Society of Anesthesiologists, and the NC Chapter of the American College of Surgeons. This position is appointed by the Medical Board.

Only one letter of interest has been received so far (Robert Kyle, DO).

PAC Recommendation: Accept as information

Committee Recommendation: Invite Dr. Kyle to the May Allied Health Committee meeting for an interview. If any other letters of interest are received, invite those applicants to the May meeting also.

Board Action: Invite Dr. Kyle to the May Allied Health Committee meeting for an interview. If any other letters of interest are received, invite those applicants to the May meeting also.

- ii. The NCHA has appointed Vanessa King, Pharm. D., to replace Richard Gannotta. Ms. King is the Vice President of Cardiac and Surgical Services at Cape Fear Valley Medical Center.

PAC Recommendation: For information

Committee Recommendation: Accept as information

Board Action: Accept as information

d. Immigration Rule (21 NCAC 32V. 0103)

- i. The public hearing was held on January 14, 2011. No comments were received. The Board approved this rule change at its January meeting, however, the Rules Review Commission requires that the PAC give final approval. The rule received final PAC approval at the March meeting.

PAC Recommendation: Approve 21 NCAC 32V .0103

Committee Recommendation: Approve 21 NCAC 32V .0103

Board Action: Approve 21 NCAC 32V .0103

- 5. Open Session Polysomnography
  - a. No items for discussion

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

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One licensee application was reviewed. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

#### **REVIEW (COMPLAINT) COMMITTEE REPORT**

Paul Camnitz, MD, Chair; Peggy R. Robinson, PA-C; John B. Lewis

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Review (Complaint) Committee reported on fifteen complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

#### **DISCIPLINARY (COMPLAINTS) COMMITTEE REPORT**

William Walker, MD, Chair; Dr. Thomas R. Hill, MD; Pamela Blizzard; Karen R. Gerancher, MD; Eleanor E. Greene, MD

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Complaints) Committee reported on two complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

#### **DISCIPLINARY (MALPRACTICE) COMMITTEE REPORT**

William Walker, MD, Chair; Dr. Thomas R. Hill, MD; Pamela Blizzard; Karen R. Gerancher, MD; Eleanor E. Greene, MD

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not

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considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Malpractice) Committee reported on 59 cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

#### **DISCIPLINARY (MEDICAL EXAMINER) COMMITTEE REPORT**

William Walker, MD, Chair; Dr. Thomas R. Hill, MD; Pamela Blizzard; Karen R. Gerancher, MD; Eleanor E. Greene, MD

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Medical Examiner) Committee reported on 12 cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

#### **INVESTIGATIVE INTERVIEW REPORT**

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Fourteen informal interviews were conducted. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

#### **DISCIPLINARY (INVESTIGATIVE) COMMITTEE REPORT**

William Walker, MD, Chair; Dr. Thomas R. Hill, MD; Pamela Blizzard; Karen R. Gerancher, MD; Eleanor E. Greene, MD

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to

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Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Investigative) Committee reported on 23 investigative cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

### **REVIEW (INVESTIGATIVE) COMMITTEE REPORT**

Paul Camnitz, MD, Chair; Peggy R. Robinson, PA-C; John B. Lewis

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Review (Investigative) Committee reported on 21 investigative cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

### **NORTH CAROLINA PHYSICIANS HEALTH PROGRAM (NCPHP) COMMITTEE REPORT**

Thelma Lennon, Chair; Janice Huff, MD; Ralph C. Loomis, MD

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Board reviewed 22 cases involving participants in the NC Physicians Health Program. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

### **RETREAT COMMITTEE**

The Retreat Committee of the North Carolina Medical Board was called to order at 1:30pm Wednesday March 16, 2011, at the office of the Medical Board. Members present were: Karen R. Gerancher, MD, Chair; Janice E. Huff, MD; Ms. Thelma Lennon and Thomas R. Hill, MD. Also present were: Christina Apperson and Maureen Bedell.

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1. Old Business
  - a. Approval of Minutes

The minutes of the January 2011 meeting were approved.
  - b. Report on Raleigh Renaissance

Maureen Bedell and Christina Apperson reported on their review of the Raleigh Renaissance meeting spaces. It was decided to reserve the Adagio and Allegro Rooms.
2. New Business
  - a. Friday Night Entertainment

Maureen Bedell reported that Sparians Night Bowling Boutique in North Hills (in close proximity to the Raleigh Renaissance) is a new, very popular Raleigh entertainment venue. It offers upscale bowling in more elegant surroundings than a traditional bowling alley. After site review by Dr. Gerancher, it was decided to include Sparians on the retreat agenda as a Friday night social activity for Board members.
  - b. Potential Speakers/Topics
    - i. Evaluation/Reevaluation of the Board's Processes

The group is interested in including this topic on the retreat agenda, particularly speakers and discussions focusing on how to streamline board processes with reliance on tools such as The Kirby Scale; at what point Board members need to be involved in licensing and discipline proceedings; an explanation of what occurs pursuant to statute, by law and by custom; implementing a precedent-based system or guidelines for discipline; each Director may be called upon to review their work over the last twelve months for opportunities for process improvement.
    - ii. Jonathan Linkous, CEO American Telemedicine Association

While it has been under discussion for many years, telemedicine is recognized as a "hot topic" now; a number of states (CA, TX, SC) have rules or position statements with varying degrees of oversight; ATA has progressive/controversial proposals that should spark robust discussion.
    - iii. Maintenance of Licensure/Mandatory Cognitive Assessment for Senior MD's

MOL should be included on the agenda and perhaps should be discussed on Friday afternoon so Board Members will have time to contemplate and discuss the issue during the retreat. Possible speakers include Janelle Rhyne, MD, FSMB President and Bill Williams, MD, of NBME. Mandatory Cognitive Assessments, like those required by the FAA for pilots age 40 and above, should not be considered at this time.
    - iv. FSMB Annual Meeting as Catalyst for Speakers/Topics

The committee agreed to leave a session open for any issues/speakers identified at the FSMB meeting to be of particular significance or interest to the Board. In the interim, staff should focus on securing speakers for the above-identified topics.
    - v. Discussion Facilitators During Sessions

It was agreed that discussion facilitators should be included during sessions to ensure the retreat stays on schedule and to allow all Board members to participate in discussion of issues. NCMB staff will likely serve as facilitators.
    - vi. Miscellaneous

Board members who live in Raleigh and nearby should be encouraged to stay at the Renaissance in order to maximize participation in after-hours events and conversations as well as to make it easier on themselves

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during the combined Board/retreat meetings by reducing commute and preparation times.

Directors should probably attend meetings that impact them, but in an effort to conserve financial resources, will be asked to stay in their homes rather than at the Renaissance on Friday evening.

3. The Committee adjourned at 2:45pm

#### **ADJOURNMENT**

This meeting was adjourned at 2:30 p.m. Friday March 18, 2011.

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William A. Walker, MD  
Secretary/Treasurer

## OFFICE-BASED PROCEDURES

### Preface

THIS POSITION STATEMENT ON OFFICE-BASED PROCEDURES IS AN INTERPRETIVE STATEMENT THAT ATTEMPTS TO IDENTIFY AND EXPLAIN THE STANDARDS OF PRACTICE FOR OFFICE-BASED PROCEDURES IN NORTH CAROLINA. THE BOARD'S INTENTION IS TO ARTICULATE EXISTING PROFESSIONAL STANDARDS AND NOT TO PROMULGATE A NEW STANDARD.

THIS POSITION STATEMENT IS IN THE FORM OF GUIDELINES DESIGNED TO ASSURE PATIENT SAFETY AND IDENTIFY THE CRITERIA BY WHICH THE BOARD WILL ASSESS THE CONDUCT OF ITS LICENSEES IN CONSIDERING DISCIPLINARY ACTION ARISING OUT OF THE PERFORMANCE OF OFFICE-BASED PROCEDURES. THUS, IT IS EXPECTED THAT THE LICENSEE WHO FOLLOWS THE GUIDELINES SET FORTH BELOW WILL AVOID DISCIPLINARY ACTION BY THE BOARD. HOWEVER, THIS POSITION STATEMENT IS NOT INTENDED TO BE COMPREHENSIVE OR TO SET OUT EXHAUSTIVELY EVERY STANDARD THAT MIGHT APPLY IN EVERY CIRCUMSTANCE. THE SILENCE OF THE POSITION STATEMENT ON ANY PARTICULAR MATTER SHOULD NOT BE CONSTRUED AS THE LACK OF AN ENFORCEABLE STANDARD

### General Guidelines

#### The Physician's Professional and Legal Obligation:

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

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

#### *Exemptions:*

*These guidelines do not apply to Level I procedures.*

#### *Written Policies and Procedures:*

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

#### Emergency Procedure and Transfer Protocol:

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

All office personnel should be familiar with and capable of carrying out written emergency instructions. The instructions should be followed in the event of an emergency, any untoward anesthetic, medical or surgical complications, or other conditions making hospitalization of a

patient necessary. The instructions should include arrangements for immediate contact of emergency medical services when indicated and when advanced cardiac life support is needed. When emergency medical services are not indicated, the instructions should include procedures for timely escort of the patient to the hospital or to an appropriate practitioner.

#### Infection Control:

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

#### Performance Improvement:

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

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

#### Medical Records and Informed Consent:

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

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

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

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

#### Credentialing of Physicians:

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

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

1. state licensure;
2. procedure specific education, training, experience and successful evaluation appropriate for the patient population being treated (*i.e.*, pediatrics);
3. for physicians, board certification, board eligibility or completion of a training program in a field of specialization recognized by the ACGME or by a national medical specialty board that is recognized by the ABMS for expertise and

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

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

#### Accreditation:

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

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

#### *Patient Selection:*

The physician who performs the surgical or special procedure should evaluate the condition of the patient and the potential risks associated with the proposed treatment plan. The physician also is responsible for determining that the patient has an adequate support system to provide for necessary follow-up care. Patients with pre-existing medical problems or other conditions, who are at undue risk for complications, should be referred to an appropriate specialist for preoperative consultation.

#### ASA Physical Status Classifications:

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

#### Candidates for Level II Procedures:

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

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Candidates for Level III Procedures:

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

### *Surgical or Special Procedure Guidelines*

#### *Patient Preparation:*

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

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

The physician performing the surgical or special procedure also should:

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

Discharge Criteria:

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

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

Information to the Patient:

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

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

### Reportable Complications:

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

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

### Equipment Maintenance:

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

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

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

### Compliance with Relevant Health Laws:

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

Nothing in this position statement affects the scope of activities subject to or exempted from the North Carolina health care facility licensure laws.<sup>1</sup>

### Patient Rights:

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

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<sup>1</sup> See N.C. Gen. Stat. § 131E-145 et seq.

#### Enforcement:

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

#### Level II Guidelines

##### *Personnel:*

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

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

#### Surgical or Special Procedure Guidelines

##### Intraoperative Care and Monitoring:

- The physician who performs Level II procedures that require conscious sedation in an office should ensure that monitoring is provided by a separate health care professional not otherwise involved in the surgical or special procedure. Monitoring should include, when clinically indicated for the patient:
  - direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
  - pulse oximetry should be performed continuously (an alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness);
  - an electrocardiogram monitor should be used continuously on the patient;
  - the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes; and
  - the body temperature of a pediatric patient should be measured continuously.

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

##### Postoperative Care and Monitoring:

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

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

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

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

#### Equipment and Supplies:

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

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

#### Level III Guidelines

##### Personnel:

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

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

#### Surgical or Special Procedure Guidelines

##### Intraoperative Monitoring:

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

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

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

#### Postoperative Care and Monitoring:

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

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

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

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

#### Equipment and Supplies:

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

1. full and current crash cart at the location where the anesthetizing is being carried out (the crash cart inventory should include appropriate resuscitative equipment and medications for surgical, procedural or anesthetic complications);
2. age-appropriate sized monitors, resuscitative equipment, supplies, and medication in accordance with the scope of the surgical or special procedures and the anesthesia services provided;
3. emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours;
4. electrocardiographic monitor;
5. noninvasive blood pressure monitor;

6. pulse oximeter;
7. continuous suction device;
8. endotracheal tubes, and laryngoscopes;
9. positive pressure ventilation device (e.g., Ambu);
10. reliable source of oxygen;
11. emergency intubation equipment;
12. adequate operating room lighting;
13. appropriate sterilization equipment;
14. IV solution and IV equipment;
15. sufficient ampules of dantrolene sodium should be emergently available;
16. esophageal or precordial stethoscope;
17. emergency resuscitation equipment;
18. temperature monitoring device;
19. end tidal CO<sub>2</sub> monitor (for endotracheal anesthesia); and
20. appropriate operating or procedure table.

### Definitions

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

AAAHC – the Accreditation Association for Ambulatory Health Care

ABMS – the American Board of Medical Specialties

ACGME – the Accreditation Council for Graduate Medical Education

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

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

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

Anesthesia provider – an anesthesiologist or CRNA.

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

AOA – the American Osteopathic Association

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

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

ASA – the American Society of Anesthesiologists

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

Board – the North Carolina Medical Board.

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

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

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

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

FDA – the Food and Drug Administration.

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

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

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

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

Immediately available – within the office.

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JCAHO – the Joint Commission for the Accreditation of Health Organizations

Level I procedures – any surgical or special procedures:

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

Level II procedures – any surgical or special procedures:

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

Level III procedures – any surgical or special procedures:

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

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

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

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

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

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

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

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

OSHA – the Occupational Safety and Health Administration.

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

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

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

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

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

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

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

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

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

### Writing of Prescriptions

It is the position of the North Carolina Medical Board that prescriptions should be written in ink or indelible pencil or typewritten or electronically printed and should be signed by the practitioner at the time of issuance. Quantities should be indicated in both numbers AND words, e.g., 30 (thirty). Such prescriptions must not be written on pre-signed prescription blanks.

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

No prescriptions should be issued for a patient in the absence of a documented physician-patient relationship.

No prescription should be issued by a practitioner for his or her personal use. (See Position Statement entitled "Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist.")

The practice of pre-signing prescriptions is unacceptable to the Board.

It is the responsibility of those who prescribe controlled substances to fully comply with applicable federal and state laws and regulations. Links to these laws and regulations may be found on the Board's Web site ([www.ncmedboard.org](http://www.ncmedboard.org)).

(Adopted May 1991, September 1992) (Amended May 1996; March 2002; July 2002)  
(Reviewed March 2005)

## PHYSICIAN SCOPE OF PRACTICE

This Position Statement is intended to guide physicians who undertake to perform new procedures, use new technologies, or migrate into areas of practice for which they have not received formal graduate medical education. The Board recognizes that medicine is a dynamic field that, along with individual practices, continues to evolve. Economic pressures, business opportunities, lifestyle considerations, and access to care are all reasons that physicians move into new areas of practice. However, patient harm can occur when physicians practicing outside areas in which they were trained are unable to meet accepted and prevailing standards of care in the new practice area.

The informed, prudent care of patients begins with adequate training and the selection of appropriate patients. Follow up care and the ability to address complications is paramount. Physicians intending to expand their practice to an area outside of their graduate medical education should ensure that they have acquired the appropriate level of education and training.

It is the Board's position that all physicians, irrespective of their training, will be held to the standard of acceptable and prevailing medical practice as set forth in N.C. Gen. Stat. § 90-14(a)(6).<sup>\*</sup> It also may be prudent for physicians to confirm that their liability insurance provides coverage for the procedures they intend to perform.

<sup>\*</sup> In some instances, the Board may have provided relevant guidance to particular practice areas. See for example the Board's position statements on Laser Surgery, Office-Based Procedures, Care of the Patient Undergoing Surgery or Other Invasive Procedure, and Advertising and Publicity

## ATTACHMENT "D"

POSITION STATEMENT	ADOPTED	SCHEDULED FOR REVIEW	LAST REVISED/ REVIEWED/ ADOPTED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED
Office-Based Procedures	Sep-00	Mar-11	Jan-03				
Writing of Prescriptions	May-91	Mar-11	Mar-05	Jul-02	Mar-02	May-96	Sep-92
Laser Surgery	Jul-99	Mar-11	Jul-05	Aug-02	Mar-02	Jan-00	
Self- Treatment and Treatment of Family Members and Others With Whom Significant Emotional Relationships Exist	May-91	Mar-11	Sep-05	Mar-02	May-00	May-96	
Prescribing Legend or Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties	May-98		Nov-05	Jan-01	Jul-98		
Sale of Goods From Physician Offices	Mar-01		Mar-06				
Competence and Reentry to the Active Practice of Medicine	Jul-06		Jul-06				
Availability of Physicians to Their Patients	Jul-93		Jul-06	Oct-03	Jan-01	May-96	
Referral Fees and Fee Splitting	Nov-93		Jul-06	May-96			
Sexual Exploitation of Patients	May-91		Sep-06	Jan-01	Apr-96		
Care of the Patient Undergoing Surgery or Other Invasive Procedure	Sep-91		Sep-06	Mar-01			
The Physician-Patient Relationship	Jul-95		Sep-06	Aug-03	Mar-02	Jan-00	Jul-98
The Retired Physician	Jan-97		Sep-06				
Physician Supervision of Other Licensed Health Care Practitioners	Jul-07		Jul-07				
Medical Testimony	Mar-08		Mar-08				
Advance Directives and Patient Autonomy	Jul-93		Mar-08	May-96			
End-of-Life Responsibilities and Palliative Care	Oct-99		Mar-08	May-07			
Drug Overdose Prevention	Sep-08		Sep-08				
Policy for the Use of Controlled Substances for the Treatment of Pain	Sep-96		Sep-08	Jul-05			
Medical Record Documentation	May-94		May-09	May-96			

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Retention of Medical Records	May-98		May-09				
Capital Punishment	Jan-07		Jul-09				
Departures from or Closings of Medical	Jan-00		Jul-09	Aug-03			
Professional Obligations pertaining to incompetence, impairment, and unethical conduct of healthcare providers	Nov-98		Mar-10	Nov-98			
Unethical Agreements in Complaint Settlements	Nov-93		Mar-10	May-96			
What Are the Position Statements of the Board and To Whom Do They Apply?	Nov-99		May-10	Nov-99			
Telemedicine	May-10		May-10				
Contact With Patients Before Prescribing	Nov-99		Jul-10	Feb-01			
Guidelines for Avoiding Misunderstandings During Physical Examinations	May-91		Jul-10	Oct-02	Feb-01	Jan-01	May-96
Access to Physician Records	Nov-93		Sep-10	Aug-03	Mar-02	Sep-97	May-96
Medical Supervisor-Trainee Relationship	Apr-04		Nov-10	Apr-04			
The Treatment of Obesity	Oct-87		Nov-10	Jan-05	Mar-96		
Advertising and Publicity	Nov-99		Nov-10	Sep-05	Mar-01		
HIV/HBV Infected Health Care Workers	Nov-92		Jan-11	Jan-05	May-96		
Medical, Nursing, Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care	Oct-99		Jan-11	Oct-99			

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## Laser Surgery

It is the position of the North Carolina Medical Board that the revision, destruction, incision, or other structural alteration of human tissue using laser technology is surgery.\* Laser surgery should be performed only by a physician or by a licensed health care practitioner working within his or her professional scope of practice and with appropriate medical training functioning under the supervision, preferably on-site, of a physician or by those categories of practitioners currently licensed by this state to perform surgical services.

Licensees should use only devices approved by the U.S. Food and Drug Administration unless functioning under protocols approved by institutional review boards. As with all new procedures, it is the licensee's responsibility to obtain adequate training and to make documentation of this training available to the North Carolina Medical Board on request.

<i>Laser</i>	<i>Hair</i>	<i>Removal</i>
<i>Lasers are employed in certain hair-removal procedures, as are various devices that (1) manipulate and/or pulse light causing it to penetrate human tissue and (2) are classified as "prescription" by the U.S. Food and Drug Administration. Hair-removal procedures using such technologies should be performed only by a physician or by an individual designated as having adequate training and experience by a physician who bears full responsibility for the procedure. The physician who provides medical supervision is expected to provide adequate oversight of licensed and non-licensed personnel both before and after the procedure is performed. The Board believes that the guidelines set forth in this Position Statement are applicable to every licensee of the Board involved in laser hair removal, whether as an owner, medical director, consultant or otherwise.</i>		

It is the position of the Board that good medical practice requires that each patient be examined by a physician, physician assistant or nurse practitioner licensed or approved by this Board prior to receiving the first laser hair removal treatment and at other times as medically indicated. The examination should include a history and a focused physical examination. Where prescription medication such as topical anesthetics are used, the Board expects physicians to follow the guidelines set forth in the Board's Position Statement titled "Contact with Patients Before Prescribing." When medication is prescribed or dispensed in connection with laser hair removal, the supervising physician shall assure the patient receives thorough instructions on the safe use or application of said medication.

The responsible supervising physician should be on site or readily available to the person actually performing the procedure. What constitutes "readily available" will depend on a variety of factors. Those factors include the specific types of procedures and equipment used; the level of training of the persons performing the procedure; the level and type of licensure, if any, of the persons performing the procedure; the use of topical anesthetics; the quality of written protocols for the performance of the procedure; the frequency, quality and type of ongoing education of those performing the procedures; and any other quality assurance measures in place. In all cases, the Board expects the physician to be able to respond quickly to patient emergencies and questions by those performing the procedures.

\*Definition of surgery as adopted by the NCMB, November 1998:

Surgery, which involves the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the

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operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skills, post-operative management, and follow up.

(Adopted July 1999) (Amended January 2000; March 2002; August 2002; July 2005)

Self-treatment and treatment of family members and others with whom significant emotional relationships exist\*

It is the position of the North Carolina Medical Board that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. The Board strongly believes that such treatment and prescribing practices are inappropriate and may result in less than optimal care being provided. A variety of factors, including personal feelings and attitudes that will inevitably affect judgment, will compromise the objectivity of the physician and make the delivery of sound medical care problematic in such situations, while real patient autonomy and informed consent may be sacrificed.

When a minor illness or emergency requires self-treatment or treatment of a family member or other person with whom the physician has a significant emotional relationship, the physician must prepare and keep a proper written record of that treatment, including but not limited to prescriptions written and the medical indications for them. Record keeping is too frequently neglected when physicians manage such cases.

The Board expects physicians to delegate the medical and surgical care of themselves, their families, and those with whom they have significant emotional relationships to one or more of their colleagues in order to ensure appropriate and objective care is provided and to avoid misunderstandings related to their prescribing practices.

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

(Adopted May 1991) (Amended May 1996; May 2000; March 2002; September 2005)